

Greater Glasgow NHS Board**Board Meeting**Tuesday 1st February 2005

Board Paper No. 2005/01

Director of Planning and Community Care

Community Health Partnerships (CHPs):

- **Scheme of Establishment for East Dunbartonshire Council's Health and Social Care Partnership**
- **Progress on CHPs with Glasgow City Council**

Recommendations:

- **the Board:**
 - **approve the proposed scheme of establishment for a Community Health and Social Care Partnership with East Dunbartonshire Council;**
 - **note progress in developing CHPs with Glasgow City Council**

A. EAST DUNBARTONSHIRE

- 1.1 Attachment 1 to this paper is the draft scheme of establishment for a Health and Social Care Partnership covering the East Dunbartonshire Council area. The proposal builds on our existing agreement with the Council, which preceded "Partnership for Care", to integrate health and community care services.
- 1.2 The draft scheme has been developed through a process led by a Joint Executive Group including representatives of the two Local Health Care Cooperatives in the area, the NHS Board, the Primary Care Division and Officers of the Council.
- 1.3 There has been active engagement of the Joint Staff Partnership Group, which has been established for two years, under the Joint Futures arrangements. The present Joint Health and Community Care Committee including GGNHSB Board members has considered the draft scheme on three occasions. The full Council has considered and approved the scheme, recognising NHS Board approval is also required before it can be regarded as final.
- 1.4 In terms of content, the scheme is in line with the principles and policies established by the NHS Board in relation to CHPs, most recently consideration of a draft model scheme of establishment at the December Board meeting. Most particularly, the scheme includes children and families social work services within the CHP structure and establishes a joint

EMBARGOED UNTIL MEETING

director post to lead the CHP reporting to the NHS Board and East Dunbartonshire Chief Executives. That post will be supported by Heads of Children's Services and Community Care, managing the full range of local NHS and social care services, outlined in the scheme. The "in principle" proposals for NHS children's services reflect discussions to date. The Child Health Strategy Group is overseeing detailed work, still to be concluded, both in terms of the management arrangements for smaller services - not presently provided in every CHP area, and a framework for service integration.

- 1.5 The scheme is in the format prescribed by the SEHD and does not set out the detail of how the CHP will operate. In terms of next steps, subject to Board approval the scheme will be submitted to the SEHD for approval. The paper and model draft scheme of establishment at Attachment 2 have already been submitted to the SEHD, as agreed at the December Board. In parallel to SEHD consideration we will develop detailed implementation proposals to establish the new Partnership Committee and the CHP management arrangements. Progress will be regularly reported to the NHS Board.

B. PROGRESS WITH GLASGOW CITY COUNCIL

- 2.1 The administration at Glasgow City Council has been considering how it wishes to participate in Community Health Partnerships and a paper which has emerged from that consideration will be put to the Council's Policy and Resources Committee next week. Pending that Committee the Council will not have a formal position. It is our expectation that the proposal for Committee approval will be that Council officers are authorised to negotiate with us to establish fully integrated CHPs led by joint directors, but with clear lines of accountability into social work services, in relation to the Council's statutory responsibilities, and clear professional social work, leadership within each CHP. If that recommendation is put and approved we will proceed to work with Council officers to develop a detailed scheme of establishment within the policy parameters set by the Board, in the draft model scheme of establishment and the policy parameters which the Council decisions establish.

Publication: The content of this Paper may be published following the meeting.

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East Dunbartonshire Council

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EAST DUNBARTONSHIRE COMMUNITY HEALTH AND SOCIAL CARE PARTNERSHIP

DRAFT SCHEME OF ESTABLISHMENT (final)

1 INTRODUCTION

- 1.1 This Scheme of establishment has been prepared in terms of regulation 10 of the Community Health Partnerships (Scotland) Regulations 2004.
- 1.1 This proposal is presented jointly by Greater Glasgow NHS Board and East Dunbartonshire Council and seeks approval to establish a **Community Health and Social Care Partnership** for the East Dunbartonshire area.
- 1.2 Having regard to this context, the Scheme of Establishment also seeks approval, under the terms of Regulation 3(4) and (5) of the said regulations, to vary the membership of the Partnerships governing Committee as detailed later in Section 7.
- 1.3 The draft Scheme of Establishment has been the subject of development over a number of months with all parts of the existing joint planning structures, as well as the separate organisational and professional interests of interested stakeholders, having had the opportunity to engage with and lead the development of specific proposals.
- 1.4 In particular the draft Scheme was formally considered by Greater Glasgow NHS Board at its meeting in January 2005 and by East Dunbartonshire Council on 13th January 2005.

2 FUNDAMENTAL INFORMATION AND OBJECTIVES

- 2.1 The proposed boundary of the Partnership will be coterminous with the boundaries of East Dunbartonshire Council. The main population centres included are Bearsden, Milngavie, Bishopbriggs, Kirkintilloch and Lenzie along with a collection of smaller more rural villages such as Milton of Campsie, Lennoxton and Twechar. The total population of the Council area is 109,400.
- 2.2 The Partnership will encompass the existing Strathkelvin LHCC (Local Health Care Cooperative) with the Bearsden and Milngavie parts of the current Anniesland, Bearsden and Milngavie LHCC. The new Partnership area will then cover a total of 17 GP practices (11 from Strathkelvin and six from Bearsden and Milngavie) with a total practice population of some 100,087 (as at October 2004). The Partnership area will also include 25 dental practices, 20 pharmacies and 15 opticians.
- 2.3 It should be stated from the outset that the intention has been to build on the progress that has already been delivered locally both within the NHS family, as well as a result of the long history of joint working between the Council and the local NHS partners.

- 2.4 Before the publication of the proposals to establish Community Health Partnerships across Scotland, the local joint working arrangements had already produced agreements of principle that would deliver a fully integrated service for Community Health and the Council's Community Care services, in order to implement the requirements of the Joint Future agenda.
- 2.5 It is intended that community services will be delivered and managed, where practical to do so, in two sub localities within the Partnership which reflect the different geographical and demographic issues between the Kirkintilloch/Bishopbriggs area and the Bearsden and Milngavie area. While these two sub localities have been identified, the Partnership will seek to ensure that a strong area wide sense of consistency and equality will remain.
- 2.6 Therefore, our starting point is one where the NHS Board and East Dunbartonshire Council are already substantive partners in the wider Partnership development process. Further, based on previous agreements, the aspiration is for both statutory partners to make significant service contributions to the new proposed Partnership under appropriate governance and accountability arrangements.
- 2.7 These current proposals sit within the wider context of the Council's Community Planning structure and have been identified within the recent review of the Community Planning arrangements for the area as a key vehicle in delivering the health and wellbeing objectives within the Community Plan.
- 2.8 The basis for continued joint working is found primarily within existing joint plans and strategies such as the East Dunbartonshire Community Plan; the Joint Community Care Plan and the Extended Local Partnership Agreement for Community Care services; the Children's Services Plan; the pre-existing Primary Care Strategy for Greater Glasgow; and the existing LHCC Development Plans and Priorities as one way of trying ensure the continuation of engagement and involvement of primary care practitioners.
- 2.9 The fundamental purpose of the Partnership is therefore 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 enhanced roles for local democracy;
 - support the engagement and involvement of its community; and
 - drive NHS and Local Authority planning processes.
- 2.10 It is intended that the Partnership will be characterised and motivated by the desire to:
- reduce bureaucracy and duplication;
 - modernise and integrate community health and social care services focused on natural localities;
 - integrate community and specialist health care through clinical and care networks;
 - promote continuous improvement and best value in the delivery of services;
 - ensure clients, their families and carers and a broad range of health care professionals are fully involved in service delivery and design decisions;
 - share governance and accountability with the Local Authority;
 - increase responsibility and influence in NHS resource deployment;
 - develop a central role in service redesign; and
 - establish a pivotal role in delivering health improvement.

- 2.11 Initial priorities for the development of the Partnership will include:
- better care pathways for clients;
 - a clear programme to tackle health inequalities;
 - community involvement;
 - realising the gains for clients of fully integrated local services;
 - reducing bureaucracy and duplication; and
 - bringing a substantial population focus to the work of the whole of the Partnership.
- 2.12 The development and subsequent implementation of these proposals will also provide a solid foundation and bridge to the other services and functions of both the Council and the wider NHS system that are not formally part of the Partnership. This, when seen in the wider context of the Community Planning arrangements within East Dunbartonshire, provides a comprehensive strategic framework within which the NHS and the Council, along with the other public agencies who operate within the area, can develop and deliver services to the maximum benefit of East Dunbartonshire residents.

