

Greater Glasgow NHS Board

Board Meeting

Tuesday 21st December 2004

Board Paper No. 2004/64

Director of Planning and Community Care

Community Health Partnerships: Progress Report and Model Scheme of Establishment

Recommendation:

- the Board note this work in progress.

A. BACKGROUND AND PURPOSE

1.1 The NHS White Paper “Partnership for Care” published in February 2003 introduced the construct of Community Health Partnerships (CHPs) to be established from April 2005 with scheme of establishment to be submitted to the Scottish Executive Health Department (SEHD) by December 2004. The purpose of this paper is to:

- B. restate our objectives for CHPs;
- C. describe our position in relation to national guidance and regulations;
- D. share the draft model scheme of establishment for an integrated CHP;
- E. report progress with each Local Authority.

B. OUR OBJECTIVES FOR CHPS

2.1 The NHS Board has discussed the development of CHPs in informal and formal meetings over the last 12 months. Three substantial reports have been considered by the Board:

- Community Health Partnerships: Boundary Proposals and Principles (January 2004);
- Community Health Partnerships - Outcome of Consultation on Initial Boundary and Service Proposals (April 2004);
- Community Health Partnerships - Update (October 2004).

Alongside these papers the Board has also considered related issues, for example, the development of integrated mental health services.

2.2 The White Paper proposed that CHPs should be new organisations which would deliver:

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- 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.

2.3 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.

2.4 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.

2.5 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.

2.6 These aspirations and objectives have driven our work in developing schemes of establishment with each Local Authority and the draft model scheme of establishment for fully integrated CHPs, which is attached to this paper reflects that approach. The purpose of this model scheme is to provide a framework within which the detailed work with Local Authorities is being undertaken so that we have a degree of consistency on key principles. It has also enabled us to engage with key professional interests and to ensure the NHS CHP Steering Group, which includes substantial partnership representation, has been fully involved in discussing key policy issues.

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C. NATIONAL GUIDANCE AND REGULATIONS

3.1 During the development of national guidance and regulations in relation to CHPs we have consistently sought to ensure that there is flexibility to construct the organisation and governance of CHPs to reflect the extent to which they are full partnerships with Local Authorities rather than a relatively limited NHS reorganisation. The final guidance and exchanges with the Scottish Executive Health Department indicate that this flexibility is potentially available. Demonstrating the additional value of our CHP in five key areas is likely to be critical. These are that:

- the CHP is designed to facilitate much stronger and more effective working relationships between specialist services and primary care and will improve care pathways for patients;
- NHS professional staff are fully and properly represented within the CHP structure;
- governance arrangements are appropriately balanced to reflect the level of NHS and Local Authority delegation;
- the proposed CHPs will add value to existing programmes to integrate and improve services - particularly in relation to children's services;
- CHP proposals are able to demonstrate real gain in terms of democratic and community accountability and the potential of the Local Authority leadership role in wider health improvement being more systematically linked to the NHS;
- CHPs will play a substantial in terms of community planning.

3.2 Our objective in promoting this integrated model scheme of establishment is to ensure and demonstrate that our proposals provide added value to the minimalist model in the guidance.

D. PROGRESS WITH EACH LOCAL AUTHORITY

4.1 This section briefly outlines our position with each Local Authority. The focus of our present discussions include:

- reaching agreement on what Local Authority budgets, services and functions will be delegated into the CHP - recognising, as outlined in the model scheme, that both parent bodies retain their statutory and employer responsibilities;
- finalising management arrangements for the CHP, most particularly endeavouring to agree the joint director and reporting arrangements outlined in the draft model scheme;
- agreeing the detail of the make up of the CHP Committee in each Local Authority area;
- seeking to establish the principle that children and family social work services should be included in the CHP, offering the opportunity to establish integrated health and social care teams to work with vulnerable children and their families.

