

Greater Glasgow NHS Board

Board Meeting

Tuesday 20th January 2003

Board Paper No. 2004/1

Director of Planning and Community Care
Chief Executive, Greater Glasgow Primary Care NHS Trust

Community Health Partnerships: Boundary Proposals and Principles

Recommendation:

- **The Board approve these initial proposals on Community Health Partnerships as a basis for consultation.**

A. BACKGROUND

1.1 One of the most fundamental proposals within the White Paper is the evolution from Local Health Care Co-operatives (LHCCs) to Community Health Partnerships (CHPs).

1.2 The proposal is that the CHPs will:

- ensure patients and a broad range of health care professionals are fully involved in service delivery, design and decisions;
- establish a substantive partnership with Local Authority services;
- have a greater responsibility and influence in NHS resource deployment;
- play a central role in service redesign;
- act as a focus for integrating primary care, Local Authority and specialist health services;
- play a pivotal role in delivering health improvement.

NHS Boards are required to review the organisation and operation of their existing LHCCs by early 2004.

1.3 Greater Glasgow has 16 LHCCs - covering populations ranging from 23,000 to 115,000. Our LHCCs have made good progress in delivering the key objectives set for them. In moving to CHPs we want to accelerate progress in a number of areas:

- service integration with Local Authorities, including for children's services;
- networking services with secondary and specialist care, reflecting the ongoing investment in new hospitals and the redesign of services;

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- developing comprehensive approaches to health improvement;
- achieving real community engagement and influence on planning and strategy;
- developing clinical networks and engagement between primary and secondary care.

1.4 Three other opportunities emerge from the development of CHPs.

- Access - we would also like to explore the benefit that can result from combining the establishment of CHPs with service redesign to improve access to services. The development of services at a local level should both impact the demand for hospital services and enable patients to more readily return to their home or care in a community setting.
- Inclusion - a further opportunity will be to explore the potential for wider responsibilities for regeneration and social inclusion as we develop the CHPs. The migration to Community Health Partnerships must build on the strengths of LHCCs, but also recognise that CHPs will be significantly different entities, with much greater resources, autonomy and responsibilities, and stronger accountability, than current LHCC arrangements.
- Patients and public - amongst the key roles of CHPs will be ensuring that they maintain an effective dialogue with their local communities through the development of the local Public Partnership Forum (PPF). The Health Department's guidance stresses that these forums should be as representative as possible.

1.5 The White Paper was not detailed or prescriptive in its propositions about Community Health Partnerships. Further guidance issued for consultation in mid July 2003 sets out more details of national thinking, and includes a number of points similar with our own initial thinking and discussions, including:

- confirming the focus of CHPs as health improvement, better services and community involvement, and their role as a key influence on strategic planning and resource allocation;
- confirming the emphasis on the implementation of the Joint Future agenda on service integration alongside the development of CHPs and re-emphasising CHPs as the substantive partnership with Local Authorities.

1.6 Alongside our work with each Local Authority our NHS Steering Group which brings together the Primary Care Trust, Health Promotion and Public Health, Acute Trusts, Yorkhill and Planning, has begun detailed discussions about the organisational form which CHPs should take, the resources they should manage and how they should exercise their wider influence.

1.7 The proposals in this paper have been developed through a continuing programme of work with each Local Authority and the Greater Glasgow NHS CHP Steering Group. They have also been shared with Argyll and Clyde and Lanarkshire NHS Boards.

1.8 The purpose of this paper is to set out:

- our proposals for the boundaries of CHPs. It is important to emphasise that there will be flows of activity across these proposed boundaries and it is not our intention to disrupt natural patterns of care. We will need to develop

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greater understanding and clarity on how such cross boundary flows will be managed in finalising CHP arrangements;

- what NHS services, budgets and staff they should directly manage;
- how we are developing proposals for the organisation and resourcing of CHPs to enable the development of detailed schemes of establishment and governance arrangements. The aim is, depending on further guidance, to return to the Board with firm proposals in the spring of 2004 alongside the outcome of this consultation exercise. Our overall objective is to be migrating to CHP arrangements during 2004 with full establishment in April 2005. That migration will include significant shifts in responsibility from the Primary Care Trust and NHS Board Headquarters and will require us to carefully consider what central arrangements should support CHPs.

B. BOUNDARIES

2.1 These proposed boundaries have been developed in partnership with Local Authorities. Our primary aims have been to:

- cover significant populations reflecting our vision of CHPs as major and significant organisations;
- recognise natural communities;
- minimise disruption to existing structures, particularly LHCCs, Social work areas and SIPs;
- take account of Local Authority boundaries.

We expect that CHPs will have substructures within their primary boundaries to reflect different communities and neighbourhoods and the different population clusters for their varied functions.

