EMBARGOED UNTIL DATE OF MEETING

# Greater Glasgow and Clyde NHS Board

## Board Meeting

**Tuesday 22nd June 2010** **Board Paper No. 2010/25**

Board Chief Executive
Director of Corporate Planning and Policy/Lead NHS Director Glasgow City CHCPs

## GLASGOW CITY CHCPS

**Recommendation:**

**The Board is asked to:**

- **approve the proposed arrangements to manage NHS primary care and community services within the Glasgow City boundary;**
- **agree these arrangements should be reflected in a detailed Scheme of Establishment to be completed over the next three to four weeks with implementation proceeding thereafter;**
- **note the current position on the Council's process of external review of its position on CHCPs.**

### 1. INTRODUCTION AND PURPOSE

1.1 The Performance Review Group (PRG) considered a detailed report at its May meeting which described Glasgow City Council's decision not to implement the agreed Scheme of Establishment and the Council's revised position on CHCPs. The report is attachment one to this paper.

1.2 The paper identified a number of critical issues which the full implementation of the agreed revised Scheme of Establishment would have addressed but which the Council's proposal did not address. PRG concluded that the Council's option did not represent a way forward to deliver viable and effective CHCPs.

1.3 The PRG further concluded that while the City Council continued to indicate it is fully supportive of the shared vision it was clear, after nearly two years of discussions, that the Council was not willing to make the substantive changes required to deliver the agreed approach.

1.4 As a consequence of those conclusions, and despite the Board's unequivocal commitment to integrated NHS and social care services as being in the best interests of the people we serve, the PRG agreed that the Board had to move to establish secure and viable organisational arrangements to manage NHS services in which NHS staff can have clear direction and confidence.

1.5 The PRG also concluded that a shift to NHS CHPs would enable a renewed focus on NHS services, issues and relationships; clear lines of accountability and responsibility for NHS employees; and reduced management costs. Importantly we would also be able to focus on and re-engage community staff and primary care contractors.

1.6 This paper outlines for approval proposals for those NHS CHP organisational arrangements to manage NHS community and primary care services. These proposals would be

developed into a detailed Scheme of Establishment over the next three to four weeks with implementation proceeding thereafter.

1.7 Since the May PRG the Council have commissioned Sir John Arbuthnott to carry out a review of its position with regard to CHCPs. We have had the opportunity to input our views to that review and the Board Chair has made a commitment that the Board would be fully briefed on any output.

## 2. CHP PROPOSAL

### 2.1 Proposal and Rationale

A number of considerations have formed the basis of the proposals outlined in this paper. These include the need to:

- provide a unified focus for the relationship with the City Council but also to have a more local focus for the management of services ensuring strong local connections;
- generate efficiency and consistency in a number of support services and in management costs, but still have a structure which ensures devolution of service delivery, health improvement, inequalities and planning activity;
- provide a strong basis for better connection with primary care contractors;
- better reflect the pattern of flows into acute services to provide a more robust platform for the engagement required to drive change across the primary and secondary care interface;
- achieve streamlined Committee arrangements which ensure appropriate overall governance in a consistent and efficient way;
- reflect the scale of the Glasgow City services and population with NHS budgets of £500 million and covering nearly 600,000 people. Our next largest CHP covers a population of 170,000.

Our conclusion is that these considerations are best met by single CHP covering the whole of Glasgow City with a substructure of three sectors - East, South and West.

This approach combines the benefit of a strong locality focus on services, health improvement, inequalities and planning with a single centre structure.

### 2.2 Boundaries

Attachment 2 to this paper illustrates the proposed boundaries. These have been developed based on NHS patient flows, achieving balanced Sector sizes, natural communities and with the aim of matching electoral boundaries as far as possible. The final boundary between the proposed East and West sectors may need to be finessed in the light of more detailed work to establish how the teams and services presently within the North CHCP are best migrated into the two new sectors.

The populations of the proposed sectors would be:

| **Sector** | **Population** |
|---|---|
| East | **177,989** |
| South | **186,874** |
| West | **219,377** |

### 2.3 Governance

The CHP would be governed by a single Committee chaired by an NHS non Executive. It is proposed that membership would also include:

- nominated City Councillors from each of the three Sectors;
- the City Councillor who is the nominated NHS non Executive Director;
- a further three Board non Executives, each with a connection to a particular Sector;
- the CHP and Sector Directors;
- the Chair of the CHP Staff Partnership Forum;
- a primary care representative from each Sector;
- the Chief Operating Officer of the Acute Division;
- the Director of the Mental Health Partnership;
- the Chairs of the three Sector Public Partnership Forums.

The objective of these proposals is to achieve strong local connections, a more prominent role for primary care contractors and strong connections across NHS services.

Clinical and staff governance substructures would be CHP wide. The successor arrangements to the current five Professional Executive Groups will reflect the current review of PEGs being undertaken by Directors across NHSGGC. We propose three PPFs because of the scale of the CHP, our commitment to public and patient involvement and the need to ensure that each Sector Management Team has a close relationship with the communities and patients it serves.

We would anticipate that the Sector Management Teams would include PPF Chairs and a sector based member of the CHP wide staff partnership forum.

### 2.4 Joint Working

This paper does not define the detail of the joint working arrangements which will need to be negotiated with the City Council to replace the processes associated with the CHCPs. However, our single CHP, sector based model would see the primary focus of the interface with social work services through the Sector Directors, who will carry responsibility for service delivery and leadership of planning for their geographic area. The Sector Directors will also each carry a lead role for a specific care group with a City wide remit. In relation to wider joint working the CHP Director will carry the responsibility for the interface with the City, including community planning. The CHP Director and management team will have responsibility for developing the detail of the arrangements with the City Council.

### 2.5 Premises

The five CHCPs currently occupy a range of NHS, Council and leased premises. We have not reached any conclusions about the premises arrangements for the CHP, these will be subject to detailed work during the transition process but our objectives will be to accommodate staff in appropriate accommodation, to reduce overall costs and to ensure that service locations reflect the revised three Sector structure where that is appropriate.