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4.2 Summarising the present position with each Authority:

- Glasgow City Council is considering the extent and construct in which they would be prepared to establish CHPs on a more integrated model.
- East Dunbartonshire had agreed before Partnership for Care to establish integrated health and social care services under a single head of community care - already appointed - these arrangements to be fully established from April 2005. We have now agreed, in principle, that children and families social care services should be managed within the CHP.
- West Dunbartonshire - we have agreed a single director post and we are in dialogue with the Council about their proposal that limited elements of community care services are delegated to the CHP without any explicit or timed commitment to any further delegation. For children's services, there is no agreement to seek, even at a principle level, to include any children and families social work within the CHP, we also wish to continue that discussion.
- East Renfrewshire - we have in principle agreement for adult community care and children and families social work to be included within the CHP but there are remaining issues about joint management arrangements at CHP director level.
- South Lanarkshire have concluded that they do not wish to delegate any Local Authority services into the CHP and that Councillors should not participate in the governance arrangements. A further discussion is planned to consider with the Council how local services could be managed given that position and the relatively small size of Rutherglen/Cambuslang.

4.3 Our objective is to conclude these discussions by negotiation and dialogue but without compromising the key principles embedded within the model scheme - most particularly the need to relate governance and management arrangements directly to the delegated responsibilities carried by the CHP.

E. FURTHER WORK

5.1 Finalising the schemes of establishment for consideration by the Board is only one element of the extensive programme of work which is required to deliver CHPs. Other key elements which are still subject to detailed work include:

- developing schemes of delegation and governance which meet the requirements of both partners most particularly in relation to financial control, audit and performance management;
- agreeing support functions to CHPs including finance, human resources and information;
- developing the final structures, roles and responsibilities for the key components of the CHPs, alongside the organisational changes to the rest of the NHS, most particularly for public health, planning and health improvement;

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- ensuring that we have clear communication and launch plans for CHPs to fully engage their communities.

F. NEXT STEPS

- 6.1 Our aim is to finalise schemes of establishment for Board and Local Authority approval during January, for submission to the SEHD by the end of that month. The Board Chief Executive has briefed the Acting Head of the SEHD on our present position and likely timeline for finalisation and submission. We have agreed with the SEHD that the draft model scheme of establishment will be submitted and replaced by individual schemes as they are approved by the NHS Board and each partner Local Authority.
- 6.2 This revised draft model scheme will also enable further dialogue with the key professional interests to ensure their concerns have been addressed. There will also be a further round of dialogue on the migration arrangements for services and functions presently managed by the Primary Care Division, the outcome of which will clearly illustrate how the highly effective operation of the PCD will be delivered in the revised working arrangements. It is recognised that the substantial change which CHPs represent alongside the rest of the NHS reorganisation means that, although we are aiming for establishment at April 2005, there will need to be a coherent programme of development and migration of responsibilities over the following 12 months.

COMMUNITY HEALTH PARTNERSHIPS DRAFT MODEL SCHEME OF ESTABLISHMENT FOR FULLY INTEGRATED MODEL

1. Fundamentals

The CHP will be called and will cover a population of living in the area

There are GP practices in the area with a population of

The CHP brings together NHS and Local Authority responsibilities but retains clear individual agency accountability for statutory functions, resources and employment issues. It is a partnership organisation not a separate, new entity. The purpose of the CHP is to:

- manage local NHS and social care services;
- improve the health of its population and close the inequalities gap;
- play a major role in community planning;
- achieve better specialist care for its population;
- achieve strong local accountability through the formal roles for lead councillors and the engagement and involvement of its community;
- drive NHS and Local Authority planning processes.

The CHP will be characterised by:

- reduced bureaucracy and duplication;
- modern and integrated community health and social care services focused on natural localities;
- integrated community and specialist health care through clinical and care networks;
- organisations which support achievement of service delivery;
- ensuring patients and a broad range of frontline health care professionals are fully involved in service delivery, design and decisions;
- shared governance and accountability with the Local Authority and substantial responsibility and influence in NHS resource deployment;
- a central role in service redesign;
- a pivotal role in delivering health improvement.

