**EAST AYRSHIRE COUNCIL**

**CABINET : 18 JUNE 2008**

# COMMUNITY HEALTH PARTNERSHIP REVIEW

**Report by Elizabeth Morton, Depute Chief Executive/Executive Director of Corporate Support and Alex McPhee, Executive Head of Finance and Asset Management**

## 1. PURPOSE OF REPORT

**1.1** With reference to the meeting of Cabinet on 2 April at which Members were asked to note the progress in relation to the Review of Community Health Partnerships across Ayrshire, attached is a report (Appendix A) to be submitted to, and considered by, the NHS Ayrshire and Arran Board on 25 June. The report details the outcomes of that review as undertaken by the Ayrshire Strategic Alliance on which the Depute Chief Executive/Executive Director of Corporate Support and the Executive Head of Finance and Asset Management are the Council's representatives.

## 2. BACKGROUND

**2.1** Community Health Partnerships (CHPs) were established in Ayrshire in 2004. They evolved from the previous role undertaken by Local Health Care Co-operatives and have operated in parallel with other partnership arrangements between local authorities and NHS Ayrshire & Arran, including, and principally, Community Planning, Joint Futures, Integrated Children's Services and the Community Justice Authority. The Council is represented on the East Ayrshire Community Health Partnership Sub-Committee, as it is currently constituted, by Councillors Filson and John MacKay.

**2.2** The appended report, in making its recommendations, takes into account the most recent policy decision by Scottish Government being that given by the Cabinet Secretary in September 2007 when she reaffirmed the central role of CHPs in improving the health of local communities and in delivering better services and care for local people and providing, as she did, the priority areas which she expects all CHPs to address.

**2.3** As has been previously stated, the statement by the Cabinet Secretary is further confirmed by the direction of travel signalled in "Better Health, Better Care: Action Plan" and the Concordat between the Scottish Government and local authorities.

**2.4** Building on all of the foregoing and recognising the concerns which had been expressed that the existing structure and framework did not seem to support the necessary service change, the conclusion of the work undertaken by the Ayrshire Strategic Alliance makes recommendations which will address these issues, as described above.

## 3. PROPOSALS

**3.1** Building on the proposed Vision Statement as described at para 3.5 of the attached report, it is proposed that there should be 3 Community Health Partnerships, co-terminus with the local authority boundaries in Ayrshire and Arran. It is further proposed that stakeholders should be engaged in 3 ways in each CHP to improve further, partnership working in each area:-

**3.2** There will be in each local authority area a CHP Committee which, in East Ayrshire, will comprise:-

- The NHS Board Member nominated by East Ayrshire Council who will chair the CHP Committee (Councillor Filson)

- 3 East Ayrshire Council Members; it is suggested that this continues to be Councillor John MacKay and that the other 2 Council Members be the Leader of the Council, Councillor Reid in his capacity as both Chair of Cabinet and Chair of the Community Planning Partnership Board to which the CHP Committee has links and one Member of the main Opposition party

- There will also be 3 Members from NHS Ayrshire & Arran who will be a Non-Executive Member, an Executive Member with a clinical remit and an Executive Member with a non-clinical remit.

**3.3** The second element of the structure will be the CHP Forum (or Sub-Committee). This will be a representative group chaired by the Non-Executive Member of NHS Ayrshire & Arran (who also sits on the CHP Committee and will also be a member of the East Ayrshire Community Planning Partnership Board) and will provide an arena where issues identified by independent contractors, NHS staff side and the public would be gathered, discussed and cross-matched with either the CHP Officer Locality Groups (see below) or the Committee for resolution. This Forum will have, as its minimum membership, those required under statute (see appendix 4 of the attached report).

**3.4** Thirdly, there will be CHP Officer Locality Groups and it is proposed that there will be 2 such groups within each local authority area, one for Adult Services and one for Integrated Children's Services. It will be the remit of these Groups to manage the delivery of services within the area in accordance with partnership agreements. Specifically, these will reflect paragraph 1.1 of the CHP Scheme of Establishment and current policy and priorities across the partnership. The Groups will also manage the delivery of relevant aspects of the Local Delivery Plan, Community Plan and Single Outcome Agreement, as specified within the Council area. Equally, the Groups will require to ensure arrangements are in place within the area to facilitate successful partnership between the various stakeholders as described in the Scheme of Establishment and report on the key performance indicators of the partnership within the area to the CHP Committee.

**3.5** CHP Committees will report directly to the Ayrshire & Arran NHS Board and this will be by the Chair who, as is stated above, is the local authority Member/link (Councillor Filson).

**3.6** To ensure completion of the network, the Chair of the Forum, i.e. the Non-Executive Member of NHS Ayrshire & Arran, will, as is stated at para 3.3 above, also sit on the East Ayrshire Community Planning Partnership Board along with the Chief Executive of NHS Ayrshire & Arran, the latter of whom is currently a Member and who, to date, has been accompanied by the Independent Chair of the CHP in the East Ayrshire area.

**3.7** It is further proposed that 3 Partnership Facilitators be appointed to support the work of CHPs and further develop partnership arrangements in each area. These posts would be funded and appointed on a joint basis by NHS Ayrshire & Arran and each local authority, employed and line managed by NHS Ayrshire & Arran and have their base within the respective local authority. It is suggested that given the re-focusing of the work of the CHP partnership on integrated health promotion activities and a reduction of health inequalities, the CHP Facilitator in East Ayrshire be hosted by the Community Planning and Partnership Unit.

**3.8** Locally, the Community Health and Wellbeing Co-ordinator post, jointly funded by NHS Ayrshire & Arran and the Council was previously part of the Community Planning and Partnership Unit structure until 2007 when it was transferred to Social Work. Given the creation of the Partnership Facilitator Post, it will be essential for the Community Health and Wellbeing Coordinator to work inextricably with the Partnership Facilitator to achieve the aims of the CHP.

**3.9** While the structures around the CHP Officer Locality Groups are still being developed, the initial mapping of mental health and health promotion services between Health and local authorities provides assurance on the consistency of service management arrangements at a local level between the agencies. This builds on the strong arrangements which already exist for Joint Future and Integrated Children's Services and the results of this early mapping are presented

## 4. AYRSHIRE STRATEGIC ALLIANCE

**4.1** While the Strategic Alliance, as referred to in the Depute Chief Executive/Executive Director of Corporate Support's report to Cabinet on 2 April, does not have a formal role with regard to CHPs, it is intended to provide a venue where Pan-Ayrshire partnership issues can be considered and, from which, clear advice can be provided to Local Partnerships.

**4.2** As Cabinet is aware, the first task of the Strategic Alliance has been to conclude the review of CHPs. The Alliance will now proceed to consider its work programme for the next 12 months or so which will immediately include a review of other existing arrangements which might be overtaken by the re-focusing and re-establishment of the Community Health Partnership, e.g. Joint Futures.

