



SCOTTISH EXECUTIVE

Health Department

COMMUNITY HEALTH PARTNERSHIPS

STATUTORY GUIDANCE

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**COMMUNITY HEALTH PARTNERSHIPS
STATUTORY GUIDANCE**

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INTRODUCTION

1. Section 2 of the National Health Service Reform (Scotland) Act 2004¹ inserts a new section 4A and 4B into the National Health Service (Scotland) Act 1978 (the Act) and provides for the establishment of Community Health Partnerships (CHPs) by Health Boards. Every Health Board is placed under a duty to establish either a CHP for the area of the Health Board or two or more CHPs for districts which, taken together, include the whole area of the Health Board, in each case in accordance with a scheme of establishment approved by the Scottish Ministers.

2. Under sections 4A(2) and (4) of the Act, CHPs must be established as committees or sub committees of Health Boards unless the area or district of a CHP will include all or part of the areas of two or more Health Boards, in which case the CHP must be established jointly as joint committees of those Boards. Health Boards will only be able to establish a CHP once the Scottish Ministers have approved their scheme of establishment.

3. Under section 4B(1) of the Act, every Health Board must prepare and submit a scheme for the establishment of one or more CHPs for approval by the Scottish Ministers within such a period as may be specified. It is expected that schemes will take account of all areas contained within this guidance and be with the Scottish Ministers **no later than 24 December 2004**.

4. Section 4A (2) of the National Health Service (Scotland) Act 1978, as inserted by section 2 of the National Health Service Reform (Scotland) Act 2004 makes provision for the functions which a CHP can have. Broadly, these are:

- co-ordinating, for its area or district, the planning, development and provision of certain services which it is the function of its Health Board to provide with a view to improving those services;
- providing, or securing the provision of certain services which it is the function of its Health board to provide; and

¹ Section 2 was brought into force in full on 30 September, 2004 by the National Health Service Reform (Scotland) Act 2004 (Commencement No. 2) order 2004 (S.S.I.2004/361).

- exercising certain other functions of the Health Board.

5. The functions that will be conferred upon a CHP under these categories will depend upon what is specified in its approved scheme of establishment and what is delegated additionally and separately by its Health Board. Details of the functions that the Scottish Ministers expect Health Boards will delegate to CHPs via their schemes of establishment are set out in this guidance.

The Guidance

6. Section 4B(7) of the Act provides that the Scottish Ministers may issue and publish statutory guidance about CHPs. Health Boards are under a duty to have regard to such guidance in preparing schemes of establishment. This guidance is issued under section 4B(7) of the Act for that purpose and should be read in conjunction with The Community Health Partnerships (Scotland) Regulations 2004². This guidance sets out:

- the policy context within which Health Boards, working in partnership with local authorities and other local agencies, should develop their plans for CHPs;
- the main aims and benefits of CHPs and their intended functions;
- aspects of their organisational arrangements; and
- **key elements (set out in Boxes 1-12) which the Scottish Ministers will expect to be evidenced in the scheme of establishment.**

7. The guidance strikes a balance between describing requirements, which are set out in The Community Health Partnerships (Scotland) Regulations 2004 and outlining issues that should be determined by local partners.

² <http://www.scotland-legislation.hmso.gov.uk/legislation/scotland/ssi2004/20040386.htm>

CONTEXT

8. CHPs are key building blocks in the modernisation of the NHS and joint services, with a vital role in partnership, integration and service design. This guidance recognises that partnerships will evolve according to local circumstances, but that there are minimum requirements for devolving appropriate resources and responsibilities for decision making to frontline staff which should be met everywhere.

9. The background to the development of CHPs is contained in the White Paper *Partnership for Care*³, and reaffirmed in the *Partnership Agreement*⁴. It stated that Local Health Care Co-operatives (LHCCs) should evolve into CHPs, which would have a new, more consistent and enhanced role in service planning and delivery, working as part of decentralised but integrated health and social care systems. The White Paper stated that CHPs would:

- ensure patients, carers and the full range of health care professionals are involved;
- establish a substantive partnership with local authority services (e.g. social work, housing, education and regeneration);
- have greater responsibility and influence in the deployment of Health Board resources;
- play a central role in service redesign locally;
- focus on integrating primary and specialist health services at local level; and
- play a pivotal role in delivering health improvement for their local communities.

10. The White Paper required Health Boards to work with local authorities to ensure more effective working with social care in appropriate locality arrangements. It also set the development of CHPs within the wider context of better integration of health services, more effective partnership working with local authorities and other local agencies and greater public, patient, carer and staff involvement. Greater partnership working is also underpinned by the continued development of community planning, the progressive application of Joint

³ Partnership for Care <http://www.scotland.gov.uk/library5/health/pfcs-00.asp>

⁴ Partnership Agreement <http://www.scotland.gov.uk/library5/government/pfbs-00.asp>

Future and the delivery of the strategic objectives of *For Scotland's Children*⁵ and *Improving Health in Scotland – The Challenge*⁶.

11. It is intended that CHPs will create better results for the communities they serve by being aligned with local authority counterparts and by playing an effective role in planning and delivering local services. Their principal role is to work with others to deliver better results and their work will be driven by a focus on jointly agreed outcomes. As they develop and mature, and partners recognise their potential, they will play an increasingly central role in the integration of services locally. All of this is aimed at improving the health of local populations as part of an ongoing programme of development and modernisation in public services.

⁵ For Scotland's Children <http://www.scotland.gov.uk/library3/education/fcsr-00.asp>

⁶ Improving Health in Scotland – The Challenge <http://www.scotland.gov.uk/library5/health/ihis-00.asp>

AIMS

12. It is intended that CHPs will build on the achievements of LHCCs and make a measurable improvement in local population health and provide higher quality, accessible, joined up services to local communities.

13. They provide a focus for integration between primary care and specialist services and with social care. To achieve this CHPs will need to link clinical teams; work in partnership with local authorities, the voluntary sector and others to support the improvement of the health of local communities; and most importantly involve the public, patients and carers in decisions concerning the delivery of health and social care for their communities. CHPs will be expected to:

- deliver services more innovatively and effectively by bringing together those who provide community based health and social care;
- shape services to meet local needs by directly influencing Health Board planning, priority setting and resource allocation;
- integrate health services, both within the community and with specialist services, underpinned by service redesign, clinical networks, and by appropriate contractual, financial and planning mechanisms;
- improve the health of local communities, tackle inequalities and promote policies that address poverty and deprivation by working within community planning frameworks;
- be the main NHS agent through which the Joint Future agenda is delivered in partnership with local authorities and the voluntary sector;
- be the main NHS agent through which the recommendations of *For Scotland's Children* are implemented in partnership with local authorities;
- be the principal NHS partner in Integrated Community and Health Promoting Schools;
- lead the implementation and monitoring of child health surveillance and relevant aspects of screening of children;
- promote involvement of, and partnership with, staff whether employed by or contracted to the NHS; and

- secure effective public, patient and carer involvement by building on existing, or developing new mechanisms.

IMPROVING SERVICES

14. It is intended that CHPs will be the main focus for service integration for local communities, with a particular emphasis on closing the health gap whilst tackling local health and social care priorities and delivering improvements, particularly in relation to the management of chronic diseases such as diabetes or asthma for both adults and children. Staff working within CHPs will be particularly well placed to meet the increasing challenge of tackling chronic disease as one of their strengths will be the ability to provide a holistic approach to care. This is particularly vital for patients who have more than one condition requiring an integrated response from professional staff.

15. CHPs will be expected to seek to reduce local health inequalities, acknowledging the different needs of, for example, children with disability, looked after children, minority ethnic communities, disabled people, homeless people etc and to deliver benefits for individuals, families and communities through action to improve health and provide better integrated services.

16. Many local health and social care services will increasingly be provided by a wide range of skilled staff working together as a team with other professions and agencies. CHPs will be expected to release the potential of all professionals and staff, working as part of multi-disciplinary and multi-agency teams, to integrate and improve services for local people.

Patient and Carer Benefits

17. Radical service improvements for patients, people who use services and carers can happen when frontline practitioners and staff are given the opportunity, skills and resources and are encouraged to introduce new and innovative ways of caring for and treating people. Professionals and staff will be expected to work in partnership to provide:

- a wider range of services (preventative, assessment, diagnostic, treatment etc) in community settings, including appropriate alternatives to hospital admission such as rapid response services and integrated out of hours arrangements;

- more accessible services focused on the needs of patients and carers delivered by skilled professionals working as part of broad based teams;
- more responsive and faster access to services for patients and clients through more single shared assessment by a wider range of professionals;
- more streamlined care pathways through better referral patterns and protocols, earlier interventions and integrated specialist care;
- services that meet patient and carer needs by reducing the number of unnecessary or inappropriate interventions by professionals and delivering care more effectively by networks of community and specialist professionals and teams;
- more co-ordinated care within the community, providing a "one - stop" approach to a range of health and social care and other services;
- targeted approaches to health and wellbeing reinforced by local public services and voluntary and community organisations with support from local people;
- better care management and design of services through the involvement of all representative groups of public, patients and carers; and
- better information to public, patients and carers about services and how to make the best use of them.