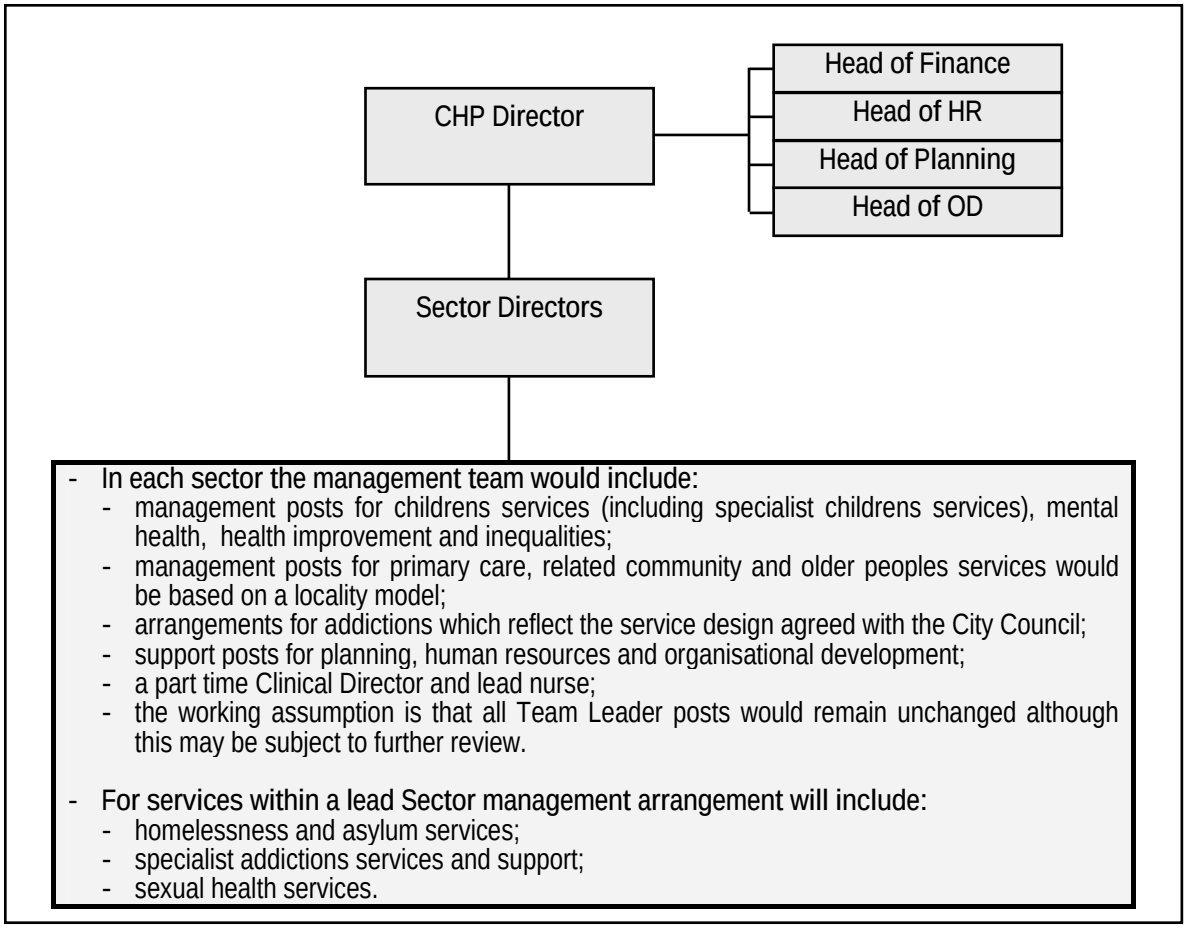
## 3. PROPOSED STRUCTURE

3.1 The diagram below sets out the proposed headline structure of the new arrangements.

3.2 The CHP Director and support team will set the overall direction for the CHP, ensure clear governance and accountability, establish the frameworks for human resources, finance and budget allocations, ensure effective staff partnership and ensure the CHP has a single coherent plan with supporting organisational development activity. The Director will be a

member of the Board's Corporate Management Team, will be the lead for relationships with the City Council and will ensure an effective cross CHP approach to working with the Acute Division. The Director will also ensure that the CHP engages effectively and establishes positive relationships with the full range of stakeholders including staff, primary care contractors, councillors, patients and the public.

3.3 The Sector Directors will manage the delivery of all of the services for the CHP; within their sector, establish positive relationships with staff, primary care contractors, patients and the public; will manage delivery of sector health improvement and inequalities activity within the CHP wide approach, and working with their local acute services identify and drive change programmes.




## 4. STAFFING ISSUES

4.1 The previous section outlined the proposed structure. This represents a substantial change to the content and number of posts filled by NHS employees within the current CHCP structure. It is proposed that there is detailed discussion with the Trade Unions to agree the detail of how the new structure will be finalised and populated within the framework of the workforce change policy, as quickly as possible. Our commitment is that with the sole exception of the CHP Director, competition for all posts in any initial process will be restricted to managers currently employed within the Glasgow City CHCPs.

4.2 For staff who are not in management positions our intention is to minimise the impact of these changes and in reallocating teams and staff into the new structure we will aim to reflect existing boundaries and relationships as far as possible.

## 5. SERVICE AND FINANCIAL ISSUES

5.1 The assumption underpinning these proposals is that all of the NHS services and budgets which lie with the present Glasgow City CHCPs will become the responsibility of this new CHP. Following a Board decision, the detailed work to reallocate budgets into the new structure will be established.

5.2 The host CHCP arrangements currently in place will be reviewed but are likely to transfer without change to the proposed new Sectors. The asylum and homelessness, services where management arrangements have already been displaced by changes made by the Council to Partnerships, are being managed in lead CHCPs and will transfer into the appropriate Sectors.

5.3 In addition to the current budgets it is proposed that the CHP will hold all of the budgets, including resource transfer and ring-fenced drug and alcohol funding, which are allocated by NHSGGC to the City Council. This will ensure that the CHP can make comprehensive decisions on the provision of services, within a joint planning approach, and provide the Board with a significantly tighter focus on the use of these resources and the outcomes they deliver for the NHS.

5.4 A key consideration for the NHS Board has been to ensure that services to patients are not disrupted by these changes and, where possible, within these revised governance arrangements integrated or co located services will continue to be delivered. For addictions services, where services are presently fully integrated within the CHCPs and the Glasgow Addictions Partnership (GAS), the West CHCP Director has been jointly charged with bringing forward recommendations on how successor arrangements to the CHCPs and GAS can fully retain service integration in an environment where we will not have integrated governance structures. If the conclusions of that work can be applied more widely to presently integrated services we will seek to agree that with the City Council.

5.5 The objective of these revised arrangements is that the final structure will reduce management and support costs from the current NHS contribution to CHCPs as much is possible. The final scale and timing of those savings will depend on the detail of the management structure and related issues, and the extent to which we have displaced staff that are not able to be redeployed elsewhere in NHSGGC. Our initial assessment suggests that these revised arrangements will reduce our current management costs by around £300, 000.