3 IMPROVING HEALTH

- 3.1 The expectation that Partnerships should be the primary vehicle for promoting the health of their population is a welcome development and a responsibility that this Partnership takes seriously.
- 3.2 Within the context of the Community Planning arrangements for East Dunbartonshire, the statutory agencies all recognise the wider role that they have collectively and individually to deal with the factors that contribute to poor health.
- 3.3 It is intended to create the Partnership with the responsibility and resources necessary for making a difference to the health of the population.
- 3.4 This means that the Partnership:
- will lead the locally based health improvement effort, covering life circumstances and lifestyle action;
 - will identify a senior officer to have responsibility for leading health improvement within the Partnership;
 - will be developed as a ‘public health’ organisation embedded within the NHS and Local Authority;
 - will promote facilitation and integration of community involvement as core to the Partnership through a Public Partnership Forum;
 - will assume the lead role for the delivery of the health and wellbeing objectives of the East Dunbartonshire Community Plan;
 - 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 Partnership staff;
 - will produce an annual health improvement and inequalities plan delivering on NHS/SGG wide priorities but also reflecting local circumstances and a full partnership with the Council and other community planning partners.
- 3.5 All of the 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 towards those objectives.
- 3.6 In addition, service delivery will reflect the imperatives of health improvement. Rather than prevention and inequalities being squeezed out by the immediacies of health and social care delivery we intend to see service delivery driven by the priority to prevent ill health and improve health. The wider reorganisation of the NHS in Greater Glasgow

will enable the Partnership to have a wide range of further specialist support for their work.

- 3.7 We do however see an obvious link between the need to improve overall the ‘health’ of the population that is served by the Partnership and the desire to ensure that the services that are delivered by, through and on behalf of the new Partnership, are subject to continuous improvement. This, along with the identification of the need for the development of new and different services, will be a priority for the Partnership.

4 IMPROVING SERVICES

- 4.1 Delivering improved services for the population of the area is a fundamental objective of the Partnership. In developing these proposals, the NHS Board and the Council have identified a number of areas where the new Partnership will provide an opportunity to further improve performance:

- as a vehicle for further community based service integration where considered appropriate (including the continued implementation of the local response to the Joint future agenda);
- to improve relationships between community based services with secondary and specialist services as a reflection and requirement of the ongoing investment in new hospital provision, and the associated redesign of services;
- to provide a focus for the continued development of comprehensive approaches that will improve the health of the community that is serviced by the Partnership;
- to develop networks between primary, secondary and social care and the development of joint services where appropriate; and
- in the delivery of health and social work services for children and their families.

- 4.2 The initial priorities are around establishing the new working arrangements for the Partnership, and ensuring the smooth transition from the current position. This is of particular importance in respect of the existing clinical priorities of the LHCCs who will migrate into the new Partnership.

- 4.3 A critical factor to the success of the Partnership will be the extent to which it is able to deliver improvements around the primary/secondary care interface. There is recognition that the Partnership will need to work alongside other adjoining CHPs who share access to the same secondary care services. Similarly, the Partnership will need to be involved in the development of the wider network services for particular specialties that are planned and delivered on either Greater Glasgow or a West of Scotland basis.

- 4.4 It is expected that the Professional Executive Group will have a lead role in ensuring that these relationships are established and maintained.

- 4.5 Our developmental agenda has already been detailed in the Extended Local Partnership Agreement to cover community care services, and in other inter agency strategies and agreements such as the LHCC Development Plans.

- 4.6 Lastly we will want to evidence our service improvements in due course through reporting in the Performance Assessment Framework (PAF) for the NHS, the Council’s Performance Report (incorporating Statutory PIs) and the Local Improvement Targets established under the Joint Future requirements.

5 IMPLEMENTATION OF JOINT FUTURE

- 5.1 The local implementation of the recommendations of the original Joint Future report, and subsequent policy initiatives, has formed a very clear foundation upon which the

proposals for this broader Partnership have been developed. The local arrangements for implementing the Joint Future requirements are being fully subsumed within the responsibilities of the new Partnership. This includes the responsibility for resource transfer and support finance.

- 5.2 The Extended Local Partnership Agreement (ELPA) for this area provides a more detailed narrative of activity in this area. The Scottish Executive's Joint Future Unit has recently assessed our implementation arrangements as 'well progressed'.
- 5.3 The continued development and usage of our Single Shared Assessment processes, with the associated improvements in both the formal sharing of information between professionals and informal communication networks, remain a priority for the Partnership.
- 5.4 Taking all of the forgoing into account, the new Partnership will be well placed to deliver on the 4 national outcomes for Joint future:
 - supporting more people at home, as an alternative to residential and nursing care;
 - assisting people to lead independent lives through reducing inappropriate admission to hospital, reducing time spent inappropriately in hospital and enabling supported and faster discharge from hospital;
 - ensuring people receive an improved quality of care through faster access to services and better quality services; and
 - better involvement and support of carers.
- 5.5 The existing Joint Health and Community Care Committee have already taken ownership of the Local Improvement Targets (LITs), and the new Partnership Committee will receive regular monitoring information on how the whole local system is performing. The Partnership Joint Committee will also be charged with ensuring that the Partnership delivers the requirements of the revised Joint Performance Information and Assessment Framework (JPIAF).
- 5.6 Additionally, we see the previous history and experience of joint working in the community care area – along with the work of the local Children's Services Core group – as providing a foundation for the further integration of NHS and social work services for children (see Para. 6.14 below).

6 SERVICES TO BE MANAGED BY THE PARTNERSHIP

- 6.1 Our proposal is that the Partnership will manage the following NHS services/ functions:
 - Community Nurses;
 - Relationships with Primary Care contractors;
 - Local Older People's services;
 - Chronic Disease Management programmes (e.g. local diabetes services);
 - Oral Health Action Teams;
 - Community Allied Health Professionals;
 - Palliative Care;
 - Local Addiction services, Physical Disability and Learning Disability services (where joint with the Council).
 - Local mental health services for adults and older people.
- 6.2 It is also proposed, given the importance of the Partnership's health improvement role, that Public Health Practitioners, geographically based Health Promotion staff and related budgets will be directly managed as well.

- 6.3 It is further proposed that prescribing budgets will be progressively devolved to Partnerships with the appropriate development of competency and management of shared risk across the wider NHS system. Additionally, consideration is being given to new approaches to involving primary care in the demand management and delivery of investigations conducted by secondary care. In conjunction with secondary care, there will be a sharing of responsibility through delegation to Partnerships for the use of aspects of laboratory and imaging functions. The Partnership will also expect to have oversight of local enhanced services under the new General Medical Services contract.
- 6.4 While the purpose of the new Partnership is to bring a significant local focus to the planning and provision of services (particularly from an NHS perspective), it is not the task of the Partnership to directly manage specialist acute services. However, these services will be provided to the population served by the Partnership, and we wish to see established a strong accountability and influence for the Partnerships on the way in which these services are planned and provided for our communities. We would expect these relationships to be led through the Professional Executive Group at a local level. These are set out more fully at Para. 7.21 below.
- 6.5 From the perspective of the Council, it is proposed that a range of its Social Work services and functions will also be directly managed within the Partnership arrangements. These are more easily grouped within the generic terms ‘community care’ (see 6.6 below) and ‘child care’ (see 6.12 below).
- 6.6 The term ‘Community Care’ is deemed to include the following services:
- Assessment and Care Management teams for Older People, Physical Disability, Mental Health and Learning Disability, including statutory interventions and other professional social work tasks;
 - Day and residential units for people with a Learning Disability;
 - Home Care (including the purchasing budget);
 - Hour Care 24 service;
 - Occupational Therapy
 - Purchasing budgets for Residential/Nursing Home care (including respite care);
 - Services provided via ‘Supporting People’ funding;
 - Planning and Commissioning for Community Care services;
 - Community Addiction Team;
 - Joint Equipment Store.
- 6.7 It will be necessary to provide clear processes which ensure that all the services that are provided within the new Partnership are clear about their accountabilities, responsibilities and interface arrangements with services out with the Partnership.
- 6.8 In addition to these directly managed services, we would expect to see established a formal accountability framework within which Mental Health services will be delivered into the Partnership from the wider Mental Health Network.
- 6.9 In terms of performance targets, the Partnership will be accountable from an NHS perspective within the usual Performance Assessment Framework (PAF) to meet the identified national and local targets.
- 6.10 Local Partnerships have only recently been required to submit their first Local Improvement Targets (LITs) to the Scottish Executive, and in our local situation these initial submissions have been assessed as meeting initial requirements. These targets will be reviewed and monitored as a routine part of the work of the Partnership and subject to scrutiny by the Joint Future Unit.
- 6.11 The Partnership will likewise be accountable within the Council’s Best Value regime for all social care services delivered by the Partnership.