Priorities for development include:

- better care pathways for patients;
- a clear programme to tackle health inequalities;
- community involvement;
- realising the gains for patients of fully integrated local services;
- reduced bureaucracy and duplication;
- bringing a substantial population focus to the work of the whole of the NHS.

2. Services Managed

For the NHS the CHP will:

- Directly manage the following services:
 - health visitors;
 - district nurses;
 - relationships with primary care contractors;
 - mainstream school nursing;
 - local older people and physical disability services;
 - chronic disease management programmes and staff;
 - oral health action teams;
 - allied health professionals;
 - palliative care;
 - addictions and learning disability services;
 - local adult mental health and older people's mental health services;
 - possibly community child health, child and adolescent mental health subject to Child Health Strategy Group process.

- Hold budgets and contracts for the following services:
 - service level agreements for direct access;
 - primary care contracts;
 - SEN school health;
 - Prescribing;
 - health improvement and promotion.

- Participate in the management arrangements for the following services:
 - non local mental health services;
 - non local older people and physical disability services;
 - community midwifery services;
 - acute and children's services;
 - community planning.

- Subject to outcome of review of present Primary Care Division functions a CHP may host services on behalf of others.

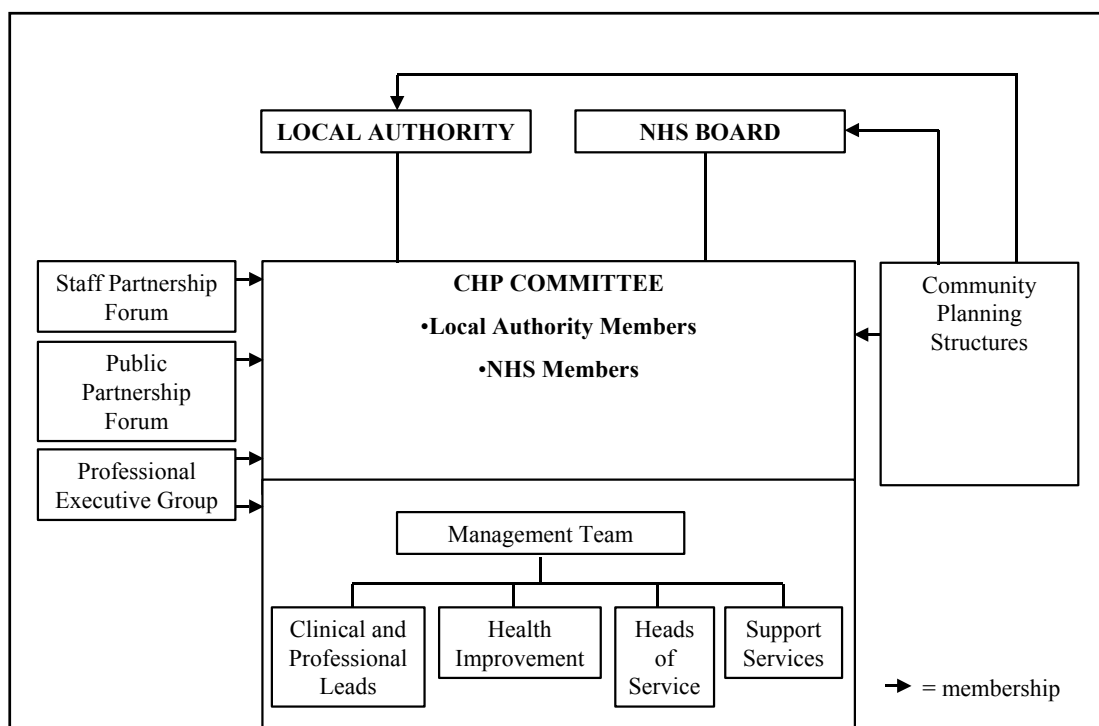
In the fully integrated CHP model we would expect individual schemes of establishment to set out substantial delegation of Local Authority social work services into the CHP to match the high level of NHS delegation outlined above.