## 6. TRANSITION ARRANGEMENTS

6.1 This paper provides a clear framework for the establishment of an NHS CHP but there remains substantial detailed work to be done to move from the five CHCPs into these new arrangements. We have proposed to the City Council the establishment of a Joint Transition Group which would provide a shared oversight of that detailed work, ensuring patient services are not disrupted, and that we design and implement the best ways of joint working in the interests of patients which can be achieved to replace the integrated CHCPs.

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

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## Greater Glasgow and Clyde NHS Board

## Performance Review Group

**Tuesday 18th May 2010** **PRG Paper No. 2010/25**

**NHS Board Vice Chair/Joint Partnership Vice Chair**
**NHS Board Chief Executive**

# COMMUNITY HEALTH AND CARE PARTNERSHIPS WITH GLASGOW CITY COUNCIL

**Recommendations:**

- **the PRG are asked to consider the Council's revised position on CHCPs and consider whether Option 1B proposed by the Council is an alternative way forward to deliver viable and effective CHCPs;**

- **If the conclusion of that consideration is that Option 1B is not a viable alternative then to confirm the next steps to put in place alternative arrangements to manage NHS community and primary care services to be reported to the June Board meeting.**

## 1. SUMMARY

1.1 Community Health and Care Partnerships (CHCPs) were proposed to the City Council by NHS Greater Glasgow in 2005. The shared vision for CHCPs was that they would:

- provide the platform to deliver further service integration and improvement, building on the success of the established Learning Disability and Addictions Partnerships;
- through formal Public Partnership Forums establish real connections with, and influence for, local communities;
- focus on the needs of local people and deliver innovation and change to respond to those needs;
- achieve greater efficiency in the delivery of public services;
- Through the substantial involvement of local Councillors as CHCP Committee members, enable stronger local and democratic accountability for NHS and Council services.

1.2 This shared vision for CHCPs required the Council and the NHS to adopt new ways of working and to be prepared to reduce central control and decision-making while retaining clear lines of accountability and governance.

1.3 From the date of establishment of the CHCPs the NHS:

- devolved the totality of the resources for community services to the CHCPs, including specialist services devolved on a host CHCP basis;
- delegated management and planning functions and capacity previously undertaken at centre to the CHCPs, with a substantial shift in staff into the CHCPs;
- agreed that Councillors would chair and form the majority group on the CHCP Committees notwithstanding that the responsibilities and budget were more substantially for the NHS.

1.4 CHCPs are widely viewed to have been successful in making progress towards the shared vision, delivering service improvements, engaging with communities, achieving community planning gain, improving health and focusing on tackling inequalities.

1.5 However, there has been continuing delays in delivering the organisational changes within the Council to enable CHCPs to fully function and fully deliver their potential.

1.6 For the last two years there have been detailed discussions with the City Council about moving to a similar approach to that of the NHS, with changes to Council budgets, centre decision making, staffing and control arrangements to enable CHCPs to fully function.

1.7 Commitments to the shared vision and the necessary decentralisation and devolution of decision-making have been consistently and unequivocally restated by senior Councillors. Detailed and prolonged discussions with the Council have seen repeated commitments to deliver the changes required to achieve that vision.

1.8 In September 2009 a Joint Partnership Board (JPB), was put in place bringing together Councillors and Board members to ensure change was delivered.

1.9 At the end of 2009 the positive outcome was reached that the Council and the NHS had joint agreement on the detail of revised arrangements which would have delivered the changes within the Council from April 2010 and

1.10 However, the Council has decided to set aside that agreement to develop its own revised proposals for CHCPs.

1.11 The Board now needs to consider whether the Council's decision to reverse the agreement to fully implement the revised Scheme of Establishment and instead make limited changes to the present position offers a viable way forward. Section 3 of this paper outlines the detail of our consideration of the implications of the Council's revised position.

1.12 Our conclusions have been informed by careful consideration with CHCP Directors of the Council's proposal. This has identified a series of issues and we have also identified a number of critical issues which the full implementation of the agreed revised Scheme of Establishment would have addressed but which the Council's proposal does not address.

1.13 These issues can be summarised as:

- the continuation of the current position where financial delegation does not reflect service responsibility putting our employees in a position where they carry responsibility for cases, often high risk, but cannot make decisions on care. Devolving commissioning budgets was critical to resolving this issue;
- the JPB continue to have a central role in the Council's proposal but the JPB has not functioned effectively and the Board has no basis for confidence that will change;
- as the limited changes do not address a number of the substantive issues between CHCPs and Social Work centre the continual focus on resolving disputes is unlikely to change. That creates significant instability, is a distraction of time from the proper management of NHS services and has created a perception that the CHCPs are social work focused. This has led to dissonance with NHS interests particularly primary care contractors and lack of focus on NHS issues, including work with the acute sector;
- the changes do not address the serious concerns about the imposition of savings on CHCP budgets which do not have clear delivery plans, for example, care home places. This approach creates risks for the NHS and leaves NHS employees with

the responsibility for delivery of decisions in which they have played no part. It also confuses responsibility for system and client service failure;

- the Council proposed changes do not address the issue of the imposition of corporate savings on Directors, for example, from notional absence reduction and management cost savings, outside the agreed financial regime which includes the JPB. This approach puts Directors in a difficult position in terms of their budget management responsibilities;
- it is not clear that the Council's proposal will address our concern about the management time and energy which is required to operate in an environment without participative decision making and appropriate lines of accountability;
- the Council's rejection of moving to the agreed devolved model of CHCPs means that the intention to make local decisions about local services, connect with local people and enable political leadership and accountability through local elected members cannot be delivered. The Council decision reinforces a centralised approach.

1.14 The conclusion of this paper is that while the City Council continues to indicate it is fully supportive of the shared vision it is now clear, after nearly two years of discussions, that the Council is not able to make the substantive changes which are required to deliver the agreed approach.

1.15 The consequence of the Council's revised position is that the Board cannot expect to have effective and fully functioning CHCPs within any known and reasonable timescale.

1.16 As we cannot achieve implementation of the agreed approach without the delivery of change by the Council we have to consider alternative arrangements which ensure that NHS responsibilities are secure.

1.17 This outcome is disappointing for a number of reasons:

- we believe CHCPs could have delivered further improved outcomes for the City's most disadvantaged communities;
- the commitment by CHCP management teams and frontline staff has delivered real change despite the significant difficulties in working in partial CHCP arrangements;
- at a time when public services will be under unprecedented financial pressure, failing to deliver the change to move to fully integrated and devolved arrangements loses the opportunity to increase efficiency and, therefore, to protect the most vulnerable service users.