Improving Outcomes

18. CHPs are being created specifically to improve outcomes. Working jointly, all professionals (particularly community clinicians and those providing acute/specialist care) together with their partners will, for example, be able to:

- reduce waiting times for assessment, diagnosis, treatment and care in a systematic way across a range of services;
- manage waiting times for inpatient and outpatient services more effectively by using their understanding of local demand to influence and adjust the supply and/or design of services;
- decrease the number of inappropriate hospital visits by improving the quality of referrals to consultants and increasing the skills of community practitioners

19. Working closely with local authorities and other partners CHPs will be expected to work to:

- reduce the number of people admitted to hospital in an emergency by improving the level and quality of chronic disease management and increasing community based support (e.g. mental health teams);
- reduce the number of delayed discharges from hospital through increased provision of rehabilitation services, rapid response services etc;
- reduce the time taken to agree care packages by extending single shared assessments;
- increase the quality of care through the systematic implementation of more evidence based care and multi disciplinary guidelines and protocols;
- increase the number of single points of access for all community based services;
- reduce inequalities in access to information by providing targeted and coherent health messages particularly aimed at excluded or disadvantaged groups;
- reduce the number of premature deaths by preventable diseases through local actions by key partners to improve health;
- improve access to services by increasing the level of joint service provision and co-location of services; and
- implement jointly agreed care packages for young children.

20. Health Boards will be expected to define the expected outcomes for CHPs in their scheme of establishment and demonstrate how they intend to make progress towards improving the quality of local services as described in the above examples. CHPs will be expected to use, as part of their performance assessment framework, the national user and carer outcomes in line with the National Outcomes paper of March 2004⁷ and the Local Improvement Targets⁸ set for the Joint Future agenda.

21. Delivering these service improvements will require significant commitment and involvement by health and social care professional staff in service redesign. This means joint service redesign by community and specialist practitioners at grass roots level working with patients/carers and the public. Critically, it means empowering practitioners

⁷ <http://www.scotland.gov.uk/Topics/Health/care/17673/17012>

⁸ <http://www.scotland.gov.uk/library5health/cccd904-00.asp>

in the decision making processes of service redesign committees, where resources are prioritised and used for programmes of change and innovation. CHPs must be key players in initiating and delivering service changes and play a central role in all service redesign activity.

22. To enable staff and frontline practitioners to deliver service improvements it will be important for Health Boards and partners to develop the right physical infrastructure such as premises, information systems, and equipment to enable CHPs to sustain and develop services for local communities and to develop and maintain the workforce. This will be essential for the delivery of better services in the community and will require a whole system response by the NHS and partners.

Range of Services

23. Health Boards will be expected to discuss and agree with local authority and other stakeholders, particularly frontline staff, the services (and associated budgets) to be devolved to CHPs. It is anticipated that CHPs will manage and provide, or have a lead role in co-ordinating, influencing or directing the delivery of the following services and functions:

- independent contractor services including primary medical services, general dental services, community pharmaceutical services, general ophthalmic services;
- all community related health services including community and public health nursing and services provided by allied health professionals;
- integrated mental health services and psychological services;
- community based integrated teams (e.g. rapid response services, hospital at home);
- maternity services provided in the community;
- community child health services;
- relevant aspects of child and adolescent mental health services;
- school health services;
- home-based services for children with complex needs;

- services to support vulnerable groups of children and young children including those looked after by the local authority and those at risk of abuse or neglect;
- family support services;
- drug and alcohol services (addiction services);
- sexual and reproductive health services;
- oral health action teams;
- joint learning disability services;
- services for people with sensory impairment and/or physical disabilities;
- respite or short break services for all client groups;
- joint health and social care services for older people;
- community assessment, rehabilitation and palliative care;
- community resource centres/hospitals/treatment centres;
- community access to outpatient and diagnostic services;
- community based health promotion and health protection activities;
- support to community based services provided by the voluntary sector; and
- community based unscheduled care.

24. It is recommended that such services are developed around maximum integration of health professionals and professionals from other agencies with strong management at a local level. For example, the Framework for Mental Health Services in Scotland⁹ recommends staff in health, social work, housing and the voluntary sector work together to plan, commission, and deliver integrated mental health services through a “comprehensive menu of community focused primary and secondary care”.

25. CHPs can provide the local organisational arrangements envisaged in the Framework to move to fully integrated models of care that will also enable the statutory requirements set out in the Mental Health (Care and Treatment) (Scotland) Act 2003¹⁰ to be delivered by partners when it is brought into force¹¹.

⁹Framework for Mental Health Services in Scotland

http://www.show.scot.nhs.uk/publications/mental_health_services/mhs/index.htm

¹⁰Mental Health (Care and Treatment) (Scotland) Act 2003

www.scotland-legislation.hmso.gov.uk/legislation/scotland/acts2003/20030013.htm

¹¹ See regulation 10(2) of the community health partnerships regulations (S.S.I. 2004/386)

26. Child health services need to be integrated into the work of the CHP in order to ensure the effective planning and development of child health services and to support the wider integration of children's services. It may not be possible to locate the full range of child health services in every CHP because of the number of staff or the specialist nature of service provision such as some child and adolescent mental health services, community paediatric specialities or some acute specialities. However, the way in which services are planned and delivered must be based on a fully integrated model of care through CHPs.

27. **The range of services that will be devolved to CHPs must be described in the scheme of establishment.** The range of services outlined above is not intended to limit Health Boards and local partners from devolving further services to CHPs if this will improve the overall quality of service delivery and deliver better outcomes for users and carers. Where there are multiple CHPs in a Health Board area then, where necessary, one CHP may host the delivery of a specific service on behalf of other CHPs in the same area. Where this is agreed it should be specified in the scheme of establishment.

Service Planning

28. Regulation 9 of The Community Health Partnerships (Scotland) Regulations 2004 provides that Health Boards must involve every CHP in its area in planning, developing and making decisions which will significantly affect the operation of the services for which the Health Board is responsible. CHPs should be fully involved in overall Health Board strategic planning, priority setting and resource allocation and they will be responsible for the delivery of their part of the strategic plans. They will have a critical role to play in the design of services that require a whole system approach, such as cancer care, maternity services, mental health services, children's services and community care services with local authority partners. Health Boards will be expected to ensure that CHPs have access to identified planning expertise to enable them to fulfil their role in the planning process. It is recommended that local CHP service plans should be made available to the public.

29. It is expected that CHPs will also ensure that in planning and providing services they are focused on reducing inequalities, for example in relation to access, and that the needs of specific groups, such as people with learning disabilities or people with dementia, are identified and appropriately addressed.

30. In relation to capital planning, the consultation on the use of Joint Ventures to deliver primary care/joint premises raised the prospect of Strategic Services Development Plans (SSDPs)¹², agreed by local partners and a private sector partner, being established to set out a vision for the development of primary and community care services to be supported by the joint venture.

31. Where SSDPs are established, whether in the context of joint ventures or not, they should become the key driver for local joint service delivery. These plans will include the capital and revenue consequences of the anticipated capital investment required in an area to give effect to joint partner's service delivery and community plans. CHPs will have a critical role to play in focusing the Health Board's strategy on developing the best infrastructure to support community based services and contributing to these plans.

Joint Future

32. It is intended that CHPs will have substantive partnerships with their local authority as the local focus for implementing Joint Future in order to achieve better outcomes for people and their carers. This will include:

- ensuring that services are focused on outcomes;
- setting, delivering and monitoring joint Local Improvement Targets;
- managing and recording performance through their agreed joint Performance Management Framework; and
- taking action on each of the JPIAF indicators.

33. Health Boards will be able to devolve authority to the CHP to progress the Joint Future agenda locally thereby building on Extended Local Partnership Agreements. At a practical level, where the delegation and payment making arrangement functions under section 15 of the Community Care and Health Act 2002¹³ have been delegated to the CHP, the CHP will be able to delegate Health Board functions permitted by the 2002 Act and the

¹² Strategic Services Development Plans <http://www.scotland.gov.uk/consultations/health/cjvpc-00.asp>

¹³ Community Care and Health Act 2002
<http://www.scotland-legislation.hmso.gov.uk/legislation/scotland/acts2002/20020005.htm>

joint working regulations (S.S.I. 2002/533)¹⁴ to the local authority and to receive functions from the local authority (again permitted by the 2002 Act and joint working regulations). The CHP will also be able to pool budgets and enter into joint management arrangements on a wide range of services.

34. The development of CHPs is an opportunity to serve communities better and to build on the joint working foundations now increasingly well developed under Joint Future. We expect local partners to continue to support and accelerate the development of Joint Future as a key component of the development of CHPs so as to maintain momentum in serving their communities and delivering better outcomes from care delivered locally.