All of the proposals outlined below have the support of the relevant Local Authority.

2.2 Our proposal is that there should be single CHPs covering each of the following Local Authority areas with boundaries coterminous with the Local Authority:

East Dunbartonshire	Population 109,400
West Dunbartonshire	Population 93,300
East Renfrewshire	Population 90,000

For East Renfrewshire and West Dunbartonshire the proposed CHP would cross two NHS Boards and we have proposed a joint group with Argyll and Clyde to ensure we develop a consistent approach for these cross NHS Board CHPs. In East Dunbartonshire the CHP development process will reflect our existing agreement to integrate local health and community care services into a single structure.

2.3 The implications of these boundaries for existing structures are as follows:

- For Local Authorities:
 - significant gain in achieving boundaries which match their own. This gain is also significant for the NHS in terms of the development of integrated services.

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- For LHCCs:
 - in East Dunbartonshire, the Anniesland, Bearsden and Milngavie LHCC, which has practices in Glasgow City and East Dunbartonshire, will migrate into two CHPs. We are working with the LHCC to mitigate the effect of this change on the services and the relationships the LHCC has developed;
 - in West Dunbartonshire, the Clydebank LHCC will be wholly within the proposed CHP. In developing more detailed organisational arrangements and delegation it will be important there is recognition of the two distinct localities within the CHP and that there is no “levelling down” of services between the two NHS Board areas. There has been a proposal from the Lomond LHCC, which lies within Argyll and Clyde NHS Board and covers part of Argyll and Bute Council as well as West Dunbartonshire, that the populations of Helensburgh and the Lochside should be covered by the West Dunbartonshire CHP. This proposal is not supported by the West Dunbartonshire Health and Social Justice Partnership, of which we are a member, which does not believe a cross boundary CHP will be a workable vehicle for maximum Local Authority delegation with strong governance and accountability arrangements;
 - in East Renfrewshire, as well as the issue of ensuring no levelling down of services and resources between the two health board areas, there are primary care and boundary issues around Thornliebank and Busby on which we would seek views as part of the consultation to arrive at final conclusions.

2.4 In Glasgow City we propose five CHPs, These require changes to a number of social work and LHCC structures although we have tried to minimise disruption.

2.5 Western

Bounded by the River Clyde to the South and the East and West Renfrewshire Council boundaries to the North and West. The eastern boundary would follow the M8 from the Kingston Bridge then the line of the River Kelvin and Forth and Clyde Canal.

The population is 138,284.

This proposal covers the Riverside, West One and Drumchapel LHCCs and the Anniesland practices, currently in a LHCC with Bearsden and Milngavie. It also covers the whole of the West Area Social Work Team and part of the North West Area Team, the whole of the Drumchapel SIP and the Dumbarton Road corridor of the small area SIP.

2.6 Northern

The western boundary would match the line of the Forth and Clyde Canal and River Kelvin, the southern boundary would be the M8, the northern boundary the boundary with East Dunbartonshire Council and the eastern boundary is Sauchiehall Street, Port Dundas Road, the M8 and Cumbernauld Road until reaching the North Lanarkshire boundary.

The population is 115,769.

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The proposal covers the North, Maryhill/Woodside LHCCs and part of the Dennistoun LHCC. It also covers the whole of the North Social Work Area Team, the whole of the North Glasgow and Milton and Springburn SIPs.

2.7 Eastern

The southern boundary would be the River Clyde, the western boundary the M8 Kingston Bridge, the eastern boundaries would be the Council boundaries of South and North Lanarkshire. This CHP would cover the whole of the City Centre.

The population is 146,155.

This proposal covers the whole of the Eastern and Bridgeton LHCCs and part of the Dennistoun LHCC. It also covers almost all of the East and North East Area Social Work Teams with some adjustments to include the City Centre, the East End and Greater Easterhouse SIPs. Although Dennistoun is split the LHCC recognise this boundary proposal does reflect natural communities

2.8 South West

Bounded to the North by the River Clyde with western and southern boundaries matching the Renfrewshire and East Renfrewshire Council boundaries and the eastern boundary following Commerce Street, the railway line, M77, Dumbreck Road and the G41/42 postcode boundary.

The population is 114,337.

This proposal covers the whole of the South West Glasgow LHCC and a small part of the Greater Shawlands LHCC. It also covers the South West and Greater Pollok Area Social Work Teams and the Greater Pollok and Greater Govan SIPs with the Penilee part of the small area SIP.

2.9 South East

Bounded to the North by the River Clyde, by Commerce Street, the M77 and Dumbreck Road to the West and Glasgow City boundary with East Renfrewshire Council sets the southern and eastern boundaries.