1.18 In conclusion, this paper describes the position the Council has taken and the consequences for the NHS of the Council's decisions. Two years of discussions aimed at delivering our shared vision for CHCPs have achieved clear agreement on the changes required but the Council has now decided not to implement those changes.

1.19 In these circumstances, despite our unequivocal commitment to integrated NHS and social care services as being in the best interests of the people we serve, the responsibility of the NHS Board is to move to establish secure and viable organisational arrangements to manage NHS services in which NHS staff can have clear direction and confidence.

1.20 A shift to NHS CHPs will enable a renewed focus on NHS services, issues and relationships; clear lines of accountability and responsibility for NHS employees; and reduce management costs, as at present we bear a disproportionate share of CHCP management costs. Importantly we also be able to focus on and re-engage community staff and primary care contractors.

1.21 The further sections of this paper provide:

- **details of the discussions with the City Council;**
- **an appraisal of the Council's revised, proposed way forward;**
- **a short appraisal of the issues for consideration in moving to NHS partnerships.**

1.22 The demonstration of our unequivocal commitment to CHCPs is clear in the successful CHCP we have had with East Renfrewshire Council for four years and the fact that during this year we will establish similar arrangements with West Dunbartonshire and Inverclyde Councils. Where Councils are willing and committed partners we will continue to promote the development of CHCPs.

## 2. BACKGROUND AND PURPOSE

2.1 In October 2008 the Board agreed and established a formal joint process with the City Council to bring forward proposals to achieve the implementation of the shared vision of devolved CHCPs, with a revised Scheme of Establishment to be in place from April 2009.

2.2 By the end of March 2009 progress had not been as anticipated. However, the Board had considered a revised draft Scheme of Establishment.

2.3 Importantly, the City Council had formally approved a paper which endorsed a highly devolved model of CHCP's including:

- a Joint Partnership Board (JPB) to be established;
- an officer "Executive" Group to ensure a shared approach to the management and development of CHCPs and underpin the work of the JPB to be established;
- explicit commitment to move to a much more devolved model including a changed relationship between CHCP Directors and Social Work centre with a high level of devolution and delegation overseen by the JPB;
- CHCP Directors would be given fully devolved decision making powers - this new arrangement was proposed to allow CHCPs to fulfil their potential;
- the Council would revise their budget setting process for the Council element of CHCP resources.

2.4 In considering the progress which had been made the Board agreed to a further three months of work to develop a final draft Scheme of Establishment with the proviso that should include definitive clarity on the budget devolution which would be in place for April 2010 before the JPB was established.

2.5 In June 2009 the Council approved a further paper including the statement that the Council and the NHS shared a joint commitment that CHCPs would hold, by April 2010, on a devolved basis, the totality of the budgets for the services and care groups for which they are responsible.

2.6 The August 2010 NHS Board meeting heard in person from the Council Chief Executive about the unwavering commitment of the Council to the devolved and integrated CHCP model and that if the Board agreed to establish the JPB that would enable the required devolution of budgets and changes to organisational arrangements to be delivered.

2.7 The commitment was the majority of budgets would be devolved by December 2009 with full devolution by April 2010. The Deputy Leader of the Council confirmed his positive view of the opportunities the full devolution of budgets to CHCPs would offer. The Board

accepted these assurances and agreed to move to establish the JPB as proposed by the Council.

2.8 The JPB was established in September 2009 under the Chair of the Council's Executive member for Social Work, and developed a detailed work programme to finalise a revised Scheme of Establishment and to deliver the agreed full devolution to CHCPs by April 2010.

2.9 The revised Scheme of Establishment, setting out the detail of full budget devolution and related changes, was considered at the November 2009 JPB. The meeting endorsed the Scheme with the full support of the six Councillors on the JPB. The Scheme of Establishment was subsequently considered and approved by the December 2009 NHS Board. At the subsequent JPB meetings there have been explicit assurances that the Scheme of Establishment had been agreed by the Council Administration and would be approved before the end of March.

2.10 During March 2010 it became clear that the Council was separately developing its own proposals at odds with the approach agreed by the JPB. A series of exchanges between the Board Chair and Chief Executive, the acting Council Leader, Councillors chairing CHCPs and Council officers made very clear the extent of our concern at this departure from fundamental agreements and the risk that the Council's change of position would create for the future of the CHCPs.

2.11 At its April meeting, the Council's Executive Committee rejected the option to fully implement the agreed Scheme of Establishment and instead approved a series of changes described as incremental progress to the Scheme of Establishment. The next section of this paper analyses the Council's proposals in detail.

2.12 The purpose of this paper is to enable the PRG to consider the Council's proposal and agree how to proceed.

## 3. THE COUNCIL'S REVISED APPROACH

3.1 As it became clear the Council was developing alternative proposals to those which had been jointly agreed, and draft papers were shared with us, we consistently raised serious concerns about the viability of Option 1B. These concerns were shared with the leadership of the Council and CHCP Chairs but were not reflected in the final version of the paper. The paper at Attachment 1 was considered by the Council's Executive Committee on 30th April 2010 and the recommendations approved.

3.2 We have carefully considered the Council's proposals and the rest of this section considers and responds to the content of the Council paper and the issues arising in three sub sections:

- commenting on the policy influences which are suggested provide the basis for the Council's revised position;
- commenting on the key elements of Option 1B;
- Consideration of the implications of Option 1B.

### 3.3 Key Policy Influences

This section of the Council paper describes the factors which have influenced the Council proposal, we have reproduced extracts in bold with comments on each section. It is important to respond to these points as they appear to be presented as the basis for the Council's decision to change its position and endorse a revised proposal.

3.3.1 SWIA Recommendation 16

**The SWIA inspection of social work services in Glasgow makes a clear recommendation about CHCPs. The report says:**

***"The services should make sure that the move to CHCPs does not result in unacceptable differences in the level and quality of provision across the city. In order to prevent this they should ensure that they retain a strong strategic core that can ensure that local plans fit within an over-arching vision for services and that can maintain oversight of service standards".***

**The report on the Social Work centre structure approved by the Executive Committee on 27 November 2009 sought to balance the need for a strong strategic centre with the ambition to give greater financial and operational responsibility to CHCPs.**

This has been articulated as a concern in the last two years of discussions. Agreement was reached with the Council that a critical element of the role of the JPB was to ensure clear strategic direction and consistency across the City where that was required. The Council's decisions about Social Work centre have underlined our concern about their commitment to move from a highly centralised approach to one in which CHCP Directors are part of a senior leadership team working with the Social Work and NHS Directors to manage services and budgets. Concerns raised by the NHS and the JPB about the extent to which the revised Social Work centre structure enabled a devolved approach were not reflected in advice to the Council and Council decisions.

