Department for Education and Employment

GUIDANCE ON THE HEALTH ACT SECTION 31 PARTNERSHIP ARRANGEMENTS

CONTENTS

PURPOSE OF THE PARTNERSHIP ARRANGEMENTS

1. People want and deserve the best public services, which will protect and improve their health and well being. The Section 31 partnership arrangements in the Health Act 1999 have been developed to give NHS bodies and local authorities the flexibility to be able to respond effectively to improve services, either by joining up existing services, or developing new, co-ordinated services, and to work with other organisations to fulfil this. They can be used from April 2000. These arrangements build on existing joint working, but offer the opportunity for further innovative approaches to user-focused services. This implementation advice gives detail which supports the Regulations, SI 2000/617, which can be found on www.legislation.hmso.gov.uk, and the HSC/LAC Implementation of Health Act 1999 Partnership Arrangements to be found on http://www..doh.gov.uk/coin.htm, and on the joint unit website – www.doh.gov.uk/jointunit/index.htm.

2. The partnership arrangements are pooled funds and the delegation of functions – lead commissioning and integrated provision. These are key operational tools which will be used in the context of wider programmes of strategic objectives and priorities, often to resolve problems which have been identified through reviews of services. Objectives and priorities have been set out nationally in *Modernising Health and Social Care National Priorities Guidance 2000/1-2002/3*, the Local Government, NHS, Modernising Government, Public Health and Social Services White Papers.

3. Raising standards and improving the quality of services are integral to these objectives in both NHS and local authority services. The *New NHS and A First Class Service* introduced a range of measures to raise quality standards and decrease unacceptable variations in service. Standards will be:

   - **Set** by the National Institute for Clinical Excellence (NICE) and National Service Frameworks (NSFs), National Care Standards Commission.
   - **Delivered** locally by means of clinical governance, underpinned by professional self regulation and life long learning, and
   - **Monitored** by the Commission for Health Improvement; NHS and PSS Performance Assessment Frameworks and NHS Patients Survey.

4. Section 3 of the 1999 Local Government Act places a duty of best value on local authorities to make arrangements to secure continuous improvement in the way in which they exercise their functions, taking account of economy, efficiency and effectiveness.

5. Local priorities and objectives will have been identified in Health Improvement Programmes and through Community Planning. The operational flexibilities will facilitate work in Health Action Zones, Sure Start and other initiatives designed to ensure a more user focused, holistic approach to the provision of services. Given that all health related local authority functions are included, they can also be considered for use in Education Action Zones and neighbourhood renewal schemes, where the aim is to improve the health of

the community. Health related local authority functions are defined in Regulation 6.

6. Local partners will continue to be accountable for the functions which are part of the partnership arrangements. They will need from the outset to be clear about the aims and outcomes that are intended to be achieved by the partnership, as well as a range of other issues. These will be identified in the specified written agreement, (see Regulations) and in the notification process, see Appendix A.

THE POOLED FUND ARRANGEMENT - Introduction

7. A pooled fund arrangement provides an opportunity for the partners to bring money together, in a discrete fund, to pay for the services that are an agreed part of the pooled fund arrangement for the client group who are to benefit from one or all of the services. Instead of users being inconvenienced by disputes about health and local authority responsibilities, organisations will agree at the outset the range of health and local government services to be purchased and provided from a pooled fund.

KEY PRINCIPLE OF A POOLED FUND ARRANGEMENT

Regardless of what contributions NHS bodies or local authority(ies) commit to the pool, the pooled resource can be used on the agreed services as set out in the partnership arrangement. This will mean that the expenditure will be based on the needs of the users, and not on the level of contribution from each partner. This gives pooled budgets a unique flexibility, whilst being bounded by agreed aims and outcomes.

Who can contribute to a pooled budget?

8. The partners who agree and contribute to a pooled fund can be Health Authorities, Primary Care Trusts, and local authorities. An NHS trust which provides an NHS service covered by the pooled fund can also be a partner to the arrangement, and with the agreement of the Health Authority can commit funds.

9. The statutory agencies which can pool funds will work in concert with other individuals, such as users and carers, groups such as PCGs, and organisations, including the independent sector, schools, and Housing Associations, to develop proposals for the use of pooled funds.

What can be contributed?

10. Resources to be contributed include:-

- Those normally used for the services identified in the pooled budget
- The partnership grant can be used in a pooled budgets which relates to the provision of community care services, as long as its use will fulfil the conditions of the grant
- Minor capital items can be paid for out of the pool
- Major capital investment will be best managed by contributions to the host agency using the money transfer powers 28A and 28BB (see forthcoming separate Directions and Guidance). This will ensure a clarity of ownership, and liabilities. Rent, overheads and capital charges can be charged through the pooled fund. Initial agreements will need to set out how the contribution to a capital asset will be repaid in the event of the dissolution of the pooled fund, or a change in the way services are provided. The need to submit a business case through the NHS procedures will be based on the gross cost of the investment and the thresholds established for PFI developments.

How large should pooled funds be?

11. Pooled funds should be a tool for 'focused' flexibility: whilst no limit is put on their size, the likelihood is that partners will want to carefully consider what they are designed for. Pooled budgets can be used in conjunction with lead commissioning and integrated provision for specified areas where flexibility is required. Partners will want to consider carefully the amount of the total budget that they commit to a pooled fund, especially when they are using it in conjunction with the delegation of functions. They need to balance the amount of flexibility that they want to enable through a pooled fund against the risk of being able to fulfil all service needs.

Aims and Outcomes

12. The first key task is to identify and agree the shared aims, outcomes and targets for the pooled fund. The intention must be to enable flexibility in fulfilling the functions which are part of the pooled fund arrangement, and therefore the use of these funds. This is important to enable the accountability in the use of the pooled fund.

Level of Contributions

13. Each partner will agree a level of contribution. The contributions they commit can be used on any of the services in the pooled fund. The pool will be managed to fulfil the agreed outcomes within the budget that has been allocated.

Accountability

14. Each partner will retain statutory responsibility for their functions carried out under the pooled fund. So there must be a carefully worked agreement drawn up between the partners over governance arrangements which address accountability, how the budget is to work, and who manages expenditure and care packages. Comprehensive monitoring arrangements must be put in place that assure partners that their shared aims are being fulfilled. These and other issues which need to be determined and agreed locally are described elsewhere: see section on Governance .

Access to the fund

15. One of the advantages of the pooled fund will be that health and local authority staff identified in the agreement will be able to access and take decisions on the use of the resources in the pool, according to the process agreed locally between those staff and the pooled fund manager (see below). There will need to be an agreed process to authorise identified staff to do this. They will assess each individual in line with the eligibility criteria for services which are part of the agreed functions to be fulfilled. There are no legal obstacles to health staff using pooled funds in the exercise of local authority functions, and vice versa.

Hosting the fund

16. The pooled fund can be hosted and managed by a statutory partner, or it can be hosted by a statutory partner and managed on their behalf by another organisation contracted to do so in e.g. a primary care group could manage a pooled budget as a sub committee of the Health Authority. The host will provide the financial administrative systems on behalf of the partners, but will not incur any additional liabilities, except those that relate to the management of the budget. Although clinical services will normally be provided through the NHS, the pooled budget could also purchase services from the independent sector.

Charging

17. The partnership may well charge for specific services provided through the pooled budget, and this will need to be made clear to users as early as possible in the process: see section on Charging **.** To ensure that only local authorities are in receipt of income from the charges, the local authority should contribute on a gross basis. All the receipts for charges should be tracked back to them. Pooled funds will have no impact on the DSS benefit entitlement of individuals, as the services provided through the fund will be no different to those presently assessed for.

Managing the Pooled Budget

The Pool Manager

18. For each pooled fund, there will be a pool manager, who will be nominated from existing staff or appointed by the partners of the pooled fund and be sited in the host agency. Having clearly defined the services and eligibility criteria, and the intended clients, an agreed service plan will be drawn up. The pool manager will be accountable for managing the budget, and forecasting and reporting to the contributing partners (on behalf of the Accountable Officer of his organisation) on the outputs and outcomes and how far targets are being met. (In a local authority, this will be the Section 151 Officer; in a health authority, NHS trust, or Primary care Trust, it will be the Chief Executive.) Each authority remains accountable for the functions they are required to fulfil.

19. Given the nature of the pooled fund arrangement, it is suggested that partner bodies would account for their contribution to the pool, but the host will send monitoring reports on a quarterly basis, and at the year end prepare a memorandum of accounts within their statement of accounts which shows what has been received, and spent, and what remains. This memorandum of accounts will be sent to each of the partners at the year's end for inclusion in their statement of accounts. Records will need to be retained for at least six years.

20. Underspends which arise from unforeseen circumstances can be carried over to the following year within the pooled fund arrangement, although it should be noted that the Partnership Grant cannot be carried over. Arrangements to prevent and address overspends will need to be agreed by partners when establishing the pool; consideration of how to cover inflation, and how to manage efficiency savings will also need to be agreed.

Audit

21. The host for the pooled fund should arrange for the audit of the pool's accounts and this will need to be certified by the Auditor appointed by the Audit Commission in the annual return, under section 28 of the Audit Commission Act 1998(a). This will relate to the level of contributions made by each agency, and the total expenditure from the pool. This will be supported by evidence that management reporting to the contributing agencies identifies how far the pooled budget is fulfilling the aims, outcomes and targets that were agreed by the partners to the pool at the outset.

22. Where a contribution from the Partnership Grant has been made to the pooled fund, this contribution will be audited as part of the grant audit requirements.

23. A proforma is being developed which will identify the requirements for the Section 28 return. There will need to be a local agreement that this auditing is recognised as valid by all the partner agencies, which can attach a copy of the return to their own accounts.

24. The timing of the auditing for local authorities and Health Authorities is different. Those hosted by local authorities will need to be audited in time to fulfil the needs of the NHS auditing timescales; the additional cost that this may incur should be borne by the pooled fund.

25. The Audit Commission will be issuing guidance on the audit arrangements for pooled budgets.

26. Notification of each pooled fund will need to be made to the NHS Regional Office. See section on Notification .

DELEGATION OF FUNCTIONS – LEAD COMMISSIONING AND INTEGRATED PROVISION

LEAD COMMISSIONING

27. Lead Commissioning provides an opportunity to commission, at a strategic level, a range of services for a client group from a single point and therefore provide a level of co-ordination which improves services for users, and provides an effective and efficient means of commissioning. In effect, one agency takes on the function of commissioning of services which are delegated to them. Local authorities, Health Authorities or Primary Care Trusts may be partners in this. The partners must decide what functions will be delegated to the lead commissioner, and what money to transfer to finance the services commissioned. There will be a written agreement setting this and other key issues out, as identified in the Regulations.