## 5. FINANCIAL IMPLICATIONS

**5.1** The appointment of the Partnership Facilitator will require to be funded in equal share by the Council and NHS Ayrshire & Arran. The grade of the post has yet to be determined by reference to the NHS grading arrangements but it is anticipated that the cost to the Council will be no more than £15,000 in 2008/09 and up to £30,000 in a full year. Proposals on the source of the funding will be presented to the Cabinet in due course.

## 6. COMMUNITY PLANNING IMPLICATIONS

**6.1** The further development of Community Health Partnerships will strengthen relations between NHS Ayrshire & Arran and East Ayrshire Council and will contribute to the achievement of the Improving Health Theme of the Community Plan.

## 7. LEGAL/PERSONNEL IMPLICATIONS

**7.1** None.

## 8. RECOMMENDATIONS

**8.1** It is recommended that Cabinet:-

(a) notes the progress in relation to the Review of Community Health Partnerships across Ayrshire;
(b) approves the terms of the proposed report to the NHS Ayrshire & Arran Board of 25 June;
(c) agrees that the Council's representation on the Community Health Partnership be Councillor John MacKay, Councillor Reid and one nominee from the majority Opposition Group, all of which requires to be agreed at the meeting of Council on 26 June; and
(d) otherwise notes the contents of the report.

Elizabeth Morton
Depute Chief Executive/Executive Director of Corporate Support
and
Alex McPhee
Executive Head of Finance and Asset Management

9 June 2008

## BACKGROUND PAPERS

1. Community Health Partnership Review – report to Cabinet on 2 April 2008

2. CHP Review – report to NHS Board meeting on 12 March 2008

For further information on the content of the report, please contact Elizabeth Morton, Depute Chief Executive/Executive Director of Corporate Support, on 01563 576001, and Alex McPhee, Executive Head of Finance and Asset Management on 01563 576300

# NHS Board Meeting

## Wednesday 25 June 2008

| | |
|---|---|
| **Subject**: | **CHP Review** |
| **Purpose:** | **To share with NHS Board Members the outputs from the Stakeholder Engagement Programme.**<br><br>**To advise Board Members of the structures, terms of reference and partnership arrangements proposed by the Strategic Alliance.**<br><br>**To recommend a way forward for the reconfiguration of Community Health Partnerships in Ayrshire and Arran.** |
| **Recommendation:** | **To review the content of this paper; consider the extent to which stakeholder views have been incorporated; and determine the appropriateness of the recommended way forward.** |

### 1. Background

1.1 In line with Community Health Partnership (CHP) Schemes of Establishment, agreed in December 2004, Ayrshire and Arran NHS Board sanctioned the CHP Review in November 2006.

1.2 On 12 March 2008 the Board agreed proposals to establish a Strategic Alliance to develop structures; schemes of delegation; terms of reference; and associated partnership arrangements to underpin the reconfiguration of CHPs.

1.3 At its subsequent meeting on 23 April 2008 Ayrshire and Arran NHS Board reviewed and endorsed the stakeholder engagement plan, designed to secure input to and views on the development of the building blocks for the future configuration of CHPs, as outline above.

## 2 Current Situation

2.1 The stakeholder engagement plan has been implemented, offering a combination of engagement methodologies, including written materials; participation in an on-line forum; and sharing views through the recently established video booth.

2.2 In addition to this, over 30 stakeholder meetings have been convened to share and gather views.

2.3 This has been complemented by Staff-Side Partnership Facilitators who have sought to engage with CHP Staff through established meetings and groups. The views they have collected have been fed into the Strategic Alliance on a weekly basis through the Director of Primary Care Development.

2.4 The key themes to underpin partnership working, as identified through the stakeholder engagement programme, were:

- Appropriate membership and composition of each level of the new structure;
- Strong, collaborative relationships between each level of the new structure;
- The development of partnership through building on experience of frontline service delivery;
- The co-location of staff from partner agencies in joint premises.
- The development of integrated Information Management and Technology systems and shared client records; and
- The creation of joint budgets to deliver health and social care services.

The development of integrated information management and technology and the co-location of staff in joint premises form part of existing plans through the Data Sharing Partnership and individual planning between Local Authorities and the NHS. These do not feature in the direct recommendations of this paper.

These themes are described in more detail in ***appendix 1*** of this document.

2.5 Commencing 27th March 2008, the Strategic Alliance has met on a weekly basis to consider these findings as they have emerged and reflect on them in delivering the actions assigned to it by the NHS Board in the pursuit effective partnership working through the reconfiguration of CHPs.

## 3. Proposals

3.1 The future vision for CHPs in Ayrshire and Arran has been derived from the key messages gathered during stakeholder engagement. From this work, it was clear that stakeholders believe that CHPs should provide the vehicle, through which the traditional barriers between care sectors and agencies are dismantled to create cohesive, integrated services that are tailored to local need and designed to remove inequalities.

3.2 These engagement activities have highlighted the strong commitment to partnership working that exists amongst stakeholders in the three CHP areas. Furthermore, there is a clear desire amongst these stakeholders to further develop and nurture these partnerships, with a broad recognition that the CHPs are the key bodies to do that.

3.3 Those leading the CHP Review recognise that the continued engagement and involvement of all stakeholders is critical to the continued development of partnerships and planning of services in each locality. Recognising the need for the stakeholders' voice to be strengthened, NHS Ayrshire and Arran must demonstrate a clear commitment to promoting the prominence and importance of stakeholder influence on local decision-making.

3.4 It is therefore proposed that the new ways of working, developed through the CHP Review, must be fully embedded into and integrated with the existing structures in NHS Ayrshire and Arran, Community Planning Partnerships and Local Authorities to ensure the opinions of stakeholders such as staff-side, independent contractors and the public continue to influence decision-making at CHP and NHS Board levels.

3.5 This approach will not only provide a clear constituency for representation to the CHP Structure, but also a series of checks and balances by which the CHP Committees can be held to account for the delivery of the proposed vision statement, namely:

*CHPs will unite all stakeholders in a locality partnership with the aim of improving the health, social care and healthcare of local populations.*

3.6 This vision should lead to:

- Local people having the healthiest lives possible;
- Integrated health promotion activities, healthcare and social care services; and
- Reduction in inequalities, protection of the vulnerable, and services tailored to local needs.

3.7 The Single Outcome Agreement will be the principal mechanism to measure the extent to which this vision and its associated impact deliver the anticipated outcomes.

3.8 To deliver this, it is proposed that there should be three Community Health Partnerships, coterminous with the Local Authority areas in Ayrshire and Arran.