The population is 120,910.

The proposal covers the whole of the South East Glasgow LHCC and the majority of the Greater Shawlands LHCC. It also covers the South and South East Area Social Work Teams and the Greater Gorbals and Castlemilk SIPs, as well as the Toryglen part of the small area SIP.

2.10 Outstanding Issues

We are working with South and North Lanarkshire Councils and Lanarkshire NHS Board on the development of CHPs.

North Lanarkshire has particular issues as the Greater Glasgow element of the Council area is a population of only 10,000 people. For South Lanarkshire the Lanarkshire NHS Board approach is still evolving and has been to see CHPs as a direct migration from current LHCCs - this would see the Rutherglen/Cambuslang area, which lies within Greater Glasgow, as a CHP in its own right with a population

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of around 50,900. We are not convinced this is a viable scale for a CHP and would prefer to develop a cross boundary CHP in partnership with South Lanarkshire Council. We will continue CHP development work in Rutherglen/Cambuslang, ensure the continuing effort through existing joint structures and continue dialogue with Lanarkshire NHS and Local Authorities.

- 2.11 Clearly the boundaries proposed above will raise significant issues for a number of LHCCs and Area Social Work Teams within Glasgow City. We are committed, through this consultation process and the detailed work on schemes of establishment, to ensuring that the positive gains of LHCCs are acknowledged and developed in these new structures.

C. SERVICES, BUDGETS AND STAFF

- 3.1 We see four potential roles for CHPs in the management of services, resources, staff and functions.

- directly managed, ie, staff and budgets;
- a service provided within the CHPs area, managed as part of another structure but with strong and direct accountability to the CHP;
- services provided outside the CHP area, with staff managed in another structure but the budget held by the CHP;
- services provided outside the CHP area with management and budgets held elsewhere in the structure but influenced by CHPs.

- 3.2 Our view is that CHPs should directly manage all NHS staff and budgets provided in their area unless there are good reasons to favour an alternative arrangements. Such reasons might include issues about critical mass, the relationship between community based and specialist services and the way patients flow through services.

3.3 So what do we propose CHPs will directly manage?

Our proposal is that CHPs should directly manage:

- community nurses;
- relationships with primary care contractors;
- local older people's services;
- mainstream school nursing;
- local chronic disease management programmes and staff;
- oral health action teams;
- allied health professionals;
- palliative care;
- locally provided addictions, physical disability and learning disability services (all joint with Local Authorities).

- 3.4 We also propose that given the importance of the CHPs health improvement role that public health practitioners, geographically based Health Promotion staff and related budgets will be directly managed. Section 4 of this paper outlines further work on ensuring effective delivery of health improvement.

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- 3.5 We also propose that CHPs will hold budgets for:
- prescribing in primary care;
 - diagnostic and laboratory services to primary care;
 - enhanced services under the new GMS contract.

It will be important that all CHP budgets reflect population and deprivation.

- 3.6 Management arrangements for community based staff presently managed within specialist services including community child health, mental health and older people's mental health, are under review to establish proposals for further consultation, which ensure we create strong local accountability as well as cross system patient flows.
- 3.7 While we see acute, specialist children, special educational needs and community midwifery services managed in other structures within the new NHS operating divisions we are committed to ensuring there is strong accountability and influence for CHPs. This thinking is outlined further in the next section.

D. ORGANISATION AND RESOURCES

- 4.1 This paper does not represent our final proposals about the organisation and resourcing of CHPs. This section briefly outlines further work in progress to bring these proposals to the Board in the spring of 2004. Community Health Partnerships have seven key roles:

- managing local health services;
- partnership with Local Authorities;
- delivering health improvement;
- contributing to service and strategic planning;
- influencing the provision of specialist services;
- playing a major role in community planning and acting as a local focus for regeneration;
- engaging and involving the local community.

In addition to these roles, CHPs will manage a significant number of staff and will have an important responsibility for staff governance.

- 4.2 Section C of this paper outlined our present thinking and work in progress to conclude issues around the NHS management responsibilities of CHPs. This section sets out our current thinking on the other six dimensions for discussion and debate. Our key proposition is that CHPs have massive potential to deliver better services and decisions for their populations, anchored in local accountability and responsibilities which connect wider health improvement with service delivery. We do not simply see CHPs as a way of better managing and integrating NHS services but also as offering an organisation which can be a partnership with Local Authorities, giving the opportunity to integrate services and drive a joint health improvement agenda.

