Paper 2

Proposal for Community Health Partnerships self-assessment process

Background

Community Health Partnerships (CHPs) were set up in 2004 under regulations and guidance from the Scottish Government following a 2003 commitment from all parties in the Scottish Parliament. Subsequent guidance and policy directives are summarised in the document at Appendix 1.

Following a comprehensive review, the three Ayrshire CHPs were transformed from traditional management units and a model developed with partners in 2008. The Schemes of Establishment of the refreshed CHPs set out clear guidance for measuring their success; they were to focus on three overarching priorities, namely:

1. Shifting the Balance of Care;
2. Tackling health inequalities; and
3. Improving health and wellbeing.

This focus was strengthened by stating explicitly that the measure of success of the CHPs would be their delivery of the health elements of the Single Outcome Agreements (SOA) and their contribution to the delivery of other SOA commitments.

Since 2008, a number of assessments of the three CHPs have taken place (such as the NHS internal audit of CHP Performance Management), but the publication of the Audit Scotland (AS) *Review of Community Health Partnerships* and its associated self-assessment checklist for CHPs in June 2011 offered an opportunity further to consider the progress of the organisations, even though the unique nature of the 'Ayrshire Model' meant that it was hardly addressed in the document.

As a result, the Chief Executives of East, North and South Ayrshire councils and NHS Ayrshire and Arran met to discuss the Audit Scotland (AS) review of Community Health Partnerships (CHPs). It was agreed that an enhanced self-assessment would be developed incorporating the checklist proposed by Audit Scotland but ensuring that the partnerships have a 'more challenging' assessment than would be provided by the AS checklist alone. In particular, the enhanced self-assessment must both reflect the direction of travel indicated by the report of the Christie Commission - with its emphasis on a shift to preventative spending, integration and increased focus on tackling inequalities - and anticipate any further guidance from the Scottish Government in relation to closer integration of public services. Accordingly, this paper sets out:

- A proposed enhanced self-assessment;
- A process and timescale to manage the self-assessment across partners;
- A flow-chart outlining the governance procedures for the findings; and
- A system of monitoring and reporting progress against the baseline position identified by this process.

Self-assessment

Audit Scotland's self-assessment focuses on the areas that were identified subsequent to the review of CHPs. It identifies 20 questions for partnerships in two areas, Governance and Use of Resources. These questions are listed at Appendix 2.

It is clear from these questions, that the self-assessment is primarily intended to test the robustness of the partnership arrangements as opposed to focusing solely on the CHPs. Furthermore, while they reflect, they do not entirely address the recommendations of the AS review that can be summarised as:

- Streamlining partnership arrangements;
- Increased transparency in governance and accountability;
- Development of joint strategies;
- Defined objectives and performance management arrangements;
- Improved collection and monitoring of data on cost, staff and activity;
- Improved financial governance and reporting; and
- Greater involvement of GPs and other clinical professionals.

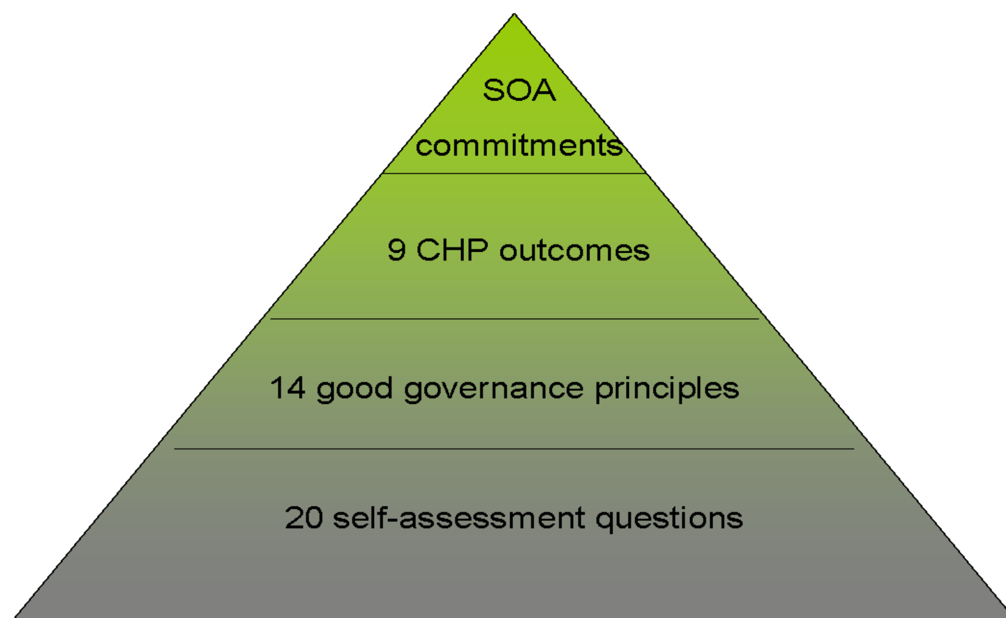
Further to these, the AS review also outlined the 'Key Principles' of good governance for partnership working. These 14 principles, under four headings of Behaviours, Processes, Performance Measurement and Management and Use of Resources (listed at Appendix 3), have some overlap with the self-assessment but probably complement it. Therefore, it would seem to be appropriate to include this as part of the enhanced self-assessment process.