A particular objective is to see the principle agreement that children and families social work services are managed within the CHP creating the medium term opportunity to achieve integration with local NHS children's services. Potential benefits of such arrangements include:

- improve coordination of assessment, care management and intervention;
- simplified access for patients;
- a stronger focus on vulnerability, early intervention and inclusion;
- shared specialist teams bringing together complementary NHS and social care professionals;
- shared systems and decision making for child protection;
- reduced interfaces, negotiations and gaps between services.

3. Governance Arrangements and Relationships

Our governance arrangements reflect the fact that the CHP will be a full partnership between the NHS and the Local Authority. They will have four components which are described in detail below and can be diagrammatically represented as:



- The CHP Committee

The purpose of the Committee is to set budgets within the CHP allocation, to take a strategic overview of the CHP's activities, priorities and objectives and to hold to account the management team for the delivery of the CHPs annual plan, which that team should develop, in partnership with the PEG. The Committee will not make operational decisions or micro manage the CHP's activities.

The members of this Committee will be appointed by the NHS Board and approved by the Local Authority:

Membership of the Committee will include a balance of NHS and Local Authority members - each scheme of establishment will propose the members and make-up of the Committee.

The NHS members will include a minimum of three NHS representatives nominated by the Professional Executive Group and an NHS Board Non Executive.

In addition to NHS and Local Authority members the staff partnership and public partnership fora will also nominate a CHP Committee member and there will also be arrangements to include the voluntary sector.

The Chair of the CHP will be a local councillor in the area covered by the CHP and, where possible, a member of the NHS Board.

The intention is that the Committee should arrive at decisions by consensus and individual schemes of establishment will set out arrangements to deal with disagreements which do not compromise the statutory responsibilities of either partner.

The Committee will not manage the day to day operation of the CHP and will be advised in professional matters by the Director and the Professional Executive Group.

- The CHP Management Team arrangements

The CHP will be managed by a Director appointed jointly by the NHS Board and Local Authority separately accountable to:

- the NHS Board Chief Executive;
- the Chief Executive of the Local Authority;

for a delineated range of functions, and directly accountable to both Chief Executives where the function is a joint one, for example, health improvement and health inequalities. The functions which fall into each of these accountabilities will be clearly set out.

The CHP Director will be jointly appointed by the NHS Board and Local Authority and may be an employee of the NHS or Local Authority depending on the background and circumstances of the agreed candidate.

- The Professional Executive Group (PEG)

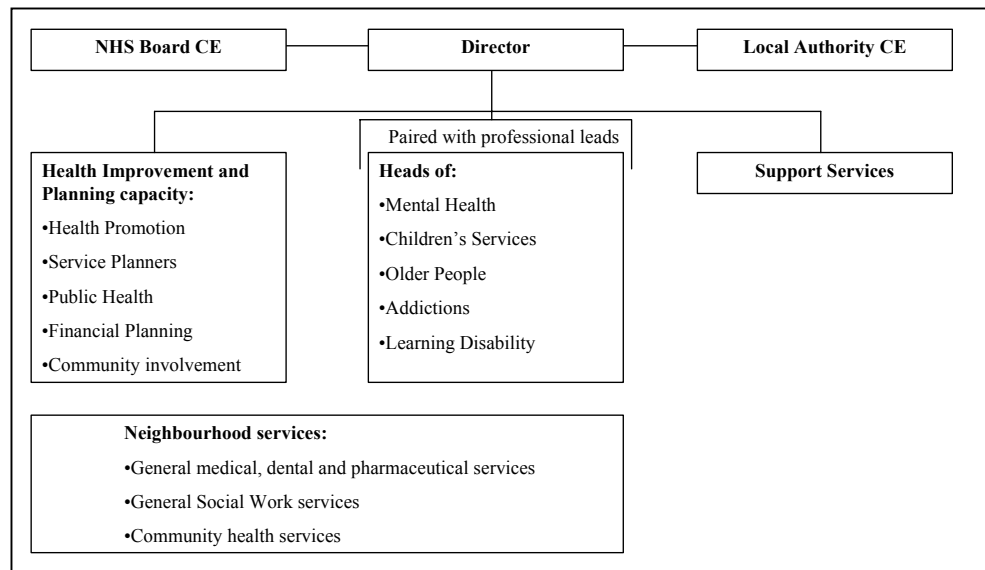
This Group is the key way to involve frontline staff in the governance and decisionmaking for the CHP. We also expect that the CHP will have a wide range of planning and working groups which will fully involve professional staff, across the range of its activities. The Group will include an older people's medicine consultant, a psychiatrist, a paediatrician, a psychogeriatrician, general practitioners, a nurse, an AHP, a pharmacist, a dentist, an optometrist and social workers.