35. The infrastructure for joint working is already firmly established and should be the basis for the evolution of CHPs as partners with local authorities. Therefore Extended Local Partnership Agreements, Local Outcome Agreements, Delayed Discharge Action Plans, Resource Transfer Agreements etc will be managed and further developed for the Health Board through CHPs, which are either individually or collectively coterminous with their local authority partners.

36. The existing accountability arrangements (e.g. though Joint Future Committees) should be aligned to CHP arrangements for the furtherance of joint planning, design, commissioning, resourcing, implementation and management of local services. CHPs will be responsible on behalf of the Health Board for meeting the requirements of the Joint Performance Information and Assessment Framework (JPIAF), and in developing and monitoring joint Local Improvement Targets with their local authority partner.

37. There is no “one size fits all” approach. Local partners have to agree what best suits their needs but as a minimum they must take the early opportunity to remove duplication in the management and organisation of services, and associated joint support functions, as they pursue more integrated approaches over a defined timescale.

¹⁴ <http://www.scotland-legislation.hmsso.gov.uk/legislation/scotland/ssi2002/20020533.htm>

Children's Services

38. CHPs will be expected to be key drivers for integrating community child health services, primary care services, respite services, social care, education and other services for children and young people. The Children and Young People Cabinet Delivery Group, which comprises Ministers from all relevant portfolios, has identified five key priorities for better integrating both universal and targeted children's services:

- a shared vision for children and young people;
- effective management arrangements for joint planning and delivery of children's services;
- coherent systems for assessment and sharing information;
- a children's workforce with the necessary skills and qualifications; and
- co-ordinated quality assurance and inspection systems that encourage excellence across children's services

39. These priorities build on the recommendations of *For Scotland's Children* and the report of the child protection review, *It's Everyone's Job to Make Sure I'm Alright*¹⁵. It is recommended that there should be a lead person within each CHP who takes responsibility for engaging with partners in the strategic planning of children's services and for the delivery of child health services. CHPs should also work closely with local Child Health Commissioners who have a critical role in the planning and delivery of children's services. CHPs should work within existing and future national, regional and local planning guidance and strategic frameworks relating to Children and Young People's services.

Drug and Alcohol Services

40. Local planning and commissioning of drug and alcohol services is currently the responsibility of Drug and Alcohol Action teams (DAATs). It is recommended that there should be a lead member of each CHP who takes responsibility for engaging with other partners in the strategic planning of drug and alcohol services. It is anticipated that CHPs, in discussion with their local partners, will agree specific local arrangements for reaching

¹⁵ It's Everyone's Job To Make Sure I'm Alright: Report of the Child Protection Audit and Review <http://www.scotland.gov.uk/library5/education/iaar-00.asp>

decisions on the planning and delivery of jointly managed and jointly resourced drug and alcohol services.

Box 1 Improving Services

It is expected that schemes of establishment will specify:

- the outcomes for CHPs, including Local Improvement Targets;
- the range of services to be devolved to CHPs from day one and then outline how this will expand over time;
- which services will be managed, co-ordinated or provided by each CHP;
- how Joint Future arrangements for jointly improving outcomes and services in particular joint services for adults and older people, will be integral to and enhanced by CHPs;
- any services hosted by a CHP and why;
- how CHPs will contribute towards better integration of universal and targeted services for children and young people;
- the formal mechanisms by which CHPs will be involved in Health Board and other strategic planning processes; and
- the formal mechanisms for ensuring that CHPs are central to service redesign decisions and resource allocation.

IMPROVING HEALTH

41. It is expected that CHPs will be designed with local population health improvement placed at the heart of service planning and delivery. Improving the health of local communities requires a multi agency response and CHPs (based around a defined population) will be well positioned to make a significant contribution to improving the health of their local communities, especially the most disadvantaged communities.

42. Under the Local Government in Scotland Act 2003¹⁶, local authorities have a statutory duty to facilitate the community planning process, by which public services in an area are planned and provided in consultation with public bodies and with the community. Other agencies (including Health Boards) have a statutory duty to participate in the community planning process. Consequently, Health Boards should enable CHPs to take a wide perspective on health as being a state of physical, mental and social well-being and not merely the absence of disease, and to act as enablers of improved health outcomes across a community, working very closely with all community planning partners. This will involve ensuring that the CHP has access to appropriate advice from specialist public health services, and that the public health function has active networks that engage key CHP staff in agreeing priority areas of work that reflect local, as well as national, priorities.

Community Benefits

43. It is anticipated that CHPs, working with a range of local partners, will fulfil their role in contributing to the health improvement of local communities by:

- supporting the delivery of the four themes contained within *Improving Health in Scotland – The Challenge* and future health improvement strategies as part of the wider community planning process;

¹⁶ Local Government in Scotland Act 2003 <http://www.scotland-legislation.hmso.gov.uk/legislation/scotland/acts2003/20030001.htm>

- informing Health Board health improvement priorities and action through ongoing needs assessment for local communities focused on reducing inequalities;
- ensuring there is a focus for health promotion within their communities, working more closely with all partners (e.g. Integrated Community Schools and Health Promoting Schools); and
- bringing national and local priorities together and taking action locally to improve the well being, life circumstances and lifestyles of local communities, especially the most disadvantaged communities.

44. In addition, it is intended that CHPs will support a “Health Promoting Health Service”¹⁷ by integrating health promotion throughout the work of the CHP. The objectives of a health promoting health service include:

- ensuring health promotion is an integral and sustainable part of health service delivery and organisational development
- identifying areas of standard setting and encourage evidence based practice and quality health promotion
- identifying how the health service can incorporate “Health for All”¹⁸ principles in its approach to health promotion and patient/client care

45. In practice, CHPs can impact on the health of local populations at various levels and over different time frames. CHP actions and involvement may be considered at 3 levels:

- individual practitioner actions
- joint actions by partners to develop and deliver Joint Health Improvement Plans
- informing and influencing community planning processes

¹⁷ <http://www.hebs.com/healthservice/hphs/pdf/hphs.pdf>

¹⁸ <http://www.euro.who.int/document/EHFA5-E.pdf>

Individual Practitioners

46. The potential contribution to health improvement of all those providing health and care for local people has been recognised by a wide range of professional groups and partner organisations and highlighted in recent strategies.

47. Day to day interactions between a patient or service user and individual practitioners provide a health improvement opportunity. By bringing together all professionals and their partners, a CHP can provide a focus for matching the knowledge those health professionals and other partners have about patient and public needs, life styles and life circumstances with the opportunity to redesign services to address individual and community needs. For example, to tackle the life circumstances of families on a low income requires the involvement of a range of professionals. There is an opportunity to put health education on diet, physical activity, smoking etc in the context of employment, income and benefit. The national Health Demonstration Project¹⁹, “Starting Well” evaluated this approach in Phase One/The Transition and will continue to provide this holistic approach with multi agency partners in Phase Two.

48. Improving the links between the knowledge that individual professionals and staff have about the needs, life styles and life circumstances of particular groups, and their knowledge of the shape of local services, can lead to more effective practitioner interventions, support and care, leading to a decrease over time in preventable diseases.

Partners in Action – Joint Health Improvement Plans

49. CHPs will be a powerful new vehicle to shape Joint Health Improvement Plans (JHIPS). JHIPS set out objectives, strategies and actions for each partner organisation, within the community planning partnerships, to improve health and reduce inequalities within their local populations. These plans are in turn reflected in local health plans, developed by each Health Board and subject to annual performance assessment. CHPs can ensure actions identified in JHIPS are based upon the best evidence of action that will, in turn, result in delivery of health improvement for the community.

¹⁹ The National Demonstration Project <http://www.scotland.gov.uk/library3/health/nhdp-00.asp>

50. Reducing health inequalities and closing the opportunity gap underpins *Improving Health in Scotland – The Challenge* and for individuals must be a core principle underpinning the work of CHPs. As CHPs work within and across communities it is expected that they will identify and address the specific needs of the full range of community needs such as low income groups, homeless people, asylum seekers, minority ethnic groups and travellers, people with HIV/AIDS or children with complex health needs, and work in partnership to address their needs.

Community Planning

51. Set within the overall community planning framework, CHPs will be effectively positioned to promote health improvement among local communities, and to ensure there is an effective, innovative and accountable community basis for health improvement activity and strengthened relationships with all partners to reduce health inequalities and promote social justice within and across local communities.

52. In developing their role within community planning frameworks, CHPs can make a valuable contribution to achieving the Executive's Closing the Opportunity Gap objectives, health targets and health improvement outcomes, e.g. in relation to smoking cessation, breastfeeding and coronary heart disease mortality.

53. They will also contribute to achieving the Community Planning Partnership's targets and to closing the gap between disadvantaged communities as defined by the Scottish Index of Multiple Deprivation 2004²⁰ and the whole population. In particular, it is anticipated that CHPs will play an active role in the integration of Social Inclusion Partnerships and Community Planning Partnerships and in the delivery of the respective Community Planning Partnership's Regeneration Outcome Agreement, especially as it relates to improving health.