3.9 Furthermore, it is proposed that stakeholders should be engaged in three ways in each CHP to improve partnership working in each area:

- CHP Officer Locality Groups
- CHP Forum (or Sub-committee)
- CHP Committee

3.10 Firstly, the CHP Officer Locality Groups would be designed to provide a forum for service representatives from health and local authority to discuss, debate and resolve issues associated with health and services at a locality level.

3.11 It is proposed that there should be two such groups within each Local Authority area, one for Adult Services and one for Integrated Children's Services.

3.12 These groups will focus on health, healthcare and social care and will involve other appropriate agencies.

3.13 Secondly, there will be a representative group called a Forum, which will be a Sub-Committee of the respective CHP. This Forum would provide an area where issues identified by independent contractors, staff-side and the public would be gathered, discussed and cross-matched with either the CHP Officer Locality Groups or the Committee for resolution. The Forum would be chaired by a Non-Executive Director of NHS Ayrshire and Arran who also sits on the CHP Committee. To strengthen links with the community planning process, it is also proposed that the Forum Chair will be a member of the respective Community Planning Board.

3.14 Thirdly, the Committee component of the proposed new structure will comprise:

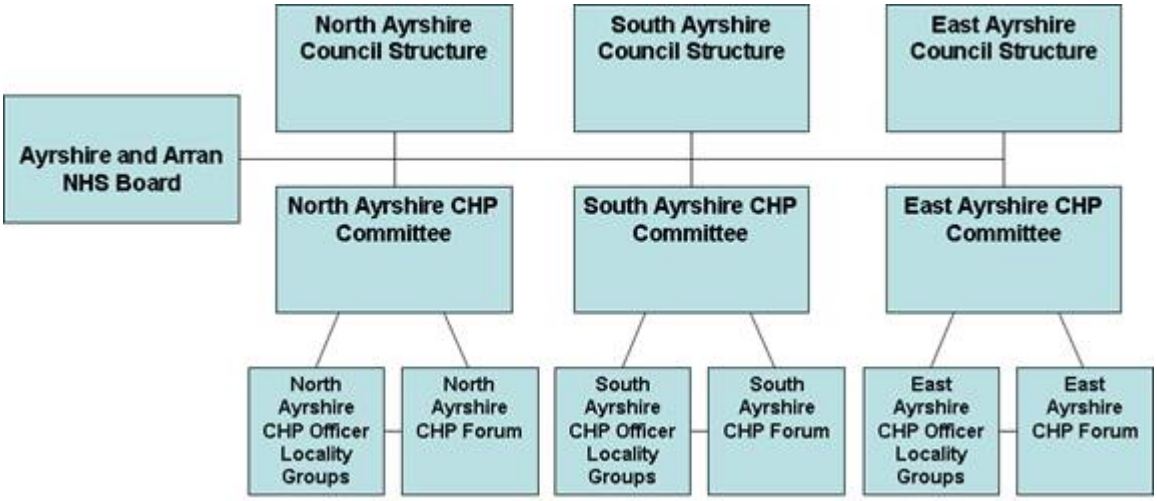
- The NHS Board member nominated by North/South/ East Local Authority who will Chair the meeting;
- Three North/South/East Local Authority elected members; and,
- Three other members from NHS Ayrshire and Arran who would be a Non-Executive member, an Executive member with a clinical remit, and an Executive member with a non-clinical remit.

This configuration has been designed to maximise focus on local need and the tailoring of services and care to meet this. In addition to this, the membership of this group is drawn from those within Health and the Local Authority who will be able to influence and encourage the use of resources to support local service change. It should also be noted that the Chair of the Committee would be appointed by virtue of their membership of the NHS Board and should therefore be viewed as an individual with equal responsibility for the delivery of the policy goals of both Health and the Local Authority.

3.15 These Committees will report directly to Ayrshire and Arran NHS Board. While there is agreement in principle that the CHP Committees will also report into each Local Authority, further discussion is required to identify the most appropriate reporting mechanisms into each Council's structure and community planning arrangements.

3.16 The Committees, Forums and Officer Groups are depicted in ***diagram 1*** below and details of their proposed Terms of Reference and membership are presented in ***Appendices 3 – 5***.

***Diagram 1 – Proposed CHP Structure***




3.17 The anticipated benefits of this structure compared to issues identified in the fieldwork stage of the review are summarised in ***Table 1*** below:

| **Identified Issues with Current Arrangements** | **Anticipated Benefits of Proposed Structure** |
|---|---|
| Purpose of CHPs and partnership is unclear | The strong vision and focus on partnership benefits are clearly articulated. |
| Scope to improve integration and delivery of health improvement and reduction of inequalities | This is now the clearly stated intention in the vision and impact statement for CHPs.<br><br>The strength of the new CHP structure and its focus on local issues should highlight the drive to improve local health and reduce local inequality. |
| Lack of direct accountability to the NHS Board | As Members of the NHS Board, the Chairs of the CHP Committees can be held to account for delivery of the vision statement.<br><br>In addition to this, the Chairs of the Forums will be in a position to ensure the views of the Forum will be reflected at Committee and NHS Board level. |

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|---|---|
| Lack of direct accountability to the NHS Board (continued) | Finally, the Chairs of the Area Partnership Forum and Area Clinical Forum will be able to hold the Chairs of the Committees and Forums jointly accountable as to the extent to which independent contractor and staff-side views are considered in forming the CHP position. |
| Lack of influence at NHS Board | With the Chair of the Committee, the Chair of the Forum and other Committee Members as full Board Members, the CHP Committee and the locality stakeholders, through participation in the Forum, have the opportunity to influence NHS Board decision-making. |
| Inconsistent Local Authority representation and participation | Local Authority representation and participation would be standardised across Ayrshire. |
| Absence of senior decision-makers to deliver change | All members of the Committee are able to influence and encourage the use of resources to support local service change. |
| Large, unwieldy senior group, with limited active participation | Streamlined Committee group capable of informed decision-making through engagement with stakeholder views expressed in the Forum. |
| Need to strengthen relationship with Community Planning | Stronger relationship with community planning. Chair of the sub-committee to be the representative from health on the community planning board, along with the Chief Executive. |
| Perceived lack of NHS Board commitment to CHPs | Committee Chaired by and populated from a Health perspective by NHS Board Members and Forum Chaired by Board Member – thereby providing a direct link between locality planning and decision-making and the NHS Board. |

3.18 It is further proposed that three Partnership Facilitators should be appointed to support the work of these groups and further develop partnership arrangements in each area. These posts would be funded and appointed on a joint basis by NHS Ayrshire and Arran and each Local Authority, employed and line managed by NHS Ayrshire and Arran and have their base in Local Authority premises.

3.19 While the structures around the CHP Officer Locality Groups are still developing, the initial mapping of Mental Health and Health Promotion services between Health and Local Authorities provides assurance on the consistency of service management arrangements at a local level between the agencies. This builds on the strong arrangements which already exists for joint future and integrated Children's Services. The results of this early mapping are presented in **Annex A of A*ppendix 5***.

