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Northumberland
County Council

CABINET

Date: 10 December 2019

Partnerships with NHS bodies

Report of the Chief Executive

Cabinet Member: Councillor Veronica Jones, Adult Wellbeing and Health
Councillor Peter Jackson, Leader of the Council

Purpose of report

To update the Cabinet on developments affecting partnership working with the NHS, and to propose updated partnership agreements between the council and Northumbria Healthcare NHS Foundation Trust, and between the council and Northumberland Clinical Commissioning Group.

Recommendations

The Cabinet is recommended:

1. **to confirm the council's continuing commitment to integrated working with local NHS bodies, particularly in adult social care and public health;**

2. **to agree to the extension of the council's Partnership Agreement with Northumbria Healthcare NHS Foundation Trust for a further year from 1 April 2020 to 31 March 2021;**

3. **to request the Chief Executive to arrange a full review of the partnership arrangement with Northumbria, to conclude by autumn 2020, taking account of the context set out in this report and including elected member involvement;**

4. **to agree to the renewal of the council's Partnership Agreement with Northumberland Clinical Commissioning Group (CCG) for the commissioning and case management of NHS continuing health care (CHC) and other services from 1 April 2020, as an open-ended agreement which either party can terminate on six months' notice, and to note that changes to the financial amounts paid by the CCG will be negotiated separately as variations to the Agreement;**

5. **to delegate to the Chief Executive, in consultation with relevant Cabinet members, authority to approve the necessary detailed modifications to the text of the two Partnership Agreements to implement these decisions, and to sign the modified agreements;**

6. **to note that discussions are taking place between officers of the council and the Northumberland, Tyne and Wear (NTW) NHS Foundation Trust about closer integration of operational services, including basing social workers who work with the same people as specialist NTW services alongside the staff in those services.**

Link to Corporate Plan

This report is relevant to the "Living" priority in the Corporate Plan.

Key issues

1. The council has three formal partnership agreements with local NHS bodies, under Section 75 of the NHS Act 2006: a partnership with Northumbria Healthcare under which most operational adult social care functions of the Council are delegated to the Trust; a partnership with Northumberland CCG under which commissioning and case management for NHS continuing healthcare (CHC) services, and commissioning of mental health after-care services, are delegated by the CCG to the council; and a separate nationally-mandated partnership between the CCG and the council covering the allocation of the "Better Care Fund". This report concerns the first two partnership agreements.

2. Under both agreements, responsibilities are delegated but financial risks remain with the body statutorily responsible.

3. The partnership agreement with Northumbria has existed since 2011. The original intention was that towards the end of a three-year initial period, there would be a fundamental review of the partnership, to consider whether it remained the best way to link adult social care to NHS services, after the impact of the then-pending restructure of the NHS was clearer. In practice, on each occasion when the partnership has come up for review, there have been continuing uncertainties about future organisational arrangements in the NHS, and this remains true. NHS arrangements remain in transition, but the NHS Long-Term Plan published in early 2019 provides some indications of the direction of change, and a full review of this partnership is now proposed, with a one-year extension to the current agreement to provide time for this to take place.

4. The partnership agreement with the CCG has existed since 2013. In its current version, it is a 12 month agreement – a decision taken in part because of the need to consider the outcome of an external review by an NHS England team scrutinising the operation of CHC across the country. Changes have been made as a result of that review, and while there are still some operational issues to be resolved, the basic structure of the partnership arrangement is working well. The proposal is therefore to move to an open-ended agreement, which could be terminated or reshaped if circumstances make that necessary.

5. Before 2013 there was a formal partnership agreement for mental health services between the council and NTW. That agreement was ended at the request of NTW. The intention at the time was to maintain close operational integration, but for a variety of reasons NHS and local authority community mental health services have become less well integrated than they should be. While there is currently no intention to restore the kind of organisational integration which existed before 2013, officers of the council and NTW are discussing greater alignment and co-location of specialist health and social care staff working with the same groups of people.

Partnerships with NHS bodies

BACKGROUND

1. Context

1.1 The Council has been carrying out many of its statutory adult social care functions through integrated arrangements with local NHS bodies since the 1990s. However the form which these arrangements have taken has changed a number of times, largely because of changes in the national and local organisational structure of the NHS.

