THE SCOTTISH OFFICE

NHS
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National Health Service in Scotland
Management Executive

St. Andrew's House
Edinburgh EH1 3DG

Dear Colleague

COMMUNITY CARE: JOINT PURCHASING, RESOURCE TRANSFER AND CONTRACTING: ARRANGEMENTS FOR INTER-AGENCY WORKING

15 September 1992

NHS Circular DGM(1992)1 is amended

Addressees

For action:
General Managers, Health Boards

General Manager, State Hospital

Chief Executives, NHS Trusts

For information:
Chief Executive Designate, NHS Trusts

General Manager, Health Education Board for Scotland

General Manager, Common Services Agency

To be copied to Unit General Managers for action

Summary

1. I enclose a letter which sets out new arrangements aimed at facilitating the transfer of resources from Health Boards to Local Authorities at the same time as responsibility passes to Local Authorities for the care of people who do not need continuing specialist medical and nursing care.

Action

2. The Management Executive will shortly discuss with Boards their plans for transferring inappropriately placed people into the community. The attached letter defines the financial framework. To inform these discussions, Boards should have prepared programmes showing how their plans will be implemented.

3. This letter should be copied to Unit General Managers and all staff involved in community care.

Yours sincerely

DON CRUICKSHANK
Chief Executive

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National Health Service in Scotland
Management Executive

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Copy to: Chief Executives, NHS Trusts
Directors of Social Work
Directors of Housing
General Manager, Health Education Board for Scotland
General Manager, Common Services Agency
Appropriate Professional and Voluntary Bodies

15 September 1992

Dear Colleague,

COMMUNITY CARE: JOINT PURCHASING, RESOURCE TRANSFERS AND CONTRACTING: ARRANGEMENTS FOR INTER-AGENCY WORKING

1. This circular describes the arrangements by which Health Boards and Social Work Departments can make better use of the resources currently committed to the community care client groups by joint purchasing, cash transfers and other inter-agency mechanisms. It includes the arrangements which will govern the transfer of money from a Health Board to a local authority or a voluntary organisation in order to provide community based facilities for patients transferred from long-term institutional care to care in the community. This circular should be read in association with Scottish Office Circulars on Community Care Planning (SW1/1991, HHD/DGM(1991)1) and Assessment and Care Management (SW11/1991, HHD/DGM(1991)40), which set out the Government's expectations for the development of community care.

Introduction

2. The policy of care in the community is designed to enable vulnerable people who require professional care to live in their own homes and communities as far as possible. An important component of this policy is that patients inappropriately accommodated in hospitals should be able to live in the community, and that inappropriate admissions to institutional care should be prevented. The substance of this policy is not new. It has been endorsed by successive Governments over many years. However, the White Paper "Caring for People" and the NHS and Community Care Act 1990 introduced a fundamental change in the arrangements by assigning to local authorities the lead responsibility for implementing the policy. This means that local authorities are responsible for co-ordinating the assessment of community care needs and planning how to meet those needs both in respect of individuals and care group populations. Health Boards will, however, continue to have a key role in community care, not just in meeting the health care needs of all those in the community but also in contributing to the assessment of all their needs, participating in community care planning and collaborating with local authorities in securing community care services.

3. The aim of the policy is, therefore, twofold. First, to shift the provision of care away from institutions and towards facilities based in the community provided not only by local authorities but also by the private and voluntary sectors and by the primary health care services.

Although there has been a shift in the pattern of care towards care in the community, it is both possible and desirable to tilt the balance further. There is still too large a volume of institutional provision and insufficient day care, domiciliary care and other forms of care in the community. Over the next decade the Government intends to secure the creation of a wide variety of additional facilities in the community and the consequent closure of a high proportion of the existing institutional provision. The timetable and the means for achieving this will have to be agreed locally between health boards, local authorities and other organisations involved in the provision of care in the community. But there should be no doubt about the importance the Government attaches to achieving a significant shift in the balance of care by the end of this century. By then the Government expects to see substantial shifts in responsibilities; in particular it expects that by the end of this decade local authorities will be responsible for providing care to the great majority of people with learning difficulties who are currently cared for by the NHS and that health boards would continue to have responsibility only for the small number of patients in this category with significant and continuing specialist medical and nursing needs. Accompanying this shift in responsibilities there will be a significant shift in resources from health boards to local authorities.

4. The second main objective of the policy is to achieve a pattern of services which meets the needs of individuals and which are well co-ordinated both at the level of planning and provision. The fact that local authorities now have the lead responsibility for the provision of care in the community does not mean that they have the sole responsibility. Many individuals will need health care provided either by the general practitioner and the primary care team or organised by health care providers, as well as a range of social care services provided by the local authority social work department and possibly also specialised forms of housing. In some cases services will be provided directly by the responsible statutory agency. In other cases they will be provided by voluntary bodies or the private sector under the terms of an agreement with the relevant statutory agency. But, so far as possible, the client should be unaware of the range of service providers involved in assessing and meeting their needs. To them it should appear to be a single co-ordinated response to their needs.