3.20 The Strategic Alliance, introduced under the NHS Board Paper of 12 March 2008, does not have a formal role with regard to CHPs but is intended to provide a venue where pan-Ayrshire partnership issues can be considered and, from which, clear advice can be provided to local partnerships.

3.21 It is evident that, given the timeline constraints for delivery of this direction of travel to the NHS Board, some of the key elements required to support its implementation will not be in place in advance of the meeting of Ayrshire and Arran NHS Board on 25 June 2008. These include:

- Establishing a Scheme of Delegation as required for NHS Ayrshire and Arran and each Local Authority in respect of the proposed CHP Structures;
- Any updating of the Scheme of Establishment, as advised by the Scottish Government Health Directorates; and
- Further development of an aligned resource framework.

3.22 As a consequence of these proposals the NHS Board's existing CHP Advisory Committee would be stood down and the CHP Committee would have a direct referring line to the NHS Board rather than through the Health & Performance Governance Committee. The proposals would also incorporate the existing joint future arrangements between Health and the Local Authorities.

3.23 These proposals radically strengthen the role of CHPs in partnership working through much greater accountability and representation from the relevant local communities, local authority and NHS structures. The voice of stakeholders is strengthened by providing direct representation to the NHS board, alongside existing mechanisms for staff and professional engagement. The relationship with community planning has been clarified and enhanced with the CHP taking the central role for the health theme. In summary this paper should lead to a major advance in partnership working and place the partners in an excellent position for the delivery of the vision of uniting all stakeholders with the aim of improving health, healthcare and social care.

## 4. Consultation

4.1 This paper and the recommendations herein have been developed through direct stakeholder engagement, including Local Authorities; the Voluntary Sector; CHP Staff; Patient Public Partnerships; the CHP Committees and Local Partnership Forums; the Independent Contractors; and Staff-Side Colleagues.

4.2 In addition to this, the emerging proposals were discussed with the Area Partnership Forum and the Integrated Care Modernisation Board on 05 and 08 May 2008 respectively.

4.3 Finally, a draft of this paper was disseminated to the Area Partnership Forum, Integrated Care Modernisation Board and Professional Committees on Thursday 15 May 2008 and was subsequently discussed with Stakeholder Non-Executive Directors at a special meeting of the Service Management Team on 20 May 2008.

## 5 Resource Implications

5.1 The facilitator post will be jointly funded across the NHS and local authority. The grade of the post will be determined using the jointly agreed job description under the NHS grading system.

5.2 These proposals will involve the redesign of existing resource use.

## 6 Potential Risks

6.1 The consultation with stakeholders has highlighted risks which require further consideration.

6.2 Principal amongst these is that while the proposals are logical and should deliver the intended benefits, they do represent a new, innovative and brave approach to partnership working and their success is dependent on the spirit in which it is adopted and the behaviours demonstrated by all partners. This risk is clearly difficult to manage as it depends upon the action and contribution of individuals but by showing complete and consistent commitment at the highest levels of the organisation to partnership working, supported by an organisational development programme, this risk should be minimised.

6.3 There is also a concern that power could be centralised at committee level with too much emphasis placed on corporate influence either through the Local Authority or the NHS. However the structure has been designed to emphasise local partnership alongside clear direct links to the NHS Board and Local Authority structures, supported by effective schemes of delegation. The combination of these checks and balances should minimise this risk.

6.4 It has been suggested stakeholders may feel disengaged from CHP working perceiving a dilution of their influence. In practical terms the new CHP structure strengthens the voice of stakeholders by giving direct representation of both the committee and forum on the NHS board. Much of the sense of dilution is actually likely to come from the behaviour of individuals and the responsiveness of the organisations to stakeholder groups.

Arrangements for engaging independent contractors are being agreed with the professions through the Primary Care Development Directorate and a strategy for primary care will give clarity over the future role and development of this sector.

The arrangements for working with the public will be strengthened through proposals from the Nursing Directorate, including improving logistical support for PPFs alongside ensuring their voice is heard in the forum.

A development day for NHS local staff partnership forums should help set out actions to allow confidence to grow in this method of partnership.

6.5 There is a risk that locality arrangements may result in fragmentation and the creation of inequity in service provision. The arrangements are designed to allow some degree of local variation and targeting of resources to address local needs and inequality. However, the strengthening of arrangements for Community Health Partnerships at a corporate level should ensure the risk of fragmentation is limited and any variations are a positive outcome from meeting local needs.

## 7. Impact Assessment

7.1 See ***Appendix 2***.

## 8. Conclusion

8.1 This paper contains a high-level set of recommendations for the future configuration and development of Community Health Partnerships, as well as three key areas for further action.

8.2 Members are invited to consider the appropriateness of these recommendations in light of the views gathered during the stakeholder engagement programme. Subject to the further development and refinement of these, members are invited to endorse this plan for immediate implementation.

**Dr. Bob Masterton**
**Executive Medical Director**
**21 May 2008**

*[Paul Ardin and David Rowland]*

***Appendix 1* – CHP Review – Stakeholder Engagement**

## 1 Background

Between 02 April and 02 May 2008 a number of opportunities have been available for stakeholders to engage with and contribute to the CHP Review. These have included a combination of engagement with and response to written materials; participation in an on-line forum; and sharing views through the recently established video booth.

In addition to this, over 30 stakeholder meetings have been convened, some with open invitations and some targeted at specific staff groups. These meetings have taken a variety of forms, including traditional information sharing with question and answer sessions and less structured engagement events where stakeholders have had the opportunity to share their experience of what makes partnership work.

Finally, Staff-Side Partnership Facilitators have sought to engage with CHP Staff through established meetings and groups. To ensure these discussions were informed by the most up-to-date information and that their outputs, in turn, shaped the direction of the CHP Review, the Staff-Side Partnership Facilitators met with the Director of Primary Care Development on a twice-weekly basis, before and after the Strategic Alliance Meeting.

## 2 Key Themes from Stakeholder Engagement

Through this programme of engagement, stakeholders raised a number of important questions and identified a number of principles to underpin effective partnership working. These are presented below:

### 2.1 Stakeholder Questions

#### *2.1.1 The Need for Change*

A key recurring theme from engagement has been why there is a need for change in the role, function and structure of CHPs. This has been coupled with a high degree of anxiety that staff within the CHPs have been perceived to have failed in the delivery of new ways of working. All of this has been compounded by a sense of frustration around the purpose of the change process if the delivery of frontline services remains largely unchanged.

Stakeholders now understand that there was broad agreement at the inception of CHPs that their structures would be reviewed. Furthermore, there appears to be acceptance and understanding that the key driving force behind the emerging changes relates to a desire to improve the interaction between healthcare sectors and health and social care.