1.2 The arrangements began during the 1990s, at a time when there was a high degree of coterminosity between the Council and the NHS bodies responsible for community-based services in the county. Working jointly with those bodies, the Council established integrated community teams for mental health and learning disability, including social workers, specialist nurses and other staff. Alongside this, social workers and related staff working to support people with physical disability or illness were closely linked to, and in some cases based in, GP practices.

1.3 Around the turn of the century, mergers of the NHS trusts established in the early 1990s began to reduce coterminosity with the Council, creating a more complex organisational environment for integrated working. However on the positive side, the Health and Social Care Act 2001 created a new organisational framework for integration of adult social care with community-based health services. The Act introduced in all areas of the country new bodies called “primary care trusts” (PCTs). These were intended to be organisations led by GPs and other clinicians, that would be responsible for both the commissioning of all NHS services for the population which they covered, and the direct operation of a range of community-based NHS services. The intention was that the combination of these roles would enable PCTs to review the balance between hospital and community services, and where appropriate change the balance between these, reducing demands on hospitals by strengthening community alternatives. In practice, the introduction at the same time of a national “tariff” payment system for acute hospital care worked against this policy goal, by creating a demand-led budget for acute procedures, while other health services continued to receive fixed budgets. Plans to extend tariff funding beyond acute hospital care came to nothing.

1.4 In Northumberland, NHS stakeholders agreed that there should be a single PCT coterminous with the Council, and the Council then agreed with the shadow PCT that the new organisation would also have delegated responsibility for almost all of the council’s statutory adult social care functions, taking up a further opportunity offered by the Health and Social Care Act, which permitted NHS bodies to become, in the rather confusing terminology of the legislation, “care trusts” responsible for both health and social care. At the time, it appeared possible that care trusts would in time become the standard national model, and that Northumberland would be in a position to contribute to shaping the future national system of health and social care.

1.5 A few years later, national policy changed and the combination in a single organisation of NHS commissioning with direct provision of community health

services came to be seen as inconsistent with the new policy that there should be a clear separation between "commissioner" and "provider" functions in the NHS. From 2007, a complicated organisational arrangement was put in place, in which a "virtual" commissioning organisation called NHS North of Tyne became responsible for NHS commissioning across Northumberland, North Tyneside and Newcastle, with Northumberland adult social care and community-based NHS services being managed within an "arm's length" governance structure, which was generally referred to as "the Care Trust", though technically the Care Trust as a statutory organisation also included the Northumberland element of the merged commissioning function based in Newcastle.

1.6 The Council participated in a joint review of the partnership arrangements during 2009. This examined a range of options. At that time one option was to maintain the status quo, which was still a nationally-permitted approach, but would have required further organisational changes to ensure that community health services operated as nearly as possible like a separate organisation. Some of the other options considered would have involved fully dismantling the integrated management arrangements established in 2002, with social care staff transferring back to Council employment. The option which the joint working group ultimately recommended was a "reverse" partnership, in which social care and community health staff would have remained NHS employees, with the Care Trust as their employer, but would been seconded to and managed within the Council.

1.7 Following further guidance from the Department of Health, it became clear that this option was no longer viable. With the election of the coalition government in 2010, it also became clear that PCTs, including the Care Trust, were going to be abolished and that the range of available options would be further changed by the "Lansley" reorganisation proposed by the new government. The Council decided that the best of the options now available was for most adult social care functions and staff in the Care Trust to transfer to the same new NHS employer as the Care Trust's community health services, which was Northumbria Healthcare. The Department of Health advised that the social care commissioning and strategic safeguarding functions of the Care Trust could not be transferred to an NHS foundation trust, so it was agreed that from 2013, when PCTs would cease to exist, the commissioning and strategic safeguarding functions, and the relatively small staff group responsible for these, would transfer back to the Council.

1.8 Most of the social care staff employed by the Care Trust therefore transferred to Northumbria Healthcare in 2011, initially under a two-year partnership agreement with an intention to carry out a fundamental review of future partnership arrangements when there was greater clarity about the local implications of the Health and Social Care Act 2012, which implemented the "Lansley reforms". In practice, NHS organisational arrangements have remained unstable throughout the period since 2011, and there have been a series of short-term extensions to the partnership agreement, the most recent of which has covered the period from April 2018 to March 2020. There has been a continuing intention to carry out a fundamental review once NHS arrangements become more established and predictable.

