



SCOTTISH EXECUTIVE

# **COMMUNITY HEALTH PARTNERSHIPS**

## **DRAFT STATUTORY GUIDANCE**

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## COMMUNITY HEALTH PARTNERSHIPS

### DRAFT STATUTORY GUIDANCE

#### Introduction

1. This paper provides draft statutory guidance on the establishment of Community Health Partnerships (CHPs). It sets the context within which NHS Boards, working in partnership with local authorities and other local agencies, should develop their plans for CHPs. This guidance takes full account of the responses to the consultation paper on CHPs issued in July 2003; a summary of the responses was published in November 2003<sup>1</sup>.
2. The statutory guidance is in draft, as the NHS Reform (Scotland) Bill<sup>2</sup>, which provides the legislative framework for the establishment of CHPs, is still subject to Parliamentary approval. It is intended that NHS Boards will be statutorily required to have regard to this guidance when preparing schemes of establishment for CHPs and it will be finalised following enactment of the Bill.
3. The guidance sets the policy context within which CHPs are to be established and developed and describes the main aims and benefits of CHPs, their intended functions, and aspects of their organisational arrangements.
4. The guidance seeks to strike a balance between describing core requirements, which will be prescribed in statutory instruments made under section 4A(5) of the National Health Service (Scotland) Act 1978, as inserted by section 2 of the National Health Service Reform (Scotland) Bill, and describing criteria against which Scottish Ministers can judge proposals for the establishment of CHPs.
5. There has been widespread support for the development of CHPs as a key building block in the modernisation of NHS and joint services, with a vital role in partnership,

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<sup>1</sup> Responses on Community Health Partnerships <http://www.show.scot.nhs.uk/sehd/chp/Pages/responses.htm>



integration and service design. The guidance recognises that models will evolve according to local circumstances, but that there are minimum requirements for devolving appropriate resources and responsibilities for decision making to frontline staff which should be met everywhere.

## Context

6. The background to the development of CHPs is contained in the White Paper *Partnership for Care*<sup>3</sup>, and reaffirmed in the *Partnership Agreement*<sup>4</sup>. It stated that Local Health Care Co-operatives (LHCCs) should evolve into CHPs which would have a new and more consistent and enhanced role in service planning and delivery working as part of decentralised but integrated health and social care system. CHPs would:
  - ensure patients, carers and the full range of health care professionals are involved;
  - establish a substantive partnership with local authority services (e.g. social work, housing, education and regeneration);
  - have greater responsibility and influence in the deployment of NHS Board resources;
  - play a central role in service redesign locally;
  - focus on integrating primary and specialist health services at local level; and
  - play a pivotal role in delivering health improvement for their local communities.
7. The White Paper also required NHS Boards to work with local authority partners to ensure more effective working with social care in appropriate locality arrangements. The intention was that CHPs would have the capacity to play an effective role in the planning, management and delivery of local services and be better aligned with local authority counterparts to create better results for the communities they serve.

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<sup>2</sup> NHS Reform (Scotland) Bill 2003 <http://www.scottish.parliament.uk/bills/pdfs/b6s2.pdf>

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

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



8. The establishment and development of CHPs has also to be set within the wider context, including the better integration of services across the NHS, more effective partnership working with local authorities and other local agencies as part of community planning and Joint Future, and greater public, patient, carer and staff involvement. It is also underpinned by the continued development of community planning, the progressive application of Joint Future and the delivery of the strategic objectives of *For Scotland's Children*<sup>5</sup> and *Improving Health in Scotland – The Challenge*<sup>6</sup>.
9. All of this is aimed at making a direct impact on improving the health of local populations and providing high quality, accessible and “joined up” services to local communities and is part of an ongoing programme of development and modernisation in public services.

## Aims

10. CHPs are being established to build on the achievements of LHCCs and to make a direct and measurable improvement in local population health and to provide higher quality, accessible and joined up services to local communities. Section 4A (2) of the National Health Service (Scotland) Act 1978, as inserted by section 2 of the National Health Service Reform (Scotland) Bill states that “the general function of Community Health Partnerships is to co-ordinate, for its area or district, the planning, development and provision of the services which it is the function of its NHS Board to provide or secure the provision of, under or by virtue of the 1978 Act, with a view to improving those services”.
11. They are a vehicle for integration with specialist and acute services and with social care. To achieve this CHPs will need to: link clinical teams; work in partnership with local authorities, the voluntary sector and others to support the improvement of the health of local communities; and most importantly involve the public, patients and