In addition, it is, perhaps, timely to revisit both the Ayrshire definition of success as outlined above and the original 9 outcomes that CHPs were set up to deliver as set out in the 2004 Statutory Guidance. These can be defined as:

- Improve specific health outcomes;
- Enable hospital discharge and rehabilitation;
- Provide more local diagnosis and treatment;
- Prevent avoidable hospital admissions;
- Improve health and tackle inequalities;
- Support people at home;
- Take a systematic approach to long-term conditions;
- Provide better access to primary healthcare services; and
- Provide anticipatory care (i.e. provide preventative services).

As can be seen from the above, there is the potential to create a self-assessment 'industry' that would not necessarily provide robust assurance to the various governance groups and, perhaps more importantly, the public that CHPs are delivering to the best of their abilities. However, using the principles of logic modelling that are now embedded in practice across all three partnerships, it is possible to develop a model that will incorporate all of these different elements while not imposing too great a burden on the partnerships. This model is given at Figure 1 below.

Figure 1: Model for enhanced self-assessment of CHPs



Consequently, it is proposed that the enhanced self-assessment incorporates a series of questions around the following four areas:

1. How successfully have CHPs delivered the health commitments of the SOAs;
2. Can the CHPs evidence improvement against the original 9 outcomes identified in the Statutory Guidance;
3. How does the CHP measure up against the 14 Key Principles of good governance for partnership working; and
4. How does the CHP rate itself using the 20 self-assessment questions from the AS Checklist.

Time pressures have meant that the proposed Task and Finish Group (T&FG) has not met in advance of the submission of this draft; however, the involvement of each partners' performance staff and others will be crucial to the analysis and understanding of the product of the self-assessment and monitoring and reporting of progress against subsequent action plans.

Process

Both the AS review and the Christie Commission Report emphasise the importance of CHPs reflecting a 'bottom-up' approach to partnership working. The Ayrshire Model already has this at the heart of its working with its structures having what is possibly a unique body in the CHP Forum. To ensure the continuation of this focus on stakeholders, it is crucial that the self-assessment is carried out by as many people as possible who are involved in the CHP and its outcomes.

Therefore, it is proposed that the four-tier self-assessment should be undertaken by individuals from the CHP Committees, CHP Forums and Officer Locality Groups. The self-assessment will be developed into an online questionnaire (using a tool such as SurveyMonkey) but will also be available in paper form. Completed responses will be analysed and reported on confidentially but should not be anonymised as useful information can be gained from knowing, for example, the respondent's partner body, professional background and/or gender. Following best practice in such assessments, the online tool should be piloted with a number of individuals from each of the CHPs to ensure ease of use and analysis. Time pressures may mean that this is not practicable.

Subsequent to the completion of the self-assessment element, good practice would again suggest a follow-up with randomly-selected individuals and a number of focus groups to test the findings of the self-assessment. Once again, pressures of time may make this part of the process difficult to deliver and it is may be, therefore, that the identified independent facilitators from each partner are used to deliver this part of the process, rather than attempting to get all stakeholders together to complete the self-assessment at the same time.