5. These objectives will be achieved only if the main statutory agencies involved - health boards, social work authorities and housing authorities - are agreed on their long-term objectives, on how these are to be achieved and what the priorities are; and if they have financial, planning and service-delivery mechanisms which support the achievement of care in the community. Planning agreements and community care plans provide the means by which agreement can be reached on these matters and on how the resource transfer mechanisms discussed in this circular can best be utilised to achieve agreed long-term aims.

Role and Responsibilities

6. Before decisions can be taken on which agency is responsible for providing care to a particular client or patient and thus for paying for it, health boards and local authorities need to have reached agreement on their respective roles and responsibilities in relation to different client groups. The negotiation of planning agreements and community care plans provides the means for doing this. While clarity of roles is important, this process should not develop into an argument over

boundaries which prevents the development of community care. There are areas of care where the distinction is difficult to draw and where varying local arrangements have developed through good joint working. There should be no unilateral withdrawal from such arrangements. There should be flexibility and collaboration in the interests of achieving the best outcome for clients and patients rather than a narrow definition of boundaries. The vital importance of a co-operative approach to joint working is discussed further in paragraph 18.

7. People who require continuing specialist medical and nursing supervision are clearly the responsibility of the NHS. It therefore falls to the NHS to meet the full costs of their care, although the provision of that care may be undertaken by an NHS Trust, a directly managed unit, a voluntary body or a private sector company. The Government's expectation is that increasingly such patients will be accommodated not in hospitals but in small-scale facilities which provide an environment approximating as closely as possible to living at home and which are located in the community.

8. The question whether or not to discharge a patient from the care of a consultant is clearly a matter of clinical judgement. Boards should ensure that clinicians regularly review their patients to establish whether they require to remain under their care. Where a consultant considers that a patient's medical condition is such as not to require continuing specialist medical care and that the patient can therefore be discharged from the care of the NHS, the fact that he or she has financial assets above the DSS thresholds and will not, therefore, be eligible, on discharge for DSS benefits is not a reason for keeping a patient in hospital. Although this needs to be applied sensitively, it is an important principle which should govern the approach taken by health boards.

9. Where patients do not need continuing specialist medical and nursing care, health boards will normally expect patients to be discharged into the community where they may be the responsibility of either the local authority or a voluntary or private sector body. Health boards will of course retain responsibility for meeting any health needs of the client which cannot be met by the general practitioner and the other members of the primary care team. But this is the limit of boards' role. It is not possible to provide a precise and unambiguous definition of what constitutes "health care needs". The guiding principle should be whether or not a person living in the community has needs which in the board's assessment can be met only by medically-led qualified health care staff. If they do, the needs met by such staff should be regarded as health care needs. The needs met by many other staff, including unqualified staff currently working within the NHS, can be regarded as social care needs. In practice, however, the question of which agency provides what can be resolved only by local discussion about how best to meet the individual needs of each patient or client. The important point is that there should be no unilateral withdrawals of service in such areas by either health boards or local authorities.

Financial Responsibility

10. Health boards are required by statute to secure the provision of services free at the point of delivery. There are only a few exceptions to this, and these are clearly defined in statute. The full financial responsibility for those resident in NHS facilities or in facilities provided under contract to the NHS rests with the NHS. Where a person is resident in the community the social care costs, insofar as they are met from public funds, are the responsibility of the local authority. The exception to this is those who retain an entitlement to DSS care allowances after 1 April 1993.

Cash Transfers

11. The transfer of responsibility for patients from a health board to the local authority should normally be accompanied by a transfer of cash.

12. It is not envisaged that the cash transfer mechanism would apply on every occasion that a patient transfers from long-stay care in the hospital to care in the community. There are numbers of patients who need intermittent hospital care or who may be admitted to hospital for a short period. It would be inappropriate in these circumstances for financial transfers to occur whenever responsibility for the care of such an individual passes from one agency to another. Accordingly, cash transfers should be paid only in relation to the discharge or transfer of responsibility for people who have been in continuous care in hospital for a long period, say, at least a year and only where payments are in line with agreed community care plans. In addition because the objective is to stimulate the development of a group of care places in the community, specifically for people being discharged from hospital, cash transfers should contribute to the costs of providing specified services rather than being linked to individually named patients. This will provide a proper basis for planning and will reflect a transfer of responsibility for the provision of social care.

13. The size and timing of the payments is necessarily a matter for local negotiation, involving as necessary other agencies including voluntary bodies. We expect each agency to make financial and other relevant information available to the other bodies involved to enable such discussions to take place on an informed basis. In approaching these discussions health boards will have to bear in mind the level of their continuing responsibilities for providing health care to clients living in the community and to long-stay patients remaining in NHS hospitals as well as the scale and timing of savings that will arise from a reduction in the volume of institutional care. The size of a cash transfer should therefore reflect the net reduction in running costs the health board will achieve through transferring people to the community. Provision should be made to up-rate payments for inflation on a basis to be agreed locally. The bridging finance scheme can, of course, assist health boards in meeting the double running costs which necessarily arise when community-based facilities are being created before the scale of institutional facilities can be reduced. The transfers should last for as long as the local authority provides or secures from another agency the services funded by the transfer.