28. Lead Commissioning is similar to Joint Commissioning, which many authorities have used in learning disabilities, mental health services, equipment services, etc. Authorities wishing to use the lead commissioner arrangement will need to notify the NHS Regional Office of their partnership. See section on notification . Those that have already established joint commissioning do not have to do this to continue to use their joint commissioning arrangement.

29. The Lead Commissioner will be able to continue to contract with a range of providers including those in the voluntary and private sector.

INTEGRATED PROVISION

Purpose of Integrated Provision

30. Integrated provision is an opportunity to resolve some of the difficulties experienced by users and, at the same time, to increase the quality of service by allowing different professionals to work within one management structure. Their ability to join up services will be enhanced and, in some cases, it may be possible for one member of staff to perform several tasks, to provide a seamless service for the user.

Who can provide?

31. The integrated provider may provide all the services itself, or it may contract with other providers, e.g. in the independent sector, for some of the work. The advantage lies in having a single management structure which brings about a more co-ordinated approach.

What organisations can be Integrated Providers?

32. Local authorities, Primary Care Trusts, and NHS Trusts will be able to be integrated providers. Local authorities and Primary Care Trusts will be able to be both integrated providers and lead commissioners, as they exercise both functions. If the partners wish to combine commissioning with providing, local authorities and Primary Care Trusts will be able to do this; alternatively, they can take on just one of the roles. ***Partner agencies which agree an integrated provider arrangement should select the most appropriate arrangement for the local situation.*** Their written agreement will set out, as specified in the Regulations, the key features of the partnership.

33. The service can also be provided through contract by an independent sector provider – from the voluntary or private sector, or an out-sourced local authority provider. The partners would still be the statutory authorities which have responsibility for the functions in the integrated provision, but they could organise the provision through another organisation including the independent sector.

What is meant by commissioning

34. The terms ‘commissioning’ and ‘providing’ reflect the distinction between the activities carried out by a health authority – strategic commissioning – and activities that are normally carried out by an NHS Trust – provision. However, this does not stop NHS Trusts from taking on ‘operational commissioning’ as in the activities of care managers within the context of care management and assessment. Thus Community Mental Health teams, and other multi-disciplinary teams can be sited in NHS Trusts as well as in local authorities.

35. The NHS or health-related local authority function will be delegated, and the agency which takes on the role will take responsibility for fulfilling the commissioning or integrated provision, although ultimate accountability remains with the originating body. The agencies that have delegated their responsibility monitor the effectiveness of the arrangement, through appropriate governance arrangements.

Resources

36. The delegation of functions will be accompanied by resources to purchase services. From the agreed funding, services will be commissioned or provided on behalf of each agency with their allocated budget; i.e., NHS money will be spent on NHS functions, and local authority money will be spent on the specific local authority functions for which it is intended. Lead Commissioning can be combined with integrated provision and be used with pooled funds. Where the delegation of functions operates with pooled funds,

partners will need to take care about where they want the flexibility of a pooled fund.

WRITTEN AGREEMENT AND NOTIFICATION

Written Agreement

37. The regulations specify that a written agreement is completed for each of the partnerships. This sets out the minimum requirements for an agreement. There will be other issues which partners will have to consider and make agreements to ensure clarity of understanding. Many of these issues are included in the Notification form, at Appendix A, which will be a summary of the detailed work that will need to be done locally.

Notification

38. The notification form should be used as a checklist. Partnership arrangements will have been consulted on, and the notification form will be sent to the relevant NHS Regional Office before the partnership is started. The responsibility for the partnership will rest with the local partners. The role of Regional Offices will be to check this, and give advice on the nature of the proposed partnership arrangements, and support where required. They will work closely with the local partnership, with SSI Social Care Regions and Government Offices for the Regions to ensure all relevant advice and input is available to local partnerships.

39. Partnership arrangements should fulfil the objectives identified in the Health Improvement Programme and those of a strategic nature will be included in Community Plans. As partnerships can be established at any time during the year, they could be supported by a statement in the HimP which confirms that Partnership Arrangements can be used to support strategic objectives; i.e. partnerships should not be held up to fit in with the planning process. They should be included in any other relevant plans, such as Joint Investment Plans, Children's Services Plans, etc. The effectiveness of the partnerships will be reported in Best Value Performance Plans and Performance Assessment mechanisms.

CONSULTATION

40. Before new arrangements can be put in place, it is important to consult and involve users and other stakeholders, and the Regulations require this as a condition (Regulation SI 2000/6i7 4(2)). Even with relatively small partnership arrangements, the benefit of involving users will outweigh the practical effort required, and is an opportunity for talking about the services. Others will be affected by the proposal - employees, other organisations, and the wider public. So thorough consultation will be an important part of the development of the proposal.

41. The size and scope of the consultation for the flexibility should be proportionate to the size and significance of the proposal. Consultation will need to be with groups and individuals and should include:-

- Users, carers, voluntary and support/voluntary groups representing the interests of the users and carers, and the Community Health Council or CHC (although, unless there is a major change of service, this does not fall within the formal consultation procedure of the CHC);
- Staff and their professional bodies and trade unions (where there is a transfer of staff, there needs to be sufficient time for the appropriate period of consultation – see TUPE regulations);
- Providers, including NHS trusts directly and indirectly affected, voluntary and independent providers;
- Other agencies, such as town and parish councils, and community organisations; and
- The general public.

Methods of Consultation

42. The partners will need to agree how the consultation will be done. It should take place as early in the process as possible so that users, staff (See section on workforce issues), providers and others are able to help develop the arrangement. It may be that one agency takes the lead in organising the consultative process. Partner organisations may well have established arrangements for consulting users, carers, and other interested parties, e.g. through best value processes or the preparation of the Health Improvement Programme process. Councillors, through their community leadership role, will have a significant part to play. These consultation arrangements, adapted as necessary, could be used to consult on the possibility of, or proposals for, new partnership arrangements. Alternatively, a separate consultation exercise might be more appropriate.

43. Good Practice Guidance published by the Cabinet Office, *'How to consult your users', (Service First)*, could be used as a guide to the process**.** Advice on consultation techniques is also available from LGA/IDA and from joint DETR Democracy Network publication, *'Guidance on enhancing Public Participation',* October 1998. See also *'Patient and Public involvement in the new NHS' http://www.doh.gov.uk/involve.htm.*
'Listen Up - Effective Community Consultation' Audit Commission: www.audit-commission.gov.uk

GOVERNANCE ARRANGEMENTS

44. The aims of good governance must be to ensure that public service bodies and the individuals within them (whether appointed or elected members, and officers) can provide an account of:-

- The improved performance in respect of the outcomes of the arrangement;
- Their operational objectives and priorities;
- Proper and efficient use of public money; and
- The quality of services provided.

They must also adopt a process which ensures proper accountability arrangements, and lay these open to appropriate external scrutiny. This will be built on the existing corporate governance arrangements of the agencies involved.

(Further guidance on how these can be responded to can be gained from 'Accountability, A framework for Public services 1998', published by CIPFA on 0207 543 5600, see www.cipfa.org.uk)

45. The legislation does not require any particular model of accountability. The Regulations suggest joint committees as an option (see Regulation SI 2000/617 10(2) but do not prescribe their composition. Partners must decide what form of governance best meets local needs and circumstances; the arrangements should be proportionate to the size of the partnership. Large committees to oversee small projects are likely to increase the inefficiency of the decision making process, and ultimately the service.

46. Partnership arrangements can offer an opportunity to involve local stakeholders in a much more creative way, and to enhance local community and democratic accountability. This means involving community representatives, providers, voluntary organisations, and users and carers, as well as the partners themselves, either directly in a Partnership Board, or if this makes it too unwieldy, in for a forum which advises and makes recommendations to the board. Decisions about the allocation of budgets will rest with representatives from those statutory authorities according to the level of delegation agreed locally.

Complaints and Joint Committees

47. The Regulations (Regulation SI 2000/617 10(3)) allow for a joint committee to take on the responsibility for hearing complaints at a formal level. This does not remove a person's rights to pursue their complaint under the present statutory arrangements, but would enable a complaint brought about a partnership arrangement to be dealt with appropriately.

Delegation and decision making

48. Local partners will need to be clear about what decisions the board or joint committee is able to make on their behalf. The amount of delegation given to a board will need to be judged in the context of the partnership arrangement. Once agreement has been reached, and the lead partner has taken on the functions, it will agree a protocol with the partners setting out the arrangements.

49. Health Authorities and NHS trusts will be required from April 2000 to provide a Controls Assurance Statement, signed by the chief executive which gives evidence that NHS organisations are doing 'their reasonable best' to manage, direct and control themselves so as to meet their objectives and protect employees, patients, the public and stakeholders against risks of all kinds. Controls assurance is complementary to developments in clinical governance and pooling of risk in the NHS. As partnership arrangements are introduced, health bodies will need to satisfy themselves that those arrangements satisfy

controls assurance requirements (see HSC(99)123 *Governance in the new NHS: controls assurance statements 1999/2000: risk management and organisational controls*) **.**

50. Local authorities' responsibilities fall within the governance arrangements under the Local Government framework.

PERFORMANCE MANAGEMENT

51. Local authorities and NHS health bodies have comprehensive performance management frameworks. These are similar and should be used as the basis for drawing up indicators for measuring the effectiveness of the partnerships.

52. Accountability should be demonstrated through the agreed measures. Targets should be set to enable staff and managers to consider how to improve their performance, and ensure that continuous improvement is part of the thinking integral to the plan. All those who introduce the new partnership arrangements must monitor their effectiveness, and use measures of performance to develop their work. There needs to be a range of performance measures which can capture a balanced view of progress, covers the interests of all stakeholders, and reflects the business activity as a whole.

53. The consistency of the data over the period of time of the partnership will need to be maintained if it is to give an accurate picture of the effect of the work of the partnership. The collection of this data and its use for monitoring and review will need to be agreed locally. Some of it will be appropriate for central returns. The DH is currently considering the possibility of the returns from partnership arrangements reflecting joint working more effectively with a common data set identified. There is currently a review of data required centrally, to see how far it would reflect the work of joint arrangements, where there are overlaps, and how to avoid double counting. This will have an impact on how partnership arrangements are performance managed, by e.g. NHS Regional Offices, and the SSI Social Care Regions.

CLINICAL GOVERNANCE

54. Clinical governance is defined as: -

"*A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish."*

It is about best practice and best process. It focuses on the use of evidence based practices delivered in a patient focused way to ensure high quality clinical services. The quality of the service, its outcomes and the processes should be easy to monitor and the outcomes comparable.

55. Clinical Governance identifies four main components:

- Clear lines of accountability for the overall quality of clinical care
- A comprehensive programme of quality improvement activities
- Clear policies aimed at managing risk
- Procedures for all professional groups to identify and remedy poor performance.