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

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



carers in decisions concerning the delivery of health and social care for their communities. CHPs will be expected to:

- bring together those who provide community based health care services to create the capacity to deliver services more innovatively and effectively for local communities;
- shape services to meet local needs by directly influencing NHS Board level planning, priority setting and resource allocation;
- integrate health services, both within the community and with acute/specialist services, underpinned by service redesign and clinical networks, and by appropriate contractual, financial and planning mechanisms;
- work in conjunction with local authorities across community planning to improve the health of local communities, tackling inequalities and promoting policies that address poverty and deprivation;
- be the main NHS agent through which the Joint Future agenda is delivered in partnership with local authorities and the voluntary sector;
- be the main NHS agent through which the recommendations of *For Scotland's Children* are implemented in partnership with local authorities;
- be the principle NHS partner in Integrated Community and Health Promoting Schools;
- lead the implementation and monitoring of child health surveillance and relevant aspects of screening of children;
- promote involvement of, and partnership with, staff whether employed by or contracted to the NHS; and
- secure effective public, patient and carer involvement by building on existing or developing new mechanisms.

### **Improving Services**

12. CHPs will be the main focus for service integration for local communities with a particular emphasis on closing the health gap whilst tackling local health and social care priorities and delivering improvements particularly in relation to the management of chronic diseases such as diabetes or asthma for both adults and children. CHPs



will be particularly well placed to meet the increasing challenges of tackling chronic disease as one of its strengths will be the ability to provide a holistic approach to care which is vital when patients present with more than one condition and require an integrated response from professional staff.

13. CHPs will be expected to address local inequalities, acknowledging the different needs of, for example, minority ethnic communities, disabled people, homeless people etc to deliver direct benefits to individuals, families and communities through action to improve health and delivery of better integrated services.
14. Many health and social care services will increasingly be provided locally by a wide range of skilled staff working together as a team with other professions and agencies. CHPs will be expected to release the potential of all professionals and staff, working as part of multi-disciplinary and multi-agency teams, to integrate and improve services for local people.

#### *Patient and Carer Benefits*

15. Radical service improvements for patients and carers can happen when people at the frontline of service delivery are given the opportunity, skills and resources and are encouraged to introduce new and innovative ways of caring for and treating patients. CHPs will be expected to work in partnership to provide:
  - a wider range of services (preventative, assessment, diagnostic, treatment etc) in community settings including appropriate alternatives to hospital admission such as rapid response teams and integrated out of hours arrangements;
  - more accessible services focused on the needs of patients and carers delivered by skilled professionals working as part of broad based teams;
  - more responsive and faster access to services for patients and clients through more single shared assessment by a wider range of professionals;
  - more streamlined patient pathways through better referral patterns and protocols, earlier interventions; and integrated specialist care;



- services that better meet patients' and carer needs by reducing the number of unnecessary or inappropriate interventions by professionals and delivering care more effectively by networks of community and acute/specialist professionals and teams;
- more co-ordinated care within the community, providing a "one - stop" approach to a range of health and social care and other services;
- locally targeted and coherent approaches to health and wellbeing reinforced by local public services and appropriate voluntary and community organisations and with the input and support of local people;
- better care management and design of services through the involvement of all representative groups of public, patients and carers; and
- better information to public, patients and carers about services and how to make the best use of them.

### *Improving Outcomes*

16. Working jointly, all professionals (particularly community clinicians and those providing acute/specialist care) together with their partners will, for example, be able to:

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

17. Working closely with local authorities and other partners CHPs will for example work to:

- reduce the number of people admitted to hospital in an emergency by improving the level and quality of chronic disease management and increasing community based support e g mental health teams;



- reduce the number of delayed discharges from hospital through increased provision of rehabilitation services, rapid response teams etc;
- reduce the time taken to agree care packages for individuals by extending single shared assessments;
- increase the quality of care through the systematic implementation of more evidence based care and multi disciplinary guidelines and protocols;
- increase the number of single points of access for all community based services;
- reduce inequalities in access to information by providing targeted and coherent health messages particularly aimed at excluded or disadvantaged groups;
- reduce the number of premature deaths by preventable diseases through local actions by key partners to improve health;
- improve the access to services by increasing the level of joint service provision and co-location of services.