For the Task and Finish Group adequately to oversee the process, the membership should reflect the CHPs and partners but be chaired by an independent person who has not been directly involved in operational management of either. The proposed membership is, therefore:

Assistant Director, Performance (NHS) Chair
3 CHP Facilitators
3 Local Authority performance officers
6 identified facilitators

To ensure pace, it is not proposed to develop extensive role and remit documentation for this group as its work is entirely to deliver this proposal.

Timescales

As noted, timescales are tight if the proposed completion date of November 2011 is to be met, however, the following is a suggested timeline:

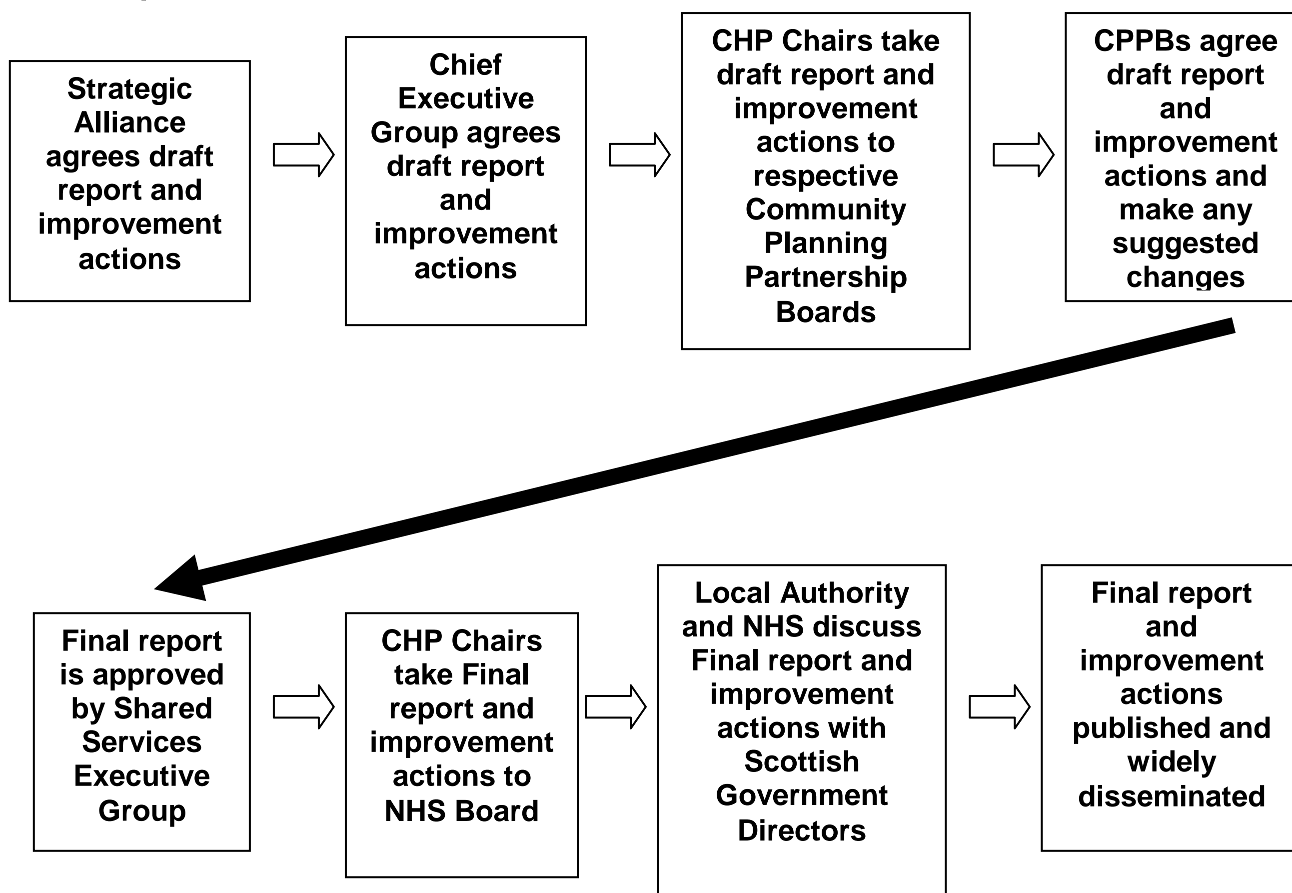
Date	Action	Responsibility
24 August	Complete draft proposal and self-assessment	Linda Semple (LS)
25 August	Agree T&FG membership self-assessment, and process for completion	Strategic Alliance (SA)
Early September	Initial T&FG meeting	LS
End September	Self-assessment link sent out to all participants with information on paper version	T&FG
Early October	Preliminary analysis of self-assessment	T&FG
November 17th	Draft report (including proposed improvement actions) submitted to Strategic Alliance	T&FG
December/January	Report taken through individual Community Planning structures and NHS Board	CHP Facilitators