1.9 Disappointingly, two years after the establishment of the partnership with Northumbria, one of the key partnerships established in the late 1990s was

dissolved. The NTW Trust gave notice on the integrated management arrangements which had been in place in community mental health services, and from April 2013 health and social care professionals were managed in separate teams. The initial intention was that these would remain co-located and would continue to operate in an integrated manner, but in practice community mental health services have subsequently become more fragmented.

1.10 One significant benefit in Northumberland of the Health and Social Care Act 2012 was the return of most (though not all) NHS commissioning functions to a local body coterminous with the council. Clinical Commissioning Groups (like PCTs in their original form) were intended to be clinically-led local bodies giving a central role to local GPs; in some other areas they covered areas smaller than the local authority, but in Northumberland a coterminous CCG was agreed. Northumberland CCG has from its creation in 2013 worked closely with the Council, and has throughout its existence delegated to the council its commissioning and case management responsibilities for NHS continuing healthcare (CHC), which had become less closely integrated with parallel social care functions during the period when commissioning was carried out by NHS North of Tyne, leading to fragmented experiences for service users and care providers, and disjointed commissioning of services such as residential care and home care which provide support both to people funded through social care and people funded through CHC.

1.11 The publication of the NHS Five-Year Forward View in 2014 marked a further shift in national policy about the organisation of NHS services, with a greater emphasis on integration of different parts of the NHS, and a reduced emphasis on competition. In Northumberland, the CCG and Northumbria Healthcare submitted in 2015 a bid to create what was then called an “accountable care organisation” (ACO), to be hosted by Northumbria Healthcare, which would have taken lead responsibility for integrating almost all health services in Northumberland other than primary health care and CHC, and would have been responsible for managing the overall budget available for these services. One of the key objectives of this proposal was to remove the distortion created by the tariff payment system. The ACO would have been in a position to allocate budgets on the basis of an overall judgement about how best to meet the needs of the county’s population, rather than receiving automatic reimbursement for acute procedures and a fixed budget for other services. It was not envisaged that adult social care would form part of the ACO contract, but it was planned that the two arrangements would work together to achieve an integrated health and social care system, while the provider-led ACO would be monitored by a combined strategic commissioning function based in the Council.

1.12 While the bid to create an ACO was initially approved, it did not ultimately proceed.

1.13 Following the 2015 spending review announcements on NHS funding, NHS England required the establishment across the country of partnerships across “health and care systems” which would prepare “sustainability and transformation plans”. The “footprint” for this task covering Northumberland included Tyne & Wear and North Durham. Nationally, these “footprints” developed into what came to be called “sustainability and transformation partnerships” (STPs), which it became clear were envisaged as a new sub-regional level of coordination of NHS commissioners and providers, remedying what was now seen as the problematic structural separation of

these two functions introduced by the 2012 Act. (Above these new sub-regional structures, the separate national organisations set up under the Act to oversee commissioning and provider organisations have recently effectively been merged). In 2017, a further NHS England publication introduced the notion of an "integrated care system" (ICS) (initially called an "accountable care system"), which would be an enhanced version of an STP, able (by agreement between NHS organisations) to take overall responsibility for NHS resources across its area.

1.14 The NHS long-term plan published in January 2019 set out an expectation that by 2021 ICSs would be established in all areas of the country, and there would "typically" be a single CCG in each ICS area. The direction of national NHS policy is now clearly towards a more cohesive national service, with less emphasis on competition and the internal market, and proposals have been published for amending the 2012 Act to reflect this change, and reduce the need for complicated workaround governance arrangements for integrated arrangements within the NHS.

1.15 The STPs have merged into a larger structure covering the whole of the north-east region and North Cumbria, which has recently been formally designated as the North East and North Cumbria Integrated Care System. This ICS (the largest in England) currently intends to operate through four more local "integrated care partnerships", one of which would cover Northumberland, North Tyneside, Newcastle and Gateshead.

1.16 At a lower geographical level, the NHS long-term plan required the establishment across the country of "primary-care networks", intended to bring GP practices together into larger groupings, typically covering 30-50,000 people. The plan proposes that these networks would link to "expanded neighbourhood teams", which would include "a range of staff such as GPs, pharmacists, district nurses, community geriatricians, dementia workers and AHPs such as physiotherapists and podiatrists/chiropodists, joined by social care and the voluntary sector." In Northumberland, six primary care networks have been established, covering populations varying from 30,000 to 80,000 people.