56. Clinical Governance applies to the treatment of NHS patients. Patients should expect to receive services which are part of a clinical governance system irrespective of where they are treated (e.g. independent sector, Local Authority etc.).

Guidance on Clinical Governance has been published. See HSC1999/065 'Quality in the new NHS' **.**

BEST VALUE

57. One of the important issues that will have an impact on the partnership arrangements will be the duty of best value on local authorities. The Local Government Act 1999 requires local authorities, from April 2000, to subject all the activities and services for which they are responsible to a best value review over a maximum of a 5 year period. Best value requires a service to be subjected to the four 'C's: challenge, compare, consult and compete.

58. Best value is about securing the best services. The expectation is that over the five-year period, all authorities will reach the level of performance achieved by the top quartile at the time the five-year period began. Some best value reviews are expected to be cross cutting, and there is therefore an opportunity to review services on a customer basis and/or across agencies, thus supporting joint working and partnership arrangements.

59. Best value will continue to operate for all local authority functions wherever they are sited; e.g. if local authority functions have been transferred to a Primary Care Trust, e.g. as an integrated provider arrangement, they will still be subject to best value. Even services which are subject to long-term external provider contracts must be subject to best value reviews as part of a partnership arrangement between private and voluntary sector providers and statutory agencies.

60. NHS bodies do not have the same duty of best value but can work in concert with local authority colleagues. The lessons of best value operating within a partnership arrangement should be absorbed by the NHS and may influence future patterns of service delivery. NHS bodies already work to a similar rigorous set of standards to ensure that the services it provides are of the required quality and value for money. There is already a strong performance management framework for the NHS, which mirrors many elements of the local government model.

61. The situation for non-clinical or support services is different. Compulsory Market testing will be replaced by a new policy of 'Value for Patients' which will be consistent with the principles of best value. Guidance on this topic is being prepared.

62. The best value approach to the review and comparison of services does, however, provide a good framework within which to consider the use of the partnership arrangements, particularly as it challenges the 'how' and 'why' of service provision. The partnership arrangements are designed to encourage better co-ordination at operational level to the user, and the most likely combinations of services will be clinical services with local authority services, although support services can be considered if a partnership including them fulfils the conditions. The implications of this are that the local authority function(s) contained in the partnership arrangement will be subject to best value, and the NHS clinical services will be subject to clinical governance arrangements. Any best value review which includes a partnership arrangement will however be able to take a holistic approach to its effectiveness as a means of providing a service to the user.

(The DETR has published guidance on best value, together with a document containing the Best Value Performance Indicators, against which local authorities and other best value authorities will set targets, published in their Best Value Performance Plan. This can be found at www.local-regions.detr.gov.uk/bestvalue)

INSPECTION ARRANGEMENTS

63. The aim would be that each partnership arrangement would be inspected as an 'organisational entity', and not separately for each of its functions. Inspections are co-ordinated from the centre, as far as this is possible, and discussions are already taking place to ensure planning and co-ordinating of inspections between the SSI and the Commission for Health Improvement (CHI) where there is a joint service involving health and social care. Further discussions will confirm the extent to which the CHI can co-ordinate with other inspectorates, such as OFSTED and the Audit Commission. The Audit Commission is already working jointly with SSI on Joint Reviews.

64. The CHCs will continue to have responsibilities in respect of the NHS part of the partnership arrangements i.e. the arrangements do not extend their monitoring role beyond their present statutory responsibilities.

ASSESSMENT ARRANGEMENTS AND ELIGIBILITY CRITERIA

65. Criteria for providing services included in a flexible arrangement will need to be developed and agreed by the partners. Criteria will have to be harmonised to ensure that they facilitate access to the services on offer. Some social services departments and health trusts have already done this. Partners will have an agreed set of joint criteria to enable a pooled budget to work effectively. The demands of integrated provision and lead commissioning will be similar. Ideally authorities may wish to develop one unified set of criteria that will cover all the user needs for which help will be provided. Forthcoming guidance for social services departments on developing eligibility criteria for social care to achieve fairer access to adult social care services further supports this approach and will require that their criteria are compatible with continuing health care criteria (this guidance will be published for consultation in spring 2000 and the final version issued in the autumn). Where the partnership has other functions, such as housing, then at a minimum, the different agencies will need to be clear about the alignment of their eligibility criteria.

66. There are opportunities to streamline the assessment and administrative processes through the use of the partnership arrangements. It may be possible for a trusted assessor role to be developed, in which one member of staff carries out an assessment on behalf of more than one agency. Assessment administrative processes could be aligned too, with the same documentation being used for the various aspects of service required. This will depend on the level of information sharing agreed with users. Whatever arrangements are agreed locally, all staff must have a full understanding of the assessment processes and the eligibility criteria and interpret them consistently.

DIRECT PAYMENTS

67. People receiving their social care through a direct payment can be included in a partnership arrangement. Where a health authority is contributing funds towards a package of care through a 28A transfer, the social services department may use these funds to make direct payments. Where it is not possible for direct payments to be made in lieu of health care, the arrangements for the delivery of the health care should be compatible with the increased independence which the direct payments are facilitating. See 'Policy and Practice Guidance' on Direct Payments, published 2000 on www.doh.gov.uk/scg/ccdp.htm; Community Care (Direct Payments) Act 1996

COMPLAINTS

68. Under current arrangements there are established procedures which users can use if they wish to complain about the service they have received. The introduction of the partnership arrangements covered by this guidance has the potential to confuse these arrangements. So, partnerships need to address this issue.

69. Ideally, complaints should be dealt with by the partnership itself, with the responsible manager taking the complaint through the informal processes, and a joint committee or sub-committee of the governance arrangement being able to take on a formal review, see Regulation SI 2000/617 (9(4)). A complaints protocol for a partnership arrangement needs to be agreed to identify the processes used.

70. However, there may be circumstances when a referral to one or more of the partners' parent bodies is necessary. In addition, a complainant may wish to use an existing statutory complaints procedure from the outset. The important point is that procedures need to be clear, and customers need to be informed of their rights, and kept up to date about how their complaint is being handled.

71. Good practice to be considered in coming to an agreement about the handling of complaints:-

- Involving users and carers and others such as Community Health Councils Citizens Advice Bureaux in developing the agreement;
- Good accessible public information about the process;
- The establishment of an independent local mediation/conciliation service;
- Identifying local access to independent advocacy, advice and support;
- Identifying timescales for the various parts of the process, including lodging complaints, accessing personal records, steps in the process, arrangements for appeals, and arrangements for monitoring outcomes;
- Clarifying boundaries with the disciplinary and grievance procedures of the partner agencies;
- Establishing an independent multi-agency review panel; and
- Training for staff who are involved with users, so that they are clear about the procedure(s).

72. The work of the Ombudsmen who consider complaints which have not been resolved locally is being reviewed. The increased level of partnership working is being taken into consideration in this review.

FINANCIAL ARRANGEMENTS

Agreement on resources

73. Agreements must include:-

- How much each partner will contribute;
- How much variation from year to year will be acceptable to the partners;
- How much variation in year is acceptable;
- How the partners anticipate that the budget will be kept to and what methods will be acceptable;
- How underspends and overspends are to be dealt with;
- How inflationary pressures are going to be managed;
- Monitoring arrangements in terms of the nature, timing and financial management information;
- Details of contracts the partnership enters into for the delivery of services; and

- Charging policies of the local authority within any partnership arrangements.

74. Resources such as accommodation, information systems, goods and services will need to be agreed between the partners.

Charges

75. NHS services are free at the point of delivery and nothing in the Health Act has changed this. Local authorities have a requirement to charge for some services, such as the provision of residential care, and the discretion to charge for other services, such as transport, leisure facilities, certain equipment, and non-residential social care. In agreeing partnership arrangements, agencies will have to consider how best to manage charging (where local authorities charge for services) and how to clarify the difference between charged-for and non-charged for services.

76. Neither the Health Act provisions nor this guidance alter existing arrangements for charging for non-residential services. There is no intention to increase or expand charging arrangements through the Partnership Arrangements. Existing guidance is given in a SSI Advice Note of January 1994. In entering into an arrangement, the partners will need to agree on the approach to be taken on charging. The areas where this will have the most significant impact will be:-

- Where a joint assessment takes place which blurs the distinction between charged-for and non-charged services, e.g. if one member of staff undertakes an assessment on behalf of health and social care
- Where a service is provided through an integrated provider, this may blur the distinction for the user.

77. If the partnership is to continue to charge for specific services provided through the pooled budget, this will need to be made clear to users at the start of the process. To ensure that only local authorities benefit from the income gained from the charges, the local authority should contribute on a gross basis. All the receipts for charges should be tracked back to them.

78. Partners will need to bear in mind that, where charging is retained, the arrangements will need to be carefully explained to users of services, to avoid any misunderstanding that NHS services are being charged for, especially when an NHS Trust is providing a service, part of which is being charged for. It will be critical that charging arrangements are properly explained at the outset of the assessment process. An indication of any charges to be incurred should normally be given in writing before users commit themselves to a care plan. The existing charging review or appeals mechanisms should be made clear to the user.

79. Some local authorities derive a significant amount of income from charging, but in others, or for particular services, it may be worth reviewing the cost of collecting the charges against the actual level of income gained. This should form part of the Best Value review of the services being considered.

V.A.T.

80. Local authorities and NHS bodies are governed by different VAT regimes. Local authorities can reclaim from Customs the VAT they incur in carrying out their statutory duties. NHS bodies, treated as government departments for VAT purposes, get refunds of tax on their contracted out services from Customs, but are recompensed through their funding for the VAT which cannot be reclaimed. The effect in financial terms is the same but in the new partnership situation it is important that participants are clear as to which VAT regime is governing their activity.

81. The leading or co-ordinating agency in any partnership notified under the Health Act 1999 will determine which VAT regime will apply. The lead agency will use their VAT regime for the partnership arrangement. The important principle is that the partnership will be established for co-ordinating services to users, and therefore will be sited in the place best able to take the lead in this. Partnerships **must not** be designed in order to avoid tax. EL(97)70 which outlaws tax avoidance within the NHS continues to govern the position.

82. It is not anticipated that there will normally be taxable supplies between those statutory agencies identified in the partnership arrangements. The partners are working together for a common purpose. If a charge is made to a patient or client the supply is to the person receiving the goods or services involved. When there is no charge, the activity is non-business.

83. For those activities in which the NHS takes the lead, it is expected that the NHS partner will carry out the required purchasing. If goods are involved, the NHS will not be able to recover VAT where the supply is non-business or exempt.

84. When the local authority takes the lead and places the order, receives the supply and no charge is made to the patient or client, then this will be a non-business activity. The local authority in these circumstances is able to recover VAT. When a charge is made to the patient or client, the activity may be business and subject to the normal rules.