Governance

The Shared Services Executive Group (SSEG) suggested a governance route for the report and improvement actions from the self-assessment process. This is summarised at Figure 2 below. It seems unlikely that this route will be completed within the timescales, given the dates of the relevant committees.

Another approach would be to conflate the governance process if it were acceptable to circulate the report outwith the scheduled meetings. Alternatively, it may be necessary to remove some steps in the process.

Figure 2: Governance process as outlined by Shared Services Executive Group



NB: At its meeting on August 25th the Strategic Alliance agreed that this process would be conflated into the process outlined under 'Timescales' (above).

Monitoring and reporting

All partners across Ayrshire have their own process for monitoring and reporting performance. However, considerable progress has been made in developing joint performance management approaches to the Single Outcome Agreements and it is proposed that delivery of the outcomes from this proposal is monitored as part of this process.

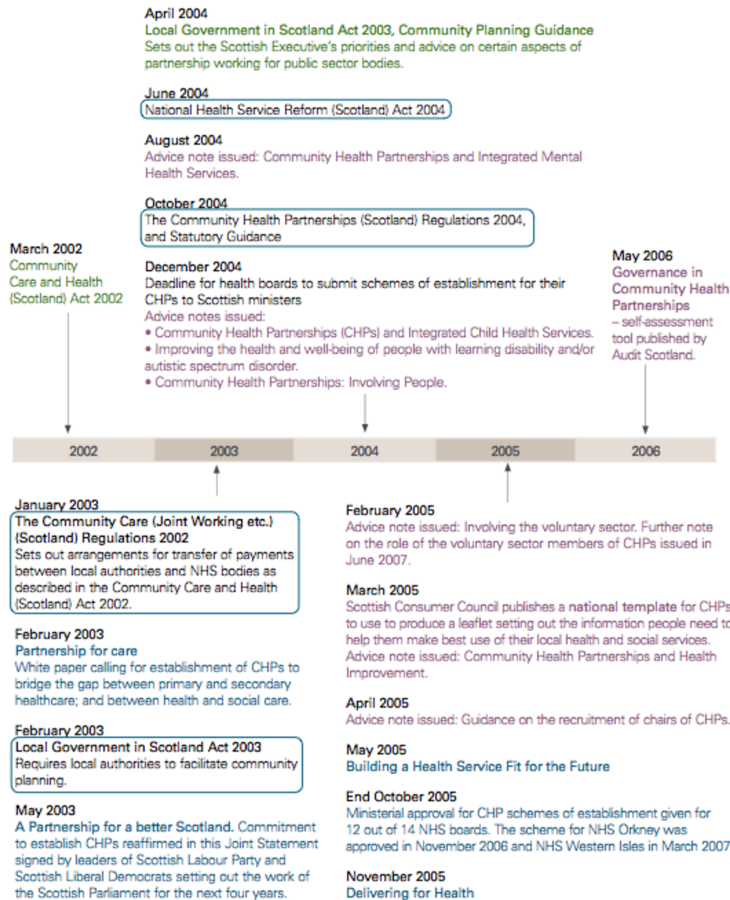
It is recommended that the Task and Finish Group take responsibility for developing procedures for the ongoing monitoring and reporting of the delivery of the improvement actions. This will build on and strengthen the current activity around joint performance management, particularly in relation to the use of shared and/or compatible electronic systems.