54. The Community Planning Partnership is recognised as the over arching partnership framework. This should help to co-ordinate other initiatives and partnerships and also to rationalise and simplify a cluttered landscape. Therefore it will be important for Health

²⁰ <http://www.scotland.gov.uk/stats/SIMD2004/>

Boards to agree with local partners the contribution of CHPs to community planning arrangements and the relationship with Joint Future arrangements.

Resources

55. All professionals and staff working in health or other partner organisations contribute to health improvement and are therefore a critical resource. CHPs, as a focus for community based partnership working between professionals, will be able to harness the potential of individuals and teams in order to take actions that will help to improve the health of local people.

56. It will be important for Health Boards and local authority partners to decide how resources, including specialist expertise, will best be deployed to enable CHPs to contribute effectively to the collective responsibility for health improvement. CHPs will need to effectively deploy and lead its health improvement workforce, who may include public health practitioners, some health promotion staff, connections to local authority health improvement and environmental health officers as well as the wider workforce, most notably public health nurses but including all clinicians.

57. For example, it would not be appropriate in terms of economies of scale, critical mass and the need for specialist expertise for each CHP to have its own fully fledged public health function. Directors of public health and local authorities will need to establish effective managed public health networks with CHPs in order to ensure that CHPs have access to public health expertise and resources; are able to influence the department's priorities based on identified local need; and that effective two way communication exists between the CHP and public health department.

58. In addition to developing the contribution that individuals may make to health improvement, CHPs also need to be aware of the wide range of financial and other resources distributed to community planning partners. In agreeing a community plan and targets to take it forward, community planning partners will want to identify resources to achieve the agreed aims.

59. It is recommended that CHPs will also need to understand how a variety of mainstream health improvement resources flow within the NHS, local authority and voluntary sector systems and agree what their involvement/role will be in helping to prioritise resources against outcomes for health improvement activity. This means removing, wherever possible, barriers to sharing funding to ensure that resources are used for the benefit of local people regardless of which partner has budgetary responsibility.

60. CHPs may also use their collective local knowledge to take advantage of opportunities such as the integration of Community Planning Partnerships and Social Inclusion Partnerships via the new Community Regeneration Fund, the New Opportunities Fund, Healthy Living Centres²¹, and Integrated Community Schools Quality of Life monies to support health improvement work locally.

61. It is anticipated that CHPs will need to have the right links into national drivers for change and strategic support. NHS National Education Scotland²², NHS Chairs and Chief Executives, Directors of Public Health and NHS Health Scotland²³, NHS Information Services (ISD)²⁴ and COSLA²⁵ will have an important role to play in supporting the evolution of new ways of harnessing expertise, sharing evidence into practice and fostering networking across agencies.

Box 2 Improving Health

It is expected that schemes of establishment will specify:

- the role of CHPs in local community planning processes
- the role of CHPs in helping to shape Joint Health Improvement Plans and local health plans
- how public health expertise will be used to support the work of CHPs
- how CHPs will be developed to maximise their contribution to health improvement and reducing health inequalities

²¹ Healthy Living Centres <http://www.ohn.gov.uk/ohn/partnerships/hlc.htm>

²² NHS National Education Scotland <http://www.nes.scot.nhs.uk/>

²³ NHS Health Scotland <http://www.hebs.scot.nhs.uk/>

²⁴ NHS National Services Scotland Information Services <http://www.isd.scotland.org/isd>

ORGANISATIONAL ARRANGEMENTS

62. Health Boards remain the Board of governance within which all organisational arrangements must fit, including CHPs. Health Board Chief Executives remain the accountable officers for the use of all Health Board resources. It is expected that CHPs will be fully involved in Health Board strategic planning and also provide leadership for the co-ordination, planning, development and provision of services for their communities and they will be held accountable, through the general manager, for the delivery of all devolved functions and services and for the use of all devolved resources.

63. Therefore CHP organisational arrangements (including standing orders and schemes of delegation) must reflect the scope of devolved functions and responsibilities and be based around a flexible management and decision making framework which can respond to the aims and key objectives outlined in the scheme of establishment. In particular, it will be important to ensure that local authority partners are actively involved in agreeing local arrangements to reflect their role in jointly providing and/or managing a range of local services.

64. Organisational arrangements within and across CHPs must reflect the fact that they will:

- directly manage and provide some services;
- lead the co-ordination and direct the delivery of some services;
- coordinate the delivery of some services as part of a managed network; and
- influence area wide planning and resource allocation.

Status

65. In developing CHPs, Health Boards must build on one of the main aims of *Partnership for Care*, which is to empower practitioners, frontline staff and key stakeholders so that they can take decisions on the planning and provision of services in the community and on the use of resources. This is critical, as the effectiveness of each CHP will depend on

²⁵ COSLA website www.cosla.gov.uk

the work of staff and on the partnerships, networks and joint working arrangements it develops within the NHS and with local authorities and other agencies.

66. In order to devolve functions and resources from the Health Board to a CHP, CHPs must be established as committees or sub committees of a Health Board unless the area or district of a CHP includes all or part of the areas of two or more Health Boards, in which case the CHP must be established jointly as joint committees of those Boards.

67. This will enable Health Boards to devolve functions and powers to CHPs within a clear accountability framework, which will ensure that decisions are made as near as possible to the frontline. Health Boards will only be able to establish a CHP once the Scottish Ministers have approved their scheme of establishment.

68. The role and responsibility of the CHP committee or sub committee will be to drive service improvement locally and to ensure the effective delivery of the functions devolved to the CHP as described in the scheme of establishment. In line with the aspirations of *Partnership for Care*, members of each CHP committee or sub committee shall include frontline staff and a wide range of key stakeholders who are best placed to understand the health and care requirements of local communities and to develop/deliver services that meet identified need.

69. It is important for Health Boards and their key stakeholders to be confident that members of the CHP committee or sub committee will work together, and with relevant professions/agencies, in the interests of the CHP and the people they serve. It is expected that Health Boards will ensure that all members of the CHP are supported to enable them to fulfil their role and to fully participate in the work of the CHP.

70. Regulation 3(1) of The Community Health Partnerships (Scotland) Regulations 2004 makes provision in relation to the membership of the CHP committee. In summary, Health Boards must ensure that, so far as practicable, at least one person from each of the following is appointed as a member:

- a general medical practitioner
- a general manager who will be an officer of the Health Board

- a nurse
- a medical practitioner who does not provide primary medical services
- a councillor or officer of the local authority
- a representative of staff (nominated by the area partnership forum)
- a member of the public partnership forum
- a community pharmacist
- an allied health professional
- a dentist
- an optometrist
- a member of the voluntary sector carrying out services similar or related to the Health Board

71. Every person appointed by the Health Board as a member of the CHP committee must, in so far as practicable, be employed or perform services in, or have a substantial connection with, the area of the CHP. Health Boards may include more than one member from the above professions/organisations on the CHP committee or sub committee and may choose to include other members. In particular, it is anticipated that local authority membership should be commensurate with their substantive partnership arrangements with the CHP.

72. In deciding who should be a member of the CHP committee or sub committee, it is recommended that the Health Board should discuss and agree with the relevant professions/groups and partner organisations an appropriate way of choosing that person. Each member will have a responsibility to work corporately to achieve the objectives of the CHP. They should also be able to put forward any views that their profession or group has on how to improve health and services. Where it is impracticable to appoint a person falling within one or more of the categories of regulation 3(1), then regulation 3(4) of The Community Health Partnerships (Scotland) Regulations 2004 provides that the Health Board must set out in the scheme of establishment (a) the persons which it is or would be impracticable to appoint and (b) the reasons for that view.

73. When determining whom to appoint as a member, regulation 3(5) of the Community Health Partnerships (Scotland) Regulations 2004 provides that the Health Board should have

regard to the need to ensure that the membership of the CHP reflects a reasonable balance of interest.

Management

74. In order to ensure that the CHP is effective and competent to deliver its devolved functions, it will require appropriate management and decision making arrangements to be put in place for the entire CHP to ensure that it has the capacity to take on new roles and responsibilities. Management arrangements are not prescribed and each Health Board and CHP should agree local arrangements that encourage innovation and quicker local decision making.

75. It is anticipated that there will be an increasing range of services jointly managed and jointly resourced which will be provided by the NHS, local authorities and other partners. CHP management arrangements should reflect this joint responsibility and joint funding arrangements. It is anticipated that CHPs, in discussion with their local authority partners, will agree specific local arrangements for reaching decisions on the joint planning, joint commissioning and delivery of jointly managed and jointly resourced services (e.g. community care services). These agreements on joint services must be based on an equal partnership and be reflected in the standing orders of the CHP.