Furthermore, assurance has been given that there is a clear recognition that the source of dissatisfaction with these areas of interaction does not rest with CHP Staff, rather it reflects the need for more senior management and improved leadership between organisations and the constituent parts.

Linked to this, those involved in the CHP Review have clarified that the remit at this stage only extends to defining the structures required to improve partnership working and that this, in effect, would lay the foundations for potential service change at a later date.

### *2.1.2 The Engagement Process*

Many questions were asked about the engagement process itself, with particular concerns being expressed about the involvement and engagement of General Practitioners and other Independent Contractors; Local Authority colleagues; and the Voluntary Sector.

Reassurance has been given that dedicated arrangements were put in place to engage with Independent Contractors through the professional committee route, complementing this with meetings with General Practitioners at a locality level.

Furthermore, stakeholders were advised that Local Authority colleagues had been advised of the programme of staff engagement and were able to participate in this. Indeed, additional arrangements were put in place to host staff engagement sessions within Local Authority premises to aid staff involvement from that sector.

Finally, the arrangements for engagement with the Council for Voluntary Organisations in each Local Authority area, as well as on Arran, were described to stakeholders. Engagement at that level has secured joint agreement to hold a CVO Summit in Ayrshire and Arran to establish how the Councils may work together in the future and how they will engage with the emerging CHP Structure.

### *2.1.3 Links with Refocusing*

Many stakeholders have expressed concerns about the magnitude of change being undertaken at the same time. Individuals questioned how the CHP Review can deliver its key recommendations when the final configuration of services resulting from the Refocusing exercise is yet to be finalised. In addition to this, line management arrangements for a large number of CHP Staff will change as a result of Refocusing, creating a high degree of uncertainty for those involved. Furthermore, a number of stakeholders have highlighted that they are likely to be affected by not only the CHP Review and Refocusing, but also by the move to single system working within specific service areas.

Stakeholders have been reassured that the CHP Review is remitted to develop a direction of travel to improve partnership working and that this will complement other aspects of change currently underway within the local NHS System. Furthermore, there have been lengthy discussions with regard to how Refocusing, and the associated move towards integrated patient pathways, can help address a key objective of the CHP Review, in terms of improving the primary-secondary care interface.

There is, however, a recognition that the successful delivery of the direction of travel set out by the CHP Review is dependent on an integrated, co-operative approach to service planning, management and delivery across the newly formed Directorates; and the further development of detailed structures for CHPs under the relevant Healthcare Director.

### *2.1.4 Delivering the Required Change*

Linked to this, stakeholders have naturally expressed concerns about how the changes recommended by the CHP Review would be progressed. Specifically, questions have been asked about how staff affected by the changes will be supported; whether account would be taken of the indirect impacts on staff; and whether there is the will and determination to deliver the cultural and behavioural change required to support the proposed conceptual changes.

Stakeholders have been assured that the Organisational Change Policy is in place to guide staff, managers and staff-side colleagues through the change process, ensuring the interests of all staff are fully protected. In addition to this, the Partnership Facilitators have described their role in the engagement process as one that focuses on protecting the rights and interests of affected staff.

Furthermore, and in relation to delivering the necessary cultural changes, the newly formed Strategic Alliance has been cited as a key source of leadership and guidance within and between the respective organisations, with a vital role to play in delivering the recommended changes.

### *2.1.5 The Future of Locality Based Services*

Stakeholders fully recognise the benefits associated with locality-based care and questioned the extent to which it will be possible to tailor services to local need if they are managed centrally through Refocusing. In addition to that, significant concerns have been expressed about the potential for centralised decision-making within the new Directorates to impact adversely on the strong partnership relationships that have been developed at a locality level. Finally, there were many questions as to where and how specific services, such as Health Improvement, would be configured in the future

Stakeholders have been assured that while responsibility for service provision will be different in the future, this will focus on ensuring consistency of service standards across Ayrshire and Arran to avoid inequities or health inequalities and that this should not jeopardise the planning, management and provision of services tailored to local need.

Linked to this, those engaging with stakeholders have shared a consistent message that the Refocused structure is designed to develop integrated patient pathways that require sound partnership relationships at all levels to be nurtured and developed. Indeed, those leading the engagement process have sought to provide assurance that if the newly formed structure prohibits or adversely impacts on the partnership relationships that have been established at locality level, then it will have failed to deliver the new culture of service planning and delivery that it promised.

Finally, those leading the engagement process have acknowledged that, at this stage, it is not possible to provide a definitive answer as to the configuration and placement of services such as Health Promotion but have agreed that these issued should be resolved as a matter of priority subject to the NHS Board's endorsement of the direction of travel.

### *2.1.6 The Emerging Structures*

The final key set of questions emerging from the stakeholder engagement programme has centred on the fine detail of the role, remit and composition of the groups within the proposed structure, as well as how they will link together.

Those involved in the engagement process acknowledged stakeholder frustration about the lack of detail and explained that this process was different to previous consultation activities, in that views were being sought on what a structure should look like, rather than on a draft structure. Staff responded positively to this and provided a clear indication of what they viewed as being crucial to effective partnership working.

## 2.2 Principles for Effective Partnership

### *2.2.1 Composition of and Relationship Between Structures*

Stakeholders view the structures in place to support partnership working as being crucial to its successful development. At the heart of this, lies a desire to see the right people around the right table at the right time to identify and address the issues impacting on service provision.

In addition to this, stakeholders have recognised the need to good linkages between the constituent parts of the structure, with cross-representation where it is appropriate and is likely to add value. Alongside this, there has been a recognition of the need for clarity around who, how and where the agenda is set for each element of the structure and how it is then held to account for delivering this by the other groups.

Underpinning all of this is the desire expressed by stakeholders to see decisions being made by these structures in an open and transparent manner.

### *2.2.2 Building on good practice at practitioner level*

Throughout the engagement process, those involved have heard about examples of partnership in action at a local level, where practitioners share resources, skills and expertise to meet the complex care needs of their clients.

Stakeholders are supportive of the principle of bottom-up partnership building and development, with this good practice influencing how partnerships are developed between health and Local Authorities at management and corporate levels.

The structures emerging from the CHP Review must therefore be supportive of this and provide the means of sharing good practice both horizontally and vertically within and between the organisations involved.

### *2.2.3 Co-location / Joint Premises*

Citing examples of good practice, such as the North West Resource Centre in Kilmarnock, stakeholders highlighted the benefits of working from the same location as colleagues from partner agencies.

It is recognised that the ability to engage directly and on a face-to-face basis with colleagues from other services not only improves the level of understanding of roles, experience and skills but also naturally enhances the ability and likelihood of staff to work together.

While the CHP Review was not remitted to specify how, where and when such arrangements could or should be put in place, its consideration of how to improve partnership arrangements should reflect the benefits identified by stakeholders in terms of co-location and joint premises.