85. However when a taxable supply is made between the “constituent partners” the lead agency must provide VAT invoices to the other partners for these supplies. The receiving health bodies, local authorities or other partners will treat these invoices under the normal VAT rules which apply to them.

86. This arrangement means that Trusts do not have to establish whether the activity in which they are involved as part of a partnership is under their Income Generating powers.

87. The Health Act 1999 and the associated Regulations made under it by the Secretary of State will lay new statutory obligations on both the NHS and local authorities when participating in partnerships. These may affect both the VAT liability of their supplies and the amount of input tax which can be recovered.

88. This advice is of an interim nature because the rules to govern partnerships formed under the Health Act 1999 are still under consideration. Customs, in association with the Department of Health, will discuss the VAT implications of the new arrangements with the specialist Joint VAT Policy Group in the first instance and subsequently with VAT committees of the Healthcare Finance Managers Association (NHS), and the Chartered Institute of Public Finance and Accountancy (Local authorities) with the aim of issuing more comprehensive guidance at a later date.

LOCAL AUTHORITY/HEALTH BODY JOINT STORES DEPOTS ETC.

89. Some Stores Depots are operated by a local authority and others by NHS bodies. The organisation which operates and maintains a joint stores depot is to charge VAT on the income received as payment for the services it supplies, such as salary costs and fuel and power. This charge is often made as a supplement to charge for stock or as a periodic charge. A local authority recipient of these services is able to reclaim this VAT under their special rules while an NHS body recipient may currently claim it as a refund under the Contracted out Service regime.

Stock Purchase

90. It is understood that only one participant in joint local authority/health body stores arrangements is responsible for accounting for an item of stock within its books. It is this participant which is to incur any VAT charged when the goods are taken into stock. When stock is ordered, arrangements should be made to ensure that the purchase invoice provided by the supplier to the operator is made out to the participant with accounting responsibility for the item in question. However Customs & Excise are willing to grant prior approval for an alternative to cover the few occasions where this may cause difficulty e.g. inability to use bulk purchase facility. This allows the store operator: -

i to initially purchase the stock;
ii to sell on those items for which the other party has accounting responsibility; and
iii for the items referred to at ii, to reclaim the equivalent VAT on the supplier's invoice as Input Tax having invoiced the other party and charged VAT as Output Tax.

VAT reclaims on stock items are available ONLY by a local authority recipient and ONLY when it has accounting responsibility. NHS operators of stores depots may wish to discuss any resultant VAT implications with the relevant local authority.

Hire of Stock

91. Where the participant with responsibility for accounting for an item of stock within its books "lends" or hires it to the other, e.g. to cover temporary shortages, VAT is not to be levied on any charge made because this is not seen to be a business activity for VAT purposes. When items are hired in

from outside contractors VAT reclaims are available ONLY to a local authority recipient and ONLY when it has accounting responsibility.

92. Because of the requirement to identify the source of the order for the equipment, it makes the use of pooled funds difficult, and it may be more appropriate to use aligned budgets with money transfer through 28A or 28BB to gain greater flexibility in the supply of equipment. to forthcoming directions and guidance.

93. Advice on specific VAT issues affecting the NHS can be obtained from the NHS Administration Unit, HM Customs & Excise, Dorset House, Stamford Street, London SE1 9PY (phone 0207 202 4008). Local authorities can consult their VAT control officer. Further advice on equipment stores can be accessed from russel.davis@hmce.gov.uk

BOUNDARIES

94. Lack of coterminosity of boundaries is often cited as a reason for partnerships being difficult to establish. It may certainly increase the number of partners that sign up to an arrangement. There is a general Government desire to move towards the alignment of local authority and other administrative boundaries where it is sensible to do so and is urging Primary Care Trusts to seek to be consistent and contained within existing HA and LA boundaries. Where existing Health Authority boundaries divide a 'natural community', and those boundaries will remain, Regulations enable those Health Authorities to arrange for one of them to be responsible for commissioning services for that community.

EXIT STRATEGIES, DISPUTES AND TERMINATION OF PARTNERSHIP ARRANGEMENTS

95. There will be a number of reasons why a partnership arrangement will need to be reviewed. These include fundamental reviews as a result of changes in customer preferences, best value reviews or inspection recommendations, the need for service changes, as the model of service develops and as strategies change. Reports to the joint board, or the individual agencies, will need to identify when this is necessary.

96. Partnerships may also be reviewed as a result of difficulties to do with the partnership itself. It will be important from the outset that it is clear how disputes will be handled. A protocol setting this out will be useful. This could include: -

- Timescales that would be required for changing the arrangement, or bringing it to an end;
- How disputes about budgets, quality of service, etc. would be handled;
- What will happen in the event of the termination of the entire partnership; staffing issues that arise – re-absorption of staff, maintaining continuity of service; asset allocation, responsibility for debts, etc.;
- Disposal, transfer of fixed assets; and
- Withdrawal of one of multiple partners.

WORKFORCE ISSUES

INTRODUCTION

97. The range of staff groups that could be involved in partnerships is great, as many health service functions (see Statutory Instrument No. (5), and health related local authority functions can be involved in partnerships. This means that administrative, clerical and support staff will potentially be involved as well a wide range of professional staff. Thus, although some staff groups are highlighted for particular comment, this is not meant to imply that other staff cannot be involved. However, given that the core of each arrangement will be health, this is the focus of much of the description in this section. This guidance assumes that partnership arrangements will be developed within the framework of existing guidance, such as *'Working Together'*, the new NHS Human Resource framework.

98. The size of Partnership Arrangements will vary according to the needs of the local situation. Partners will need to consider the organisational impact that arises from large schemes as well as that of small schemes. The latter may affect staff by isolating individuals from their professional team, and could make the recruitment and retention of staff problematic.

What will be the impact of the partnership arrangements on staff?

Pooled fund

99. Pooled funds will, according to the local agreement, and level of delegation, enable nominated staff from partner agencies to be able to access the fund to purchase services. The eligibility criteria for use of the pooled fund will have been agreed in order to set it up, and the normal assessments will take place. The possibility of staff being able to use joint assessment records, do joint assessments, and in some cases, establish 'trusted assessment', where one person assesses on behalf of other service areas, is likely to arise, at least for some of the services. This will have significance for training, education, and the development of core competencies, as well as the need for clarity in accountablities for fulfilling tasks.

Lead Commissioning and Integrated Provision

100. The delegation of functions from one statutory agency to another is likely to lead to the transfer of those staff who perform those functions. There are two likely scenarios. The transfer may consist of closer co-ordination of the present services, in which case it will require the movement of staff from one organisation to another, by whatever means is considered to be the most appropriate to the stakeholders involved. The transfer may be part of a re-development of services, as a result of a best value review, for instance. In each case, the human resource issues they raise will reflect the size of the partnership, the level of change and the number of functions involved.

101. The impact of delegating functions to a body or authority that has not previously managed those functions before will need to be considered carefully. Although there has been a significant level of joint working between health services and local authorities, the partnership arrangements are intended to enable much closer co-ordination. In particular, both lead commissioning and integrated providing will lead to a single management structure. In both cases, there is a delegation of functions, and therefore potentially of staff.

102. Primary Care Trusts will be able to be partners under Section 31 of the Health Act. As they are established, they are developing plans to ensure that they can manage human resources activities effectively. This is included in guidance *'Working together: Human Resources guidance and requirements for Primary Care Trusts'*.

103. The different cultures that staff are accustomed to, and the methods of working, training, supervision, policies and procedures, will all require thought to ensure that the staff involved feel that they can 'fit' in to the new organisational arrangement. The expertise of all the staff will need to be valued if the team(s) are to work effectively, and gain trust in each other.

Health Improvement Programme

104. Health Improvement Programmes (HImPs) will develop coherent planning to improve health and health services, and to reduce health inequalities. Health bodies, local authorities, independent sector organisations and the community are to be involved in devising them. Partnership arrangements will be set in the context of the strategies that are agreed locally. Each HImP will need to be supported by a comprehensive Human Resource and Organisational Development action plan, addressing workforce implications and development needs – and endorsed by all participating organisations. This will need to take into account the impact of the introduction of partnership arrangements.

105. Because there has been, until the introduction of the partnership arrangements in the Health Act, a restriction on the functions that local authorities and health bodies have been able to perform on each other's behalf, there has been a general assumption that certain staff cannot be employed by each agency. Now that functions can be delegated, staff normally associated with those functions can be employed in the authority which is taking the lead in performing those functions.

106. Independent organisations have provided services across the range of functions that are provide both by health bodies and local authorities. They are therefore well placed to be considered in the development of integrated provision. This is an important consideration in maintaining the variety of sources of provision to ensure sufficient choice for the user, and is at the discretion of the local partners. If a decision is made to use the independent sector, this should be dealt with according to the principles of best practice, market testing, PFI guidance, and with TUPE legislation.

Establishing a Partnership Arrangement

Consultation

107. The Regulations (Statutory Instrument 2000/617 No. 4(2)) require consultation with all the relevant stakeholders in developing a Partnership Arrangement. The guidance makes it clear that key stakeholders are the staff and staff groups and organisations. It is important to consult and work with staff from the earliest possible time to consider and develop the arrangement. Where there are existing bodies that can be consulted which are representative of the staffing groups that are likely to be affected, then it will be appropriate to use those. However, the partnerships may cover a broader range of staff groups, and consideration will need to be given to fora that can be brought together to fully represent those staff across the agencies involved. Local authorities have Joint Staff Consultative Committees, whilst most NHS organisations have Joint Negotiating Committees. The human resource guidance for the establishment of PCTs, *HSC 1998/139,* requires health authorities to set up Human Resource fora. It may be that either of these models could be the basis for activity to establish partnership arrangements.

108. Many staff will be able to contribute a valuable input to the development of partnership arrangements, and may well come up with proposals themselves about a better co-ordination of services. Operational staff are often in a good position to see what the barriers are, and how they can be overcome. They, like all the other stakeholders, will be able to make suggestions about the better delivery of services.

Developing the appropriate human resource arrangements for the Partnership Arrangements

109. At the outset, it may be easier to arrange the transfer of staff through secondments. Certain staff groups may wish to preserve their route to career and professional development by being seconded. However, in the medium to long term, other arrangements are likely to be required in order to develop the stability of the partnership arrangement, and create a more consistent approach.

110. Staff may be transferred under TUPE arrangements: see ‘Statement of practice on staff transfers in the public sector’ published by the Cabinet Office. This makes clear that transfers of staff within the public sector should be conducted on the basis that TUPE will apply, unless there are genuinely exceptional reasons for their not doing so – for example where an activity is an essentially new or one-off project. The Government expects all public sector organisations to adopt this statement of practice.