Conclusion

The Ayrshire Model of CHPs has been in existence for almost three years. While there is a requirement to undertake the Audit Scotland Self-assessment, it would be a missed opportunity if partners did not enhance the approach to using the self-assessment in order more robustly to gather information on the success or otherwise of the CHPs in delivering the outcomes they were set up to achieve.

The process outlined in this paper will, if agreed, ensure richer information on the CHPs' – and wider partnerships' – achievement of outcomes, provide a robust baseline against which to set challenging improvement actions, measure progress against these actions and provide assurance that future monitoring and reporting of that progress will be aligned along appropriate governance structures.

Linda Semple
Assistant Director, Performance, NHS Ayrshire and Arran
20 August 2011



Policy summary

March 2002
Community Care and Health (Scotland) Act 2002

April 2004
Local Government in Scotland Act 2003, Community Planning Guidance
Sets out the Scottish Executive's priorities and advice on certain aspects of partnership working for public sector bodies.

June 2004
National Health Service Reform (Scotland) Act 2004

August 2004
Advice note issued: Community Health Partnerships and Integrated Mental Health Services.

October 2004
The Community Health Partnerships (Scotland) Regulations 2004, and Statutory Guidance

December 2004
Deadline for health boards to submit schemes of establishment for their CHPs to Scottish ministers
Advice notes issued:
- Community Health Partnerships (CHPs) and Integrated Child Health Services.
- Improving the health and well-being of people with learning disability and/or autistic spectrum disorder.
- Community Health Partnerships: Involving People.

May 2006
Governance in Community Health Partnerships – self-assessment tool published by Audit Scotland.

2002 | 2003 | 2004 | 2005 | 2006

January 2003
The Community Care (Joint Working etc.) (Scotland) Regulations 2002
Sets out arrangements for transfer of payments between local authorities and NHS bodies as described in the Community Care and Health (Scotland) Act 2002.

February 2003
Partnership for care
White paper calling for establishment of CHPs to bridge the gap between primary and secondary healthcare; and between health and social care.

February 2003
Local Government in Scotland Act 2003
Requires local authorities to facilitate community planning.

May 2003
A Partnership for a better Scotland. Commitment to establish CHPs reaffirmed in this Joint Statement signed by leaders of Scottish Labour Party and Scottish Liberal Democrats setting out the work of the Scottish Parliament for the next four years.

February 2005
Advice note issued: Involving the voluntary sector. Further note on the role of the voluntary sector members of CHPs issued in June 2007.

March 2005
Scottish Consumer Council publishes a national template for CHPs to use to produce a leaflet setting out the information people need to help them make best use of their local health and social services.
Advice note issued: Community Health Partnerships and Health Improvement.

April 2005
Advice note issued: Guidance on the recruitment of chairs of CHPs.

May 2005
Building a Health Service Fit for the Future

End October 2005
Ministerial approval for CHP schemes of establishment given for 12 out of 14 NHS boards. The scheme for NHS Orkney was approved in November 2006 and NHS Western Isles in March 2007.

November 2005
Delivering for Health

February 2007
The Scottish Government issues the Community Health Partnership Long-Term Conditions Self Assessment Toolkit. All CHPs are expected to use the toolkit and develop an Action Plan to ensure services and care are integrated, responsive and of high quality.

April 2007
Scotland Performs – A National Performance Framework

August 2007
Advice note issued: Governance for Joint Services: Principles and Advice.

November 2007
Concordat between the Scottish Government and local government

December 2007
Better Health, Better Care action plan. Sets out five-year programme of work for the NHS in Scotland. CHPs will increasingly be expected to shift the balance of care. Commits the Government to developing an integrated resource framework to extend the responsibility and accountability of CHPs for delivering better outcomes by ensuring that resources follow the patient.

Key
- Key legislation and statutory guidance
- Other relevant policies and legislation
- Scottish Government reports and action plans
- Advice notes and other (non-statutory) guidance

June 2009
Health Improvement and Community Health Partnerships advice note. Summarises current policy context, background to Single Outcome Agreements approach to community planning, and need for partnership working.

July 2009
Shaping the Future of Care Together, Green Paper. Sets out a vision for a new care and support system across England. The Scottish Government, NHS and COSLA establish a programme of eight primary workstreams to develop ways of reshaping care and support services.