3.3.2 Chief Social Work Officer

**The role of the Chief Social Work Officer is set out in legislation in the Local Government (Scotland) Act 1994. New guidance was issued in April 2009 and considered and endorsed by the Council's Executive Committee. This guidance is designed to be applicable in any structure which a Council chooses to establish for the delivery of social work services.**

**The Council's position has been that the Chief Social Work Officer role is one of a small number of key statutory appointments, that the functions are laid out in the newly revised guidance and that it is not open to the Joint Partnership Board to revise this.**

The role of the Chief Social Work Officer is fully reflected in the agreed revised Scheme of Establishment there has been no proposal by the JPB to revise that role.

3.3.3 Partnership Working

**The intrinsic interdependence of health and social care services is captured in long established national policies that direct joint working, including Joint Futures. The recent Arbuthnott report reinforces the importance of the health-social care relationship, which we know from audit and inspection evidence assumes any number of structural forms across the country. However, it is important to note recent SWIA evidence which confirmed that effective leadership, not organisational structures, is the key determinant of effective outcomes for users of social care services.**

It is the Board's view that strong and integrated leadership between the NHS and the Council is essential to deliver these outcomes. There is clear evidence that integrated

services and structures have delivered improved services in Glasgow City the next stage of devolution, would have delivered that leadership if the Council had supported it.

3.3.4 Kerelaw Report

**The Kerelaw Report was of huge significance to the Council. Within the report it analyses the conditions which allowed this service failure to develop. In particular it highlighted that the combination of a divided management team and severe financial problems resulted in managers not being sufficiently focused on improving service standards. The Council needs to take all possible steps to ensure that the lessons from Kerelaw are learned.**

There has not been a discussion with the Council on the issues the Kerelaw report raises for CHCPs. The report was published several months before the revised Scheme of Establishment was adopted, It is certainly the case that a divided management team is highly problematic and our conclusions about the absence of a team approach between CHCP Directors and Social Work centre are important in framing advice to the Board.

3.3.5 Financial Issues

**CHCPs already hold significant budgets (£180M approx) and the proposals developed over recent months would see the extent of financial devolution grow markedly. Reports to the Council's Executive Committee in relation to Financial Monitoring have previously highlighted the risk to the Council's overall financial position which arises from overspends within CHCPs. These risks would be increased by rapidly devolving budgets and the capacity of the Social Work Centre to offset overspends from under spends outwith CHCPs would no longer exist.**

One of the core issues which it was agreed the JPB and the revised Scheme of Establishment must address was the budget setting arrangements for CHCPs. The revised budget arrangements approved by the Council's Executive Committee in March 2009 have only been partially implemented. It has been clear for the last two years that the allocation of costs and budgets between CHCPs and Social Work centre does not properly reflect where expenditure actually occurs. This mismatch is clearly evidenced by the fact that CHCPs overspend while the overall Social Work budget breaks even. Savings requirements have continued to be set at Social Work centre independently of CHCP Directors and of their deliverability in service terms.

The agreement to devolve budgets was approved by the Council in March 2009 but there has been almost no progress in delivering the required changes. The Council's paper offers no insight into why the level or nature of risk has changed from the point where the revised Scheme of Establishment, which included full budget devolution, was agreed only a few months ago. CHCPs hold £500 million of NHS budgets and there are no financial management issues.

Senior Councillors chair CHCP Committees which are responsible for scrutinising CHCP financial performance.

**Given the financial challenges which face Social Work Services over the next few years, any proposal to devolve additional budgets needs to balance the financial risks against the potential service benefits. In the context of a social work service, inadequate financial management would result in additional service cuts and increased risk to vulnerable clients**

CHCPs have single management teams. These teams manage over £500 million of NHS resources and have consistently delivered financial break even and NHS savings targets. The JPB agreed the Social Work financial management processes require substantial overall to be fit for purpose to properly support CHCPs those changes have not been implemented.

In conclusion, from our perspective it is unclear why these "key policy issues" are deemed to provide the basis for the Council to unilaterally develop a revised approach to CHCPs. All of these issues were already visible when the revised Scheme of Establishment was approved by the Joint Partnership Board and the Executive member for Social Work confirmed it had the support of the Labour Administration.

**3.4 <u>Commentary on Option 1B</u>**

Option 1B is framed in the report as incremental implementation of the Scheme of establishment. The specific steps set out are in bold below with out comments.

1. **Transfer the management of the Community Casework Teams within the Homelessness Partnership to CHCPs.** It was previously agreed the JPB would decide the successor arrangements to the Homelessness Partnership. The Board has not agreed the Council's proposals which would unilaterally dissolve a partnership arrangement and disintegrate currently integrated services. This decision undermines the role of the JPB.

2. **Create new management arrangements for residential child care in one CHCP on a pilot basis and create a clear monitoring and evaluation process and timescale. Success in this pilot site will lead to the progressive transfer of the management of this element of service to CHCPs.** CHCP Directors were tasked by the JPB with developing proposals for the devolution of these budgets within the Council's overall commitment to devolve all budgets for the care groups and services to CHCPs from April 2010. This proposal from Social Work centre is not in line with the Council's headline commitment or the approach proposed by CHCP Directors.

3. **Conclude the winding up of the Learning Disability Partnership and transfer the commissioning staff to Social Work Centre.** The Council had previously agreed that the JPB would make final decisions about the future of the Learning Disability Partnership. This decision undermines the role of the JPB, further centralises control of budgets and reinforces the separation of CHCP management responsibilities from financial decision making.

4. **Transfer the budgets for residential schools to CHCPs subject to the conclusion of an agreed protocol for the management of the budget, including arrangements for joint funding with Education.** No comment.

5. **Agree a process to review the management costs with CHCPs in order to accommodate severance requests from managers in joint posts and contribute to the Council's Corporate savings target for middle managers (£700k).** Agreement to CHCP management structures was confirmed by the JPB in approving the revised Scheme of Establishment, six months ago. There is no agreement with the NHS to change management arrangements. The savings target has not been set through the agreed joint process nor discussed by the JPB. Savings at this level would seriously undermine the management capacity of the CHCPs which will create significant risks for NHS services. It is difficult to understand why at a point when the agreement was that the CHCPs would take on

substantial additional responsibilities for social work services these savings would not be targeted at Social Work centre management costs.