2. Refreshing our approach to integration

2.1 Earlier this year, officers in adult social care arranged a series of engagement events with operational staff involved in coordinating care and support for individuals. These events were designed to assess to what extent the organisational arrangements currently in place are succeeding in achieving a seamless experience for people with care and support needs, both within social care and between social care teams and the NHS services which most social care service users also rely on.

2.2 The conclusions that emerged from this exercise were mixed. While there is much good work being done by highly skilled and experienced workers, the way in which teams are currently organised creates an undesirably fragmented experience for service users – and, disappointingly, limits the extent to which they are able to plan people's care jointly with key NHS professionals.

2.3 As a result of these discussions, we are now rethinking the way in which we organise the coordination of care and support for individuals. One objective is to minimise the number of hand-offs between different teams and services within

social care that service users experience; another is to strengthen relationships with two key parts of the health service: primary care, including the emerging primary care networks; and specialist mental health services.

2.4 The model which we hope shortly to begin piloting will see current rather complex arrangements replaced by just two kinds of multidisciplinary care coordination team:

a) “Care and support teams”, with caseloads based on the lists of a single large GP practice, or a cluster of smaller practices. Where there are suitable opportunities, we will explore basing these teams in primary care premises, alongside community health staff.

b) Specialist teams, coordinating care and support for the smaller group of people whose health needs – primarily mental health needs – require close joint working with specialist professional teams in the NTW trust. In this case too, we are exploring the potential for basing these workers alongside the NTW teams that they link with.

2.5 We will also be reviewing the operation of the teams created since 2011 which focus directly on the interface between acute hospitals and the community. While it is crucially important to ensure that people who are ready for discharge from hospital are able to return home with suitable support, and that people undergoing a health crisis of a kind which does not require hospital treatment can be supported at home without needing a hospital admission, the engagement exercise and other information which we have gathered suggest that current arrangements create some issues about handoffs between hospital-based and community-based teams, and there may be scope for providing more support for people in hospital from community-based staff to improve continuity.

3. The Northumbria partnership

3.1 The national and local developments described above clearly affect the context in which the Council might consider the partnership arrangement with Northumbria Healthcare. While there have been some significant benefits in the closer integration with acute hospital care which the partnership has brought about, the primary rationale for the decision to enter into the partnership in 2011 was that it would maintain existing integration with community health services. If, as seems possible, community health services come to be managed largely through primary care networks, there may be reasons to review the best organisational framework for the integration of social care with health services in the community.

3.2 A return to closer joint working with specialist mental health services may also mean that some professionals have closer links with NTW than with Northumbria. This need not necessarily have structural implications, but does provide another reason to consider whether the current partnership structures still provide the best framework for integration.

3.3 Northumbria also provides public health services funded by the Council, and these wil be reviewed during 2020. The current contract for sexual health services comes to an end in March 2020 (there is an option to extend). 0-19 services such as health visiting and school nursing, and well-being services such as health trainers are

provided by Northumbria through the partnership agreement, and these will also be reviewed.

3.4 It is recommended that the partnership agreement with Northumbria is extended for 12 months from April 2020, to allow time for a full review of the current partnership arrangement.

4. The partnership with the CCG

4.1 The partnership agreement with the CCG covers commissioning, case management, and associated administrative support including budget monitoring and payment of invoices for CHC, NHS funded nursing care (FNC), and "shared care" arrangements. It also covers the commissioning from independent sector providers of mental health after-care services for people who have been detained for treatment in hospital. Under Section 117 of the Mental Health Act 1983, the CCG and the council have a joint responsibility for providing after-care, which as a result of case law and ombudsman decisions now in many cases includes all care that people receive for the rest of their lives following detention for treatment, particularly where this is related to dementia. By local agreement, costs of after-care services are split 50-50 between the council and the CCG, which is also the usual arrangement elsewhere in the region.

4.2 The logic of these arrangements is that most of the services are delivered by the same providers, using the same facilities and staff, regardless of the funding stream responsible. An integrated commissioning arrangement avoids the risk that service users will experience discontinuity in elements of their service which do not need to change simply because of a change in the funding stream, simplifies administrative arrangements for care providers when people's funding streams change, and minimises administrative overheads for the public sector.