76. To reinforce this equal partnership paragraph 5 (2) of the Schedule to The Community Partnerships (Scotland) Regulations 2004 provides that where a question relates to services delegated to the CHP committee or sub committee by virtue of Community Care and Health (Scotland) Act 2002, those members present and voting who represent any local authority shall collectively have half the available votes (excluding the second or casting vote of the person presiding). If the local authority does not delegate functions to CHPs under the Act then existing arrangements for decision making (e.g. under Joint Future Committees) would apply. This is to assist local partners seeking high levels of integration.

77. In developing local management and other organisational arrangements with local authorities, the aim will be to streamline and integrate, as far as practicable, local decision making processes and to set CHPs within an explicit accountability framework. This

framework should seek to reduce bureaucracy and duplication, and enable and encourage local partners to rationalise existing “aligned” arrangements. This approach could facilitate the functions of the Joint Future Committee being combined with the functions of the CHP committee, and so streamline local partnership arrangements.

78. CHPs will require highly effective leadership and management at all levels and arrangements should be put in place to ensure that there is appropriate clinical and professional leadership. A chairperson and also a general manager should be appointed to each CHP committee or sub committee in accordance with section 5 of The Community Health Partnerships (Scotland) Regulations 2004.

Chairperson

79. The chairperson will be responsible for chairing the CHP committee or sub committee and for developing the CHP as a truly multi disciplinary and multi agency partnership, with a clear focus on the needs and aspirations of the local communities which they are set up to serve. This role will require very skilled leadership to create and sustain effective working relationships across a number of organisations and between professional groups.

80. Where a CHP is a committee of the Health Board then the chairperson of the CHP will be accountable for their performance to the chairperson of the Health Board. Where a CHP forms part of an Operating Division (i.e. it is a sub committee) then the chairperson of the CHP will be accountable to the chairperson of the Operating Division.

General Manager

81. The general manager will be appointed in accordance with regulation 5 of The Community Health Partnerships (Scotland) Regulation 2004 and will be accountable to the Health Board Chief Executive or Division Chief Executive for the overall management and use of resources of the CHP. It is expected that the general manager will ensure that the views of managers (including general practice managers) are taken into account and reflected at CHP management team discussions.

Leadership

82. Leadership is not the preserve of a small group of people in senior positions but needs to be nurtured at all levels of the service. In leading service improvements it will be particularly important for CHPs to have clear and highly developed clinical and professional leadership. Clinical leadership is taken to mean the effective leadership of clinical services within the CHP. Professional leadership is taken to mean the leadership of individual professional groups within the CHP. Both will be vital to the successful development of the CHP.

Clinical Leadership

83. Mechanisms must be put in place to ensure effective clinical leadership of the work of the CHP and this should be led by the CHP management team. An overall clinical lead/director for each CHP should be identified. Their responsibilities should include ensuring that:

- local health needs and priorities are identified and integrated strategies developed to address them;
- clinical and care networks are developed;
- local clinical governance arrangements are put in place to improve quality and ensure patient safety
- multi disciplinary education and training is promoted; and
- new contract opportunities are used to develop new models of care.

84. The CHP clinical lead/director should be a health care professional drawn from one of the professional disciplines making up the CHP and should be accountable to the CHP chairperson. The clinical lead/director will have a professional line of accountability to the relevant Health Board (or Division) Director.

85. In addition, consideration should be given to identifying a clinical lead within the CHP for national or Ministerial priorities (e.g. mental health, child health etc) or for overseeing the population health improvement focus of the CHP. In some circumstances, or

in some clinical areas, this may not be practicable or desirable, in which case schemes of establishment should describe how clinical leadership for these services will be provided to the CHP.

Professional Leadership

86. It is anticipated that Health Boards will ensure effective professional leadership is available to all the clinical and non clinical professions working within the CHP in order to support the effective delivery of services and promote innovative and safe professional practice.

87. Professional leadership should be available wherever possible within the CHP, with effective lines of communication and lines of accountability through to the appropriate Director at Division or Health Board level. These arrangements should be agreed with the relevant professions locally and outlined within schemes of establishment and should take account of the principle of devolution of responsibility and decision making to CHPs. For services jointly managed/delivered, professional lines of accountability to staff in another agency should be made explicit.

88. It is anticipated that Health Boards, in discussion with the relevant professional groups, will take the opportunity to review the relationship of CHPs to existing professional advisory structures to take account of the evolution of CHPs. In particular they will need to review the LHCC Professional Committee in light of the development of CHPs.

Summary of Organisational Arrangements

89. It will be critical to the success of CHPs that those fulfilling key roles and positions within the CHP (including members of the committee or sub committee) have the confidence of both the Health Board and local stakeholders and that they are selected on the basis of competency and not only professional status. In addition, it will be critical for CHPs to have the necessary range of identified support services such as finance, human resources, information technology, estates, planning and training and development to be able to deliver their functions. This realignment of capacity will require a whole NHS system response.

90. Health Boards will need to consider the impact of the establishment of CHPs on their wider organisational arrangements, such as operating divisions, and ensure that there is appropriate migration of skills and resources into CHPs to reflect their significance and responsibilities. As joint working develops with local authorities there may be potential for wider discussions locally about the most effective use of staff resources and skills to deliver the outcomes agreed by local partners. CHPs and local authorities should ensure that effective patient centred arrangements are in place to address cross boundary needs.

Box 3 Organisational Arrangements

It is expected that schemes of establishment will specify:

- membership of each CHP committee;
- the formal position of each CHP within the Health Board structures;
- the formal links with the Local Authority;
- how CHPs will work with local partners to jointly plan, commission and deliver services for all care groups;
- the outcome of the review of the LHCC Professional Committee;
- arrangements for professional and clinical leadership including lines of accountability; and
- organisation and management support arrangements (e g finance, human resources, IT, estates, planning) to enable CHPs to deliver their functions

Size and Geographical Coverage

91. CHPs will need to be fit for purpose and match local authority boundaries. This means that the organisational boundaries of one or more CHPs must be coterminous with the local authority boundary. In entering into these arrangements each CHP must ensure that there are arrangements in place to address the needs of their local communities. Organisational boundaries will not cut across natural flows of people into health services.

92. Ensuring that CHPs relate to local authority boundaries or clear sub divisions of boundaries will enable more effective integration of the planning and delivery of health and social services for local communities and of health improvement activity as part of

community planning. Where there are multiple CHPs within one local authority boundary then an appropriate mechanism should be found to enable CHPs to work corporately within the relevant community planning partnership arrangements. It is essential that the development of CHPs is considered with reference to existing and proposed arrangements for the planning and delivery of multi agency services at local or community level.

93. In determining the size of the population served by each CHP, Health Boards, working with all stakeholders and partners, should aim to reduce bureaucracy and achieve economies of scale in delivering improved health outcomes and benefits to patients. They should also take into account: the critical mass of patients required to deliver cost effective local services; the availability and capacity of partners to plan and manage services; the need to avoid duplication of activities; and the impact of any physical or geographical constraints.

94. It is expected that CHPs will be responsible for a minimum population size of around 50,000 unless there are significant local reasons otherwise. There will be no absolute maximum population size but CHPs must be able to reflect the needs of communities and specific localities and engage effectively with frontline staff.

Box 4 Size and Geographical Coverage

It is expected that schemes of establishment will specify:

- the number, size and catchment areas of each CHP;
- relationship to local authorities and to existing or proposed local arrangements for planning and delivering multi agency services at community level; and
- any proposed locality arrangements within the CHP.

WORKING IN PARTNERSHIP

Engaging Local Communities – Involving People

95. CHPs will need to maintain an effective and formal dialogue with their local communities through the development of a local public partnership forum (PPF) for each CHP. Whilst these forums will be a mechanism by which the CHP maintains this formal dialogue this should not be their only mechanism for engaging with local communities.

96. The relationship between CHPs and their local communities should be based on the following principles:

- the duty placed on Health Boards to involve and consult the public will apply to CHPs and any current or future national guidance or standards for public involvement should underpin the work of CHPs;
- wherever possible CHPs should seek to use or tap into local authority, voluntary sector and other existing public involvement mechanisms;
- public partnership forums should have a formal role in the decision making processes of CHPs but this must not compromise their “independent voice”;
- the role of the Scottish Health Council locally will be to monitor and support the development of the public partnership forum and to ensure that it operates effectively in accordance with standards developed by the Council, and according to Standards for Community Engagement²⁶ currently being developed by Communities Scotland, COSLA and other partners

Role and benefit of public partnership forums

97. There will be three main roles for PPFs. The first will be to ensure that the CHP is able through the PPF and other means to inform local people about the range and location of services and information which the CHP is responsible for, including Health Board wide

²⁶ <http://www.scdc.org.uk/standards>

services which are available within the CHP area. This will lead to better understanding by local people about how and where to access to services.

98. The second will be to engage local service users, carers and the public in discussion about how to improve health services. This will enable the CHP to respond to the needs, concerns, and experiences of patients, carers and families. This will mean engaging local people in issues concerning the nature, design and quality of service delivery and outcomes. The PPF will need to ensure that it is able to represent the views of all members of the communities served by the designated CHP area paying particular attention to those who could be socially excluded or face discrimination when accessing services. This will help to inform the work plans of CHPs and to determine local priorities for service improvement.