6. **Transfer management of Care Homes budget for older people to CHCPs (£75M).** This limited additional devolution signals the withdrawal of the Council's commitment that by April 2010 the CHCPs would hold fully devolved budgets. This additional devolution is in line with a proposal made twelve months ago and would leave around £135 million of the Social Work budget which was to be devolved continuing to be held at Social Work centre. Option 1B further centralises budgets which have previously been delegated into partnership arrangements. The reasons that budget devolution has been, and remains, such an important issue are:

   - CHCPs are responsible for delivery of services to their population and can only operate effectively if they hold the budgets for that delivery - whether for service provision or to purchase services;
   - case and care decisions and responsibility should be aligned with budgets;
   - coherent lines of accountability for Directors require coherent budgetary arrangements which properly reflect their responsibilities;
   - management of service provision and service purchasing for defined client groups should be aligned in order that CHCP management teams can shift resources between purchased and provided services and between residential and community services to best meet need - and be held accountable for those decisions.

7. **Addictions Partnership - agree that for an interim period (either 6 months or 1 year) that the existing arrangements for the Addiction Partnership continue and we agree a joint review process to determine future arrangements.** It had previously been agreed that the JPB would decide on the future arrangements for the Addictions Partnership from April 2010, this decision undermines the role of the JPB.

Finally, Option 1B is described as "consistent with the views and expectations of the scrutiny bodies responsible for the Best Value 2 Audit process". We are not aware that scrutiny bodies have framed expectations to the Council which advise it not to proceed on the previously agreed basis.

Audit Scotland have confirmed to the Board the importance they attach to partnership working, noted that their draft report makes little detailed comment on CHCPs but is supportive of the partnership approach and confirm that their draft report is not an audit report and is not underpinned by any specific audit work on CHCPs.

### 3.5 Implications of Option 1B

There are a number of implications of option 1B from our perspective. These are set out below under the four key areas of concern.

#### 3.5.1 JPB Role

The development of and decision-making on the Council's incremental proposal has substantially undermined the credibility of the JPB. The Board had significant reservations about establishing the JPB until the agreed programme of work to sign-off a revised Scheme of Establishment was concluded. In August 2009 we set aside those reservations following the Council's direct reassurances that putting the JPB in place would ensure full devolution of resources and progress on all of the outstanding issues by April 2010. The Council membership of the JPB, with five senior Councillors and the Executive member of

Social Work in the Chair, was promoted by the Council as creating a forum where key decisions could and would be made.

The reality has been that agreements reached at the JPB have been consistently set aside, the detailed and approved JPB work programme has not been progressed, and, most importantly the JPB approval of the revised Scheme of Establishment has now been deemed irrelevant. The decisions reached by the Executive Committee on option 1B include issues which the Council had previously agreed would be decided at the JPB. This further underlines the credibility gap.

3.5.2 Centre/CHCP Relationships

Option 1B underlines the Council's intention to further centralise decision-making and budgets. In the face of significant concerns from the JPB, the Council has already put in place revised Social Work management arrangements which are inconsistent with the devolution required for CHCPs to function effectively. CHCP Directors have been increasingly marginalised from Social Work decision-making.

3.5.3 Budgetary Control

There have been continuing concerns for the NHS Board that the CHCPs are presented in Council papers as not exercising proper financial control. We do not believe this fairly reflects the causes of financial issues. The devolution of partial budgets to CHCPs has simply allocated a number of under-resourced areas to CHCPs while areas of underspend and additional income are retained elsewhere in the Social Work structure. As outlined earlier in this section, overall Social Work budgets break even. It is also worth noting that senior Councillors chair the CHCP Committees which are responsible for oversight of CHCP financial management.

3.5.4 Devolution of Budgets

The withdrawal of the agreement to fully devolve budgets from April 2010 inherent in Option 1B has a number of consequences:

- CHCP management teams will continue to be in a position where they cannot make decisions with regard to their responsibilities for client care without onward referral to Social Work centre decision-makers who have no case responsibility but hold budgets. This continuing misalignment of client and financial responsibility is not a viable approach to budget management, to financial accountability or to accountability for service performance;
- CHCPs are unable to manage and make decisions over the totality of resources for clients for whom they are responsible. For example, if Directors agreed that additional community investment would enable reduced residential support costs and wanted to shift the balance of resources the proposed devolution would not enable that. The effect is to close down opportunities for innovation and to disincentivise CHCP teams from driving service change. Integrated management of the continuum of care is an essential part of driving service change, delivering efficiency and establishing clear lines of accountability. The parallel NHS examples include our delegation into CHCP structures of the management of elderly mental health and mental health beds and of specialist children's services, enabling the CHCPs to shift resources into the most economic forms of care;
- the continuation of the current budgetary arrangements loses the opportunity to reduce management costs and sees Social Work centre, with a significant number of senior management posts, carrying responsibilities which should be devolved to CHCPs. CHCP Directors advice is that there is potential to transfer budgets and

functions to CHCP management teams without the full transfer of the management and support resource thus reducing overall management costs.

### 3.6 Consideration of Option 1B

The points outlined above illustrate why the Council's decision to approve Option 1B and reject full implementation of the agreed Scheme of Establishment does not resolve issues which are fundamental to the effective functioning of CHCPs.

Clearly it was for the Council to decide whether or not it could deliver the approach it had agreed to fully establish CHCPs. The Council now has a clear position that it is not willing to deliver the changes which had been jointly agreed as essential for effective CHCPs.

The delivery of viable and fully functioning integrated partnerships required both the Council and the NHS to make the significant changes to move to very different ways of working. The NHS has delivered, but delivery of change by only one partner is not enough, nor is the Council's commitment to the CHCP vision without delivering the change required to realise that vision.

The approval of option 1B, rejecting the full implementation of the jointly agreed Scheme of Establishment, after such a prolonged period of detailed negotiation must lead to the conclusion that the Council is not able to make the those changes within any meaningful timescale.

The Board remains committed to the CHCP model of a single organisation managing health and social care services with key leadership roles for Councillors as its preferred approach.

However, in circumstances where the Council will not make the changes which were agreed to enable this way of working to succeed we need to consider whether NHS CHP(s) are a better option than continuing with the present unsatisfactory arrangements which the last three years of joint work was intended to resolve.

The NHS Board has no option but to consider how it can move to establish stable and viable organisational arrangements to replace the CHCPs.

## 4. SHIFTING TO NHS COMMUNITY HEALTH PARTNERSHIPS

4.1 Our focus has been on trying to reach agreement with the City Council to make positive progress and we have not undertaken work on alternative organisational arrangements. The proposal is that this work is now established and that recommendations are brought to the NHS Board in June to define those new arrangements, for approval, and begin an orderly transition out of the CHCPs, probably to be concluded by the end of October 2010.

