NORTH LANARKSHIRE COUNCIL

REPORT

AGENDA ITEM No. 1

To: SOCIAL WORK COMMITTEE		Subject: COMMUNITY HEALTH PARTNERSHIPS- RESPONSE TO SCOTTISH EXECUTIVE DRAFT STATUTORY GUIDANCE
From: DIRECTOR OF SOCIAL WORK		
Date: 20 MAY 2004	Ref: DM/SM	

1. PURPOSE OF REPORT / INTRODUCTION

1.1. This report advises Committee of the contents of draft statutory guidance issued by the Scottish Executive in respect of Community Health Partnerships (CHPs); and seeks homologation of the response attached at Appendix 1.

2. BACKGROUND

2.1. As part of the reorganisation of the National Health Service, the Executive requires the establishment of Community Health Partnerships. In July 2003 the Executive produced a paper setting out potential functions of Community Health Partnerships, to which North Lanarkshire responded. New draft guidance, together with draft regulations, has now been issued, with comments required by 7th May 2004.

3. PROPOSALS / CONSIDERATIONS

3.1. The statutory draft guidance requires Community Health Partnerships to be established as Committees of NHS Boards. Schemes of establishment are to be submitted to the Scottish Executive by December 2004 and CHPs to be operational by April 2005. Schemes should be developed in the context of:

- Single NHS systems (ie integration of primary care and acute services)
- Joint health improvement plans
- Plans to extend implementation of "A Joint Future" whereby community care services and planned and delivered collaboratively
- Plans to integrate children's services.

3.2. The lengthy draft guidance (it runs to over 50 pages) states that local authority partners must be fully involved in the development of CHPs, which are likely to replace Local Healthcare Co-operatives (LHCCs) but are likely to operate on a larger scale and with a greater strategic role. The extent to which the role of local authorities is reflected throughout the guidance is uneven, though it helpfully proposes that boundaries of CHPs should be co-terminous with those of local authorities (ie either one or more than one within a given local authority area).

3.3. Though CHPs are to be constituted as NHS bodies the guidance invites them to provide a range of services, some of which are provided or commissioned by local authorities, through local agreement. These positions are potentially difficult to reconcile. The guidance is challenging in a number of ways and the following issues are reflected in the Council's response:

- How to increase capacity to plan and deliver improved, more joined-up services, whilst at the same time retaining and enhancing a strong locality focus.
- How to integrate key activities for which Councils act as the lead agency (eg community planning) into the work of Community Health Partnerships.
- How to ensure local authorities and other key stakeholders are significant partners and not simply minority participants.
- How to ensure proper governance and accountability for joint services for which a Community Health Partnership might be responsible.
- How to maximise existing arrangements for public engagement when creating new "public partnership forums."

3.4. The Council's response is attached at Appendix 1. *(note: to follow)*

4. FINANCIAL / PERSONNEL / LEGAL / POLICY IMPLICATIONS

4.1. There are no implications at this stage in the process. These would arise if partners choose in future to integrate specific the management and resourcing of identified services.

5. RECOMMENDATIONS

5.1. Committee is asked to:

(i) Homologate the response attached at Appendix 1; and

(ii) Otherwise note the contents of this report.

Jim Dickie
Director of Social Work
31 March 2004

For further information on this report please contact Duncan Mackay, Head of Social Work Development, Scott House, 73-77 Merry St, Motherwell TEL: (01698 332004)

North Lanarkshire Council

North Lanarkshire Council Response to Statutory Draft Guidance and Regulations on Community Health Partnerships

North Lanarkshire Council welcomes the opportunity to comment on statutory draft guidance on Community Health Partnerships (CHPs), issued by the Scottish Executive in March 2004.

We are committed to meeting the aspirations of key integration policies. The Council and its partners have been commended by the Executive for achieving considerable success in a range of joint initiatives. There is, nonetheless, much that still requires to be delivered. The comments that follow are set firmly in that context.

The guidance is significantly different from the earlier consultation paper issued in July 2003. That paper was widely criticised by local authorities for failing to properly recognise the inter-relationship between the NHS and local government in taking forward joint working. These views were, to some extent, reflected in the "Summary of Consultation Responses" posted on the Scottish Executive website.