6.12 CHILDREN'S HEALTH AND SOCIAL WORK SERVICES

6.13 As has been evidenced earlier in this draft Scheme, the local approach to the development of the new Partnership has had much to do with the strong history of joint activity between the Council and the NHS over recent years and particularly around the implementation of the response to the Joint Future Agenda.

6.14 It should however be emphasised that this history of joint work and development activity has not been restricted to community care services. The joint agenda for Children's Services has been every bit as active and the local Children's Services Core Group brings together senior representatives from the Council and the NHS with other Partners such as the Police, the Reporter and others, and is seen as a successful vehicle for delivering the common objectives and improved outcomes for children and their families.

6.15 Over recent months, as part of the development process for the new Partnership, the Children's Services Core Group have had to examine the potential impact of the new Partnership on existing services and potential future organisational arrangements.

6.16 The key conclusions of these discussions has brought about an 'in principle' agreement between the Council and the NHS Board that:

- NHS Children's services (Health Visitors, School Nurses, Community Child Health and Child and Adolescent mental health services) should be locally managed as opposed to the present arrangements where they are managed on a Greater Glasgow basis by the current Yorkhill and Primary Care Divisions;
- This change offers the opportunity to integrate the NHS and Social Work Children's Services, which in many instances are working with substantially overlapping client groups of children and families, for example, those that are vulnerable or have a disability. This operational integration would bring:
 - A further extension of the successful integration and better outcomes for children achieved to date through the work of the Core Group; and
 - A significant additional opportunity to improve services, strengthen child protection and further develop relationships across the totality of children's services in East Dunbartonshire (including for example schools).
- Whilst existing Council structures already offer a high level of integrated management and reporting, the new Partnership will provide the joint governance and accountability structures within which integrated children's health and social work services will report and furthermore will aid the development of extended partnerships with the wider health community. Although the Partnership is a fully joint body, which is to be chaired by a local elected member, it is proposed that the manager of the integrated children's service referred to must be an East Dunbartonshire Council employee. This is to recognise the specific statutory social work responsibilities of the local authority and builds on the effective integration and improved outcomes already achieved by the Council through its Community Directorate; and
- It is essential that the present Children's Services Core group arrangement, which is the key to joined up planning, policymaking, monitoring and effective resource management continues, and is strengthened to ensure that the activities of the new Partnership in relation to Children are fully linked to the rest of the Council's departments and functions as well as those of the other key partners, e.g. Police and Reporter to the Children's Panel.

6.17 These 4 principles will form the basis of a further programme of work to develop the detailed arrangements flowing from the 'in principle' decision.

6.18 An additional benefit delivered by the inclusion of an integrated children's service as outlined above, will be the continued viability of the present arrangements for a variety of support services and functions that currently support both child care and community care services within the existing social work service. There is also acknowledgment that with the proposed review across Greater Glasgow of the wider NHS system, there may well be opportunities more generally under the banner of 'efficient government' to consolidate a variety of support functions across the Council and the NHS. The new Partnership will be in a good position to benefit from any such revised arrangements.

7 ORGANISATIONAL ARRANGEMENTS

7.1 The NHS Board proposes that the new Partnership Governing Committee is established as a formal sub committee of the NHS Board to emphasise the status and significance that the Partnership will have within the overall NHS system within Greater Glasgow. The emergence of these new Partnerships has been a significant factor in the NHS Board's wider review of the local system.

7.2 Likewise, the Council proposes to establish the Partnership Committee formally within its Scheme of Administration. This would be as a sub-committee of the Social Services Committee but operating with the same delegated powers as the main Committee. Decisions that were beyond the delegated authority would require to be remitted to the full Council. The requirements of the Council's Standing Orders that require certain matters relating to resources to be referred to the Council's Policy and Resources Committee, will also remain in place.

7.3 The expectation is that both statutory partners will delegate significant and substantial authority to the Partnership Committee, albeit consistent with each Partner's Standing Orders, Schemes of Delegation and Standing Financial Instructions.

7.4 While the National Guidance on the development of CHP's recognises the powers that are available to Councils and NHS Boards under the Community Care and Health Act 2002, it is not deemed an acceptable or desirable local solution for either statutory partner to formally 'delegate' its functions to the other Partner.

7.5 In this situation, both statutory partners wish to establish a single integrated working arrangement through which the Council and the NHS Board will together plan/deliver/manage a range of agreed functions and responsibilities as detailed earlier within this draft scheme.

7.6 However, current legislation does not provide for such a joint solution to be promoted – particularly as the legislation surrounding the establishment of local authority committees and sub committees is significantly different to that governing who can and cannot be formal members of NHS Boards.

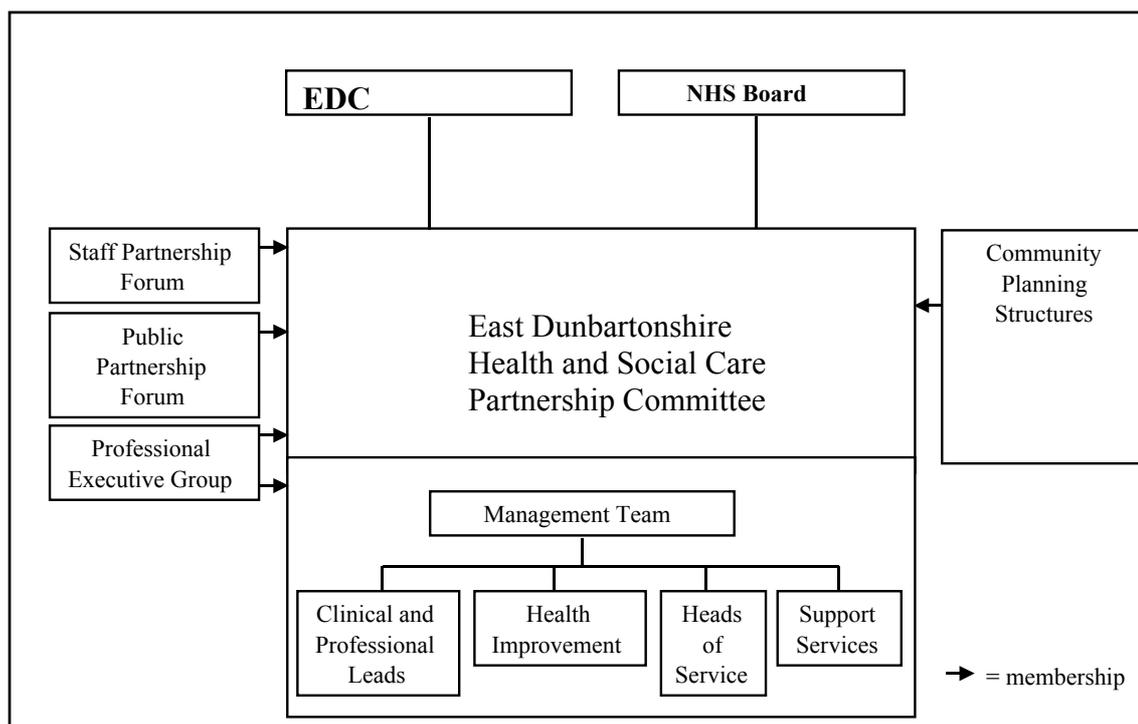
7.7 The most obviously contrasting position is to compare the NHS model, where officers of the Board carry certain executive functions and sit as full voting members of the NHS Board, against a local authority model where officers of the Council cannot sit as 'members' of Council Committees or Sub Committees.

7.8 While initially not appearing to present a streamlined response, the view is that the NHS Board and the Council will each establish a sub committee with the agreed delegated authority from each statutory partner. Both Sub Committees will actually meet together in the same place at the same time with an agreed common agenda. This model has been used in other parts of Scotland as a way dealing with the statutory limitations identified earlier. This is known as a **Concurrent Partnership Body**.