4.2 The rest of this section outlines a number of the key issues for consideration.

### 4.3 CHP Numbers and Potential Boundaries

The current CHCP boundaries were principally driven by Glasgow City Council electoral boundaries. Moving to NHS only CHPs enables us to give higher priority to boundaries which are of greater significance to NHS services.

In considering the number of and potential boundaries for CHPs the following points will important:

- ensuring that the CHPs are of the optimum scale to enable the efficient and effective deployment of management resources;
- reflecting the flows of patients into acute services in order to create a stronger platform for joint working and developing primary care relationships;
- Previous sectoral arrangements which were used in the structure of the former Primary Care Division and provide the basis for a number of specialist services.

Continuing with five CHPs managing only NHS services is not a viable option in relation to management costs. Across Scotland CHPs range in size from population coverage of a maximum of around 300,000, too much smaller scale. We will appraise the options for CHP numbers and boundaries for consideration at the June Board.

**4.4 Currently Integrated Services**

In our view the integration of services at the front line, with integrated management and governance structures, has begun to be one of the real benefits of CHCPs. In addition to CHCPs we have integrated services managed within Partnerships for Homelessness and Addictions. However, without the integrated governance and management structures which CHCPs have provided we will need to consider three options for those services:

- provision by the NHS within NHS resources, this may include redirection of resource transfer and transfer of staff and redirection of ring-fenced allocations routed through the NHS;
- services delivered by the NHS on behalf of the Council under a service level type agreement;
- separate provision of NHS and social care services.

Our focus in considering these options will be on continuing to deliver the best services for patients and clients.

**4.5 CHP Committees**

CHP Committees will have a very different construct from CHCPs we will bring forward proposals for revised Committee arrangements led by NHS Board non Executives.

**4.6 Services and Structures**

In developing our transition arrangements we will need to ensure that services to patients are not disrupted and there is no break in the continuity of care. Service systems will need to be redesigned where that is required before changes are implemented.

When final boundaries are established we will need to develop management structures which will cover the responsibilities of the new CHPs - these will include:

- district nursing and related services;
- health visiting and school nursing;
- rehabilitation and disability services;
- primary care support;
- health improvement and inequalities;
- prescribing;
- community mental health;
- addictions services;
- learning disability services;
- planning;
- partnership working;

- public and patient engagement;
- a range of AHP services;
- community child health and CAMHS;
- Older people's mental health.

Issues for further consideration include:

- whether specialist services are managed by all CHPs or on a lead or host basis. This will include services presently managed by the Addictions and Learning Disabilities Partnerships;
- whether we adopt structures within the CHP boundaries based on care groups or locality general management or combination of the two;
- how the CHPs will work with community planning and related structures.

### 4.7 Staff

Moving to NHS only arrangements has the most significant implications for the CHCP staff holding joint posts with responsibility for NHS and Council services. These staff number around 100. There are also a number of joint management staff in the other Partnerships, the NHS functions of which would migrate to the new CHP(s). In addition to the management posts which carry joint responsibilities there are a large number of team leaders who cover NHS and Council services. If we are not able to reach agreement on the basis outlined above with the Council then a further, larger group of staff will be directly affected.

The NHS will have responsibility for all of the NHS employees who are displaced or affected by this organisational change. Our aim will be to maximise redeployment into the new organisational structures by appropriate process under the Organisational Change Policy. The Council will have similar responsibilities for its employees working within the CHCPs and Partnerships.

In addition to the Board's responsibility to those staff it employs, it is important to recognise that since the CHCPs were established in April 2006 the management teams have made huge efforts to develop and improve services despite the significant organisational barriers highlighted in the first section of this paper. The end of CHCPs will be extremely difficult for the staff that have led and managed them.

### 4.8 Property

An analysis of the shared use of property is underway and detailed transitional work will ensure that the NHS services are provided in appropriate premises at an appropriate cost. Our initial assessment is that this is likely to reduce NHS costs.

### 4.9 Financial Issues

There will be a range of financial issues which will need to be resolved with the Council in moving on from CHCPs to establish CHPs. These will be identified in the June paper.

### 4.10 Joint Working

There will need to continue to be joint working arrangements with the City Council but we will need to consider what those arrangements should be, at what level they will operate and that there is a clear focus on engagement which delivers tangible outcomes.

## 4.11 Communication

The CHCPs work with a wide range of stakeholders who will be concerned by the outcome of this process. Our aim will be to agree detailed communication plans with the Council.

There will also be significant media interest in the disintegration of a long running partnership between the Council and the NHS and we will need to ensure that the Board position is clearly articulated and understood..

## 4.12 Conclusion

This section has briefly outlined issues for consideration in shifting to NHS Partnerships and the content can be developed further for the June Board.

**Item 3**

**20th April 2010**

**Glasgow City Council**

**Executive Committee**

**Report by Councillor Archie Graham, Executive Member for Social Care**

**Contact: David Crawford**

# Joint Working with NHS Greater Glasgow and Clyde

**Purpose of Report:**

The purpose of this paper is to consider the issues which surround the current CHCP model created by the Council and the Health Board, and to outline options to strengthen future joint working.

**Recommendations**:

Committee is asked to:

a) consider the report ;
b) approve Option B, Incremental implementation of the Scheme of Establishment during 2010/11;
c) confirm the formal establishment of the Joint Partnership Board; and
d) approve the addition of 1 opposition member to the Joint Partnership Board

Ward No(s): Citywide: ☐

Local member(s) advised: Yes ☐ No ☐ consulted: Yes ☐ No ☐

## 1. Purpose

The purpose of this paper is to consider the issues which are currently impacting on the CHCP model created by the Council and the Health Board to promote joint working, and to outline options in relation to the future structure of joint working.

## 2. Background and Context

**2.1** The CHCPs were created in 2006 with the expectation that they would:

- Manage local NHS and social care services;
- Improve the health and well being of its population and close the inequalities gap;
- Play a significant 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.

**2.2** In March 2009 the Council proposed a revised model for the oversight of CHCPs by creating a Joint Partnership Board and sought to enhance the levels of devolved budgets and services managed by CHCPs. The Joint Partnership Board was set up as a "Shadow Board" in September 2009 with a remit to include:

- resolution of current budget issues;
- the speed of budget devolution; within the agreement to full devolution of the agreed budgets by April 2010;
- the detail of professional advisory agreements and the relationship between social work centre, within the agreement to the Directors accountability and individual performance arrangements, the single planning and performance system with the NHS and the framework of this Scheme of Establishment;
- the development of service level agreements;
- the development of a framework for future budget savings and challenges.

