NORTH LANARKSHIRE COUNCIL

REPORT

AGENDA ITEM No. 6

To: SOCIAL WORK COMMITTEE		Subject: SCOTTISH EXECUTIVE DRAFT GUIDANCE ON COMMUNITY HEALTH PARTNERSHIPS
From: DIRECTOR OF SOCIAL WORK		
Date: 30 OCTOBER 2003	Ref: DM/AB	

1. PURPOSE OF REPORT / INTRODUCTION

1.1. The purpose of this report is to seek homologation of North Lanarkshire Council's response to Scottish Executive Draft Guidance on Community Health Partnerships.

2. BACKGROUND

2.1. On 27 February 2003 the Scottish Executive published "Partnership for Care" which set out planned changes for the NHS in Scotland. Part of this entailed the replacement of Local Healthcare Co-operatives (LHCCs) with Community Health Partnerships (CHPs). A further document was received from the Scottish Executive on 18 July 2003 inviting comment on Draft Guidance on Community Health Partnerships.

2.2. Responses were required by 12 September, necessitating homologation of the Councils' response.

3. CONTENT OF GUIDANCE

3.1. The draft guidance sets out the purpose of Community Health Partnerships as:

- Work as a key NHS partner with local authorities and others in relation to community planning to tackle priority health issues, and in developing and delivering joint approaches to local health and social care services for all ages
- Directly influence NHS Board level strategic planning, priority setting and resource allocation
- Plan primary and community based services with delegated authority from the NHS Board to deliver services in the way that best fits the needs of local people
- Create and strengthen local networks and partnerships with hospital and specialist practitioners and teams to deliver integrated health services.

3.2. It goes on to ask a number specific questions in relation to matters such as role and size of CHPs; core services; performance indicators; management and governance arrangements; partnership working; public involvement.

4. THE COUNCIL'S RESPONSE

4.1. The Council's response raises a number of issues that are set out in detail at Appendix 1. The main issue is that this is a change initiated and designed by NHS Scotland without proper engagement of local authorities. The Executive's aspiration for CHPs to be the vehicles for delivering joint priorities will not succeed if the model does not create equality of partnership with local authorities.

4.2. Whilst the paper appropriately seeks to tackle some of the internal boundary issues in the health services and achieve integrated health care within the NHS, it is increasingly the case that partnership working is required to deliver integrated health *and* care. This is at the heart of other key Executive policies such as Joint Future and Integrated Children's Services. If CHPs are to deliver this requirement local authorities have to be equal, not contributing, partners in their planning and operation.

4.3. Locally there are anxieties that the proposed changes may impair existing local planning and service delivery arrangements. This is currently the subject of discussions between the Council and NHS Lanarkshire.

5. FINANCIAL / PERSONNEL / LEGAL / POLICY IMPLICATIONS

5.1. None at this stage.

6. RECOMMENDATIONS

6.1. Committee is asked to:

(i) Homologate the Council's response; and

(ii) Otherwise note the contents of this report.

Jim Dickie
Director of Social Work
17 September 2003

For further information on this report please contact Duncan Mackay, Head of Social Work Development, TEL: (01698 332004)

Our Ref: GW/AF
Your Ref:
Contact: Gavin Whitefield
Tel: 01698 302452
Fax: 01698 230265
E-Mail: chief.executive@northlan.gov.uk
Date: 12 September, 2003

North Lanarkshire Council

Mrs Kathleen Bessos
Directorate of Service Policy and Planning
Scottish Executive
St Andrew's House
Regent Road
Edinburgh EH1 3DG

Chief Executive's Offic
Gavin Whitefield, Chief Executi
PO Box 14, Civic Centre
Motherwell ML1 1TW
www.northlan.gov.uk

Dear Mrs Bessos

Draft Guidance on Community Health Partnerships

Thank you for your letter of 18 July 2003 and the opportunity to comment on the above draft guidance. These comments are made on behalf of North Lanarkshire Council.

General Comments:

Community Health Partnerships (CHPs) represent further structural change in the NHS. It is important to note that, from a partnership perspective, any change of this nature creates a level of turbulence in joint planning. Reorganisations of the Health service, whether local or national, generally occur on a more frequent basis than in local government. It is only 5 years since Local Healthcare Co-operatives (LHCCs) were created and the concept of Community Health Partnerships goes significantly beyond that original notion. There is an anxiety within local authorities that progress towards delivering joint and complex work such as Joint Future -already scheduled against demanding timescales- will be impaired because of the organisational consequences of proposed change. It is recognised that this would be an unintended outcome, but this scenario is assessed as being of significant risk.