- 7.9 In this model it would be expected that decisions would be reached by consensus. In instances where a consensus cannot be reached, because the NHS and the Council have each retained their own statutory responsibilities, there is no question of one party overriding the wishes of the other in the exercise of their separate responsibilities. The reality of this position will only reinforce the need to proceed on the basis of agreement and partnership in its widest sense.
- 7.10 In effect, a Joint Committee is created that includes the properly constituted Sub Committees of the parent bodies – supplemented by representatives that have an interest across health and social care (e.g. the public) and/or officers with delegated authority, meeting as a single body with all ‘members’ contributing to consideration of all items of business.
- 7.11 Any decisions that exceed the delegated authority of each of the respective sub committees or officers would be subject to approval by the separate parent bodies. Any proposals to amend the levels of authority and decision making arrangements would again need to be approved by the parent bodies.

The governance arrangements reflect the fact that the Partnership will be a full and equal relationship between Greater Glasgow NHS board and East Dunbartonshire Council.

There are a number of components which can be diagrammatically represented as follows:



- 7.12 The membership is proposed as follows and has been built upon the existing arrangements that established the Joint Health and Community Care Committee (JHCCC) in late 2003. This would be renamed the **East Dunbartonshire Community Health and Social Care Partnership Committee**.

NHS BOARD

1 NHS Board Non- Executive Director

The East Dunbartonshire Councillor who sits as a member of the NHS Board

The Director of the Partnership

3 Health Members of the Professional Executive group

EAST DUNBARTONSHIRE COUNCIL

6 Councillors selected by the Council (including the Councillor who sits as the member of the NHS Board)

OTHER MEMBERS

1 representative of the Public Partnership Forum

1 representative of the Voluntary Sector

1 representative of the Joint Trade Union Partnership Forum

It is proposed that an East Dunbartonshire Council representative be the chair of the Committee, and an NHS Board representative be the vice chair. As with current arrangements, other officers will routinely be expected to attend meetings of the Joint Committee to provide formal advice on issues under consideration. This will include the statutory duty of the Council's Chief Social Work Officer to provide advice to the Council on the discharge of its statutory responsibilities.

7.13 The purpose of the Committee will be to set and monitor budgets within the allocations made by the NHS Board and the Council, and to take a strategic overview of the Partnership's activities, priorities and objectives. The Committee will also hold to account the management team for the delivery of the Partnership's Annual Plan, which that team should develop in partnership with the Professional Executive Group. The Committee will not make operational decisions or micro manage the Partnership's day to day activities.

7.14 The Joint Committee would have the following principal areas of responsibility:

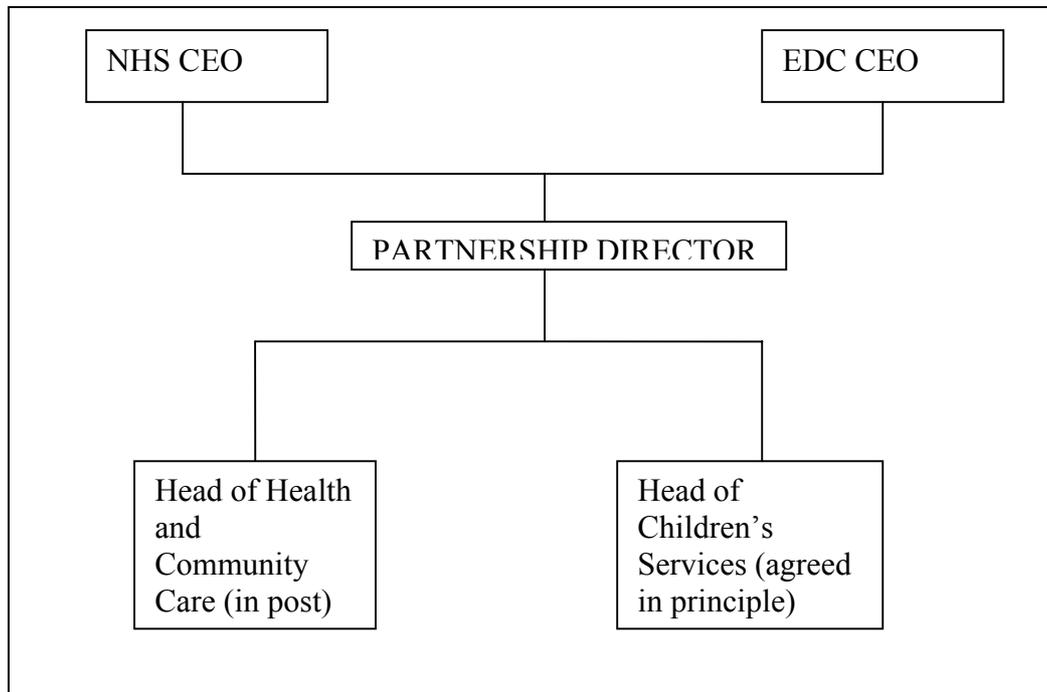
- the approval of policy and strategy for those service areas and functions included within the remit of the Partnership and within the overall frameworks set by the NHS Board and the Council;
- to deal with consultations from Government and other statutory bodies and to make representations to Ministers and those bodies regarding services within the Joint Committee's remit;
- to approve the allocation of resources within the specific revenue and capital budgets as delegated by the NHS Board and the Council in accordance with the standing financial instructions/orders of both parent bodies;
- to monitor and review the performance of the Partnership against national and local performance targets and best value requirements;
- to consider issues relating the staffing and structure of the Partnership and where necessary to make recommendations to the parent bodies.

7.15 The foregoing represents a position that would see the Partnership Committee performing a high level strategic governance function through which the formal authority of the statutory partners can be exercised.

7.16 By implication this means that the day to day responsibilities for both managing the Partnership, as well as the development agenda, will be carried forward within structures operating below the Joint Committee but with accountabilities to it.

7.17 The diagram above refers to the establishment of a management team who will be accountable to the Partnership Committee for day to day operational activities and forward planning as well as providing overall managerial, clinical and professional leadership for the Partnership.

7.18 The Partnership will be managed by a Director appointed jointly by the NHS Board and Local Authority. The Director would be separately accountable to the NHS Board Chief Executive and the Chief Executive of the Council for the delineated range of functions that are NHS or Council specific, 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 in the job description for the post.



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

7.19 A key element in the proposed new Partnership will be the functioning of the Professional Executive Group (PEG). This will be the principal mechanism for ensuring that clinical and professional leadership for the activities of the partnership is established and maintained. This, when brought together with the executive authority vested in the management team, should ensure that the new Partnership will deliver on the objectives and priorities that it has been set.

As a consequence of our particular local situation, and as a result of the consultation earlier in 2004 on the draft statutory guidance issued by the Scottish Executive on the establishment of Community Health Partnerships, the existing Joint Committee decided to establish a shadow Professional Executive Group in September in order that all the professional/stakeholder/service interests could be engaged at the core of both the initial development and implementation arrangements for the new Partnership. The Group is also charged with making recommendations to the JHCCC on what the role, remit and function as well as membership of an operational Professional Executive Group should be once the Partnership is fully operational in April 2005.

This Group is the key way to involve frontline staff in the governance and decision making for the Partnership. We also expect that there will be a range of planning and working groups which will fully involve professional staff, across the range of its activities. The Group will include an elderly medicine consultant, psychiatrist, paediatrician, psycho-geriatrician, general practitioners, nurse, AHP, pharmacist, dentist, 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. We will seek to ensure that the nominations sustain a balance between frontline staff and senior professional staff. The three representatives on the Partnership Committee will be nominated from the local practitioner members of the Group.

The Professional Executive Group will be fully meshed with the Partnership 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 Partnership and clinical input from specialist divisions including acute services, child health and mental health.

7.20 The shadow group includes all the stakeholder interests detailed within the Guidance and it will ensure that all of these required interests are fully engaged with the final operational structure post 1st April 2005.

7.21 LINKS TO SPECIALIST AND NON LOCAL SERVICES

7.22 Critical to the success of the Partnership will be ensuring effective working relationships with the Acute Division and other specialist services to improve services for patients.

7.23 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 Partnership management arrangements and in local service delivery teams;
- creating a strong geographic focus within the proposed single Greater Glasgow Acute Division which will ensure direct senior management connection and cross population of the Acute Division and Partnership management teams;
- organisational arrangements for rehabilitation and enablement services, women and children's and adult mental health services which fully engage the Partnership at the heart of decision making for those services and ensure the important vertical integration between hospital and community care is strengthened.

The Partnership's planning and policy structures will include representatives of other Council services such as education, leisure and housing as well as local housing associations and the voluntary sector. The framework for these relationships is described in more detail below in Para. 7.27 on planning and development.