The consultant members will be nominated by the relevant NHS Division. Lead professionals will be nominated by the local staff of that profession. The three representatives on the CHP Committee will be nominated from the local practitioner members of the Group.

The Professional Executive Group (PEG) will be fully meshed with the CHP Committee and an integral part of the management team. It will have clear responsibilities to lead service redesign, planning and prioritisation. Its members will include all of the professions covered by the CHP and clinical input from specialist divisions including acute services, child health and mental health;

- The Management Team

Will include managers, clinical and professional leads as shown below.



Members of the management team may be employed by either the NHS or Local Authority, but given the particular statutory responsibilities it is proposed that the mental health lead is an NHS employee and the lead for children's services is a Local Authority employee. Each member of the management team will manage health and social care services in their defined area of responsibility.

- Public Partnership Forum (PPF)

The PPF will provide the formal component of voluntary sector and community engagement within the CHP, but it is only one component of creating the vision for engagement of CHPs as:

“inclusive organisations whose processes for strategic and service development engage stakeholders, users and communities throughout, in accordance with the Community Planning Standards. That CHP staff at all levels recognise and utilise the experience and views of communities to the betterment of service provision and foster ownership that bridges people to services and services to people.”

The corporate management of community engagement and the PPF will be managed through the Head of Health Improvement and Planning.

The PPF will include a wide range of community and voluntary sector organisations in a virtual network utilising community planning processes and existing local structures, that will have periodic opportunities to be informed and engaged in line with local needs/requirements.

The virtual PPF network will come together formally through a PPF Executive Group which will be a mix of sought representation (including equalities, carers and other key groups operating across CHP areas from recognised local engagement processes and self selected membership. The PPF Executive Group will elect annually representatives for the CHP Committee.

The structures and mechanisms for membership and operating of the PPF will be informed by the Community Engagement Strategy for Community Planning currently being developed in Glasgow City.

Beyond the PPF the CHP will be responsible for developing as a:

- visible and engaged organisation - through staff involvement in key local public forums, community events, community planning;
- organisations with a capacity to create opportunities for users and communities to learn about their services and structures - proactively enabling local communities and organisations to understand how CHPs work and how to influence them;
- able to inform residents and users of the range of services and business of the CHP;
- active in all aspects of engagement from information provision and consultation, through to influencing service delivery (including community management of services where appropriate and agreed) to quality management and accountability;
- pursues the views of users and hard to reach communities through formal structures, eg, young people, BEM communities, etc;
- able to adapt for engagement, eg, with translation, physical access and other physical and social adaptation facilities available to enable engagement of people with a wide range of needs;
- staff skilled in managing conflict and opposition between communities and between communities and service providers.

- Staff Partnership Forum

Each CHP will include a staff partnership forum covering all of its employees and meeting the relevant governance standards of both partner organisations.