### *2.2.4 Shared Records and Integrated IT*

Similar to the issue above, stakeholders identified the limitations imposed by service or sector specific patient/client records and information systems prohibits the further development of partnership working.

Citing the example of the FACE system in Mental Health Services, where a wide variety of practitioners involved in the provision of treatment and care can access the relevant aspects of the client record, stakeholders identified the benefits of access to and recording within a shared case record.

While the ability to deliver this may be some way off, the benefits identified by stakeholders are such that the CHP Review should a least lay down a marker for further exploration of short-, medium- and long-term options for shared records.

Similarly, the lack of a shared or integrated information system was identified as establishing barriers to successful partnership working.

### *2.2.5 Develop joint budgets to deliver health and social care services*

Many stakeholders indicated a belief that the key to successful partnership working would be to establish joint budgets, with associated joint management arrangements.

This fits with the one of the key aspirations identified early within the CHP Review, namely the development of Health and Social Care Partnerships.

There is therefore an expectation that a commitment to move in the direction of increased joint budgetary and management arrangements would be reflected in the proposals for new CHP structures.

## 3 Incorporating Stakeholder Views

The views of stakeholders have, as far as possible, been incorporated into the final set of recommendations from the CHP Review. Board Members should therefore consider the recommendations in light of the views that have been expressed and satisfy themselves that they accurately and appropriately reflect the principles identified as being central to the development of partnership working.

***Appendix 2 - Diversity and Equality Impact Assessment Form for NHS Ayrshire and Arran Board***

| | | | |
|---|---|---|---|
| **Title:** | CHP Review | | |
| **Department:** | Primary Care Development | **Author:** | P Ardin,<br>Director of Primary Care Development<br>D Rowland,<br>Interim Assistant Director (Access and Capacity) |
| **Person(s) Reviewing:** | P Ardin<br>D Rowland | | |
| **New or Existing Policy:** | New | | |
| **Reviewing Date** | May 2013 | **Date Created:** | 06 May 2008 |

**Relevance to General Duty:**

| | |
|---|---|
| **Eliminate Unlawful Racial Discrimination** | Positive Impact |
| **Promote Equality of Opportunity** | Positive Impact |
| **Promote Good Relations Between People of Different Racial Groups** | No Impact |
| **Data / Research Considered** | None |
| **Performance Review** | |

**Relevance to Other Diversity Issues:**

| | |
|---|---|
| **Disability Discrimination Act (2000)** | Positive Impact |
| **Gender** | Positive Impact |
| **Sexual Orientation** | Positive Impact |
| **Older and Younger People** | Positive Impact |
| **Religious and Faith Issues** | Positive Impact |
| **Recommendations** | CHPs will unite all stakeholders in a locality partnership with the aim of improving the health, social care and healthcare of local populations. |
| **Action Taken or Further Action Required** | Monitoring and evaluation of the new structures and associated processes will determine the extent to which the anticipated positive impacts have been realised. |

**Appendix 3**

## Draft Terms of Reference Community Health Partnership Committee

### 1. Introduction

1.1 The North/South/East Ayrshire Community Health Partnership (CHP) Committee is identified as a committee of NHS Ayrshire and Arran and reports to the North/South/East Council structure. The approved Terms of Reference and information on the composition, and the frequency of the committee, will be in accordance with the, the Community Health Partnership (Scotland) Regulations 2004 (SSI 2004 386) and the extant NHS Ayrshire and Arran CHP Scheme of Establishment approved by Ministers**.**

1.2 The committee will be known as the North/South/ East Ayrshire Community Health Partnership (CHP) Committee

1.3 The vision for Community Health Partnerships is that

*CHPs will unite all stakeholders in a locality partnership with the aim of improving the health, social care and healthcare of local populations.*

The vision should lead to:

- *Local people having the healthiest lives possible;*
- *Integrated health promotion activities, healthcare and social care services; and*
- *Reduction in inequalities, protection of the vulnerable, and services tailored to local needs.*

The principal mechanism to measure the extent to which this vision and its associated impact deliver the anticipated outcomes will be the Single Outcome Agreement.

### 2. Remit

2.1 To provide assurance to the NHS Board and North/South/ East Local Authority that systems, procedures and resources are in place to monitor, manage and deliver on the key outcomes identified for CHPs, as specified in paragraph 1.1 of the CHP Scheme of Establishment taking cognisance of current policy, including:

- Shifting the balance of care to more local settings,
- Reducing health inequalities,
- Improvement in the health of local people
- Responsibility for integrated working between Health and the Local Authority
- The interface of the Single Outcome Agreement, Community Plan, JHIP

2.2 To monitor the delivery aspects of the Single Outcome Agreement as specified

2.3 To approve the contribution of CHP Officer Locality Group to the Local Delivery Plan and similar.

2.4 To ensure a successful partnership between the various stakeholders described in the CHP Scheme of Establishment.

2.5 To provide assurance to the NHS Board and North/South/East Local Authority that the CHP is working within the CHP Scheme of Delegation as approved by the NHS Board and respective Local Authority.

## 3. Committee Membership

3.1 The Committee will be established as a Committee of NHS Ayrshire and Arran and the North/South/East Local Council structure, and be comprised of the following members:

- The NHS Board Member nominated by North/South/ East Local Authority who will Chair the meeting
- Three other North/South/East Local Authority elected members
- Three other members from NHS Ayrshire and Arran who would be a Non-Executive member, an Executive member with a clinical remit, and an Executive member with a non-clinical remit.

## 4. Quorum

Four members will constitute a quorum with at least one member from Health and the Local Authority.

## 5. Attendance

5.1 The Partnership Facilitator will attend the Committee in accordance with

the remit of that post.

5.2 With the prior approval of the Chair, officers of NHS Ayrshire and Arran, will be able to provide deputies on an exceptional basis.

## 6. Frequency of Meetings

6.1 In general this will be on a bi-monthly basis, with a minimum of four meetings per annum.

6.2 The Chair may at any time convene additional meetings of committee.

## 7. Authority

7.1 Committee is authorised to:

- Investigate matters which fall into its Terms of Reference;
- Form sub-groups to support its functions;
- Seek and obtain information as required to carry out the function of the partnership taking account of policy and legal rights.

## 8. Duties

8.1 The committee will have oversight to ensure systems are in place for children and adults to address current and future priorities and the delivery of the key outcomes as detailed in the Statutory Guidance and Scheme of Establishment, specifically:

- 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 the local actions taken by key partners to improve health.
- Improve access to services by increasing the level of joint service provision and co-location of services.
- Increase the quality of care through the systematic implementation of more evidence based care and multi-disciplinary guidance and protocols.

- Increase the number of single points of access for all community based services.

- Reduce the time taken to agree care packages by extending single shared assessments.