7.24 FINANCE

7.25 The Partnership will be allocated funding on an agreed basis for the defined range of functions, by the Council and the NHS Board. Those budget allocations will be based on synchronised planning processes and a transparent approach to addressing identified pressures and issues. The Partnership 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 Council and NHS systems, a combined set of financial protocols reflecting the requirements of both organisation and related audit requirements. Budgets will be aligned and not pooled. This will provide for a clear track for expenditure to each allocating body.

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

7.25 In the current financial year (04/05) the gross budgets for the services identified earlier in section 6 (services to be managed) can be summarised in the following broad areas. These are general high level figures to assist in scoping the overall size and scale of the new Partnership's responsibilities and have been rounded for presentation purposes.

NHS SERVICES

	£m
COMMUNITY SERVICES	5.0
PRESCRIBING	15.3
GMS CONTRACT	9.6
PHARMACY	2.1
OPTOMOTRISTS	0.9
DENTAL	4.3
MENTAL HEALTH	1.5

EAST DUNBARTONSHIRE COUNCIL

A – COMMUNITY CARE

ASSESEMENT/CARE MANAGEMENT	1.4
HOME CARE	6.9
DAY CARE	3.4
NURSING HOMES	6.6
EQUIPMENT	0.8
SHELTERED HOUSING	0.3
HOSTELS	0.6
CARE PACKAGES	9.0
OTHER SERVICES	1.3

B - CHILDRENS SOCIAL WORK SERVICES

ASSESSMENT/CARE MANAGEMENT	1.7
RESIDENTIAL SCHOOLS	0.8
FOSTERING/ADOPTION	0.6
DAY CARE	0.1
CHILDRENS UNITS	1.1
OTHER SERVICES	1.1

C – FINANCE 0.3

D - PLANNING 1.1

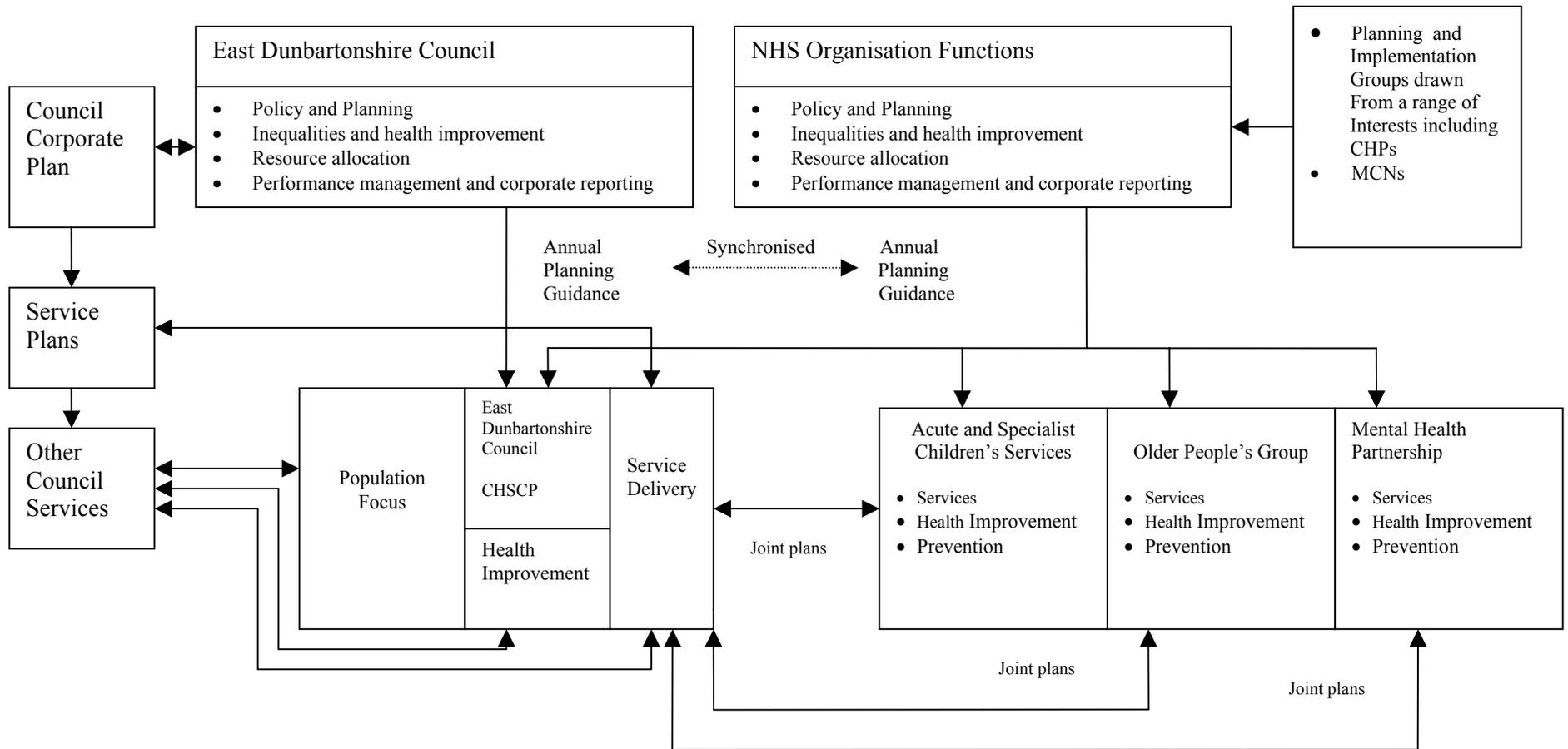
7.26 STRATEGIC FRAMEWORKS AND STATUTORY RESPONSIBILITIES

7.27 The Partnership will be expected to operate within the strategic frameworks established by the Council and NHS Board and to meet the statutory obligations of both bodies. There will be synchronised performance management arrangements to ensure the Partnership's activities are fully integrated into the corporate governance arrangements of both organisations.

7.28 PLANNING AND DEVELOPMENT

7.29 The Partnership will be responsible for the planning and development of the services it has direct responsibility for and will participate in the development and delivery of the full range of services to its population.

7.30 The diagram on the next page illustrates the planning system which will be established by NHSGG in partnership with the Council taking account of the wider systems of both organisations.



- 7.31 Within the planning framework established by the NHS and the Council, the Partnership 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 specialist and non local services delivered by others to the population of East Dunbartonshire. These joint plans will cover shared care groups, chronic disease, demand management and access issues and service redesign and improvement.

These plans will be matched to meet the statutory obligations on the Council and the NHS as well as the local requirements to comply with each agency's corporate planning processes.

8 WORKING IN PARTNERSHIP WITH THE PUBLIC, SERVICE USERS, CARERS AND THE VOLUNTARY SECTOR

- 8.1 The recent publication of draft circular guidance on the establishment of Public Partnership Fora (PPF) has been welcomed locally. This has been viewed as a sensible way forward in drawing together the range of existing groups/processes/arrangements that are already in place and operational.
- 8.2 The Council and local NHS services already have in place a variety of mechanisms that appropriately involve patients, service users and their families and carers, the voluntary sector, and the wider general public in the planning and delivery of local Health and Social Care services.
- 8.3 Currently, all the local planning process either have or are working towards having Service Users, Carers and the Voluntary Sector represented and/or involved directly in activities.
- 8.4 In addition, the two existing LHCCs which will evolve into the new Partnership, also have arrangements in place that comply with the current requirements of both the PFPI (Public Focus & Patient Involvement) agenda in the NHS, and with the performance assessment requirements of LHCCs more specifically.
- 8.5 We welcome the emphasis in the new guidance that current arrangements should be built upon and supported, rather than seeking to start from first principles with entirely new arrangements for the new Partnership.
- 8.6 However, the Council and the NHS locally are committed to ensuring that these vital stakeholders are able to play a full part in both establishing the new arrangements and thereafter are supported to take their place in all aspects of the work of the Partnership – including ensuring that the Voluntary Sector, Service Users and their Carers can participate as full members of the Partnership's Joint Committee.
- 8.7 The PPF will provide the formal component of voluntary sector and community engagement within the Partnership, but it is only one component of delivering the vision for Partnership to be an:
“ . . . Inclusive organisation whose processes for strategic and service development engage stakeholders, users and communities throughout, in accordance with the Community Planning Standards. That 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.”
- 8.8 The corporate management of community engagement and the PPF will be managed through the senior officer who has responsibility for health improvement and forward planning.
- 8.9 The virtual PPF network will come together formally through a PPF Executive Group which will be a mix of representation from across the Partnership area from recognised

local engagement processes and self selected membership. The PPF Executive Group will elect annually representatives for the Partnership Committee.