The language and content of the document in places, creates anomalies that, if not addressed, have the potential to disable progress on the shared, critically important national agenda. This is characterised throughout by references to such as Joint Future; Community Planning; and public participation, which are not sufficiently rooted in an overall vision of integration between the NHS and local government. This is because the draft guidance itself is not the product of the sort of the integration that partners are, rightly, exhorted to achieve.

The guidance properly indicates that much progress has been made in joint working between LHCCs and Councils. In one sense the proposals are an evolution of LHCCs, albeit one with significant and far-reaching consequences. What this should represent is an evolution that metamorphoses into Health **and Care** Partnerships in ways that reflect the emerging and necessary partnerships between our respective agencies. It would be a missed opportunity not to cast new models in this way. It is not appropriate to set out guidance on Community Health Partnerships in ways that set out a contributory, but far from equal role, for local authorities in this context. Neither is it necessary for structural change across both the NHS and Councils to deliver this model and achieve the shared aspirations of the Executive, the NHS and local government.

Some colleagues in the NHS point out that there are functions of the NHS that are of little direct relevance to Councils and vice versa and that essentially Community Health Partnerships have to deliver health care. This is not contested (through the welcome inclusion of health improvement in the remit challenges these sort of assumptions) - but equally there are important, and growing, areas of mutual interest that require close collaboration in order for partner agencies to meet the needs and expectations of the public they serve. It is these areas that need to be addressed collectively within an integrated health and care approach. **Proposing organisational changes in the NHS then saying to key partners that this will be the vehicle to deliver joint working is inherently contradictory and not joined-up in approach.**

Local solutions in North Lanarkshire may not be identical to those put in place elsewhere. The guidance must provide sufficient scope, time and flexibility for local partners to design what is best for their areas.

Specific Comments:

Question: Do you agree with the overall role of Community Health Partnerships?

That Community Health Partnerships should play a key role in planning and delivering integrated health services is accepted. The NHS is a complex organisation and there have been historical tensions across and between the strategic functions of Boards, and the planning and delivery of primary and secondary care. Joint planning has made considerable progress sometimes despite, not because, of these organisational issues. The remit to "work as a key NHS partner with local authorities....in developing and delivering joint approaches to local health and social care services" will not succeed unless local authorities are equal partners not just participants. The role described for Community Health Partnerships will inhibit that for the reasons set out in the general comments.

Question: How can CHPs best work with community planning partners to support the health improvement agenda?

Many documents that emanate from various sources now routinely use the phrase "community planning" without that use necessarily being informed by a shared understanding of what community planning is and, critically, how it can be effected in localities. It is important to explicitly recognise that, firstly, delivering on shared agenda such as Joint Future and integrated childrens' services is community planning in action and secondly, that there has to be coherent arrangements to integrate planning activity. Community planning is still, relatively, in its infancy. There are major questions about how community planning arrangements incorporate or connect with Community Health Partnerships, and with other initiatives such as new community schools. Partners require time to carefully consider and consult on these issues to prevent duplication and wasted effort.

Question: Are these the right service outcomes and what indicators would we use to measure these outcomes?

The statement that "Community Health Partnerships will be the main focus for service integration for local communities" lays out an aspiration that can only be achieved by partnerships focussing on health and care in ways that are generally not reflected throughout the guidance. The reference to Managed Clinical Networks "and other care networks" suggests a lack of clarity in this regard. Partners should be creating managed networks that map out the patient journey through clinical and care settings in an integrated way, not in one or the other. Some people only have health needs, some only have care needs, others have both. Pathways such as these require to reflect that. There is a clear need to agree service outcomes – work is taking place on identifying appropriate indicators nationally in other places in this respect. However what are described in the bullet points are not actually service *outcomes* for users/patients and carers. There appears to be a confusion between organisational outputs and outcomes, and outcomes for users and carers (eg quicker assessment and faster access to services arising from single shared assessment not single shared assessment in itself).

Question: What should the core services be?

It would seem appropriate to set out a menu rather than a prescriptive list so that local circumstances can determine need and organisational arrangements. There is a persuasive argument to suggest that some functions which have not been carried out by LHCCs should be delivered through CHPs- services such as that health promotion, community mental health etc. As stated previously if they are to deliver integrated services then the balance of the relationship between local authorities and the NHS needs to be recast in the guidance.

Question: What are your views on population size?

The view that there should be "maximum alignment between CHPs and natural communities" is strongly supported. LHCC boundaries in North Lanarkshire are, in the main, grouped around principal townships, and are broadly co-terminous with local authorities. They are mostly in the region of what is the expressed minimum size of 50,000 but neither are they so large that they become remote from localities. Significant joint progress to date has been achieved in Local Care Partnerships in North Lanarkshire around these geographical boundaries.