99. The third role will be to support wider public involvement in planning and decision making and to seek to make public services more responsive and accountable to citizens and local communities. This will require CHPs to work collaboratively with the Health Board and their partners and to engage through the PPF with relevant Health Board groups, community involvement and consultation structures such as local authority area committees, community councils, citizen's panels, and community planning etc. PPFs will be able to link in with local involvement mechanisms in relation to health improvement and service planning issues.

How will public partnership forums work?

100. In order to fulfil these roles, and to build on good local approaches and the work of local user/carer groups, we envisage the PPF will be a network of existing local user and carer groups, voluntary organisations, interested individuals and others with the key role of considering and informing the CHP on specific issues.

101. Local systems should agree the best arrangements to deliver the public involvement function of CHPs, recognising that the PPF alone will not necessarily enable CHPs to fulfil the statutory duty to involve.

102. It is anticipated that PPFs will engage with their local communities through existing networks of patient/user and carer groups and community care forums on how their views are taken into account in the work of CHPs and to ensure that the views expressed through the PPF have a wider validity. They will also be expected to develop strong links with the Scottish Health Council locally, reporting areas of concern or where there is a need for support.

103. Each CHP committee or sub committee must in terms of regulation 3(1) of the Community Health Partnerships Regulations have a PPF member. It is expected that the PPF member will have been appointed through a fair and open process with advice from the Scottish Health Council locally (once established). It is anticipated that those appointed to the CHP from the PPF will be able to represent the views of the wider patient and public interest rather than their individual interests.

104. It is recommended that mechanisms should be put in place to enable a two way dialogue on a regular basis between the wider PPF and members of the CHP committee. Formal involvement on the CHP committees must not compromise the “independent voice” of the PPF members.

105. Members of the PPF will be expected to agree with the CHP what is expected of them and draw up a working agreement to reflect the local arrangement. This working agreement should have clear terms of reference that reflect members’ responsibility to ensure that the work of the PPF is fully shared and communicated with local groups and that the issues, concerns and priorities of local groups are fed into the work of the CHP. It is anticipated that once established the Scottish Health Council locally will support CHPs and PPFs in drawing up the terms of reference.

106. PPF members will require proper administrative support, training and development to enable them to fulfil the role envisaged for them on the CHPs. Health Board will be expected to fund this support through a delegated budget to each CHP.

107. CHPs will be expected either to commission the administration for the PPF, including any support they need, through a tendering process for example, by commissioning

existing local community organisations or by delivering the administration and support needed through the CHP itself.

Links to joint planning partnerships

108. It is intended that the work of PPFs will be tied in to the public involvement structures and processes already in place to support joint planning initiatives, including Joint Future and Children's Services as well as community planning. This offers a real opportunity for those working in the health arena to discuss with their local authority and voluntary sector partners how best to streamline and improve local involvement processes.

109. Health Boards are committed to developing local sustainable frameworks for Patient Focus and Public Involvement, and should aim to ensure that PPFs add value and complement local community planning processes.

The Scottish Health Council

110. The proposed role of the Scottish Health Council and its local advisory council was set out in the consultation paper, *A New Public Involvement Structure for the NHSScotland*.²⁷ These proposals are currently being further developed by an implementation team. The role of the Scottish Health Council (once established) in relation to CHPs will be to:

- provide a quality assurance role in terms of whether or not Health Boards are effectively carrying out their statutory duty to involve the public through the work of PPF members on the CHP committee and other patient and public involvement activities carried out locally;
- provide a source of advice and support to CHPs in the development of their PPF and agreeing any arrangements;
- provide a source of advice and support to PPF members on a range of involvement methodologies, tools and techniques and help to identify and support their training and development.

²⁷ *A New Public Involvement Structure for the NHSScotland*
<http://www.scotland.gov.uk/library5/health/npis-00.asp>

111. The Scottish Health Council and its local advisory councils will have an important external scrutiny role. Where a CHP is not effectively engaging with its local community through the PPF, then the Scottish Health Council may ask the Health Board to take action.

112. For this reason it may not be appropriate for the same people to sit on a local advisory council and also to represent local communities on the CHP. However, in remote and rural communities with a small or sparse population, such as the Islands, it may be necessary to make an exception due to the size of the population.

Resources

113. Significant national investment and support has already been made to improve the quality of Health Board's partnerships with patients, carers and communities. Health Boards have a duty to encourage public involvement introduced by section 7 of the National Health Service Reform (Scotland) Act 2004 which inserts a new section 2B into the National Health Service (Scotland) Act 1978. Health Boards should build on the significant good practice already in place within their communities e.g. Managed Clinical Networks; redesign models, local Health Council work, community planning. Where necessary, they should redirect or pool existing resources with other partner organisations to deliver this statutory duty, including providing the support needed by the PPFs.

Box 5 Working in Partnership

It is expected that schemes of establishment will specify:

- how CHPs will discharge their responsibility to involve patients, carers and communities
- how these arrangements will fit with other existing or proposed arrangements for consulting with people about public services in the area covered by each CHP
- the mechanism for appointing PPF members to the CHP
- the level of support for CHPs to develop their capacity and capability to effectively involve local communities

Linking Clinical and Care Teams

114. Clinicians and their teams work more closely together when there are clear benefits for their patients and if it is in their professional and organisational interests to develop new ways of working. CHPs will be well placed to deliver benefits for patients and professionals as outlined in this guidance, by creating opportunities for much closer working and inter-dependency between all health and social care professionals and teams and they will have the means to support professionals in developing new ways of working.

115. It is intended that CHPs will be a focus for bringing clinical and care teams together to work as part of a single local health system, acting as the focus for integrating health and social care services at a local level, building on the range of clinical and quality standards already available. They will have a pivotal role in enabling clinicians and other health and social care professionals to share local service delivery problems, make decisions on the solutions and to implement those decisions locally.

116. The traditional view of primary care, secondary care and social care should change over time as professionals working within and across these areas remove barriers to joint working and design alternative models of care delivery based around patient pathways that are adapted to suit local circumstances. This is already happening in some chronic disease areas such as diabetes, where allied health professionals such as podiatrists and dieticians are working with general medical practitioners and consultants to provide more integrated care for patients in their local community.

117. CHPs will be expected to deliver care along a continuum based wherever possible on evidence and, most importantly, provided by the most appropriate professional regardless of historical job/role profile.

118. This means **all** health and care professionals are stakeholders in the work of the CHP as they work together to make patient pathways of care smoother, more accessible, less complicated and less subject to delays. For example, improving information and services for people with mental health problems at a local level will have real spin-offs in terms of reduced admissions to hospital.

119. It will require all clinicians and other professionals to align their skills, knowledge and experience to serve patients and local communities differently. It is happening already. For example, community pharmacists have already demonstrated the benefits for older people of reviewing the medication of patients who have been identified by social work staff as having problems with their medicines. It is expected that CHPs will deliver direct benefits for patients by strengthening working arrangements and relationships between clinical and care teams particularly in areas where there are service pressures or problems.

Managed Clinical and Care Networks

120. Clinicians, managers and other professionals must be encouraged and supported to work together as part of an integrated health system, using managed clinical and care networks to design services and care pathways to enable more specialist treatment to be available in community facilities. Working together as part of networks of clinicians and with other professionals will be a critical aspect of the way in which CHPs operate.

121. Where managed clinical or care networks exist they will have a lead role in designing services, quality assurance, improving access and agreeing pathways of care and potentially agreeing new investment and improved information for patients and the public. A wide range of clinicians and professionals will need to be involved in the work of these networks (including public health networks) and be accountable for those elements of service delivery agreed with the networks.

122. CHPs will be well placed to redesign services by working in new ways with local people to better meet the needs of their communities. It is expected that they will have sufficient devolved responsibility to enable services to be redesigned, as well as having influence over the way that specialist services are deployed. In particular, they should be clear about how they see the need for services to be provided and developed so that this can form part of local discussions by Medical and Clinical Directors at the job planning stage with consultant colleagues.

123. More generally CHPs will be positioned to use the opportunities and flexibilities offered by the 3 main strands of Pay Modernisation as a vehicle to develop new and

innovative approaches by different professionals to service delivery. To be effective in service redesign they will need to be fully involved in the work of Health Board service redesign committees.

124. Working as part of a “virtual” team requires the widespread use of information technology and the rapid creation and roll out of an electronic patient record as part of the development of an e-health care culture. CHP committees, management and clinical teams will be expected to use a wide range of information to inform decisions on enhanced services and service improvement more generally, and this information should also be used to inform the work of managed clinical networks.

125. Health Boards will be expected to ensure that clear clinical governance arrangements are put in place within and across CHPs and this should be described in local schemes of delegation. Each CHP committee or sub committee will be accountable through the general manager for clinical governance and the clinical lead will be responsible for developing and implementing the local arrangements. These arrangements should identify the person responsible in each area for clinical governance. The Chief Executive of the Health Board will remain accountable overall for clinical governance. In relation to jointly resourced and jointly managed services, suitable arrangements should be put in place with local partners for clinical and care governance.