111. As Partnership Arrangements develop they may also need to take on new staff to fulfil new roles, and as vacancies arise, it will be important to establish the appropriate terms and conditions under which they are employed. It could be that the terms and conditions of the statutory agency taking the lead in the arrangement, or a modified version of those existing terms and conditions could be used, although this is up to the discretion of the local partners,

working in agreement with staff bodies. These arrangements will be based on job evaluation schemes already developed.

112. The NHS in partnership with the Staff Side is developing a new national pay system. Proposals for the new pay system were published in *Agenda for Change* which was published in February 1999. If negotiations are successful, implementation of the new system is scheduled to start from April 2001. *Agenda for Change* proposes three pay spines, with increases determined by the two Review Bodies and a single pay negotiating council for all other staff replacing the current separate Whitley Councils and other negotiating bodies. For further detail please see HSC 1999/227.. Local authorities have developed a single status scheme for staff.

113. Policies that govern the activities of staff within the partnership arrangements will need to fulfil the statutory employment requirements. They will also need to be harmonised across the health bodies' and local authorities' present policy and procedural arrangements. This includes issues such as Health and Safety, rights of access to Occupational Health, and a response to the Public Interest Disclosure Act 1998.

114. Staff seconding or transferring will use their existing disciplinary and grievance procedures and these will need to be updated in order to reflect the management arrangements in the partnership. In particular, the procedures should clearly specify the bodies of appeal and representations rights. It is expected that the policies should reflect best local practice and should be agreed with trade union representatives. The General Whitley Council and the ACAS code of practice provide a sound basis for developing local procedures.

115. Where people have been seconded to a partnership, their pension rights will not be affected in any way. Where staff are transferred, even under TUPE arrangements, they cannot usually remain members of their organisation's scheme. Individuals have a number of options about their pension rights which will need to be fully explained to them. Broadly comparable pension arrangements must be made available and differences between schemes may require adjustments to the overall remuneration package. Bulk transfer of pension rights should be available to protect those who wish to transfer their accrued pension rights to their new employer's scheme, and these will be offered to provide year for year service credit. Where there are new staff, the agreement on the terms and conditions will need to include arrangements about pensions.

116. Some staff have special terms and conditions which relate to their job role. This includes those with mental health officer status, and section 46 General Whitley Council (GWC) Handbook (Superannuation Act 1972, Regulations 1980) payment of superannuation and compensation benefits on premature retirement. NHS staff are able to make claims against the NHS Injury benefits scheme. These rights will need to be recognised within the partnership arrangements.

117. In all cases, these are matters for local negotiation and agreement, ideally through the local HR forum, and the overriding principle is that the overall level of trade union facilities must not be reduced as result of service reconfigurations or reviews of facilities arrangements.

Maintaining and Raising Standards

Management Supervision

118. The operational managers who are responsible for the partnership arrangement will need to ensure that staff are working to the standards and the objectives that have been set by the partners to the arrangement. Supervision of staff will be key to this. Managers will need to be given specific training to effectively manage this supervision, given that they are likely to be managing staff from a number of backgrounds and professions. A consistent supervision policy will enable teams to work better together, even if the arrangements for their transfer to the partnership are different.

119. Operational managers should be responsible for all the day to day activities of their staff, even if they are seconded from other agencies. They will deal with disciplinary, grievance issues, and all other policy issues to do with staff. If there were a serious employment matter, this would need to be dealt with by the employer.

Clinical Governance (see section on clinical governance)

120. The key to ensuring appropriate clinical governance arrangements will be to ensure that, where staff are not managed by the NHS, there are explicit agreements about how these staff will meet the expectations of clinical governance. There should be clear written statements identifying responsibilities and accountability arrangements for the provision of clinical services.

Professional Supervision

121. Where arrangements are made for staff to work outside their normal professional setting, either on secondment to another agency, or following a transfer, there should be prior discussion and agreement as to arrangements for professional supervision. The member of staff concerned should be confident that a source of professional advice and support is available, from a named person.

Training and Development

Shared Learning

122. Shared learning across health services and local authorities will need to underpin the partnership arrangements. Given the wide range of functions that can be delegated, in time this is likely to involve many staff, some of whom will not have a history of working so closely together. The shared learning they take part in will be crucial to the success of schemes, both to develop an understanding of the different roles that people perform, and to

develop a common language on which to base those activities. In some areas, especially health and social care, joint training is well established; a training plan will be important for all partnership arrangements.

123. Partnerships also offer an opportunity to develop training plans that take a more comprehensive approach to the training needs of all staff. Although the funding mechanisms are different, there could be the potential for a range of basic joint training for all staff, on top of which specialist training and updating could be given.

Partnership Competencies

124. A range of competencies will be needed by managers and professionals to enable successful partnership working, such as negotiation, networking and communication skills, influencing without control, user responsiveness and performance management. Occupational standards provide a useful framework for common understanding of these competencies across organisational boundaries. The National Training Organisations will be examining the need for further development. Occupational standards can also be used as a common language helping those from different backgrounds and training routes to understand the roles of others. In the meantime, information on standards, competencies and requirements for particular occupations and sectors are available from NTOs and from the regulatory and awarding bodies for the relevant professions. Information on NVQ units may also be searched via the national database available on subscription from the Qualifications and Curriculum Authority (QCA).

The role of Education and Training

125. Education and training at national and local levels will have a significant part to play in developing competencies, training and promoting lifelong learning activities which take account of the opportunities offered in the partnership arrangements.

126. Education Consortia bring together representatives of health authorities, Trusts, primary care employers, social services and non NHS employers to determine their workforce planning needs and to commission the appropriate education and training required to support local healthcare services. Education consortia are in a strong position to develop partnership arrangements through the use of pooled budgets to fund joint training needs.

127. Some of these arrangements will involve staff whose education and training needs are not normally within the remit of education consortia. Partnerships between consortia, the Learning Skills Councils, NTOs, such as the Training Organisation for Personal Social Services (TOPSS) and Healthwork UK, the Health Care National Training Organisation, will need to play a significant role in ensuring these needs are met.

Continuing Professional Development

128. Training will be a crucial element to developing successful partnership arrangements in the provision of high quality services. *Modernising Health and Social Services: Developing the Workforce* (HSC 1999/111:LAC(99)18) includes two objectives for Health Service organisations which are particularly relevant:
    - Service developments should be supported by education and training strategies
    - More investment in education and training programmes and collaborative activities, which bring together health and social staff. *Social Services Training Support Programme* (LAC(99)10) reminded local authorities that Training Support Grant can be used to support joint training and shared learning initiatives.

129. Some staff will already have organised training arrangements, as set out in such documents as *'Continuing Professional Development: Quality in the new NHS',* some staff will have had little access to training.

130. Partnership arrangements will not change the responsibilities for the separate staff groups for their continuing professional development. Where training opportunities for students may be created through partnership arrangements, these will need to be agreed with the requisite professional bodies. Education consortia will need to consider the implications of the partnership arrangements, both in terms of education commissioning, and student placements. Useful documents for reference include: -

    - *Medical Staff - The Recruitment of Doctors and Dentists in Training* under cover of HSC 228/98
    - *Nursing Staff* – Collaboration will assist in the provision of effective programmes that integrate practice and theory. Practice Placements for students on pre-registration nursing programmes are already provided across both the health and social care sectors, including the independent and voluntary elements of those sectors. The creation of partnership arrangements offer the potential to explore these opportunities further. Consortia were required to provide an action plan as outlined in *Making a difference to nursing and midwifery pre-registration education* HSC 1999/219**,** and examples of partnership working as outlined in the joint NHS Executive/CVCP publication *Good Practice in the recruitment and retention of nurses in higher education institutions and joint principles***.**

Contacts

QCA Enterprises: 0207-50905555; e mail info@qca.org.uk
Healthwork UK: The Health Care National Training Organisation; tel 0207 692 5550; E Mail; office@healthwork.co.uk
TOPSS England: The National Training Organisation for Social Care, 26 Park Row, Leeds LS1 5QB; e mail: topssengland.enquiries@ccetsw.org.uk; Tel 0113-245-6417; TOPSS Training Strategy (Consultation draft) 'Modernising the Social Care Workforce'; www.topss.uk
English National Board for Nursing, Midwifery and Health Visiting 1997, *'Standards for Approval of Higher Education Institutions and Programmes',* London. This is available on a CD-ROM produced by the Board which can be purchased from the Board's Publications Department, English National Board for Nursing, Midwifery and Health Visiting, Victory House, 170 Tottenham Court Road, London W1P OHA, telephone 0207 391 6314.

'Post Registration Studies Programme'*; on website http://www.enb.org.uk/199905.htm*

Appendix A

NOTIFICATION FORM
SECTION 31 PARTNERSHIP ARRANGEMENTS
(to be completed for each partnership arrangement and sent to appropriate NHS Regional Office)

1. NAMES OF THE STATUTORY PARTNERS	**SIGNATURE OF THE REPRESENTATIVE OF EACH PARTNER**
2. DATE OF AGREEMENT	
3. DATE WHEN PARTNERSHIP IS INTENDED TO START	
4. NAME OF OFFICER RESPONSIBLE FOR PARTNERSHIP	
5. WHICH FLEXIBILITIES ARE BEING USED?	

6. What are the intended aims, outcomes and targets set by the partnership?	
7. How will the partnership lead to improvement in services as defined by the strategies in the Health Improvement Programme?	
8. Who has been consulted, and how has this been done? If there is to be a movement of staff, have staff and their unions been consulted?	
9. How is/are the local authority functions going to contribute to a health outcome through this partnership?	
10. How does this promote existing local joint working?	
11. Who will be the services users? Define in terms of e.g. client group, age range, PCG, PCT, LA, HA, NHS trust area.	
12. In financial terms, how much resource is to be committed to the partnership by each partner?	
	PLEASE TICK

13. Are the signatories, following consultation, satisfied that arrangements for the following are robust? • **Governance arrangements, including, decision-making processes, monitoring, accounting and auditing, operational and management arrangements** • **When the partnership arrangement will be reviewed** • **Human resources, including staffing, terms and conditions, policies** • **Information sharing** • **Identification of functions that are included in the arrangement** • **Eligibility criteria and assessment processes** • **Complaints** • **Financial issues such as Charging and VAT implications. Has the appropriate office of HM Customs and Excise been consulted on the arrangements to be adopted? Has the partnership arrangement been discussed with the relevant auditors?** • **How disputes will be resolved, and how will partners resolve changes in the arrangement, or dissolve it?**	

Appendix B

FUNCTIONS THAT CAN BE INCLUDED IN SECTION 31 PARTNERSHIP ARRANGEMENTS

Health Authority functions

1. The functions of NHS bodies in providing or securing the following services under the National Health Service Act 1977(a) –

Services under sections 2 and 3(1) which are

- hospital accommodation
- accommodation for the purpose of any service provided under the 1977 Act
- medical, dental, nursing and ambulance services
- other facilities for the care of expectant and nursing mothers and young children, in order to fulfil their health needs which are appropriate as part of the health service
- facilities for the prevention of illness, for people who are ill, or recovering from illness; ***this includes rehabilitation services, and services intended to avoid admission to hospital*** which are appropriate as part of the health service
- other services needed for the diagnosis and treatment of illness.