8.10 Beyond the PPF the Partnership will be expected to develop:

- as a visible and engaged organisation - through staff involvement in key local public forums, community events and community planning;
- the capacity to create opportunities for users and communities to learn about the Partnership's services and structures - proactively enabling local communities and organisations to understand how we work and how to influence us;
- the ability to inform residents and users of the range of services and business of the Partnership;
- 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;
- the views of users and communities under-represented through formal structures, e.g., young people and Black and minority ethnic communities;
- the ability to engage, e.g., with translation, physical access and other physical and social adaptation facilities available to enable engagement of people with a wide range of needs; and
- staff skilled in managing conflict and opposition between communities and between communities and service providers.

8.11 As no specific additional funding to develop PPFs has been made available at a national level, it will be vital to ensure that the resources currently utilised to support this area of activity are identified as part of establishing the PPF for this area.

9 CLINICAL AND PROFESSIONAL GOVERNANCE

9.1 The clinical and professional governance framework will build on the existing clinical governance arrangements which have developed in both pre-existing LHCCs and across the NHS more generally.

9.2 A clinical governance lead clinician will be appointed and be accountable to the Director of the Partnership. It is envisaged that a clinical governance sub group of the PEG will be responsible for planning and overseeing the implementation of clinical governance throughout the Partnership.

9.3 In addition it is intended that clear professional support arrangements are put in place that support the role of the Councils Chief Social Work Officer (CSWO). This needs to be set in a dual context of the CSWO continuing to provide formal advice to the Council on the discharge of its statutory social work functions, as well as the specific managerial arrangements for service delivery on a day to day basis where the CSWO does not have day to day managerial accountability for the service.

9.4 The specific organisational structure for the Partnership will address these requirements.

9.5 However, it is also recognised that some of the historical differences that have been experienced between clinicians working within the NHS and professional social workers and others working in social work, are coming closer together with the relatively new requirements for social workers to become registered with the Scottish Social Services Council. Many of the systems and processes that have become routine within the NHS are now equally applicable in terms of social work practice, and we would see the arrangements being put in place for the Partnership being developed and applied consistently and comprehensively for all professional staff.

9.6 In this context, we would see the Clinical and Professional Governance sub group of the PEG taking a lead in ensuring that:

- services are client centred;
 - professional staff can evidence the development and application of the knowledge base to support their professional decision making;
 - services provided by/within/for the Partnership are safe and reliable;
 - clinical and professional effectiveness is enhanced;
 - appropriate quality assurance and accreditation processes and systems are a routine and organised part of the work of the Partnership;
 - every professional is supported in gaining and sustaining the skills, knowledge and attitude that delivers high quality care; and
 - the coordination of effective action is achieved by the communication and application of effective information.
- 9.7 The arrangements for clinical and professional governance do not sit in isolation from many of the core functions and responsibilities that the new Partnership will have. These arrangements will all have obvious links to: service redesign and best value; health improvement and service improvement; forward planning and to the core governance and accountability structures for the Partnership.
- 9.8 Indeed, these linkages go out-with the Partnership as well. While the Partnership is an extension of the Council and the NHS Board, its activities do need to link back to other services and functions both within the Council and the wider NHS family.
- 9.9 While the Partnership accepts full responsibility for what it does, we need to develop strong linkages with services that are provided by others (mainly in the wider NHS system) for the whole population within East Dunbartonshire.
- 9.10 The diagram at Para. 7.30 above sets out a number of the wider structures and processes that the new Partnership will establish links with. The primary route for these linkages will be through the Professional Executive Group where through the broader membership outlined in Para. 7.19.
- 9.11 As with any change programme, there always exists a danger that some will disengage in the short term rather than remain as key leaders in the new arrangements. We are very aware that the Partnership does not sit in isolation from the work of other agencies, and that we all have a responsibility to ensure that we work effectively together to ensure the best possible service for our population. This ultimately is the primary focus for everything that we do.
- 9.12 It is recognised that clinical and professional staff (both directly employed and contractors) have a duty to develop and maintain their ability to deliver high standards of care independently of any contractual relationship with the Partnership.
- 9.13 One of the major achievements of LHCCs has been in increasing co-operation of the practices and community teams involved in the delivery of care. The consideration of a wide range of issues that directly impacts on the continued delivery of high quality care takes place on a regular, planned and recorded basis through LHCC meetings and protected learning time events, with audit data being shared and discussed.
- 9.14 The Professional Executive Group will wish to encourage all practices in the Partnership to engage in these processes and the associated audit activity. There is an acknowledged risk that the good development work that has been achieved by LHCCs in the last 5 years could be lost if the Partnership does not take action to build on these developments. It is therefore proposed that the Partnership takes responsibility for maintaining and developing this shared working after April 2005.
- 9.15 The CHP will therefore, through the PEG, promote:
- a) clinical audit and significant event analysis within the CHP;
 - b) sharing of audit data;

- c) needs based protected learning events; and
 - d) the detection and remediation of under-performance.
- 9.16 To facilitate the development of the new clinical and professional governance agenda and to provide continuity with the present local arrangements, the PEG proposes to establish a framework within which local clinical and professional staff can continue to develop the previous LHCC based audit and review activities after 1st April 2005.
- 9.17 These local fora should comprise representatives from all practices and community teams and would be extended to include relevant Social Work staff where not already included. These groups would be responsible for implementing and promoting cross-practice audit and for developing projects in care and professional development which would then go to the PEG for approval.
- 9.18 The funding that currently is available through the management allowances to LHCCs is expected to be included within the budget for the new Partnership. This funding should therefore be available to the Partnership to support these developments, and would provide a resource to enable NHS contractors to continue to participate in these revised arrangements.

10 STAFF GOVERNANCE

- 10.1 Initially, to support the implementation of the Joint Future agenda within the East Dunbartonshire Area the statutory partners and the trade union and professional bodies recognised within this area, established the East Dunbartonshire Joint Trade Union Partnership Forum in 2002. This Forum has an agreed constitution and has proved to be a successful vehicle in delivering the HR (human resource) and wider OD (organisational development) aspects of the Joint Future agenda.
- 10.2 It is expected that this Forum will be extended to cover the wider aspects of Partnership development, and provide the local focus to ensure that the legal obligations of the NHS staff Governance standard are met.
- 10.3 From the Council's perspective it would be expected that the Forum will continue to function within the established local authority arrangements and work to ensure compliance with local and national policy for local authority employees.
- 10.4 A formal review of the existing constitution will be completed before April 2005. This review will also detail the accountability of the person appointed to the trade unions, professional bodies and the wider staff working within the Partnership.
- 10.5 It is intended that the existing accredited members of the Joint Trade Union Partnership Forum will select, from within their members, a representative to take up the seat on the Partnership Committee (see Para. 7.12 above). It is also proposed that a nominated named deputy will be identified by the accredited trade unions who could attend the Joint Committee in the absence of the named representative. If the identified representative on the Joint Committee is from an NHS Trade Union then the named deputy would be from a Council trade union and vice versa.
- 10.6 This person will serve for a 2 year period and be eligible for re-appointment.
- 10.7 The arrangements for linkages to the Area Partnership forum (in respect of NHS interests) are currently under review and will be detailed on a Greater Glasgow wide basis.

- 10.8 Again as part of the implementation of the Joint Future agenda, every planning/strategy group in place within the area has a formally allocated staff partnership representative member. These existing arrangements will in due course be extended to cover the wider aspects of the new Partnership.
- 10.9 The 5 fundamental principles for sound staff governance while legally applied to the NHS are none the less appropriate for the local authority. The Partners are fully supportive of the need to ensure that all staff either employed within or working with the Partnership through NHS contractors are:
- well informed;
 - appropriately trained;
 - involved in decisions that affect them;
 - treated fairly and consistently; and
 - provided with a safe and improved working environment.
- 10.10 The formal reporting arrangements to ensure delivery of the staff governance standard will be overseen (from an NHS perspective) by the Area Partnership Forum and by the Council from a local authority perspective. This will encompass assessment, action planning and monitoring of the staff governance standard and will be directed by the existing Joint Trade Union Partnership forum.
- 10.11 It is recognised that there will be non-NHS employed staff working within the Partnership, such as staff working in general practice. With the support of the NHS Board, the Partnership will seek to develop jointly with all employers within the Partnership, common employment practice frameworks that meet staff governance and employment law requirements. The Partnership will also seek to commend best practise to all employers for the benefit of all employees, patients and carers, whilst recognising the separate responsibilities and role of independent contractors working within the NHS.