September 2009
First meeting of the Integrated Resource Framework Programme Board set up to oversee the development of the IRF.

2007 | 2008 | 2009 | 2010

June 2008
Equally Well: Report of the Ministerial Task Force on health inequalities. Sets out 78 recommendations for reducing health inequalities.

December 2008
Equally Well implementation plan describes how the recommendations of Equally Well will be turned into action. Gives responsibility for progress to Community Planning Partnerships through the Single Outcome Agreements but acknowledges the 'critical role' of CHPs.

May 2010
NHSScotland Quality Strategy – putting people at the heart of our NHS.
Identifies the need for effective joint working between health and social care to move more services from hospitals to the community.

August 2010
Delivering Quality in Primary Care National Action Plan setting out how the NHS will deliver quality primary care over the next five years.

October 2010
Self-Directed Support National Strategy giving people control over how their individual budget is used to meet their care needs.

November 2010
Scottish Government announces £70 million Change Fund in 2010/11 budget to shift the balance of health and social care towards primary and community care.

Scottish Government publishes Delivering better outcomes and use of joint resources setting out how it will support further development of CHPs.

Appendix 2

Self-assessment for NHS boards, councils and other partners to improve joint working between health and social care

<table>
<tr><th>Governance</th></tr>
<tr><td>We have carried out a fundamental review of the various partnership arrangements for health and social care in our local area to ensure these are efficient and effective and add value.</td></tr>
<tr><td>We have delivered a programme of education to ensure leaders and staff understand the differences between partners’ governance arrangements, including decision-making processes.</td></tr>
<tr><td>Health and social care planning is integrated within the Community Planning process and CHPs are linked to this framework.</td></tr>
<tr><td>We have agreed a clear joint vision, priorities and strategy for health and social care services which focuses on outcomes for service users, based on an analysis of need.</td></tr>
<tr><td>We have a clear strategy to involve GPs and other health and social care professionals in planning services for the local population, in decisions about how resources are used and work with them to address variation in GP referral and prescribing rates.</td></tr>
<tr><td>We have developed sustainable strategies to address delayed discharges and emergency admissions within the local area and regularly monitor our performance.</td></tr>
<tr><td>We have clearly defined objectives for measuring CHP performance, agree what success looks like and implement a system to report performance to stakeholders. Measures used:
reflect the priorities in the national guidance
enable partners to demonstrate that their actions produce the intended outcomes.</td></tr>
<tr><td>We have up-to-date schemes of establishment for CHPs. As a minimum this:
clearly covers the requirements set out in the statutory guidance for CHPs
is consistent with our corporate governance documents such as standing orders and schemes of delegation, as well as any partnership agreements.</td></tr>
</table>

We have partnership agreements for all integrated or delegated services, including those delegated to the CHP. Agreements cover our respective roles and responsibilities, decision-making and accountability processes. This is underpinned by a comprehensive joint financial framework.
We have a joint financial framework to ensure budgets are devolved or delegated and managed in a transparent and structured way. The joint financial framework is consistent with the CHP's scheme of establishment, partnership agreements and each partner's scheme of delegation.
Accurate and up-to-date schemes of delegation are in place. These include details of specific services and budgets which are delegated to each other to manage, including via the CHP. Financial authorisation levels of individuals or groups are clear.
We systematically collect, monitor and report data on costs, staff and activity levels to help inform decisions on how resources can be used effectively. This should include information on staffing numbers, sickness levels and vacancies.
We ensure partnership financial reports are regularly considered by the CHP, NHS board and appropriate council committees. This should include any information on overspends.
We acknowledge and have a joint system for identifying and managing risks associated with partnership working.
We have clear policies and procedures which are consistently applied for appointing and managing joint staff. Policies cover arrangements for dealing with differences in employment terms and conditions for staff working in integrated teams. Managerial and professional lines of accountability are clear for all staff.
We have identified and addressed local barriers to sharing information between health and social care staff. This includes: • ensuring that information sharing protocols developed by Data Sharing Partnerships address any specific local issues • adoption of eCare electronic system or ensuring compatibility issues are identified and addressed where eCare is unsuitable • ensuring that Single Shared Assessment forms accurately capture information required to assess and manage risks of those requiring care.
Use of Resources
We have processes in place for identifying, allocating and monitoring resources used to administer joint working.
We have reviewed the scope for and have a plan for achieving efficiencies through sharing assets including staff, buildings, equipment and IT.
We are using the Integrated Resource Framework to help plan how resources are used in the local area.
We always carry out an options appraisal, including an assessment of the costs and benefits before implementing service changes or initiating pilot projects. This includes an assessment of workforce, finance and other resource implications. Decisions on service delivery changes secure value for money.