EXCLUSIONS

Specifically excluded are surgery, radiotherapy, termination of pregnancies, endoscopies, the use of Class 4 laser treatments, and other invasive treatments, and emergency ambulance services.

Services under section 5(1), (1A), (1B) of schedule 1.

1. These relate to medical and dental inspections of school age children, and children in LEA education post 16. They also are about giving advice, examination and treatment on contraception, substances and appliances.

2. The functions of Health Authorities and Primary Care Trusts under sections 25A to 25H and 117 of the Mental Health Act 1983. These are the functions related to after-care and supervised after care; to applications for supervised after care, review of and ending after care.

Education Act (1996)

3. Help provided to a Local Education Authority in connection with assessing and meeting the special educational needs of children.

The Local Authority functions are: -

Social Services

Social services functions specified in Schedule 1 to the Local Authorities Social Services Act 1970.

4. Schedule 1 has been updated as amendments and additions have been made to social services functions in a number of statutes. (It is a long list of statutory functions set out in rank order of the statutes, which have been re-ordered here.

Children and Families

5. A broad range of responsibilities within the Children Act, 1989:- welfare reports; consent to application for residence orders for children taken into care; family assistance orders; provision of services to support children and families, including accommodation, after care for Children Looked After; care and supervision; protection of children; functions relating to community homes, voluntary homes and voluntary organisations, registered children's homes, private arrangements for fostering children, child minding and day care for young children; research and returns of information; functions relating to children accommodated by NHS Trusts, LEAs or in residential care, nursing or mental nursing homes or in independent schools.

(Children Act 1989)

6. Adoption services

Adoption Act

7. The protection, care, control, treatment, and remand of children who face criminal and summary proceedings.

(Children and Young Persons Act 1933, Children and Young Persons Act 1963, Children and Young Persons Act 1969)

8. Help provided to a Local Education Authority in connection with assessing and meeting the special educational needs of children.

(Education Act 1996)

9. The supervision of a ward of court
   (The Family Law Reform Act 1969)

10. Care of expectant and nursing mothers and young children, prevention, care and aftercare; home help and laundry facilities
    (National Health Service Act 1977)

Legislative functions for Adults

11. Provision of residential care, welfare services for people with disabilities, visual and hearing impairment, (for persons aged 18 or over for the elderly, ill, disabled etc.) or who have mental health problems. Recovery of costs of providing certain services. Temporary protection of property belonging to people in hospital or accommodation provided under Part III of the Act; paying expenses of LA officer acting as receiver for certain patients; prosecution of individuals for failure to maintain a person, giving false statements, and obstructing a person with power of entry and inspection.

(National Assistance Act, 1948)

12. Assessment of needs for community care services.
    (National Health Service and Community Care Act 1990)

13. Direct Payments -Making of assessments and payments to individuals for purchasing community care services.
    (Community Care Direct Payments Act 1996)

14. Assessment of ability of carers to provide care
    (Carers (Recognition and Services) Act 1995)

15. The provision of facilities for disabled people, including those with sensory disabilities to be employed or work under special conditions
    (Disabled Persons (Employment) Act 1958)

16. Identifying the need for, and publishing information about welfare services, provision of certain services, and providing certain information to the Secretary of State.
    (Chronically Sick and Disabled Act 1970)

17. The welfare and accommodation of mentally disordered people
    (Mental Health Act 1959, Registered Homes Act)

18. Guardianship, and the exercise of the functions of the nearest relative of a person with mental health problems, including those where there is an application and reference to Mental Health Tribunals.
    (Mental Health Act, 1983)

19. Representation and assessment of disabled persons
(1986 Act)

20. The promotion of welfare of old people

21. Financial and other assistance to voluntary organisations
    (Health Services and Public Health Act, 1968)

22. Co-operation in relation to homeless people and people threatened with homelessness
    (Housing Act 1985, 1996)

EXCLUSIONS

Certain sections of the National Assistance Act, 1948. These are about charging for accommodation, and the recovery of costs.

Sections 6 and 7B of the Local Authorities Social Services Act, 1970, which relate to the appointment of a Director of Social Services, and the Social Services Complaints Procedure.

Adoption Panels (Adoption Act, 1976)

Inspection of children's homes

Duties under Part 1 of the Registered Homes Act 1984 (registration of residential care homes)

Approved Social Worker duties (Mental Health Act 1983)

Other Local Authority functions

Local Education Authority

22. Functions of local education authorities under the Education Acts.

Leisure and Sport

24. Providing or securing the provision of sports and leisure facilities.

Housing Authorities

25. Functions of local housing authorities under Part I of the Housing Grants, Construction and Regeneration Act 1996; these include the provision of Home Repair Assistance for small scale works, which is not means tested but which is only available to the elderly, disabled, infirm or those receiving income-related benefits. It is limited to £2,000, or £4,000 over a three year period.

26. Functions of local housing authorities under Parts VI and VII of the Housing Act 1996 (2): these include: -

- the operation of the housing register and housing allocation scheme,
- the duty of the local authority to provide advisory services about homelessness and prevention of homelessness,
- financial assistance to voluntary organisations concerned with homelessness on matters relating to homelessness,
- duties to accommodate persons in priority need and in cases of threatened homelessness.

Other functions include: -

27. Providing a youth service;

28. Providing environmental health services- functions of waste collection authorities under the Environmental Protection Act 1990; these include: -

- arranging the collection of household waste in its area
- arranging the collection of commercial waste in its area if requested to do so by the occupier of commercial premises
- delivering for disposal all waste it collects to such places as the waste disposal authority directs
- preparing waste recycling plans
- requiring or arranging for the removal of illegally deposited waste.

29. Functions of waste disposal authorities under the Environmental Protection Act 1990; these include: -

- arranging for the disposal of controlled waste collected in its area by the waste collection authority
- providing places for residents to deposit their household waste, and the disposal of waste so collected.

30. Duty to provide Public Libraries (public Libraries and Museums Act, 1964)

31. Functions of local highway authorities; - functions of local highway authorities; these include functions under section 39 of the Road Traffic Act 1988 whereby local authorities must prepare and carry out a programme of measures designed to promote road safety and may make contributions towards the cost of measures for promoting road safety taken by other authorities and bodies.

32. Functions under section 63 of the Transport Act 1985**(**1**)** (passenger transport) and section 93 (travel concession schemes).

(1**)** 1985 (c.67).

INFORMATION SHARING BETWEEN THE NHS AND LOCAL AUTHORITIES

SECTION 1 – INTRODUCTION AND OVERVIEW

1. This guidance has been written principally about sharing information between social services and NHS bodies. The principles can be applied across other local authority services, but there will be further guidance on the issues involved with this broader range of services later in 2000 (see Section 6). Such guidance was first promised in *Information for Health: An Information Strategy for the NHS 1998-2005,* published in September 1998.

2. The guidance can be used in all partnership arrangements but has been developed to assist the establishment of the new partnership flexibilities in section 31 of the Health Act 1999: pooled budgets, lead commissioning and integrated provision.

3. The provision of effective procedures and management structures is covered in **Section 2** of this guidance. The issue of resources to support this work is also addressed here briefly. Work on mapping exactly what information needs to be exchanged for which purposes is described in **Section 3**.

4. The issues relating to sharing the right information in a legally and ethically acceptable way are covered in **Section 4**. The key principle to follow is that the information provided in confidence by service users to one agency should, in normal circumstances, only be disclosed to other agencies with the consent of the patient/client concerned. People understand the need for staff to share information in the interests of integrated services, and they will generally give their consent to it as long as they have confidence in the agencies providing the services. There must be a clear and shared understanding of how information will be protected and used.

5. Various barriers have led to concerns and to uncertainties about the circumstances of information sharing. The key issues here are related to the preparation of staff, having effective procedures for people to work together, and having inter-agency protocols and contracts. These can ensure that boundary-crossing processes work smoothly and are effectively managed, and they are covered in **Section 5**.

6. **Section 6** focuses on the need to develop a coherent multi-agency IM&T strategy and on the necessary supporting technical framework.

7. The table below lists the recommended actions and indicates which section in this guidance covers the actions in more detail.

ACTION	WHO	COVERED IN
Establish clear leadership for information sharing and confidentiality/security	Each agency	Section 2
Establish local "confidentiality" groups to include representatives from each agency and local user representation	Information community	Section 2
Ensure management and accountability procedures are in place and that s to other relevant areas, e.g. complaints, are in place	Information community	Section 2
Map information flows and identify which information needs to be shared	Information community	Section 3
Review procedures and ensure compliance with the Data Protection Act 1998 and other relevant legal requirements	Each agency	Section 4
Establish procedures for informing patients/clients about proposed information sharing	Each agency and/or information community	Section 4
Ensure that required 'consent' procedures are in place	Each agency	Section 4
Develop and agree inter-agency protocols to cover appropriate information communities	Information community	Section 5
Adopt and disseminate a code of practice to all staff involved in information sharing	Each agency	Section 5
Ensure staff are prepared and appropriately trained	Each agency	Section 5
Develop multi-agency local IM&T implementation Strategies	Information Community	Section 6
Establish procedures for joint system, data and file management for joint patient/client records	Information community	Section 6

SECTION TWO – MANAGEMENT ISSUES

8. Guidance issued last year on Local Implementation Strategies (LIS) for *Information for Health* stressed the importance of involving both managerial and operational staff from social services in strategy development, recognising that **effective 'on the ground' joint working needs high profile senior management support** if it is to be successful. The information sharing that is needed to underpin joint working requires similar senior input.

9. **It is essential that the accountability and management arrangements that govern information sharing are both robust and transparent.** It is important to clearly identify interface management responsibilities at an early stage, and to give adequate priority to joint management tasks to overcome operational difficulties and cultural barriers.

10. Within the NHS a network of **Caldicott Guardians**, generally board level clinicians, are acting as the focus for information sharing issues where the information to be shared refers to patients who have provided information in confidence. Local authorities will want to consider adopting similar procedures for information referring to their clients and, e.g. appoint a senior member of the Social Services management team, preferably with current responsibilities for policy and strategy, to act as a Caldicott guardian for their services.

11. **Local information communities should also establish 'confidentiality' or 'information sharing' groups**, with each agency being represented and all local Caldicott Guardians or equivalents being included. Representatives of service users and staff with technical skills might also contribute usefully. These groups will need to maintain close s with the local LIS Management Board and might be an extension of that Board.