126. CHPs will require effective and timely information in order to fulfil their role in improving quality and patient safety; enable a consistent assessment of needs; and facilitate the effective sharing of information between professionals and staff across agencies, for example, in relation to child protection or other children’s services.

127. CHPs will need to consider the most effective way of ensuring that clinicians are supported to enable their active involvement in the work of the CHP. This means developing innovative ways of providing equitable backfill for clinical staff and providing a strong focus on protected learning and educational opportunities.

128. Developing the relationships between community and acute/specialist clinicians will be key to the success of a CHP and a prerequisite for effective integration of services.

Therefore clinical leaders and managers should promote joint working and closer integration of clinical and care teams and:

- develop a “whole system” approach to service design
- widen clinical involvement in managed clinical and care networks
- evolve CHP clinical governance arrangements and care pathways/protocols
- extend the opportunities for joint clinical education and training
- align some specialists more closely with CHPs
- encourage the creative use of consultant job plans to work more closely with community based practitioners
- roll out electronic clinical information systems
- involve a wider range of clinicians in whole system redesign and promote closer working with social care managers and professionals
- jointly agree how to deploy development resources to improve service delivery

Box 6 Working in Partnership

It is expected that schemes of establishment will specify:

- the overall clinical governance arrangements
- how CHPs will enable healthcare and other professionals to develop new models of care including joint health and local authority services
- how CHPs will bring closer working between clinicians, for example, managed clinical/care teams
- how CHPs will contribute towards more effective information sharing between the NHS and other agencies

Involving Staff

129. CHPs provide an opportunity to build on successful partnership working locally and evolve existing arrangements to support frontline staff, whilst recognising that CHPs are partnership organisations that represent different employer interests.

130. CHPs will be expected to ensure staff are treated as full partners in decisions that affect the planning and delivery of services in line with the objectives set out in *Partnership for Care* and the NHS Staff Governance Standard.²⁸ The priority given to staff involvement must be reflected in the organisational arrangements of CHPs where a staff representative will be a full member of the CHP committee.

131. It is intended that CHPs will be responsible for planning and delivering a range of services. Some of these services will be delivered by NHS employees and some by independent contractors and their employees. Section 3 of the National Health Service Reform (Scotland) Act 2004 introduces a new section 12I to the National Health Service (Scotland) Act 1978 which imposes a new duty on Boards to put in place and keep in place arrangements for the purpose of improving the management of NHS staff and for monitoring such management. Therefore the Staff Governance Standard must be implemented for all NHS staff working within a CHP.

132. Health Boards will be expected to support CHPs in developing employment practice frameworks for non NHS employed staff working within CHPs (such as staff working in general practice) that meet staff governance and employment law requirements. CHPs should seek to commend best practice to all employers within the CHP, for the benefit of all employees and, in turn, for the benefit of patients and carers.

133. Health Boards and area partnership forums will be expected to put in place local partnership arrangements that will ensure that there is effective local implementation, through CHPs, of the Staff Governance Standard on behalf of the Staff Governance Committee of the Health Board. As Joint Future arrangements evolve through greater partnership working and joint service arrangements with local authorities, then staff partnership arrangements should evolve to reflect the changing requirements.

²⁸ <http://www.scotland.gov.uk/library5/health/sgss.pdf>

Box 7 Working in Partnership

It is expected that schemes of establishment will specify:

- the relationship and accountabilities between the staff representative member of the CHP committee, the area partnership forum and frontline staff;
- the formal arrangements for involving staff in the work of CHPs;
- how staff governance principles will be delivered; and
- the links with Joint Future staff partnership arrangements.

Working with Local Authorities

134. If CHPs are to serve their communities better, they need to work very closely with their local partners, especially local authorities, particularly in relation to health improvement and the development of joint services. They should work as a full partner in community planning partnerships. Some of the more developed LHCCs already have integrated approaches with their partners that can form the foundation for the greater expectations of CHPs.

135. Greater integration with social services may take on a different form to greater integration with specialist and acute services. However, consistency of boundaries between local authority and health services locally will itself be significant.

136. More generally, while the development of CHPs is clearly an opportunity to build on past success, local authorities are likely to look in the main to incremental progression. Most will look initially to opportunities at service level, with any organisational opportunity thereafter. A few may wish to effect organisational change more quickly. This guidance facilitates both approaches to greater partnership working.

137. Maintaining the impetus on developing integrated working flowing from Joint Future and *For Scotland's Children* should remain central to these new arrangements. Boards are already working with local authority partners to build on their Extended Local Partnership Agreements by producing plans aimed at ensuring better outcomes for people and their carers

through more effective joint working with social care in appropriate locality arrangements. Joint Children's Services Plans and resources through the Changing Children's Services fund have encouraged more co-ordinated arrangements for joint planning and delivery across children's services between the NHS, local authorities and other partners.

138. It is intended that CHPs should build on the success of Joint Future implementation and engage fully in the delivery of joint resourcing and joint management, and on applying single shared assessment across all of community care. But perhaps more significantly, they should turn their attention to the new focus of developing joint outcomes across the range of care groups. From the outset, CHPs will be expected to be a core component of local arrangements for translating joint planning of children's services at a strategic level into better integrated service delivery on the ground and improved outcomes for children and young people.

Box 8 Working in Partnership

It is expected that schemes of establishment will specify:

- the working relationships between each CHPs and local authority

Working with the Voluntary Sector

139. The voluntary sector has an increasing and vital role to play in planning and delivering services for local people. As key service providers they are well placed to understand the needs and aspirations of those they care for and to share local knowledge of the range of services and information available for local people.

140. The voluntary sector already has a long tradition of close working with local authorities and CHPs should seek to build on these relationships. The development of CHPs, which will have substantive partnerships with local authorities, provides a unique opportunity for closer working with the voluntary sector to reflect the multi agency approach required for improving services for local communities.

141. In developing CHPs, Health Boards will be expected to discuss and agree with their local Council of Voluntary Services and other appropriate key networks such as Voluntary Health Scotland, Community Health Exchange (CHEX) and local members of Community Care Providers Scotland, on how the views and experience of the voluntary sector locally may be built into the organisational arrangements of each CHP.

Box 9 Working in Partnership

It is expected that schemes of establishment will specify

- formal arrangements for involving the voluntary sector in CHPs

BUILDING WORKFORCE CAPACITY

A Shared Culture

142. CHPs are intended to be flexible and innovative organisations, free from unnecessary bureaucracy and administrative burdens. They should operate within a shared culture based on partnership and team working. They will have a key role in unlocking the potential of all professionals and staff by providing a forum for independent contractors and all staff working in health and social care to come together to support health improvement and develop local services.

143. Within this shared culture CHPs will be encouraged, wherever practicable, to promote joint learning opportunities within the NHS and also with local authorities and voluntary sector.

144. This shared culture should reflect the need for CHPs to take a proactive and positive approach to engaging with the people they serve and to demonstrate that they have listened to, understood and acted upon their views. It is intended that this approach at a local level will be supported by new arrangements nationally and locally under the umbrella of the Scottish Health Council (once established).

145. We envisage CHPs acting as the focus for local networks for sharing good practice and encouraging links into research activities and national organisational learning. In particular, CHPs will be encouraged to use networks being developed by the Scottish School of Primary Care,²⁹ NHS Health Scotland, COSLA, Public Health Departments and NHS Education, both as sources of evidence on which to base improvements and as mechanisms to generate locally important questions and to get them answered. NHS Quality Improvement Scotland³⁰ and the Care Commission³¹ will also play an important role in informing the work of CHPs.

²⁹ Scottish School of Primary Care <http://www.sspc.uk.com/>

³⁰ NHS Quality Improvement Scotland <http://www.nhshealthquality.org/nhsqis>

Developing Roles

146. The success of a CHP in improving health and meeting the health and social care needs of its population will depend significantly on the extensive use of expertise from a wide range of health and social care professions and support staff. It is essential that role development, including extending the scope of practice and diverse skill mix, are used in designing services to ensure that direct care for patients is delivered by the most appropriate professional or member of staff.

147. This should go beyond shifting first point of contact only to existing practice based staff to utilising other practitioners such as allied health professionals and pharmacists, clinical support workers. Such innovation has already enhanced the provision of chronic diseases management, and has the potential to enhance community based services and reduce onward referrals or admission to hospital.

148. It is intended that CHPs will use the opportunities provided by Pay Modernisation³² across the NHS (e.g. Agenda for Change, Primary Medical Services, Consultant Contract) to facilitate service redesign and role development, maximising the contribution of all health professionals to benefit local communities.

149. CHPs will also be expected to play an important role in supporting the delivery of the new Primary Medical Services arrangements, in particular supporting the full implementation of the GMS contract and of enhanced services, and the development of new services under Section 17C as part of the duty placed on the NHS to provide Primary Medical Services.