- Specialist and Non Local Services

Critical to the success of the CHPs will be ensuring they work with the Acute Division and other specialist services to improve services for patients. In the context of the wider reorganisation of the NHS in Greater Glasgow we intend to take the opportunity to create strong and effective management and clinical relationships to drive change between local and specialist services. Our approach to achieve this objective has a number of complementary strands:

- involvement of clinical leaders from key specialities, including older people's medicine, paediatrics and psychiatry in the CHP management arrangements and in local service delivery teams;
- creating a strong geographic focus within our proposed single Greater Glasgow Acute Division which will ensure direct senior management connection and cross population of the Acute Division and CHP management teams;
- organisational arrangements for rehabilitation and enablement services, women and children's and adult mental health services which fully engage the CHPs at the heart of decision making for those services and ensure the important vertical integration between hospital and community care is strengthened.

In terms of other connections, the CHPs planning and policy structures will include representatives of key Local Authority departments, education, leisure and housing as well as local housing associations and the voluntary sector.

The framework for these relationships is described in more detail in Section 6 on planning and development which illustrates how planning and performance management arrangements will underpin whole system working.

- Finance

The CHP will be allocated funding on an agreed basis for the defined range of functions, by the Council and GGNHSB. Those budget allocations will be based on synchronised planning processes and a transparent approach to addressing identified pressures and issues. The CHP Committee will set budgets for its activities within the overall allocation.

Detailed financial delegation and monitoring arrangements will be developed. They will include regular reporting into the Local Authority and NHS system, a combined set of financial protocols reflecting the requirements of both organisation and related audit requirements. Budgets will be aligned and not pooled, therefore there will be a clear track from expenditure to each allocating body.

The CHP Director, as with any Local Authority or NHS Director, will be responsible for remaining within the allocated budgets and accounting to the Local Authority and NHS Chief Executive for financial probity and performance.

In the case of cross boundary CHPs the two NHS Boards will have a consistent approach to allocations.

- Strategic Framework and Statutory Responsibilities

The CHP will be expected to operate with the strategic frameworks established by the Local Authority and NHS Board and to meet the statutory obligations of both bodies. There will be synchronised performance management arrangements to ensure the CHP activities are fully integrated into the corporate governance arrangements of both organisations. The wider reorganisation of NHS Greater Glasgow will provide a sharper focus on planning and performance management systems to ensure proper accountability back to the NHS Board.

4. Joint Futures

All service, planning and financial joint futures arrangements will be migrated into this CHP structure which will:

- fully align budgets for local services;
- deliver integrated management arrangements;
- achieve aligned service and resource planning cycles.

5. Health Improvement

We are constructing CHPs as “health” organisations resourced and responsible for making a difference to the health of their population and reducing inequalities and as partners in working with other organisations to improve health.

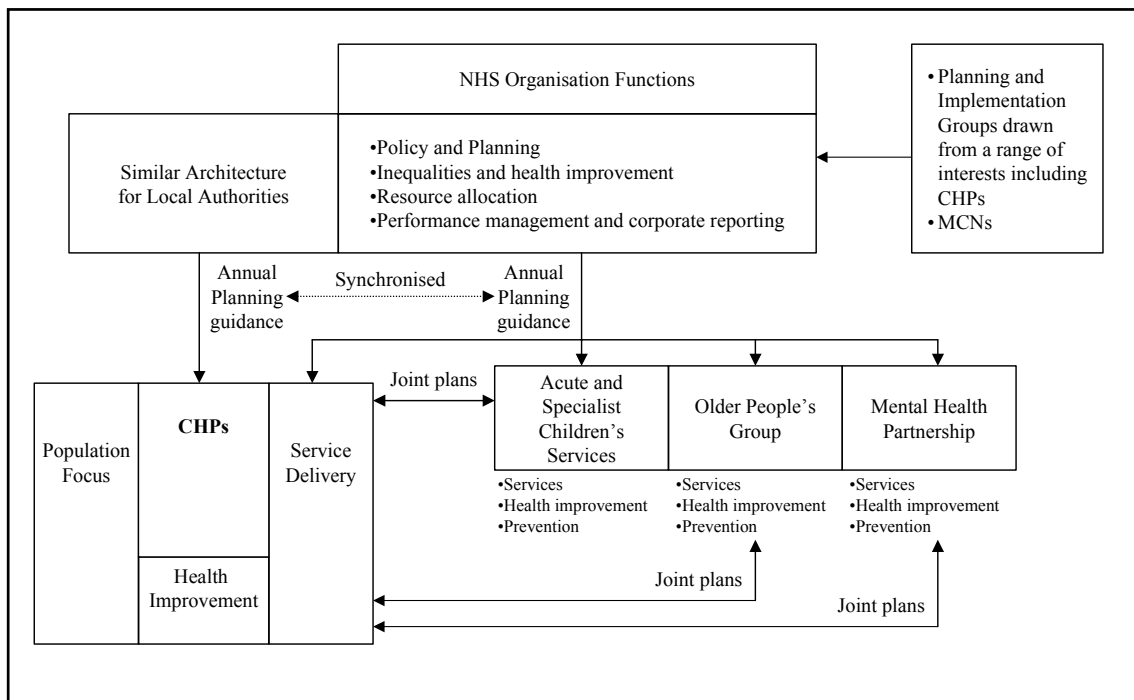
This means:

- CHPs will lead the locally based health improvement effort, covering life circumstances and lifestyle action;
- a senior officer will have responsibility for leading health improvement within the CHP;
- the CHP will be developed as a public health organisation embedded within the NHS and Local Authority;
- the facilitation and integration of community involvement will be core to the CHP through a Public Partnership Forum;
- CHPs will lead the “health” contribution to local community planning;
- CHPs will have specialist health improvement resources bringing together staff from the LHCC, health promotion and local government forming a specialist health improvement team, supporting the public health orientation and activity of a wide range of non specialist CHP staff;
- CHPs will produce an annual health improvement and inequalities plan delivering on NHSGG wide priorities but also reflecting local circumstances and a full partnership with local government;
- CHPs will contribute to the development and delivery of regeneration outcome agreements;
- all of the CHP management team will have responsibility for health improvement in their area, supported by the specialist resources. This connection of service delivery and health improvement will drive a focus on addressing inequalities by targeting resources and services. In addition, service delivery will reflect the imperatives of health improvement. Rather than prevention and inequalities being squeezed out by the imperatives of health and social care delivery we intend to see service delivery driven by the imperative to prevent ill health and improve health.

The wider reorganisation of the NHS in Greater Glasgow will enable CHPs to have a wide range of further specialist support for their work.

6. Planning and Development

The CHP will be responsible for the planning and development of the services it directly manages and will participate in the development and delivery of the full range of services to its population. The diagram below illustrates the planning system which will be established by NHSGG in partnership with the Local Authority.



Within the planning framework established by the NHS and the Local Authority, the CHP will produce a three year plan for the range of its responsibilities including resources, service delivery, health improvement and tackling inequalities. That plan will include agreed joint components for acute, older people's, mental health and children's services

These joint plans will also cover shared care groups, chronic disease, demand management and access issues and service redesign and improvement.

7. Improving Service Quality

Section in development:

- Build on chronic disease and management.
- Consolidate gains of present integration.
- Organise local services around patients:
 - integrated older people;
 - children's;
 - mental health.
- Stronger clinical and professional involvement:
 - PEG;
 - funded clinical time;
 - acute/paediatric/psychiatry embedded in services and management structure.
- Local Improvement targets.

8. Reducing Bureaucracy

The development and implementation of integrated CHPs will enable us to reduce bureaucracy in a number of different ways. At a headline level these include:

- reducing duplication in management and planning between the Primary Care Division, NHS HQ and Local Authorities;
- for the cross boundary CHPs reducing duplication in working with those Local Authorities caused by having two NHS Boards;
- creating single local governance and management arrangements to replace the web of structures established around Joint Futures;
- offering the potential to rationalise support functions between the NHS and Local Authorities.