Individual Responsibility and Self-Management

12. **Front line staff are responsible for ensuring that the data they gather is accurate, coherent, as comprehensive as is needed, and is properly recorded**. Observance of rules and guidelines should be an integral part of each professional's standards and self-management practices. **The focus of information sharing also needs to be wider than the operational exchange between health and local authority staff**. In particular, the interface with users, and the wider public, needs careful management. Seamless care includes seamless information s with users.

Local Implementation Strategy

13. NHS funding for IM&T developments has been made available to support the implementation of *Information for Health* through the development of Local Implementation Strategies (LISs). All Health Authorities are expected to submit, by April 2000, a full LIS outlining their plans for health community. Local Authorities as key stakeholders should be involved closely in the development of these plans.

14. Local authorities working with health authorities might find scope to bid for support from NHS modernisation funding for information projects designed to improve joint services. Some of the special and specific grants for social services also include some provision for authorities to make improvements in their information systems. The current spending review will consider all potential areas of investment and the Chancellor will announce the results in July.

SECTION THREE – MAPPING THE USE OF INFORMATION

15. Information about patients/clients will be either individual or aggregated. **It is important that what is shared between individuals or agencies is adequate for the intended purpose, and not excessive or insufficient.**

16. Where there is an imperfect understanding of information flows, it may be helpful to bear in mind that information that is flowing into the agency may prove the most straightforward to map. Those mapping the flow and use of information may best determine this by interviewing key staff to establish what patient / client related information they routinely receive, hold and send, both electronically and on paper. Outputs from computerised systems should be reviewed by contacting the system manager and local information analysts to find out what outputs/reports are regularly run.

17. A blank questionnaire that can be used to gather information about information flows and usage can be found on the Caldicott website at www.doh.gov.uk/confiden/index.htm. Flows to and from other agencies need to be discussed with the agencies concerned within information sharing working groups or as part of the work of confidentiality groups put in place to support local work on *Information for Health*.

18. A separate section 1 of the questionnaire should be completed for each 'role' or staff group receiving a data flow, even if it is identified that two different roles are receiving the same data flow. This is important because it is the individual role's use of the data flow that will govern what information is required, whether it can be anonymised etc. Questionnaires should be completed in enough detail to support external review of the information use.

19. Whilst this guidance focuses on sharing information in health and social care, it has wider applications. It is important to remain aware that 'working together' applies across many areas of local authority functions and health services, not just social and community care. **Agencies need to comprehend and, through clear and agreed protocols, exercise a degree of control over the use of information they supply to others**, particularly when that information has been obtained from another source. Consideration will also need to be given to research proposals involving joint information or information obtained from other agencies. (Guidance on the framework for a protocol can be found on the Caldicott guardian website.)

Using the Minimum Necessary Information: Need to Know

20. Although the mapping of information sharing needs to be given priority to support information sharing, it is also important to remember that **information provided in confidence by patients/clients should not be used inappropriately for internal purposes**. Such use is likely to be unlawful. Section 2 of the questionnaire (provided at the website address above) should be completed for any flows, external or internal, that are seen to hold more information than needed. Guidance on the process of reviewing data flows is provided with the questionnaire on the Caldicott website.

21. The purpose of section 2 of the questionnaire is to help establish whether a flow should be changed. Further interviews are likely to be needed with the sender of the data flow and any other recipients to establish what other users of the data flow require with the aim of identifying as many different options for change as possible. These may include:

- **redesigning system print outs, reports and screens to hide unnecessary data;**
- **changing message definitions in electronically exchanged flows.** This will require both the sending and receiving system to be changed and may be costly;
- **redesigning printed forms to remove name and address or other unused identifiers,** replacing them with less revealing identifiers, such as NHS Number. Guidance on forms can state 'provide name if NHS Number is not known' (see section 6 for more on the NHS number);
- **leaving the flow unchanged, but improve the security of the flow (e.g. not using faxes, encrypting the data, etc);**
- **stopping the flow from going to recipients that do not need it;**
- **splitting flows that go to multiple recipients** so that each one only gets the data they need;
- **possible options for longer term strategic action to change the flow include:**
    - implementation of electronic s for the data flow area; and
    - revisiting the procedures and systems supporting the whole business area.

22. A degree of judgement is required when determining whether an improvement in privacy gained by removing data items outweighs the cost, risk and impact of making the change. It is important to bear in mind that it is a Data Protection Act requirement **that data should only be exchanged if it serves a purpose**. If however, it is not thought to be justifiable to change a flow in current circumstances, due to prohibitive cost or impact on staff, consideration should be given to the possibility of reviewing the flow at a later point.

23. For each data flow recommended for change a more detailed proposal should be drawn up. Agreement to this proposal should be sought from the sender, recipient(s), Caldicott Guardian or equivalent, and senior management.

24. If the sender or recipient of the data flow is from another organisation negotiations will need to take place, with the Caldicott Guardian or equivalent senior manager consulting their counterpart in the sending organisation.

SECTION FOUR – LEGAL AND ETHICAL REQUIREMENTS

25. This Section identifies background principles, stemming from legislation, the common law and public policy, and identifies or flags up sources of best practice guidance. **Compliance with legal requirements is the necessary starting point for information sharing, though ethical considerations may at times require even higher standards to be met**. Whilst this Guidance summarises important aspects of the law, it is not a substitute or replacement for existing guidance on legal requirements.

26. It is necessary to distinguish between information capable of identifying an individual and aggregated/anonymised data derived from such information. It is also necessary to distinguish whether information has been provided in confidence and whether it relates to a living individual.

27. From 1 March 2000 the key legislation governing the protection and use of identifiable patient/client information (Personal Data) held by the NHS and other services will be the **Data Protection Act 1998**. (DPA) The DPA 98 does not however apply to information relating to the deceased. The arbiter as to whether activity is consistent with the Act will be the Data Protection Commissioner (currently the Data Protection Registrar). The key requirements of the data protection principles that must be complied with are listed at Annex 1.

28. Personal Data must be processed (e.g. collected, held, disclosed) fairly and lawfully (looking to the common law and other legislation) and processing must satisfy one of the conditions in schedule 2 of the Act. Sensitive data, e.g. health information, is further protected in that processing must satisfy at least one of the conditions listed in schedule 3 of the Act.

29. Although provided by case law rather than legislation it is also important that all staff working in health and local authority services - whether from health, LAs or the independent sector - are aware that they are subject to a **common law duty of confidentiality**, and must abide by this.

30. The **duty of confidentiality** requires that unless there is a statutory requirement to use information that has been provided in confidence, it should only be used for purposes that the subject has been informed about and has consented to. This duty is not absolute, but should only be overridden if the holder of the information can justify disclosure as being in the public interest (e.g. to protect others from harm). This may apply particularly in child protection cases. Decisions to disclose information without consent should be documented and the public interest justification clearly stated. Whilst it is not entirely clear under law whether or not a common law duty of confidence extends to the deceased, the Department of Health and professional bodies responsible for setting ethical standards for health professionals accept that this is the case.

31. Information is provided in confidence when it appears reasonable to assume that the provider of the information believed that this would be the case. It is generally accepted that most (if not all) information provided by patients/clients is confidential in nature. The duty of confidence only applies to identifiable information and not to aggregated data derived from such information or to information that has otherwise been effectively anonymised – i.e. it is not possible for anyone to the information to a specific individual.

32. The following paragraphs summarise what is understood to be best practice in respect of the above legal requirements. Agencies should adhere to best practice in order to ensure that users can have confidence and trust in the ways their personal information is handled.

33. Any living person who is the subject of personal information held by a health body or social services authority has a **right of access** to that data, though in some circumstances access to health data may be constrained or denied. Where there is a joint personal record both sides must have arrangements in place to provide access. Health and social services authorities are already likely to have procedures in place for dealing with requests for access and should consider whether these are appropriate for handling jointly held data, or whether new integrated procedures are needed. It is essential that staff responsible for dealing with access requests are provided with guidance on the detailed legislative requirements.

34. The **Access to Health Records Act 1990** provides rights of access to the health records of deceased individuals for their personal representatives and others having a claim on the deceased's estate. In other circumstances, disclosure of health records relating to the deceased should satisfy common law duty of confidence requirements (see below).

35. Unless there is a sufficiently robust public interest justification for using identifiable information that has been provided in confidence - and this is something on which an organisation may wish to seek advice - then the consent of the individual concerned should be gained (deceased individuals may have provided their consent prior to death).

36. In circumstances where it is clear that the individual has been given sufficient information to make an informed decision about whether or not to consent, consent can sometimes be implied e.g. sharing information within a care team when an individual presents him/herself for care. However, for wider purposes divorced from the immediate environment of care it may be unwise to rely on implied consent as it is difficult to be certain in any particular case whether or not it has been obtained. The law is not clear on this point, but if an information community opts to rely on implied consent to justify information exchange, this should be supported by clear and effective policies for informing patients/clients about what may happen to their information and any objections should be respected.

37. The Data Protection Act 1998 provides, in schedules 2 and 3, additional conditions that must be met before personal data can be processed fairly and lawfully – schedule 2 for all personal data, schedule 3 as an additional test for

sensitive data e.g. sex life and physical or mental health.
These apply whether or not the information was provided in confidence.

38. ‘Consent’ is one way of meeting the requirements of schedule 2. With sensitive personal data ‘explicit consent’ is required to satisfy the requirements of schedule 3. Although explicit consent is not defined in the Act, in practice, this almost always requires the provision of sufficient information to support an informed decision and a signed consent form. Health and local authorities will, for many purposes, be able to satisfy other conditions and therefore will not require any form of consent. However, it is important to note that disclosure will still be unlawful and thus be in breach of the Data Protection Act 1998 if it does not satisfy the common law requirements in respect of information provided in confidence.

39. All organisations need to be aware of the circumstances in which they are required to obtain:

- *explicit consent* where they cannot satisfy any of the other conditions in schedule 3,
- *consent* (which may arguably be implied where an individual has been effectively informed of the possibility of a disclosure taking place and hasn’t objected) where they cannot satisfy any of the other conditions in schedule 2.

And where information is held under a common law duty of confidence:

- consent (identical to that required to satisfy the schedule 2 condition) where the disclosing body does not wish to rely upon a public interest defence to justify disclosure.

The need for clarity in this area will be particularly acute where the local information community has opted to rely on implied consent to satisfy the common law requirement.

40. It will be necessary for agencies using joint information to ensure that their procedures for obtaining and recording consent are consistent, and agreed by all parties.

41. Children who are judged to be able to understand what they are consenting to (*Gillick competence*) may provide consent. Where a person under 18 is not judged competent to consent on their own behalf, then consent may be given by a person with parental responsibility for the child, which could be a guardian ad litem (Children Act 1989). Note that children who are able to consent in this way are entitled to the same duty of confidence as an adult and in these cases disclosure of confidential information to their parents must satisfy the common law requirements.