Appendix 3

Exhibit 5

Good governance principles for partnership working

There are several key principles for successful partnership working.

Key principles	Features of partnerships when things are going well	Features of partnerships when things are not going well
Behaviours		
Personal commitment from the partnership leaders and staff for the joint strategy Understand and respect differences in organisations' culture and practice	• Leaders agree, own, promote and communicate the shared vision • Leaders are clearly visible and take a constructive part in resolving difficulties • Be willing to change what they do and how they do it • Behave openly and deal with conflict promptly and constructively • Adhere to agreed decision-making processes • Have meetings if required but focus of meetings is on getting things done	• Lack of leader visibility in promoting partnership activities (both non-executive and executives) • Be inflexible and unwilling to change what they do and how they do it • Adopt a culture of blame, mistrust and criticism • Complain of barriers to joint working and do not focus on solutions • Take decisions without consulting with partners • Have numerous meetings where discussion is about process rather than getting things done
Processes		
Need or drivers for the partnership are clear Clear vision and strategy Roles and responsibilities are clear Right people with right skills Risks associated with partnership working are identified and managed Clear decision-making and accountability structures and processes	• Roles and responsibilities of each partner are agreed and understood • Strategies focus on outcomes for service users, based on analysis of need • Have clear decision-making and accountability processes • Acknowledge and have a system for identifying and managing risks associated with partnership working • Agree a policy for dealing with differences in employment terms and conditions for staff and apply this consistently to ensure fairness • Review partnership processes to assess whether they are efficient and effective	• Roles and responsibilities of each partner are unclear • Unable to agree joint priorities and strategy • Lack of clarity on decision-making processes • Partnership decision-making and accountability processes are not fully applied or reviewed regularly • Risks are not well understood or managed through an agreed process • Deal with differences in employment terms and conditions for staff on an ad hoc basis

Continued overleaf

Key principles	Features of partnerships when things are going well	Features of partnerships when things are not going well
Performance measurement and management		
Clearly defined outcomes for partnership activity Partners agree what success looks like and indicators for measuring progress Partners implement a system for managing and reporting on their performance	• Understand the needs of their local communities and prioritise these • Have a clear picture of what success looks like and can articulate this • Have clearly defined outcomes, objectives, targets and milestones that they own collectively • Have a system in place to monitor, report to stakeholders and improve their performance • Demonstrate that the actions they carry out produce the intended outcomes and objectives	• Prioritise their own objectives over those of the partnership • Unable to identify what success looks like • Fail to deliver on their partnership commitments • Do not have agreed indicators for measuring each partner's contribution and overall performance or do not use monitoring information to improve performance • Unable to demonstrate what difference they are making
Use of resources		
Identify budgets and monitor the costs of partnership working Achieve efficiencies through sharing resources, including money, staff, premises and equipment Access specific initiative funding made available for joint working between health and social care	• Integrate service, financial and workforce planning • Have clear delegated budgetary authority for partnership working • Identify, allocate and monitor resources used to administer the partnership • Understand their service costs and activity levels • Plan and allocate their combined resources to deliver more effective and efficient services • Assess the costs and benefits of a range of options for service delivery, including external procurement • Have stronger negotiating power on costs • Achieve better outcomes made possible only through working together	• Do not integrate service, financial and workforce planning • Unable to identify the costs of administering the partnership • Deliver services in the same way or change how services are delivered without examining the costs and benefits of other options • Have duplicate services or have gaps in provision for some people • Plan, allocate and manage their resources separately • Fail to achieve efficiencies or other financial benefits • Unable to demonstrate what difference the partnership has made

Note: To download an A3 poster version of this table visit: http://www.audit-scotland.gov.uk/work/health_national.php
Source: Audit Scotland, 2011