

Greater Glasgow NHS Board

Board Meeting

Tuesday 12th October 2004

Board Paper No. 2004/58

Director of Planning and Community Care

Community Health Partnerships - Update

Recommendation:

- **The Board note progress on the development of Community Health Partnerships.**

A. BACKGROUND AND PURPOSE

- 1.1 It is important to introduce this update on progress in developing Community Health Partnerships (CHPs) by restating the guiding principles which underpin our approach to their development.
- 1.2 The NHS White Paper "Partnership for Care" proposed that CHPs should be new organisations which would deliver:
 - substantive partnerships with Local Authorities;
 - community involvement;
 - resource deployment;
 - service redesign and professional development
 - service integration:
 - within NHS;
 - with local government;
 - health improvement and community planning.
- 1.3 In responding to the White Paper we established two fundamental aspirations:
 - the massive potential for CHPs to deliver better services and decisions about their populations anchored in local accountability and responsibilities which connect wider health improvement with service delivery;
 - CHPs as not simply a way of better managing and integrating NHS services but also as offering an organisation which can be:
 - a partnership with Local Authorities, integrating NHS and Local Authority services and driving a joint health improvement agenda;
 - a community planning partner.

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- 1.4 We have developed these aspirations into seven key objectives for CHPs:
- real action on health improvement;
 - focus on health of population as well as services and ensuring that a population perspective has clout corporately;
 - delivering quality, effective and responsive personal care;
 - driving externally provided services, quality and priorities;
 - achieving staff and community influence, engagement and ownership;
 - influencing and driving other local services;
 - credibility with elected members.
- 1.5 In order to deliver these objectives we are aiming to establish CHPs to:
- be integrated and substantial organisations with strong accountability;
 - be a local community planning structure;
 - have substantial involvement of elected members;
 - have significant health improvement capacity, equal to services element;
 - be organisational structures with community and staff interest prominent;
 - have structured links to housing, regeneration, employment.
- 1.6 The first stage in moving from the abstract to the concrete was to establish CHP boundaries. The Board considered the outcome of consultation on boundary proposals in April 2004 and confirmed its support for:
- five CHPs coterminous with Glasgow City Council;
 - three CHPs coterminous with the boundaries of East Dunbartonshire, West Dunbartonshire and East Renfrewshire Councils;
 - further development work in Rutherglen/Cambuslang linked to Lanarkshire NHS Board's process
- 1.7 In consulting on the boundaries we also took the opportunity to consult on two other areas which are linked to the development of CHPs.
- 1.8 The first set of issues related to our thinking about the roles of a CHP in managing services, resources, staff and functions. We saw four potential roles:
- 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.

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- 1.9 Our proposal was the CHPs should directly manage all NHS staff and budgets provided in their area unless there are good reasons to favour 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.
- 1.10 We proposed that this would mean 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).
- 1.11 We also proposed 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.
- 1.12 In addition to these direct management responsibilities we also proposed that CHPs would hold budgets for:
- prescribing in primary care;
 - diagnostic and laboratory services to primary care;
 - enhanced services under the new GMS contract.
- 1.13 Finally we noted that management arrangements for community based staff, presently managed within specialist services, including community child health, mental health and older people's mental health, were under review to establish proposals for further consultation, which ensure we create strong local accountability as well as cross system patient flows. While we suggested that acute, specialist children, special educational needs and community midwifery services would be managed in other structures within the new NHS operating divisions we are committed to ensuring there is strong accountability and influence for CHPs.
- 1.14 Our second set of additional proposals focussed on the potential organisation and resourcing of CHPs. When we issued our boundary consultation paper we were not yet in a position to consult on final proposals on organisation and resources for CHPs but we took the opportunity of the consultation exercise. To restate our key proposition 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.

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- 1.15 The purpose of this paper is to provide the Board with a brief update on work in progress across this range of issues.

B. CURRENT POSITION

- 2.1 This section describes the current position on a number of key issues.

2.2 Schemes of Establishment

We are required to submit detailed schemes of establishment to the Scottish Executive Health Department (SEHD). These need to cover:

- the size and catchment area of the CHP;
- the desired outcomes and success factors;
- priority development areas;
- functions and services to be devolved to CHPs;
- key relationships and how these will be organised;
- how joint future arrangements will relate to the CHP;
- how integration of children's services will be enhanced;
- how health improvement and reduction in inequalities will be delivered;
- the CHP role in the community planning process and in NHS planning and development;
- how service quality will be improved;
- performance management issues;
- how patients, service users and carers will be engaged;
- financial arrangements;
- access to support including finance, human resources and training;
- governance and accountability arrangements;
- organisational development arrangements.

Our objective is to draft the schemes of establishment over the next three to four weeks to enable detailed discussions with each of our Local Authorities, enabling the NHS Board and appropriate committees to consider a final draft during December.

2.3 Service Issues

Our aspiration from the start has been that CHPs should be in a position to manage as many local health and social care services as possible. We are in detailed discussions with each Local Authority about the extent to which the services for which they are responsible can be managed within CHP structures. This includes review of older people and children's services, where integration is less well developed.

In terms of health services we have concluded our thinking on a number of services in line with paragraph 1.10 of this paper but are continuing to discuss the final pattern of responsibilities for children and older people.

In concluding these discussions with Local Authorities a critical factor will be the resolution of the issues about governance and accountability which are outlined later in this section.