It may not be helpful to use language like minimum and maximum, but instead to emphasise the concept of design around natural communities, without which the notion of meaningful public participation becomes seriously eroded. There will be a temptation for the NHS to tackle undoubted issues of capacity by enlarging the current size of LHCCs, but this would have negative aspects for local communities.

Question: What effect will CHPs have on existing LHCC Professional Committees and the relationship with the Area Clinical Forum?

The present arrangements are purely internal to the NHS. If CHPs are to deliver integrated health and care then these sorts of arrangements may require to be revisited.

Question: What role do you envisage for CHPs in relation to workforce planning and development and the new contractual arrangements?

The guidance here is written in respect of the GMS contract, which is an internal matter for the NHS. There are wider workforce planning relating to Joint Future and, potentially, integrated childrens' services, for which partners have other arrangements in place.

Questions: What are the most appropriate mechanisms for filling the formal roles on the CHP?; Should a Public Partnership Forum member have a formal role within the CHP?; Should the Chair of the CHP be a non-executive?; How can joint responsibility for outcomes across primary and secondary care be reflected in the management arrangements?; What are your views on the proposed CHP organisational arrangements?

If CHPs are to be established by NHS Boards (as opposed to say, community planning partnerships), though they are not statutory bodies, then serious consideration has to be given to the participation of local authorities in devising the new arrangements. Councils are represented, but not equal partners, on LHCCs and their capacity to influence what happens lies at the margins. Whilst this may not be inappropriate in internal NHS matters, the remit for CHPs is much broader yet the proposals to establish CHPs seem to based upon the LHCC model. In North Lanarkshire we have jointly created Local Care Partnerships to give partners, service users, carers and other stakeholders an equal voice in the planning and delivery of services in their localities. If there is to be such an animal as a Public Partnership Forum then it would seem wholly appropriate that they have an equal voice in the decision making process.

Question: How can primary care and specialist clinicians be most effectively brought together in the working arrangements of CHPs?

The NHS is a large and complex bureaucracy which faces major challenges to integrate the activities of primary care and specialist clinicians. CHPs require to be able to deliver in this respect if they are not to perpetuate some of the historical problems associated with this issue. Their capacity to do so depends to a very large extent on the local arrangements that are put in place.

Question: How should staff partnership arrangements evolve?

The local staff partnership arrangements that are in place for Joint Future provide a base on which to build and consolidate in respect of other areas of activity.

Questions: How can we ensure that CHPs are an integral part of the delivery of the Joint Future agenda? What further opportunities do CHPs offer for partnership working?

Badging these bodies as Community Health Partnerships gives a clear message about their primary purpose and function. Creating Health and Care Partnerships (in North Lanarkshire we already have this at strategic and local levels) signals a fundamentally different approach and agenda. Given that the guidance mostly concerns itself with the planning and delivery of integrated health care, the alternative might be to encourage partners to create sub-sets of CHPs charged with delivering the joint agenda. Joint working cannot and must not be presented in the guidance as an afterthought. Shared approaches across a range of Council functions under the umbrella of community planning is the way forward.

Question: Do you agree with the role of Public Partnership Forum?; Do you agree with the proposed close link between the Public Partnership Forum and the local office of the Scottish Health Council?

Local authorities have, albeit not always in comprehensive ways, facilitated the effective participation of service users and carers in ways that are generally less well developed in the NHS. The guidance does not reflect that there are well established local mechanisms – not just in North Lanarkshire but in many parts of Scotland – already functioning effectively in this respect. Consequently it invests heavily in the notion of a Public Partnership Forum to fill the vacuum. Local user and carer organisations in North Lanarkshire are cautious about the creation of a new body when there are already mature relationships between themselves and statutory agencies. What added value would this bring? The question about the proposed Forum and the Scottish Health Council is difficult to respond to as it invites comment on the relationship between bodies that either do not yet exist or have just been created.

Question: What do you see as the relationship between operating divisions and CHPs?

Whilst it is likely to be expedient for the NHS to work within separate operating divisions in the short term, there must be a question as to the medium/longer term appropriateness of such arrangements in pursuit of integrated health care.

Question: What do you see as the development priorities?

Setting out development priorities before the partnerships have been created and in advance of discussion between joint planning partners seems somewhat premature. What will inevitably be an issue is the capacity of CHPs to deliver a wide agenda; their flexibility to respond to different local circumstances; and their ability to sustain the momentum of key national priorities at a time of organisational change.

Question: Are the financial arrangements clear?

Whilst this is substantially a matter for the NHS, of local authority interest is the proposal that CHPs should "ensure the deveopment of joint health and social care budgets and financial frameworks." This will require the modelling of the Joint Future approach to a broader range of services in ways that partners have not yet sufficiently explored or tested locally.

I trust you find these comments helpful and that they will be reflected in the final guidance.

Yours sincerely

S. Whitefield

Chief Executive