14. Cash transferred under these arrangements will come from the health vote, for which health board general managers and the Chief Executive, NHS will remain accountable to Parliament. In the case of transfers to local authorities the ultimate objective is to transfer provision in the

public expenditure programmes from health to local authority current expenditure. This can be considered only when the volume of provision which has been transferred from institutional care to the community has stabilised. It is therefore likely to be several years before this will be possible. Health board general managers should therefore agree with local authorities appropriate arrangements to ensure that they can discharge their accountability for the money involved in cash transfers for so long as this continues to be transferred annually from health boards to local authorities.

Contracts Between Health Boards and Voluntary Bodies

15. Questions have arisen in the past about whether patients who have been discharged to the care of a voluntary body under the terms of a contract between it and a health board, would retain eligibility for DSS care allowances.

16. The decisive consideration is that the voluntary organisation concerned should be free to act independently of the board and, in particular, to decide whether or not to accept payments from the board in return for providing services to patients. Subject to that, the legal advice is that a contract between a health board and a voluntary body may include agreements as to the admissions policy of the voluntary body or of the particular project managed by the voluntary body to which the contract relates, without calling into question the fact that the patient concerned has been discharged from the care of the NHS and thus without prejudicing his or her entitlement to DSS care allowances.

17. This advice overtakes the guidance given in HHD/DGM(1992)1.

Joint Purchasing

18. A further development of the arrangements discussed in this circular - and one which we would welcome - would be for health boards and local authorities to pool the resources that each currently devotes to the long-term care of the elderly, the care of those with mental illnesses or learning difficulties and the care of the young physically disabled, and jointly to decide on how the totality of available resources might best be used to meet the needs of clients and patients. The development of joint purchasing should enable health boards and local authorities more effectively to meet the needs of people living in the community who require substantial health and social care and those whose needs fluctuate. Joint purchasing should enable the NHS and local authorities to use staff and other resources more flexibly and effectively. It means that less emphasis is given to the boundary between health care and social care; instead of seeking to maintain that boundary joint purchasing enables the NHS and local authorities to concentrate on producing imaginative solutions to the needs of individuals. It will be important therefore, to ensure that this is the main focus and that excessively complex planning and control systems are avoided.

19. One of the first steps in establishing joint purchasing arrangements is to agree an inventory of the current resources committed by each agency and also those available in the private and voluntary sectors. The agencies concerned can then consider whether any real additional resources are likely to be available within the foreseeable future; what their joint priorities are for altering the balance in how resources are

currently allocated to the different client groups; and thus how the existing pattern of services might be reshaped over the period.

Joint and Support Finance

20. These arrangements remain available. The details are set out in Circular SW 5/1985, NHS 1985 (GEN) 18.

Estate Transfers

21. Under some circumstances Health Boards or NHS Trusts may wish to transfer assets rather than cash and this may be achieved via a financial transfer within the Scottish Office. Any Health Board or NHS Trust wishing to transfer land or buildings to a local authority or voluntary body should contact the NHS Management Executive to discuss in detail the steps necessary to achieve this.

Staff Transfers

22. Circumstances may arise where it would be appropriate for staff to transfer from employment by the NHS to the employment of a local authority to facilitate the development of care in the community. The Secretary of State for Scotland has statutory powers to make regulations, after carrying out appropriate consultations, to facilitate such a transfer. However, since local authorities cannot employ doctors or nurses to provide health care, such regulations would cover only certain groups of staff such as professions allied to medicine, auxilliary staff, health care assistants and administrative and clerical staff. The Secretary of State is examining the possibility of making regulations which enable the transfer of those with the necessary skills and would protect the rights of an employee by ensuring continuity of employment where he or she is offered suitable alternative employment by a local authority. No entitlement to redundancy payments would therefore be created by such a transfer. The Secretary of State has no powers to make regulations in connection with the transfer of staff to employers other than local authorities.

Enquiries

23. Enquiries on this circular should be addressed to:-

David Wishart	Social Work Services Group
William Moyes	NHS Management Executive
John Thomas Billy Gorman	Community Care Implementation Unit

Enquiries on staff transfers should be addressed to Sandy Murray, Room 73, St Andrew's House.

Conclusion

24. This circular paves the way for the shift in responsibilities, resources and the pattern of care which the policy of care in the community is designed to achieve. The arrangements it describes will be reviewed from time to time. We hope that health boards and local authorities will jointly use these arrangements effectively and imaginatively to secure better care for the client groups concerned.

N. G. Campbell

N G CAMPBELL
Under Secretary
Social Work Services Group

DON CRUICKSHANK
Chief Executive
NHS in Scotland