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2.4 Working with Argyll and Clyde

We have two CHPs, covering East Renfrewshire and West Dunbartonshire, which will cover Argyll and Clyde and Greater Glasgow. We have a joint NHS group to try and develop consistent approaches. Issues under discussion include:

- there are significant differences in funding of community services between the two NHS Boards which will need to be resolved to establish equitable CHP funding streams;
- Argyll and Clyde have a different view about governance arrangements, with a less significant role for Local Authorities. This issue is covered in more detail in the section on governance and accountability;
- there are some differences in position on the services and resources which CHPs will directly control.

Our aim is to resolve these differential positions to enable agreement on schemes of establishment.

2.5 Governance and Accountability

We have developed a proposal about governance and accountability which is based on a number of key assumptions. These assumptions are that CHPs will:

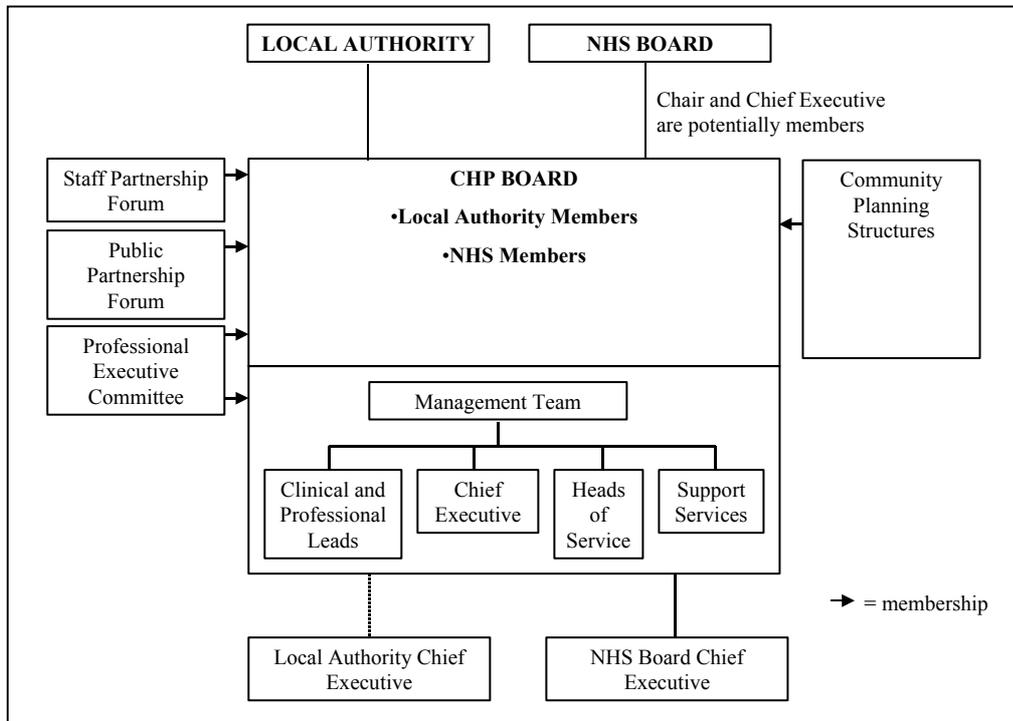
- be substantive partnerships with Local Authorities managing a full range of NHS and local government personal care services provided within their area;
- deliver effective services alongside health improvement;
- have a substantial role in NHS resource deployment and decisions;
- act as a focal point for local service integration and better service paths between local and specialist services;
- plan local health services and health improvement and contribute to the planning of services across Greater Glasgow;
- be a key partner in community planning processes particularly regeneration;
- involve patients and the local community;
- work in partnership with other key Local Authority functions including education and culture and leisure;

Our proposal is that the CHP should be:

- jointly governed by the NHS and Local Authority;
- have formal links to staff and public partnership fora and community planning structures;
- include a Professional Executive Committee with clear responsibilities;
- have a management team which brings together managerial and professional leadership.

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That proposal is illustrated diagrammatically below:



We believe these arrangements balance the need for real professional and clinical involvement with the requirements of proper and balanced governance and offer the opportunity to meet the requirements of Local Authorities to consider delegating services and functions into CHPs. Our LHCC Professional Committee has supported this approach.

The draft guidance from the Scottish Executive would not enable this model of governance and we continue to try to influence the shape of the final Scottish Executive guidance alongside our Local Authority partners.

2.6 Health Improvement

One of the most important responsibilities of CHPs will be to drive health improvement and tackle inequalities in their area, both through their own functions and in partnership with other organisations. A sub group of the NHS CHP Steering Group has developed a discussion paper on how CHPs can deliver their health improvement responsibilities and that thinking is now being debated in our Local Authority based groups.

We are continuing to work through the implications for the public health, health promotion and planning functions, presently managed at Board HQ of the development of CHPs. It will be critical that we balance the delegation of resources and expertise to CHPs with the need to discharge the Board's strategic responsibilities and recognise small specialist functions.

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2.7 Primary Care Division Services

The Primary Care Division has established a detailed review of its services and support management to finalise proposals on the migration of responsibilities.

2.8 Engagement with LHCCs

In its April consideration the Board gave a particular commitment to ensure the full engagement of all primary care practitioners in the migration from LHCCs to CHPs. The LHCCs are fully involved in the CHP establishment processes with each of the Local Authorities outside Glasgow City. For Glasgow City's five CHPs we have now launched local development groups bringing together LHCC leads and Area Social Work staff with health improvement specialists to anchor our work with the City Council in a local structure.

C. CONCLUSION

- 3.1 There is a substantial programme of work in place to ensure we can offer the Board fully developed schemes of establishment for consultation in December. Resolving the outstanding debate around governance and accountability will be critical to ensuring we can deliver the fully integrated CHPs which will maximise the service improvement for patients and our ability to tackle wider health issues.