It is recognised that, in terms of the revised guidance, efforts have been made to address this. However in developing the concept of CHPs as the means by which partners will deliver major partnership initiatives, the guidance raises important issues concerning governance and accountability.

In the context of Joint Future, the Executive's shifting focus towards outcomes and away from structures has been supported by this Council in pursuit of improved health and care services. In themselves, organisational structures cannot deliver required whole system change. Organisational arrangements should facilitate necessary change to achieve agreed outcomes. The closer alignment between the Executive and local partnerships on the shape of these outcomes and how they are determined is positive.

It is, though, for local partnerships to determine the most effective organisational and managerial arrangements that can best deliver such outcomes in their areas. Where these are not working to the satisfaction of local partners or the Executive there are range of existing corrective measures that can be put in place. The draft guidance is ambivalent about this. On the one hand it "recognises that models will evolve according to local circumstances" but on the other parts of it are quite prescriptive with regard to the form and function of CHPs.

The vision of Community Health Partnerships poses a basic question on which the draft guidance falls somewhere in-between. Are they, first and foremost, the vehicle to achieve better integration of primary and secondary health care within the NHS? Or are they the mechanism through which partnership initiatives will be planned and delivered, such as Integrated Children's Services or Joint Future? The guidance clearly wants the answer to be both but is more coherent and developed in the way it seeks to achieve the former and significantly less so in respect of the latter. Indeed if the latter was such an explicit objective, why badge them as Community *Health* Partnerships and establish them as Committees or Sub-Committees of NHS Boards, as set out in the guidance?

As NHS bodies, Community Health Partnerships will arguably be well placed to bridge the divide between primary and acute care. Few would disagree that this is not an absolute necessity and that the current degree of integration across NHS settings, nationally, is weak. Enabling the NHS to speak as one voice would assist positive working relationships between the NHS and local authorities.

But there is an inconsistent thread that runs throughout the draft guidance related to this fundamental question. The language and primary focus of the document is clearly reform of the NHS. Partners are expected to participate, as equal partners, in an NHS body which will assume governance and accountability for a range of services, some of which may currently be provided or purchased by local authorities.

Ambiguity about the primary purpose of CHPs characterises the document. For example, the "Aims" set out in Paragraph 11 on Page 4 describe CHPs as "*the main NHS agent* through which the Joint Future agenda is delivered in partnership with local authorities and the voluntary sector." Similar comments are made about implementing the recommendations of "For Scotland's Children", "Integrated Community and Health Promoting Schools", and involvement of staff. These policies have to be planned and implemented together. If CHPs are to be "the main NHS agent" what are the implications for other joint structures and the place of local authorities?

In North Lanarkshire there are 3 tiers of Joint Future activity. A "de facto" Committee of Members and Chief Officers; and Implementation Group of officers; and 5 Local Care Partnerships aligned to LHCCs. The draft guidance requires that "existing governance and accountability arrangements e.g. through Joint Future Committees should be aligned to CHP arrangements." It is not entirely explicit what this means, though Page 23 Paragraph 74 suggests that functions of high level Committees could be absorbed within CHPs. By implication this would mean CHPs being overseen by a group of senior members and officers. Though this, in turn, is not reflected in proposed membership of CHPs (Page 21 Paragraph 66).

The proposed minimum membership reflects the difficulties local authorities face in seeing these bodies as the mechanism for delivering joint objectives, notwithstanding the statement in the following paragraph. Establishing CHPs as Committees or Sub-Committees of NHS Boards, apart from the strong message this conveys about their focus and jurisdiction, ascribes them no formal status within local government.

The draft guidance states that "local partners.....must take the early opportunity to remove duplication in the management and duplication of services as they pursue more integrated approaches over a defined timescale." This is a contentious statement that is not evidenced. It is contentious because it implies significant levels of duplication in management and services between the NHS and local government, whereas analysis shows that, whilst overlaps undoubtedly exist, these tend to be at the margins of our overall respective responsibilities.

It is also important to emphasise that there is a big difference between integrated *approaches* and integrated *services*. There is little or no evidence, worldwide, that integrated services achieve better outcomes *except for people with complex health and social care needs* (which has been and will continue to be our focus in North Lanarkshire). Integrated approaches are equally effective for other people. One good example of how this has been developed in North Lanarkshire is joint access to resources through single shared assessment processes.