42. Where it is judged that an individual is unable to provide consent (for example due to mental incapacity or unconsciousness), other conditions in schedule 2 and 3 of the Data Protection Act 1998 must be satisfied (processing will normally need to be in the *vital interest* of the individual). Whilst under current law no-one can provide consent on behalf of an adult in order to satisfy the common law requirement, it is generally accepted that decisions about

treatment and the disclosure of information should be made by those responsible for providing care and should be in the best interests of the individual concerned.

SECTION FIVE – PREPARING TO SHARE INFORMATION

43. **Ideally,** the transfer of all confidential information should be governed by clear and transparent protocols that satisfy the requirements of law and regulate working practices in both the disclosing and receiving organisations**.** Protocols**, which should be developed by local confidentiality or information sharing working groups,** need to be agreed by the senior management of each organisation involved**.**

44. **The local information community is likely to include:**

- The Health Authority
- NHS Trusts
- Primary Care Groups and emerging Primary Care Trusts
- Social Services
- Education Services
- Voluntary Sector Providers
- Private Sector Providers
- Housing
- Youth Offending Teams (YOTs)
- Crime and Disorder Local Responsible Authorities (LRAs).

45. Advice on devising a protocol can be found on the Caldicott Guardians website. The Department of Health is currently sponsoring work to develop more detailed best practice guidelines and example and will make these available in due course.

Training Staff

46. **It is essential that all staff who have access to patient/client information are aware of their responsibilities in respect of confidentiality and security, and of the procedures and standards that have been agreed and incorporated within information sharing protocols**. This is a key organisational responsibility. It needs to be addressed through the preparation and dissemination of a concise and easily understood code of practice, supported by training where appropriate, including training of new staff. Local information communities might productively consider joint training sessions in this area. Guidance on implementing an awareness programme for staff is provided in the February 1999 publication *Ensuring Security and Confidentiality in NHS Organisations* which can be obtained from the NHS Information Authority, 15 Frederick Road, Edgbaston, Birmingham B15 1JD. Whilst this guidance was produced for the NHS the content is relatively generic.

47. The NHS has a specific IM&T Training and Education Strategy that will increasingly focus on the skills needed to successfully implement *Information for Health*. A General Social Care Council (GSCC) is to be established in April 2001 to set standards for professional training and performance in social care, supported by the new National Training Organisation (NTO), which has already published its first training strategy for consultation.

48. **It is worth noting that the need for training is not confined to the handling of patient/client information**. The effective development and use of management information is another area that may warrant particular attention, especially if there is evidence of a failure to get to grips with internal management information requirements and national reporting standards.

SECTION SIX – MANAGING THE TECHNICAL AGENDA: FUTURE WORK

49. The NHS IM&T strategy, *Information for Health*, seeks to improve the use of information throughout the NHS by providing high quality person based information at the point of care delivery. Although there is currently no equivalent strategic framework for social care or other local authority functions, there are a number of initiatives being taken forward on the social care side which are addressing similar issues.

50. A core component of this strategy is the development of electronic records and communications to support the delivery of care. A number of demonstrator sites are being set up to show how electronic records can improve patient care. A key part of this work will involve the need to share information across organisational boundaries. This current guidance prepares the ground for developments in this area.

51. Local Health Communities are currently preparing their Local Implementation Strategies (LIS) to support *Information for Health*. The process of developing the full LIS should be seen as a key component in the Government's aim of improving the health of the population and modernising the health and social care system. All key stakeholders, including Social Services will be directly involved in the planning and decision making processes. The plans are due to be completed by 31 March 2000, and will be subject to formal evaluation and on-going review.

52. Local Authority Directors of Social Services should ensure that they have made appropriate arrangements for both their information management and social care professionals to contribute to the development of the full LIS at both management and working levels, and that their Local Authority colleagues are aware of their role as a key stakeholder in the development of the full LIS.

53. The National Service Frameworks, Long Term Service Agreements and Health Improvement initiatives require different agencies to work together to deliver a person-centred approach providing continuity of care and service planning. There are already many good examples of joint working and these need to be supported by developing guidance that can be built upon locally and incorporated into the local LIS.

54. A working group is currently being set up with representation from all interested parties to look at cross-Departmental and cross-Government issues around information sharing and to take forward the technical aspects of the information sharing agenda. The group will also need to consider:

- Access to the *NHSNet;*
- Access to knowledge bases through the National electronic Library for Health (NeLH), and the ed (developing) electronic Library for Social Care (eLSC), which is being funded by the Dept to act as a focal point for the dissemination of best available evidence for social workers. The target date for full launch is 2002; information about the NeLH can be found at www.nelh.nhs.uk and about eISC at www.nisw.org.uk/elsc;

- The use of the NHS Number as the unique patient identifier across all service providers (public, private and voluntary sector);
- Information sharing with a wider community (housing, education, private organisations and voluntary groups, police, etc);
- Proposals for development of an Information Strategy for Social Care, including the creation of an electronic (social) care record.

55. In Social Care, development of an information strategy for social services is being explored. This would include the creation of a National electronic Library for Social Care (NeLSC); and putting in place electronic records in social services, which, with health service electronic records, would increase the scope for data sharing, and therefore more seamless care.

56. Detailed guidance which supports this developing technical agenda will be available later in the year. In the meantime further information can be obtained from the Information Policy Unit, Tel 0113 254 5969.

APPENDIX 1: DATA PROTECTION ACT 1998

From 1 March 2000 the key legislation governing the protection and use of identifiable patient/client information (Personal Data) held by the NHS and/or social services will be the **Data Protection Act 1998**. The key requirements of the data protection principles that must be complied with are:

1. Personal Data must be processed (e.g. collected, held, disclosed) fairly and lawfully (looking to the common law and other legislation) and processing must satisfy one of the conditions in schedule 2 of the Act. Sensitive data, e.g. health information, is further protected in that processing must satisfy at least one of the conditions listed in schedule 3 of the Act (schedules 2 and 3 are reproduced in Appendix 3 of this guidance).
2. Personal Data shall be obtained and processed only for one or more specified and lawful purposes
3. Personal Data shall be adequate, relevant and not excessive in relation to the specified purpose(s)
4. Personal Data should be accurate and kept up to data
5. Personal Data shall not be held longer than is necessary
6. Processing must be in accordance with the rights of the individual (in particular the right of access to information held)
7. Appropriate technical and organisational measures should protect Personal Data
8. Personal Data should not be transferred outside of the EU unless adequate protection etc is provided by the recipient.

SCHEDULE 2 - CONDITIONS RELEVANT FOR THE PROCESSING OF ANY PERSONAL DATA

1. The data subject has given his consent to the processing.

2. The processing is necessary -

   (a) for the performance of a contract to which the data subject is a party, or
   (b) for the taking of steps at the request of the data subject with a view to entering into a contract.

3. The processing is necessary for compliance with any legal obligation to which the data controller is subject, other than an obligation imposed by contract.

4. The processing is necessary to protect the vital interests of the data subject.

5. The processing is necessary-

   (a) for the administration of justice
   (b) for the exercise of any functions conferred on any person by or under any enactment
   (c) for the exercise of any functions of the Crown, a Minister of the Crown or a government department
   (d) for the exercise of any other functions of a public nature exercised in the public interest by any person.

6. (1) The processing is necessary for the purpose of legitimate interests pursued by the data controller or by the third party or parties to whom the data are disclosed, except where the processing is unwarranted in any particular case by reason of prejudice to the rights and freedoms or legitimate interests of the data subject.

   (2) The Secretary of State may by order specify particular circumstances in which this condition is, or is not, to be taken to be satisfied.

SCHEDULE 3 - CONDITIONS RELEVANT FOR THE PROCESSING OF SENSITIVE PERSONAL DATA

1. The data subject has given his explicit consent to the processing of the personal data.

2. (1) the processing is necessary for the purposes of exercising or performing any right or obligation, which is conferred or imposed by law on the data controller in connection with employment.

   (2) The Secretary of State may by order-
   (a) exclude the application of sub-paragraph (1) in such cases as may be specified, or
   (b) provide that, in such cases as may be specified, the condition in sub-paragraph (1) is not to be regarded as satisfied unless such further conditions as may be specified in the order are also satisfied.

3. The processing is necessary-
   (a) in order to protect the vital interests of the data subject or another person, in a case where-

   i) consent cannot be given by or on behalf of the data subject, or,
   ii) the data controller cannot reasonably be expected to obtain the consent of the data subject, or
   (b) in order to protect the vital interests of another person, in a case where consent by or on behalf of the data subject has been unreasonably withheld.

4. The processing -

   (a) is carried out in the course of its legitimate activities by any body or association which-
   i) is not established or conducted for profit, and
   ii) exists for political, philosophical, religious or trade-union purposes,
   (b) is carried out with appropriate safeguards for the rights and freedoms of data subjects,
   (c) relates only to individuals who either are members of the body or association or have regular contact with it in connection with its purposes, and
   (d) does not involve disclosure of the personal data to a third party without the consent of the data subject.

5. The information contained in the personal data has been made public as a result of steps deliberately taken by the data subject.

6. The processing-
   (a) is necessary for the purpose of, or in connection with, any legal proceedings (including prospective legal proceedings),
   (b) is necessary for the purpose of obtaining legal advice, or
   (c) is otherwise necessary for the purposes of establishing, exercising or defending legal rights.

7. (1) The processing is necessary -
   (a) for the administration of justice,

(b) for the exercise of any functions conferred on any person by or under an enactment, or
(c) for the exercise of any functions of the Crown, a Minister of the Crown or a government department.

(2) The Secretary of State may by order -
(a) exclude the application of sub-paragraph (1) in such cases as may be specified, or
(b) provide that, in such cases as may be specified, the condition in sub-paragraph (1) is not to be regarded as satisfied unless such further conditions as may be specified in the order are also satisfied.

8. (1) The processing is necessary for medical purposes and is undertaken by-
(a) a health professional, or
(b) a person who in the circumstances owes a duty of confidentiality which is equivalent to that which would arise if that person were a health professional.
(2) In this paragraph "medical purposes" includes the purposes of preventative medicine, medical diagnosis, medical research, the provision of care and treatment and the management of healthcare services.

9. (1) The processing-
(a) is of sensitive personal data consisting of information as to racial or ethnic origin,
(b) is necessary for the purpose of identifying or keeping under review the existence or absence of equality of opportunity or treatment between persons of different racial or ethnic origins, with a view to enabling such equality to be promoted or maintained, and
(c) is carried out with appropriate safeguards for the rights and freedoms of data subjects.

(2) The Secretary of State may by order specify circumstances in which processing falling within sub-paragraph (1)(a) and (b) is, or is not, to be taken for the purposes of sub-paragraph (1)(c) to be carried out with the appropriate safeguards for the rights and freedoms of data subjects.

10. The personal data are processed in circumstances specified in an order made by the Secretary of State for the purposes of this paragraph.