4.3 The current partnership agreement was extensively revised in the light of advice from NHS England's service improvement team. While there is still scope for operational improvements – including the planned changes in care coordination arrangements described in section 2 of this report – the framework of the partnership agreement does not currently appear to need further change, and it is suggested that it now becomes an open-ended agreement, with provision for six months' notice on either side.

4.4 Financial arrangements associated with this agreement can be negotiated annually and incorporated as variations. If the council was at any point unable to reach agreement over the level of funding, it would have the option of giving six months notice.

4.5 Because of the transitional state of NHS commissioning arrangements described in section 1 of this report, it is uncertain whether Northumberland CCG will continue to exist in its present form beyond 2020/21. If and when plans emerge for merged NHS commissioning arrangements affecting Northumberland, it would be highly desirable to retain a joint arrangement for CHC and other services. The NHS long-term plan refers to the importance of "place"-level joint working between the NHS and local authorities within an "integrated care system", and we understand that in some areas elsewhere where existing integrated commissioning arrangements between

local authorities and CCGs have been called into question by CCG merger plans, local authorities have agreed with the relevant ICS the delegation of key NHS commissioning functions for community-based services to the local authority. It is recommended that if and when merger plans for Northumberland are proposed, options for retaining the current integrated commissioning arrangement, and possibly extending it to further services, should be explored.

5. Integrated mental health services

5.1 Between the late 1990s and 2013, community mental health teams in Northumberland were fully managerially integrated, initially within the county council, and subsequently within the Care Trust and then Northumbria for older people's mental health teams, and within NTW (and its predecessor FT) for working age mental health teams.

5.2 There is no current proposal to return to integrated management, but there is agreement between council officers and officers in NTW that since 2013 operational arrangements have become undesirably fragmented, creating a poor user experience and in some extreme cases a risk to service user safety.

5.3 Officers are therefore exploring the potential for basing social workers and other social care staff alongside specialist NTW services working with the same groups of people. This might include people with severe and enduring mental health problems, and also some other groups in need of focused specialist services, such as people with complex needs arising from a head injury and people with chaotic lives because of dependency on drugs, alcohol or other substances. In the last of these cases, discussions have been taking place between adult social care and public health about adding social work support to NTW's existing service, funded through public health grant.

5.4 Currently the changes which are being discussed are operational integration of kinds which need not require a formal partnership agreement. However as these arrangements develop, the case for a stronger formal framework will be kept under review. If such a framework is needed, it may be concerned with ensuring that both health and social care professionals are authorised to carry out some functions of one or other statutory body, rather than with reinstating joint management.

IMPLICATIONS ARISING OUT OF THE REPORT

Policy	The council has a long-standing commitment to integrated working with the NHS.
Finance and value for money	Across all partnership arrangements, the principal will continue to be that financial risks are borne by the body with statutory responsibility for the functions involved.
Legal	Partnership agreements are entered into under Section 75 of the NHS Act 2006, and regulations made under that Section.

Procurement	Partnership agreements are arrangements between two statutory bodies, rather than contractual arrangements for the purchase of services.
Human Resources	Most operational adult social care staff carrying out statutory functions are employed by Northumbria Healthcare. This is expected to continue pending the outcome of the proposed full review of the arrangement, though decisions about the best employment arrangements for some specific posts will continue to be based on case-by-case consideration.
Property	No immediate changes are proposed to the existing arrangement, under which many of the social care staff employed by Northumbria Healthcare are based in premises owned or leased by the Council.
Equalities (Impact Assessment attached) Yes ☐ No ☒ N/A ☐	This report proposes no immediate changes which will directly affect either staff or services. Changes to specific services to improve integration, and any changes resulting from the proposed review of the partnership with Northumbria will where relevant be screened for potential equality impacts.
Risk Assessment	The recommendations in this report introduce no new risks.
Crime & Disorder	Closer integration of mental health services is likely to include a more integrated approach to people whose mental health issues have been associated with offending behaviour.
Customer Considerations	One of the principal benefits of integration is a less fragmented experience for people who need support from multiple health and care services.
Carbon reduction	No direct implications have been identified.
Health and wellbeing	The recommendations of this report are designed to maintain and develop an organisational framework which supports effective health and care services.
Wards	All

BACKGROUND PAPERS

There are no background documents for this report within the meaning of the Local Government (Access to Information) Act 1985.

Report sign off.

Authors must ensure that officers and members have agreed the content of the report.

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