- Reduce the number of delayed discharges from hospitals through increased provision of rehabilitation services, rapid response teams and other similar interventions.

- 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.

- Decrease the number of inappropriate hospital visits by improving the quality of referrals to consultants and increasing the skills of community practitioners.

- Management of waiting times for in-patient and out-patient services more effectively by using their understanding of local demand to influence and adjust the supply and/or design of services.

8.2 In addition, the committee will address locally identified priorities as described in the Single Outcome Agreement, Integrated Children's Service Plan and other integrated service planning.

8.3 The committee will also be responsible for ensuring that appropriate systems and procedures are in place to monitor and manage the performance of the Partnership and for delivering against agreed outcomes and actions in accordance with the Scheme of Delegation from NHS Ayrshire and Arran and the North/South/East Local Authority.

## 9. Conduct of Business

9.1 Meetings of committee will be called by the Chair of the Committee.

9.2 In the absence of the Chairperson, members of the Committee will nominate a member who is not an Officer of either the NHS Board or Local Authority to chair the meeting.

9.3 The Agenda and supporting papers will be sent to members at least five working days before the date of the meeting.

9.4 The meetings will not be held in public.

## 10. Reporting Arrangements

10.1 Minutes will be kept of the proceedings of the committee and these will be circulated in draft, normally within five working days to the Chair of the Committee, and within five working days thereafter to members prior to consideration at the subsequent meeting of the Committee.

10.2 The Chair of the Committee shall provide assurance on the work of the Committee and the unapproved minutes will be submitted to the NHS Board and North/South/East Council structure.

10.3 The Committee will work within the performance management framework jointly determined by the NHS Board and respective Local Authority

10.4 Items requiring urgent attention by the NHS Board and North/South/East Local Authority can be raised at any time at the Committee meeting, subject to the approval of the Chair.

10.5 No member of Committee will make any official statement in public or to the Press relating to the work of the CHP Committee without prior consultation with the Chairperson of the CHP Committee.

**Appendix 4**

**Draft Terms of Reference**
**Community Health Partnership Sub-Committee - Forum**

## 1. Introduction

1.1 The North/South/East Community Health Partnership (CHP) Sub-Committee is identified as a Sub-Committee of the North/South/ East CHP Committee. The approved Terms of Reference will be in accordance with the Terms of Reference of the parent Committee.

1.2 The CHP Sub-Committee will be known as the North/South/East Community Health Partnership (CHP) Forum

1.3 The vision for Community Health Partnerships is that

*CHPs will unite all stakeholders in a locality partnership with the aim of improving the health, social care and healthcare of local populations.*

The vision should lead to:

- *Local people having the healthiest lives possible;*
- *Integrated health promotion activities, healthcare and social care services; and*
- *Reduction in inequalities, protection of the vulnerable, and services tailored to local needs.*

The principal mechanism to measure the extent to which this vision and its associated impact deliver the anticipated outcomes will be the Single Outcome Agreement.

## 2. Remit

2.1 To provide the CHP Committee with expert advice and views of frontline staff, stakeholders, the public and voluntary sector.

## 3. Membership

3.1 The Sub-committee will be established by the CHP Committee, and be comprised of the following members as a minimum, additional members will be for local determination:-

A member of the CHP Committee who will chair the Sub-committee
A Healthcare Director or representative
A Medical Practitioner who is not a General Practitioner
Nurse
Allied Health Professional
An accredited representative of staff within the locality from Health
A Local Authority representative
General Medical Practitioner
Dentist
Optometrist
Pharmacist
Two representatives from the Public Partnership Forum
One representative from the voluntary sector (with the exception of NA CHP which will have an additional representative from Arran)
A representative from Public Health
A clinical representative from Mental Health Services.

3.2 The term of office of a member of the Sub-committee will be three years with the exception of officers of NHS Ayrshire and Arran or the Local Authority partners who are members by virtue of their post.

3.3 The method of appointing members is as follows:

For professional representatives (doctor, nurse, allied health professional, general medical practitioner, dentist, optometrist and pharmacist) these should be practitioners working in the locality who will be nominated by their Professional Advisory Committee.
The staff member from Health will be nominated by the Area Partnership Forum. Other members are nominated by their respective Directorate/ Organisation

3.4 Members will be able to be re-appointed to the Sub-committee without limit, but under good practice and succession planning, members should expect to sit for a maximum of three terms. There will be an initial phased membership for the first term of office with half of the membership holding office for two years.

## 4. Quorum

4.1 Fifty percent of the membership will constitute a quorum

## 5 Attendance

5.1 The Partnership Facilitator will attend the Sub-committee in accordance with the remit of that post.

5.2 Co-chairs from the officer groups for community care and children will attend the Sub-committee.

5.3 Subject to the approval of the Chair, other officers of NHS Ayrshire and Arran and the Local Authority may attend for specific items of business

5.4 With the prior approval of the Chair, officers of NHS Ayrshire and Arran and the Local Authority may provide deputies on an exceptional basis.

## 6. Frequency of Meetings

6.1 Meetings will be held bi-monthly with a minimum of four meetings per annum

6.2 The meeting cycle will be arranged to ensure that the Sub-committee meets between CHP Committee meetings

6.3 The Chair may at any time convene additional meetings of the Sub-committee

## 7. Authority

7.1 Investigate matters which fall into its Terms of Reference.

7.2 Seek and obtain information as required to carry out remit of Sub-committee, taking account of policy and legal rights.

## 8. Duties

8.1 To provide advice at the CHP Committee's request

8.2 To provide feedback on proposals to the Officer Locality Group

## 9. Conduct of Business

9.1 The meeting will be chaired by a member of the CHP Committee.

9.2 Meetings of the Sub-committee will be called by the Chair of the Sub-committee

9.3 The meetings will not be held in Public

9.4 Papers will be issued at least one week before the meeting

## 10. Reporting Arrangements

10.1 Minutes will be kept of the proceedings of the Sub-committee and these will be circulated in draft, normally within five working days to the Chair of the Sub-committee, and within five working days thereafter to members prior to consideration at the subsequent meeting of the Sub-committee.

10.2 The Chair of the Sub-committee shall report on the work of the Sub-committee and the unapproved minutes will be submitted to the CHP Committee

10.3 Items requiring urgent attention by the CHP Committee can be raised at any time at the Committee meeting, subject to the approval of the Chair.

10.4 No member of the Sub-committee will make any official statement in public or to the Press, relating to the work of the Sub-committee, without prior consultation with the Chairperson of the Sub-committee.

**Appendix 5**

**Draft Terms of Reference**
**Community Health Partnership Officer Locality Group**

## 1. Introduction

The vision for Community Health Partnerships is that:

*CHPs will unite all stakeholders in a locality partnership with the aim of improving the health, social care and healthcare of local populations.*

The vision should lead to:

- *Local people having the healthiest lives possible;*
- *Integrated health promotion activities, healthcare and social care services; and*
- *Reduction in inequalities, protection of the vulnerable, and services tailored to local needs.*

The principal mechanism to measure the extent to which this vision and its associated impact deliver the anticipated outcomes will be the Single Outcome Agreement.