150. The new GMS contract introduces far reaching and fundamental changes to the way in which primary care works. Supported by 33% increase in investment it will provide improved quality of care for patients and better working conditions for staff. It offers important levers for change across the whole of the NHS and in better chronic disease management for patients, better access to services for patients, a wider range of services in primary care and improved infrastructure.

³¹ Care Commission <http://www.nationalcarestandards.co.uk/>

³² Primary Medical Services <http://www.show.scot.nhs.uk/sehd/paymodernisation/>

151. They should also consider the potential opportunities arising from the proposed new Pharmacy Contract for developing new ways of working and designing better services that will enable the delivery of the patient and carer benefits described earlier in this guidance.

152. To support new ways of working, Health Boards will be expected to devolve funding to CHPs for the enhanced services component of Primary Medical Services and all appropriate other funding streams to support Primary Medical Services. CHPs will be able to use the opportunities presented through the new contractual arrangements to take a co-ordinated approach by all practices to delivering improved service quality and outcomes in their area.

Workforce Development

153. CHPs, as local multi professional and multi agency partnerships will have an important role in local workforce planning and development to support new models of care and service delivery. In particular it is intended that they will:

- influence the development of future enhanced professional and staff roles which respond to the profiles of patient/carer demand and new models of care
- ensure there are appropriate links between local service developments and Health Board wide and regional workforce planning
- promote locality networking to develop enhanced services and to share skills, professional support and multi disciplinary training and development opportunities.

154. The Scottish Executive has issued the Scottish Health Workforce Baseline Plan - 2004³³. Health Boards should agree with each CHP their role in workforce planning and development locally and ensure that arrangements are in place for providing appropriate expertise and support to enable CHPs to fulfil this role.

³³ <http://www.scotland.gov.uk/library5/health/shwp04b-00.asp>

Development Plans

155. In order to deliver the functions devolved to them and improve services and care for people, CHPs will require significant and sustained organisation, leadership and management development support. Schemes of establishment should describe the nature and extent of the development support to be put in place to support the evolution of CHPs. This support should focus on actions that will enable the delivery of the service and care outcomes highlighted elsewhere in their scheme of establishment. Plans should also reflect local priorities and take into account the need to do the following:

- develop a shared culture where individuals and organisations understand the benefits and opportunities of CHPs (including the Primary Medical Services contract) and to secure their involvement in the change process;
- engage staff and support those taking on new roles within CHPs particularly leadership roles at a number of levels across the CHP, including induction and adequate backfill arrangements for those with ongoing clinical responsibilities;
- develop management styles that increasingly support innovation and change and patient/carer focus, public involvement building on the concept of “interface” managers that work across organisational boundaries to support clinical reform;
- involve staff and independent contractors to create a corporate identity for the CHP, achieved through for example, shared training, education, communication and a renewed focus on the benefits of staff partnerships which include independent contractors;
- evolve links between CHPs and managed clinical and care networks to promote evidence based delivery of services and to encourage the development of shared network managers and redesign facilitators to support service improvements;
- speed up service design in priority areas and ensure that the skills of all professionals are fully deployed; and
- develop workforce capacity to deliver the range of community based services and in particular developing competences in relation to health improvement within the wider workforce to enhance and support the work of public health practitioners.

Box 10**Building Workforce Capacity**

It is expected that schemes of establishment will specify:

- the priority organisation development areas for CHPs;
- the leadership and management development strategy for CHPs;
- how senior management and specialist expertise will support CHPs;
- how human resource and organisation development issues will be addressed including joint human resource and joint organisation development; and
- how workforce planning will underpin the operation of CHPs

FINANCE AND ACCOUNTABILITY

156. Health Boards will be expected to maximise the amount of funding and resources devolved to CHPs and put in place transparent accountability frameworks and decision making processes and lines of communication.

157. Effective schemes of delegation will be crucial to the delivery of improved services and care throughout CHPs. However, devolution and delegation of decision making and responsibilities should not stop at CHP management team level. These principles must be applied consistently through to the frontline.

158. CHPs will be expected to be involved in decisions on spending priorities of the Health Board. This is where difficult decisions will be taken and CHPs must take a shared responsibility.

159. In addition to the budgets for devolved services Health Boards will also be expected to devolve:

- primary care investment funds;
- funding for the enhanced services component of Primary Medical Services;
- development funding for Primary Medical Services; and
- any further budgets to support service integration and the shift in the balance of care into the community.

160. In relation to the drugs element of the unified budget, Health Boards and CHPs should agree and indicate in the scheme of establishment arrangements for managing the prescribing budgets in the context of overall risk management.

161. CHPs must have access to resources without unnecessary filters within the organisation and they should have flexibility and powers of virement to enable them to use their devolved budgets/savings to greatest effect. They will be expected to operate within Health Board policy, planning and performance management arrangements; standing

financial orders, audit and risk management systems and ensure actual expenditure is monitored against budget and corrective action taken if necessary.

162. All CHPs in a Board area will also be expected to work closely together to deliver jointly agreed health and service improvements and to address inequalities. It will be important for Health Boards to have clear and integrated accountability arrangements and they should agree with their CHPs:

- a CHP dimension to their local performance management framework in order to benchmark and monitor delivery of services and relationships with partners;
- shared accountability and performance management arrangements within the NHS system for service outcomes and the use of resources; and
- the nature of CHP reports on the planning, development and provision of services.

163. CHPs will be accountable, on behalf of the Health Board, for the joint management and joint resourcing of services provided within the CHP area as agreed with local authority partners and other partners within the joint governance arrangements of the Extended Local Partnership Agreement and subsequent agreements. This will include the responsibility for the delegation of functions and resources (under the Community Care and Health Act 2002), pooled and aligned budgets and joint management arrangements.

164. Health Board Chief Executives will remain accountable to the Chief Executive of NHSScotland and to the Scottish Parliament for the use of all financial resources.

Box 11 Finance and Accountability

It is expected that schemes of establishment will specify:

- all budgets for devolved functions and services including budgets in paragraph 159;
- arrangements for managing the prescribing budget;
- the joint resourcing arrangements with local authority partners including agreed financial frameworks and budgets;
- the budget devolved to CHPs for their public partnership forums;
- the % of the total Health Board allocation to be devolved to CHPs;

- the formal mechanisms for fully involving CHPs in decisions on the use of all NHS financial resources within a CHP and across the Board area;
- the formal mechanisms for ensuring CHPs are involved in decisions on the use of **all** development funding;
- how CHPs will influence the use of integrated funding streams, e g children;
- the Development Plan budget (organisation, training and learning plan);
- budgets for support services (e g finance, human resources, IT, estates, planning)
- areas of “earmarked” funding to be devolved to CHPs;
- the level of devolved resource transfer funding and support finance;
- the lines of accountability including joint accountability arrangements for joint resourcing.

SCHEMES OF ESTABLISHMENT

165. Under section 4A(1) of the National Health Service (Scotland) Act 1978, as inserted by section 2 of the National Health Service Reform (Scotland) Act 2004, Health Boards are required to submit CHP schemes of establishment for approval to the Scottish Ministers within a time period which they may specify.

166. Schemes should cover the whole Health Board area and be developed in the context of single NHS systems, the development of joint health improvement plans, and local plans to extend Joint Future and *For Scotland's Children*. Local authority partners must be fully involved in the development of CHPs and proposed schemes must be in line with Extended Local Partnership Agreements.

167. All schemes should be developed through an inclusive process and demonstrate that the views of stakeholders have been taken into account. Where a CHP is proposed which spans more than one Health Board area, then the Health Boards concerned should agree the local CHP arrangements with the local authority and include the arrangements for that entire CHP in their respective schemes of establishment. It should identify the resources that each participating Board will put into that CHP.

168. Schemes must address all areas contained within this guidance and be with the Scottish Executive **no later than 24 December 2004**. The key elements that the Scottish Ministers will require to be evidenced are set out in Boxes 1 -12 in this guidance. The schemes must include development plans that indicate how CHPs will be supported to deliver the services and care outcomes for which they have devolved responsibility.

169. If schemes are rejected because there is insufficient detail, or Health Boards have failed to meet the requirements set out in this guidance, then schemes will be returned to the Health Board with a requirement to resubmit them within a timescale to be determined by Scottish Ministers.

170. Once schemes have been approved then Health Boards will have a duty to implement the schemes. We expect CHPs to be established by 1st April 2005 and to be provided with development support to enable them to become fully effective.

171. Once CHPs have been set up then Health Boards will be able to extend the range of devolved functions without having to resubmit schemes for approval by Ministers. However, if a Health Board wishes to alter the number of CHPs in its area or alter functions delegated to the CHP which have been specified in the original scheme of establishment then they should submit a new scheme to Scottish Ministers.

Box 12 Schemes of Establishment

It is expected that schemes of establishment will:

- address all questions included in Box 1-12 in this statutory guidance;
- describe the process for developing schemes including the level of stakeholder involvement.