11 BUILDING WORKFORCE CAPACITY

- 11.1 The East Dunbartonshire area established a Joint Future Partnership Forum 2002. An HR sub-group of the partnership forum was established in January 2003 to specifically focus on HR and OD issues. This group reports directly to the Joint Future Partnership Forum. As has already been mentioned in paragraph 10.2, it is expected that the Joint Future Staff Forum and the HR sub-group will naturally evolve to take on wider aspects of the local Partnership. This review will also take on board the developing role that the PEG will have in its remit for service redesign and development.
- 11.2 Joint Future arrangements have led to the HR sub-group producing a Joint HR/OD Plan. The first plan produced covered 03/04 and was reviewed recently to cover period 04/05. This plan forms the basis of how the joint human resource and organisational development issues will be prioritised and addressed. The Plan is reviewed on a regular basis to ensure its continued relevance and revised formally on an annual basis. The current plan includes priority areas that will support the establishment of the new Partnership including a communication strategy, staffing frameworks, joint OD and training initiatives as well as management/governance frameworks
- 11.3 To further develop the HR infrastructure within this area and to support the implementation of the Partnership, two working groups that report directly to the HR sub-group, have been established to work on two specific areas currently identified as priorities under HR/ OD plan. One group will take forward Joint Workforce Planning

and the other group will take responsibility for a Joint OD and Training plan for the area.

- 11.4 As has been evident throughout the draft scheme; our starting position is a combination of development activity under the Joint Future banner, and separate but related initiatives from within either the NHS or the Council. An example of this is our recent agreement to establish a Joint Workforce Planning Group to ensure an integrated approach to workforce development for the whole of the new Partnership. This plan will help the Partnership by crucially examining the current work force and extend future analysis to inform recruitment, retention and identify future skills and competencies required to deliver services. This group will make linkages to national workforce initiative in both NHS and National Workforce Group for Social Care.
- 11.5 A number of existing staff from both the NHS and the Council (and the voluntary sector) have also participated in both the National and Greater Glasgow CHP leadership programmes. These participants are all involved in the new Partnership development processes. These programmes are based on delivering high level skill on areas of competence critical to effective delivery of the Partnership. Additional cohorts for the Greater Glasgow programme are being considered for 2005. Ongoing and emerging development of leadership and management development initiatives are focussing on continuing to grow skills in areas of integrated team working, collaborative decision making and effective relationship building.
- 11.6 Both statutory partners have pre-existing personal development processes which will be used to identify future development needs, and to support staff as new roles develop. The Social Work Training & Development Steering group have just produced a Training Directory and training strategy. A driver for this has been the Scottish Social Services Council codes of practice in relation to the regulation of Social Services in Scotland. A similar process occurs in the NHS, which results in a production of a learning plan and informs a training directory. Currently, there are some reciprocal arrangements in relation to joint training e.g. Domestic abuse training, adults with incapacity training. The East Dunbartonshire Joint OD and Training group have identified that this is an area which will evolve as the Partnership develops and it is anticipated that there will be increasing opportunities for delivering both joint organisational development and joint training initiatives to support the Partnership.
- 11.7 Again, because of the extent to which Council services and staff are being committed to the new Partnership, much of the initial organisational development activity will be focused around working towards common cultural values and expectations, developing cross boundary relationships, and focus on the development needs of integrated teams and staff most affected by the transition in particular those moving into new roles with dual accountabilities. Specific OD and training initiatives are being developed to support these key themes.
- 11.8 In addition, the Professional Executive Group will be integral from an organisational development perspective in contributing to influencing the education and training bodies, to ensure that functional and professional areas fully encompass core skills required for the Partnership to be an effective organisation.
- 11.9 The importance of the need to identify and deal with organisational development issues has been recognised as a strategic management priority. As part of the response, specific additional capacity has been recruited to provide a dedicated HR/OD support to the wider Partnership development process. The continued availability of this dedicated resource will be vital to ensuring that the HR and OD objectives and priorities of the Partnership continue to be delivered.

- 11.10 Discussions are beginning, as part of the Greater Glasgow NHS move to single system working, to ensure that city wide HR and OD support will be aligned to Partnerships. Similarly in Local Authorities, the Efficient Government report has outlined a requirement on Local Authorities to review functions so any alignment of the Partnership's HR resources will be considered within this context for the respective organisations.

12 CONCLUSION

We believe that we have presented a proposal that has the potential to deliver significant benefits to the people of the East Dunbartonshire area and has addressed the fundamental policy intentions that Scottish Ministers had when publishing the NHS white paper 'Partnership for Care'.

This proposal is a product of the significant and sustained joint work over many years at a local service delivery level and at a strategic planning level.

We commend the proposal to the Minister.

Tom Divers
Chief Executive
Greater Glasgow NHS Board

January 2005

Sue Bruce
Chief Executive
East Dunbartonshire Council

January 2005

COMMUNITY HEALTH PARTNERSHIPS: INTEGRATED MODEL

1. Purpose

This short paper sets out our approach to proposing integrated model Community Health Partnerships which can fully deliver the policy aspirations of Partnership for Care. The attached draft model scheme of establishment provides further detail, presently work in progress, on our approach.

2. Background

2.1 The White Paper 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.

2.2 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.

2.3 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.

2.4 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.

2.5 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 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 professional interests and to ensure the NHS CHP Steering Group, which includes substantial partnership representation, has been fully involved in discussing key policy issues.

3. **Key Issues**

3.1 This section describes the six key challenges which we believe should be considered in testing our model scheme of establishment.

3.2 **The CHPs are designed to facilitate much stronger and more effective working relationships between specialist services and primary care.**

Through incorporating our integrated model CHPs into a redesign of the whole NHS organisation we have been able to achieve a number of critical clinical and managerial relationships:

- Professional Executive Groups include secondary care clinicians from a range of disciplines, at the heart of CHP decision making;
- integrated services within CHPs will include secondary care clinicians working in local service teams;
- the incorporation of responsibilities for chronic diseases and related services into the Acute Division and CHPs reinforces the requirement for integrated working;
- the structure of the Acute Divisions enables integration with the CHP clinical and management teams;
- the planning and performance system ensures a shared, structured approach to service change and improvement;
- the organisational arrangements for mental health and rehabilitation and enablement services ensure that vertical integration between local and specialist services is given equal strength to the horizontal integration which CHPs are able to achieve.

3.3 **NHS staff are fully and properly represented within the CHP structure.**

The CHP Committee we propose has much wider responsibilities than would be the case for an SEHD model CHP. Therefore we have proposed that there is a separate Professional Executive group (PEG) to ensure broader engagement and representation of NHS professional staff through a formal structure, with clearly defined responsibilities, and a substantial role in advising the CHP Committee. This approach has been fully discussed with local professional interests to ensure their support.

The PEG has a direct role in nominating members to the CHP Committee and its nominees will provide the majority of NHS membership to that grouping.

3.4 Governance arrangements are appropriately balanced to reflect the level of NHS and Local Authority delegation.

The assumption in the model scheme of agreed NHS and Local Authority representation is based on the assumption that there is delegation of budgets and decision making for social care services into the CHP.

3.5 The proposed CHPs will add value to existing programmes to integrate and improve services - particularly in relation to children's services.

This model of CHP, bringing NHS and social care services into a single local partnership arrangement will enable a major and radical step forward to integrate the local public services. Very limited progress has been made across Scotland in delivering real integration and yet there is clear evidence that bringing together NHS and social care services into a single management arrangements improves services for patients and reduces transaction costs.

At present there are no integrated NHS and social care services for children and families anywhere in Scotland. Our CHPs will enable that integration to be achieved.

3.6 CHP proposals are able to demonstrate real gain in terms of democratic and community accountability.

Our proposal that CHP Committees have strong local Councillor membership and are chaired by a Councillor give a real and clear message about the role of elected members in decision making about local health services. These arrangements also properly reflect that CHPs are about much more than service delivery. The visible involvement of Councillors reinforces the message about the CHP's role in health improvement which is a formal Local Authority responsibility.

3.7 CHPs will play a substantial role in community planning.

We anticipate that our final schemes of establishment will see CHPs embedded within community planning structures and with the lead role for the health component.

4. Next Steps

- 4.1 Our aim is to submit final schemes of establishment approved by the NHS Board and each Local Authority during February. Submission will be followed by the development of a detailed process to establish the CHPs from 1st April 2005 but with their first year focused on managed migration of responsibilities and organisational development.

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 and SEN school health subject to Child Health Strategy Group process.

- Hold budgets and contracts for the following services:
 - service level agreements for direct access to diagnostic and laboratory services;
 - primary care contracts;
 - prescribing;
 - health improvement and promotion.