## 2. Remit

2.1 To manage the delivery of services within the North/South/East locality in accordance with partnership agreements. Specifically, these will reflect paragraph 1.1 of the CHP Scheme of Establishment and current policy and priorities across the partnership.

2.2 To manage the delivery of relevant aspects of the Local Delivery Plan and Community Plan and Single Outcome Agreement, as specified within the locality.

2.3 To ensure arrangements are in place within the locality to facilitate successful partnership between the various stakeholders as described in the Scheme of Establishment.

2.4 To report on the key performance indicators of the partnership within the locality to the CHP Committee.

## 3. Membership

3.1 Representatives will be nominated from NHS Ayrshire and Arran and the North/South/East Local Authority by merit of the post held within the respective organisations. An organisational map reflecting the arrangements is provided at Annex A for reference.

3.2 Members are expected to nominate a deputy with the appropriate level of authority to take forward the work of the group in their absence.

Core Membership for Community Care Group

There will be one representative for each of the following services

<table>
<tr><td>NHS</td><td>Local Authority</td></tr>
<tr><td>Mental Health Services</td><td>Community Care Adult Services</td></tr>
<tr><td>Older Peoples Services</td><td>Community Care Older People</td></tr>
<tr><td>Health Promotion</td><td rowspan="2">Housing, regeneration, lifelong learning and leisure services</td></tr>
<tr><td>Primary Care Development</td></tr>
<tr><td>Others as determined</td><td>Others as determined</td></tr>
<tr><td colspan="2">Partnership Facilitator post</td></tr>
</table>

There will be a similar arrangement for Children's Services

## 4. Quorum

4.1 To be determined by the membership.

## 5. Frequency of Meetings

5.1 Meetings will be held on a six weekly cycle

## 6. Accountability

6.1 The CHP Officer Locality Group will be accountable to the CHP Committee for managing the delivery of the key outcomes identified within the locality for Community Health Partnerships as specified in paragraph 1.1 of the CHP Scheme of Establishment and extant guidance.

6.2 The CHP Officer Locality Group may seek advice from the CHP Forum on the views of staff, stakeholders, public and voluntary sector.

6.3 Matters relating to pan Ayrshire business will be forwarded to the Strategic Alliance.

6.4 Matters which cannot be resolved within the CHP Officer Locality Group will be passed to the Strategic Alliance for advice, guidance or resolution depending on the subject matter.

## 7. Conduct of Business

7.1 The Group will be jointly chaired by health and local authority officers.

7.2 The meetings will not be held in public

7.3 Papers will be issued at least one week before the meeting.

7.4 Items requiring the urgent attention of the Group may be circulated for advice and any agreements made will be homologated at the next meeting of the CHP Officer Locality Group.

7.5 The work of the Group will be supported by the administrative support for the Partnership Facilitator.

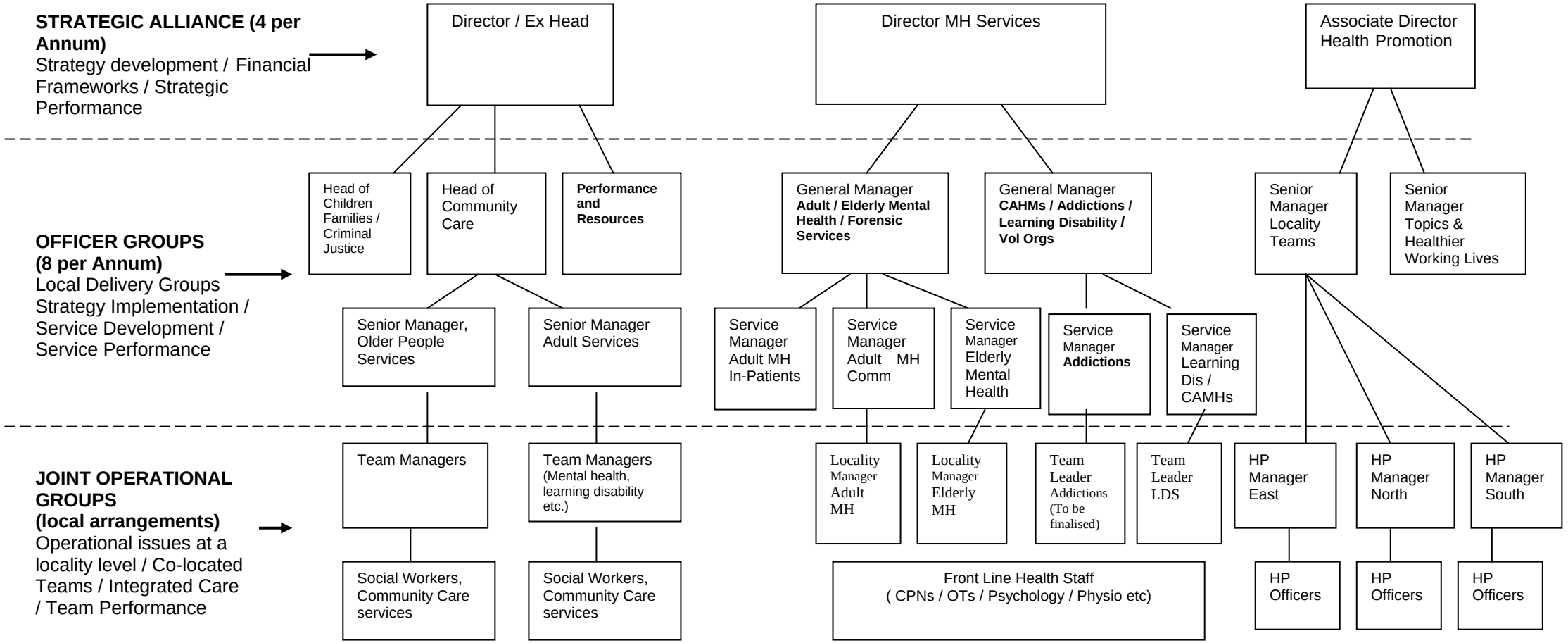
## 8. Reporting arrangements

8.1 Draft minutes will be prepared, normally within five working days and circulated to members.

8.2 Reports will be made to the CHP Committee on the work of the Group in pursuit of its remit.

8.3 Reports will be made to the Strategic Alliance on the progress of matters referred to the Group from the Strategic Alliance.

## Appendix 5 – Annex A - Organisational Map of Social Work, Mental Health Services and Health Promotion Structures




Primary Care and
Health Care Directors to be added
There will be similar arrangements for Children's Services