Page 8 Paragraph 21 claims that "from the consultation process there is a consensus that CHPs within a NHS Board area should directly manage and provide, or have a lead role in co-ordinating, influencing or directing the delivery of the following services and functions." There follows a lengthy list.

The earlier consultation document and the "Statement of Consultation Responses" however states that NHS Boards will be expected to define the range of "core NHS services" to be managed or co-ordinated by CHPs. The revised draft guidance therefore makes a substantial leap to embrace local authority services (eg "respite or short-break services") within the governance of NHS bodies, ie CHPs.

The process introduces more change within the NHS, an organisation that has experienced almost continuos structural change over many years. Our experience in North Lanarkshire has been that Local Healthcare Co-operatives (LHCCs), which have only been in existence for 5 years, have helped to promote closer joint working. The geographical boundaries for Community Health Partnerships have still to be determined in Lanarkshire at the time of writing. Whilst there is a shared commitment to sustain and develop locality arrangements for service planning and delivery, some of the existing LHCCs are too small to comply with the minimum size prescribed in the guidance.

Furthermore, Community Health Partnerships are clearly intended to be much more than "LHCCs Plus" so there is a fundamental tension between capacity and retaining a strong locality focus. That focus is essential if community planning and indeed most partnership activity is to be meaningful for people in local communities. Community planning is a necessary means to achieve health improvement and other shared priorities. It seems, though, unlikely that there will be a direct fit, at least in North Lanarkshire, between numbers of CHPs and community planning areas for the reasons described above. The draft guidance sets out implications for the organisation, leadership, management develop and support aspects of CHPs. We are aware of concerns within NHS partners about the capacity of CHPs and the impact this requires to have on size and function. This presents its own challenges in terms of partnership working.

The statement that "wherever possible CHPs should seek to tap into local authority, voluntary sector and other existing public involvement mechanisms" (Page 29 Paragraph 93) is welcomed though the draft guidance is vague on some aspects of how these arrangements will work. Partners in North Lanarkshire have articulated how they intend to enact this in their Extended Local Partnership Agreement. Mechanisms for securing public nominations should be made explicit locally. Provided that is the case NHS Boards should not be able to veto the participation of any named members of the public as the draft Regulations appear to state.

The section "Working with Local Authorities" (Paragraphs 130-134 Pages 38-39) characterises some of the tensions contained within the draft guidance, typified by the statement that CHPs "need to *work very closely* with local partners, especially local authorities." Working very closely is clearly not the same as being "equal partners", a term used elsewhere in the document. In itself the accuracy of the statement is not contested but it is not consistent with other content in the guidance.

Whilst not seeking to resolve lack of co-terminosity between Board and local authority boundaries, the guidance does helpfully address the problematic issue of boundaries as far as Community Health Partnerships are concerned.

The subsequent section entitled "Working with the Voluntary Sector" curiously omits any reference to private sector partners in the delivery of care, an omission that runs through the document. Given that the private sector are the largest providers in some fields of activity, the term "independent sector" should be used.

The section entitled "Finance and Accountability" raises major issues for local authorities. The NHS in Scotland does not have a track record of sound financial governance. This is clearly illustrated by the current level of deficit incurred by Boards across Scotland, the scale of which is unthinkable in local government. As in other areas, North Lanarkshire Council has taken steps to align or pool budgets with the NHS for some fields of activity. We will continue to do so where these can achieve better outcomes for people who need health and care services. However this Council is not prepared to do this if it means assuming responsibility for a significant deficit, nor would it expect the NHS to do if the roles were reversed.

In order for local authorities to delegate functions to the NHS in the form of CHPs, Councils would have to be satisfied that strong financial governance and management accountability were in place.

There is a determination amongst joint planning partners that the development in the scale and functions of CHPs should be carefully managed. The aspirations set out for them in the draft guidance are considerable and difficult to realise from the point of their initial conception. It would be a mistake to assume CHPs could at once assume the range of responsibilities proposed for them in the paper. This does not mean being unambitous; it does mean sustaining and enhancing the significant gains already achieved in joint resourcing and management. This requires preserving strong governance and accountability arrangements or replacing them in equally robust ways. That way CHPs stand a much improved chance of meeting the expectations the Executive have for them.