- Participate in the management arrangements for the following services:
 - non local mental health services;
 - non local rehabilitation and enablement services;
 - community midwifery services;
 - acute and children's services.

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

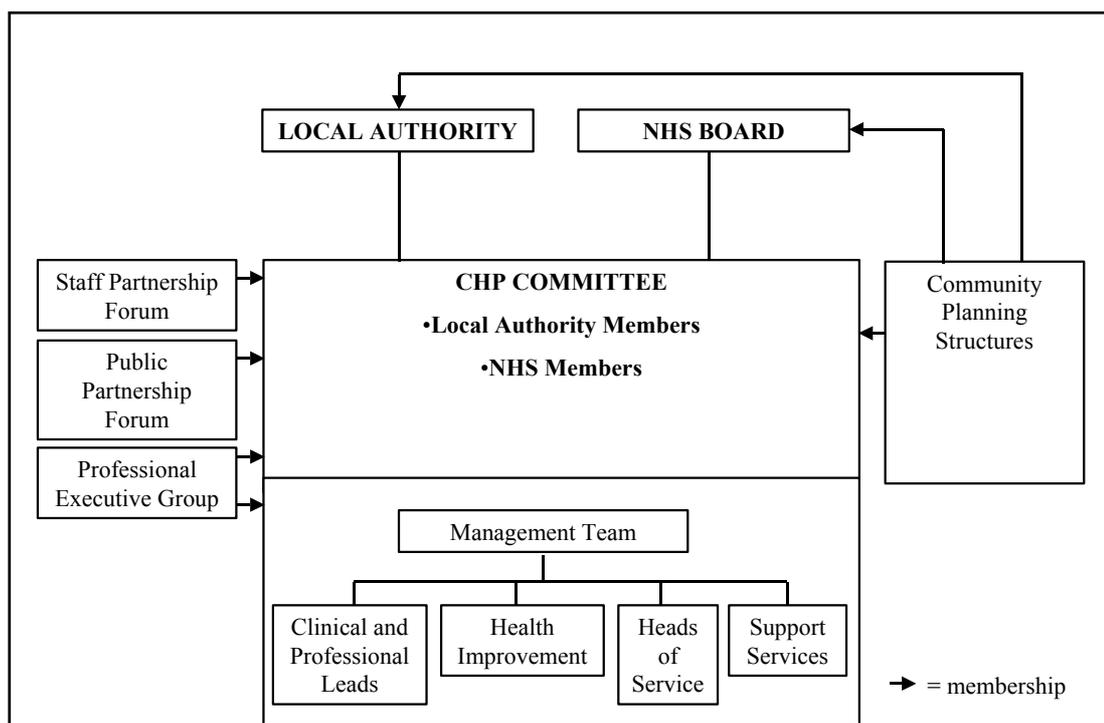
In the fully integrated CHP model we would expect individual schemes of establishment to set out substantial delegation of Local Authority social work services into the CHP to match the high level of NHS delegation outlined above. This section will then include the detail of the budgets each CHP will hold.

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)

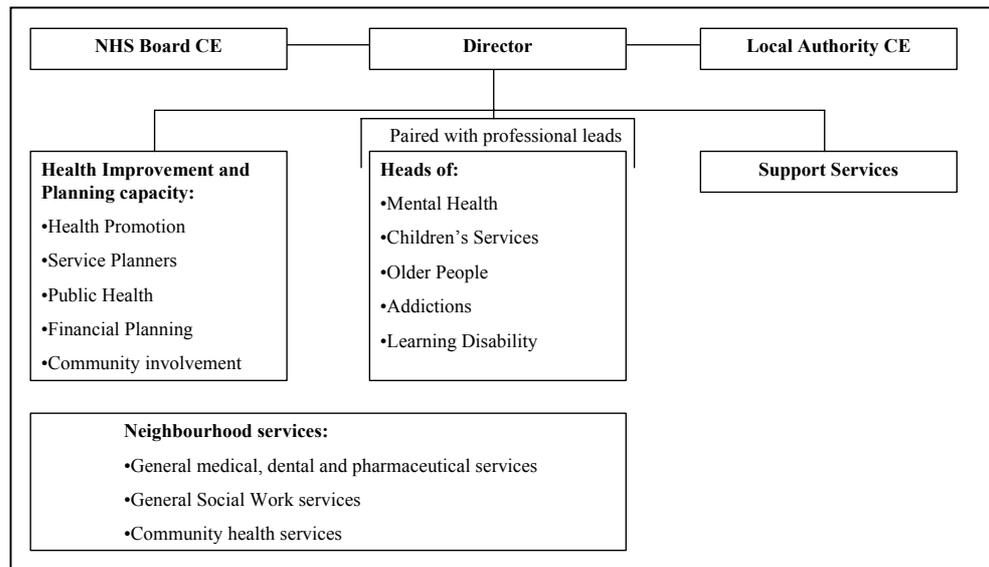
This Group is the key way to involve frontline staff in the governance and decisionmaking for the CHP. We also expect that the CHP will have a wide range of planning and working groups which will fully involve professional staff, across the range of its activities. The Group will include an older people's 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.

We will also set out arrangements to engage the voluntary sector at all levels in the CHP including the Committee.

- 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 in line with and building on existing financial frameworks within extended local partnership arrangements. 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 endeavour to have a consistent approach to allocations and to move towards equitable funding arrangements.

- 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 service arrangements for mental health, older people, rehabilitation, children and families, learning disability and addictions;
- 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:

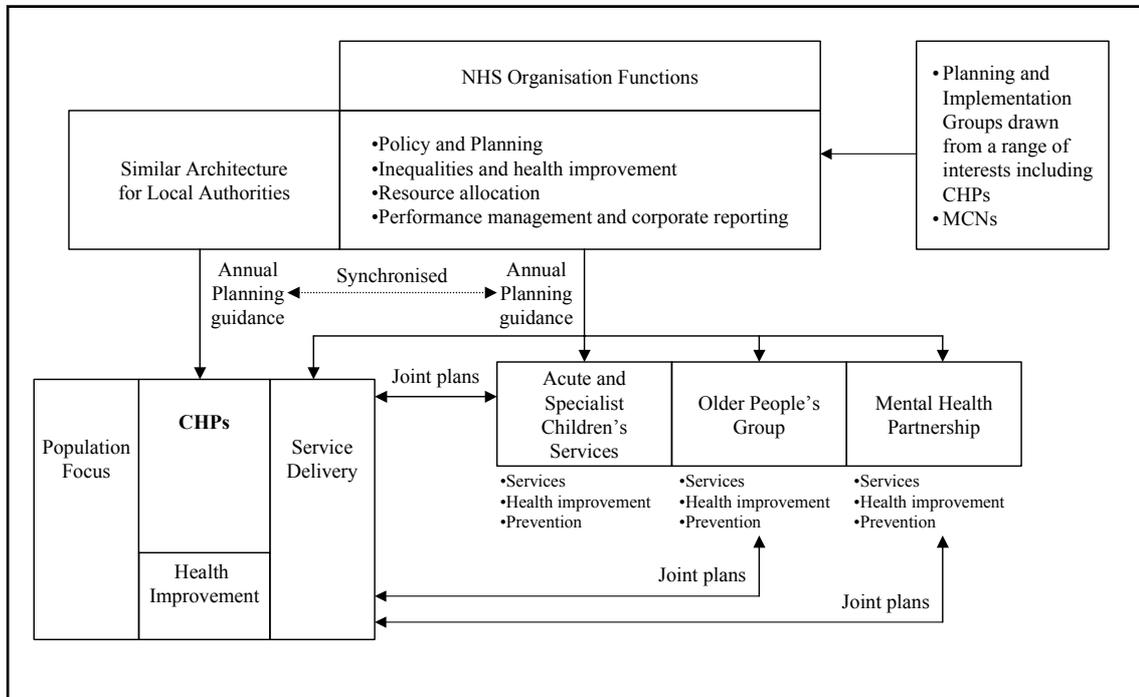
- CHPs will lead the locally based health improvement effort, covering life circumstances and lifestyle action;
- a senior officer will have responsibility for leading health improvement within the CHP;
- the CHP will be developed as a public health organisation embedded within the NHS and Local Authority;
- 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 from health promotion and public health staff.

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 resources to support these responsibilities will migrate from the present NHS HQ and Primary Care Division and each Local Authority to achieve a single planning

function across the CHP's responsibilities. 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

The focus for the CHPs to improve service quality will include:

- 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.