4.3 Partnership with Local Authorities

Our aspiration is that CHPs should enable us to further integrate the delivery of personal care services with Local Authorities and consolidate the integration we have achieved so far. We do not want CHPs to be seen solely as NHS bodies as we believe

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that would miss the opportunity to make significant services and community engagement gains. Applying this concept of CHPs as a full partnership, we would hope that Local Authority personal services, matching the health services we propose that CHPs will directly manage, could also be managed within the CHP. These would include services provided in the CHP area covering mental health, addictions, children, older people and learning disabilities. This would need the agreement of a Local Authority.

We would also want CHPs to have very strong relationships with other Local Authority functions, including education and housing. For example, this might include cross representation on School management teams.

There are significant implications of such proposals for accountability arrangements. We will debate with each Local Authority the extent to which they are willing to delegate functions and resources to CHPs - creating genuine partnership bodies with us. Accountability arrangements could include local Councillors as CHP Board members and the involvement of senior Local Authority officers as part of CHP management teams.

In addition to the services which we hope CHPs could manage we believe that their health improvement responsibilities should include the Local Authority dimensions and we want to consider with each Local Authority how this could work and the implications for other structures and responsibilities. We have a number of workshops established for interests within Glasgow City and will discuss similar arrangements with other Local Authorities.

If we pursue fully substantive partnership further important responsibilities of CHPs in terms of public engagement and service and strategic planning could also have significant implications for Local Authorities.

4.4 Delivering Health Improvement

There is a clear intention the CHPs will be a local focus for health improvement activity. This poses a range of issues about how we can maximise the effect of this. But three questions are key:

- How should CHPs be structured to ensure that health improvement is a primary focus of their activity and has equal weight to managing services?
- What resources, people and budgets should CHPs have to discharge their responsibility? We are proposing that the public health practitioners and geographic health promotion staff should be part of the core CHP teams. How should public health specialists be included and what changes might be required to the organisation of other health promotion resources? The working group outlined below will bring forward proposals for debate on these issues. Current resources include geographic and programme based health promotion staff and public health specialists all currently organised as NHS HQ functions.
- How will Local Authority responsibilities for major and wider health determinants be linked to the work of CHPs?
- How should CHPs be organised to work with other key interests?

Our suggested process to consider these issues is a small working group of the key interests reporting back to the Steering Group and a dialogue with each Local Authority.

4.5 Contributing to Service and Strategic Planning

CHPs should be significant players in the planning of services for their population, both those provided within the local area but also specialist services. To enable them to discharge this role we need to look at how the planning functions in the PCT and NHS Board HQ are organised. Our aim should be to achieve effective locality planning linked to coherent strategic frameworks. We have established a small group to make detailed proposals for NHS arrangements and we need a similar discussion with each Local Authority. Performance management structures for CHPs will also be important - NHS performance management arrangements, which currently are combined with planning, are under review as we move to a different NHS structure and performance management arrangements are also under discussion with Local Authorities.

4.6 Influencing the Provision of Specialist Services

A critical objective for CHPs is to deliver an effective relationships with specialist services, particularly acute care, to ensure that the organisation and delivery of services reflects more closely the needs of patients, particularly in terms of access, clear care pathways and quality. CHPs also need to take responsibility for demand pressures and to deliver local services changes, for example, in addictions interventions and chronic disease management, which will reduce the use of acute facilities. The organisation of each CHP needs to reflect this key imperative as does the organisation of the new operating divisions which need to look again at their arrangements to engage with local services.

We need to create mutual accountability between CHPs whose population and staff will be key drivers of the use of specialist NHS services and the NHS operating divisions which provide those services. One potential option is cross representation on corporate management teams between the two organisations.

We have established a small group to make detailed proposals for relationships with acute services.

4.7 Playing a Major Role in Community Planning and Acting as a Local Focus for Regeneration

Achieving this objective will be an important part of our discussions with each Local Authority and needs to link to changes to community planning and regeneration structures. There are a number of options around how this could operate, depending on whether a CHP is Authority wide or on the structure of community planning. At a minimum we would expect CHPs to have a strong role in the health gain and improvement theme and the development of joint health improvement plans.

4.8 Engaging and Involving the Local Community

Our local aspiration, reinforced by national guidance - is that CHPs should focus on community engagement and involvement.

At present, a whole range of organisations and structures have responsibility for these activities in each local area. Examples include, SIPs, LHCCs, other NHS bodies, Local Authorities, community care and community planning structures. We need to debate, in the detailed organisational and operational arrangements for CHPs, how they can co-ordinate and add value to existing mechanisms.

E. CONCLUSIONS

- 5.1 These proposals for consultation on boundaries and direct management responsibilities enable us to seek views on core propositions about the organisation and resources for CHPs and also enable the points in Section D, about the wider development issues to begin to be thoroughly debated.
- 5.2 We will develop clear public information for this consultation exercise which we aim to run in partnership with each Local Authority.