## 3. Key Policy Influences

**3.1** The approach of the Council is influenced by a range of factors including existing Council policies, responses to inspection and audit reports, key national policies and the budget and service plan process. At a joint seminar held in May 2009, which was attended by both the Health Board and Council Chief Executives, senior staff from the Council and the Health Board and CHCP staff, the Council outlined the key policy influences which guided its approach to CHCPs. Since that time circumstances have moved on and the key influences at this time are outlined below.

### 3.2 SWIA Recommendation 16

The SWIA inspection of social work services in Glasgow makes a clear recommendation about CHCPs. The report says:

*"The services should make sure that the move to CHCPs does not result in unacceptable differences in the level and quality of provision across the city. In order to prevent this they should ensure that they retain a strong strategic core that can ensure*

*that local plans fit within an over-arching vision for services and that can maintain oversight of service standards".*

The report on the Social Work centre structure approved by the Executive Committee on 27 November 2009 sought to balance the need for a strong strategic centre with the ambition to give greater financial and operational responsibility to CHCPs.

**3.3 Chief Social Work Officer**

The role of the Chief Social Work Officer is set out in legislation in the Local Government (Scotland) Act 1994. New guidance was issued in April 2009 and considered and endorsed by the Council's Executive Committee. This guidance is designed to be applicable in any structure which a Council chooses to establish for the delivery of social work services.

The Council's position has been that the Chief Social Work Officer role is one of a small number of key statutory appointments, that the functions are laid out in the newly revised guidance and that it is not open to the Joint Partnership Board to revise this.

**3.4 Partnership Working**

The intrinsic interdependence of health and social care services is captured in long established national policies that direct joint working, including Joint Futures. The recent Arbuthnott report reinforces the importance of the health-social care relationship, which we know from audit and inspection evidence assumes any number of structural forms across the country. However, it is important to note recent SWIA evidence which confirmed that effective leadership, not organisational structures, is the key determinant of effective outcomes for users of social care services.

**3.5 Kerelaw Report**

The Kerelaw Report was of huge significance to the Council. Within the report it analyses the conditions which allowed this service failure to develop. In particular it highlighted that the combination of a divided management team and severe financial problems resulted in managers not being sufficiently focused on improving service standards. The Council needs to take all possible steps to ensure that the lessons from Kerelaw are learned.

**3.6 Financial Issues**

3.6.1 CHCPs already hold significant budgets (£180M approx) and the proposals developed over recent months would see the extent of financial devolution grow markedly. Reports to the Council's Executive Committee in relation to Financial Monitoring have previously highlighted the risk to the Council's overall financial position which arises from overspends within CHCPs. These risks would be increased by rapidly devolving budgets and the capacity of the Social Work Centre to offset overspends from underspends outwith CHCPs would no longer exist.

3.6.2 Given the financial challenges which face Social Work Services over the next few years, any proposal to devolve additional budgets needs to balance the financial risks against the potential service benefits. In the context of a social work service, inadequate

financial management would result in additional service cuts and increased risk to vulnerable clients

## 4. Implementation of Scheme of Establishment

**4.1** In the context of the issues raised earlier in this report it is now proposed that the Council agree to implement the Scheme of Establishment recently approved by the Health Board and included as Appendix 1 to this report. In doing so there are two approaches to implementation –

**Option A** – Full implementation of the Scheme of Establishment with immediate effect, including full delegation of budgets and revised and integrated core group planning arrangements. However, this option would not be consistent with the Council response to SWIA or the recent decision by the Executive Committee on the role of the Social Work Centre. It could also create a risk to the financial stability of Social Work Services and, indeed, the Council's overall financial position. It could also increase the variations in performance across the CHCPs.

**Option B** – Incremental implementation of the Scheme of Establishment during 2010/11.

The Council could continue to work towards the implementation of the Scheme of Establishment through a series of incremental steps which seeks to manage risk, build confidence and rebuild relationships. The steps are as follows:

1. Transfer the management of the Community Casework Teams within the Homelessness Partnership to CHCPs.

2. Create new management arrangements for residential child care in one CHCP on a pilot basis and create a clear monitoring and evaluation process and timescale. Success in this pilot site will lead to the progressive transfer of the management of this element of service to CHCPs.

3. Conclude the winding up of the Learning Disability Partnership and transfer the commissioning staff to Social Work Centre.

4. Transfer the budgets for residential schools to CHCPs subject to the conclusion of an agreed protocol for the management of the budget, including arrangements for joint funding with Education.

5. Agree a process to review the management costs with CHCPs in order to accommodate severance requests from managers in joint posts and contribute to the Council's Corporate savings target for middle managers (£700k).

6. Transfer management of Care Homes budget for older people to CHCPs (£75M).

7. Addictions Partnership - agree that for an interim period (either 6 months or 1 year) that the existing arrangements for the Addiction Partnership continue and we agree a joint review process to determine future arrangements.

This option reduces the financial and service risk to the Council while still maintaining the potential for improvement and efficiency.

**4.2** In terms of the 2 options identified in this paper Option B is recommended as it offers the Council the opportunity to continue to support CHCPs and to develop its joint agenda with the NHS while taking a measured approach to services devolutions and an appropriately cautious approach to the management of financial risk. It is believed that this option is consistent with the views and expectations of the scrutiny bodies responsible for the Best Value 2 Audit process

## 5. Scheme of Establishment

The Scheme of Establishment as approved by the Health Board on 1 December 2009 is attached at Appendix 1.

Since the approval of the Scheme, the Board have subsequently agreed to amend the membership of the Joint Partnership Board to include an additional Elected Member from the Opposition and an additional member from the Health Board.

The formal approval of the Scheme of Establishment would end the "Shadow" status of the Joint Partnership Board and for the future the Joint Partnership Board would be a formal part of the governance structure of both the Council and the Health Board.

## 6. Staffing Implications

6.1 In agreeing to establish the Shadow Joint Partnership Board the Council and the Health Board agreed to appoint lead advisors to the Joint Partnership Board. The Council agreed to nominate the Executive Director of Social Care Services. The Health Board made an interim appointment subject to the conclusion of other organisation changes. A Lead Director was appointed in January 2010 and is due to take up the role at the end of April 2010.

## 7. Legal Implications

The nature of the Scheme of Establishment reflects the voluntary agreement between the Council and the Health Board in relation to CHCPs.

## 8. Service Plan Implications

The service plan for 2010/11 is currently being finalised.

## 9. Recommendations

Committee is asked to:

a) consider the report;

b) approve Option B, Incremental implementation of the Scheme of Establishment during 2010/11;

c) confirm the formal establishment of the Joint Partnership Board; and

d) approve the addition of 1 opposition member to the Joint Partnership Board.

**ATTACHMENT TWO**

## PROPOSED BOUNDARIES