18. NHS Boards should define their success factors and expected outcomes for CHPs in their schemes of establishment and demonstrate how they intend to make progress towards improving the quality of local services as described in the above examples. CHPs will be expected to use, as part of their performance assessment framework, the national user and carer outcomes and local improvement targets set for the Joint Future agenda.

19. Delivering these service improvements will require a significant commitment and involvement by professional staff in service redesign. This means joint service redesign by community and specialist practitioners at grass roots level and critically it means empowering them in the decision making processes of service redesign committees where resources are prioritised and used for programmes of change and innovation. CHPs must be key players in initiating and delivering service changes and play a central role in all service redesign activity.

20. To enable CHPs to deliver service improvements it will be important for NHS Boards to develop the right physical infrastructure (premises, information systems, equipment etc, and development support) to sustain and develop services for local communities



and to develop and maintain the workforce. This will be essential for the delivery of better services in the community and will require a whole NHS system response.

*Range of Services*

21. NHS Boards will be expected to discuss and agree with local authority and other stakeholders, particularly frontline staff, the services (and associated budgets) which each CHP will manage and/or co-ordinate. 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:

- independent contractor services including primary medical services, general dental services, community pharmaceutical services, general ophthalmic services
- all community related health services including community and public health nursing and services provided by allied health professionals
- integrated mental health services
- community based integrated teams (e.g. rapid response teams, hospital at home)
- community based midwifery services
- community child health services
- relevant aspects of child and adolescent mental health services
- school health services
- home-based services for children with complex needs
- services to support vulnerable groups of children and young children including those looked after by the local authority and those at risk of abuse or neglect;
- family support services
- drug and alcohol services (addiction services)
- sexual and reproductive health services
- oral health action teams
- joint learning disability services
- services for people with sensory and/or physical disabilities



- respite or short break services for all client groups
  - joint health and social care services for older people
  - community assessment and rehabilitation
  - community resource centres/hospitals
  - community access to outpatient and diagnostic services
  - community based health promotion and health protection functions;
  - support to community based services provided by the voluntary sector
22. Services must be developed around maximum integration of health professionals and professionals from other agencies with strong management at a local level. For example, the Framework for Mental Health Services in Scotland<sup>7</sup> recommends staff in health, social work, housing and the voluntary sector work together to plan, commission, and deliver integrated mental health services through a “comprehensive menu of community focused primary and secondary care”.
23. CHPs provide the local organisational arrangements envisaged in the Framework and will enable mental health services to move to the fully integrated model of care that will also ensure that the statutory requirements set out in the Mental Health (Care and Treatment) (Scotland) Act 2003 are delivered by all partners.<sup>8</sup>
24. Child health services will need to be fully integrated into the work of the CHP in order to ensure the effective planning and development of child health services and to support the wider integration of children’s services. It may not be possible because of the number of staff or the specialist nature of service provision to locate the full range of child health services in every CHP - e g some child and adolescent mental health services or community paediatric specialities. However, the way in which services are planned and delivered must be based on a fully integrated model of care through CHPs.

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<sup>7</sup>Framework for Mental Health Services in Scotland  
[http://www.show.scot.nhs.uk/publications/mental\\_health\\_services/mhs/index.htm](http://www.show.scot.nhs.uk/publications/mental_health_services/mhs/index.htm)

<sup>8</sup>Mental Health (Care and Treatment) (Scotland) Act 2003  
[www.scotland-legislation.hmsso.gov.uk/legislation/scotland/acts2003/20030013.htm](http://www.scotland-legislation.hmsso.gov.uk/legislation/scotland/acts2003/20030013.htm)



25. The range of services outlined above is not intended to limit NHS Boards and local partners from devolving further services to CHPs if this will improve the overall quality of service delivery and deliver better outcomes for users and carers. Where there are multiple CHPs in a NHS Board area then it will be possible for one CHP to host the delivery of a specific service on behalf of other CHPs in the same area and this should be reflected in the scheme of establishment.

### *Service Planning*

26. CHPs will be actively involved in overall strategic planning, priority setting and resource allocation for the whole NHS Board area and be operationally responsible for the delivery of their part of the overall strategic plans. They will have a critical role to play in the overall design of services that require a whole system approach such as the provision of acute care, maternity services, mental health services, children's services and community care services with local authority partners. NHS Boards will be expected to ensure that CHPs have identified access to planning expertise to enable them to fulfil their role in the planning process.
27. CHPs must also ensure that in planning and providing services they are focused on reducing inequalities, for example in relation to access, and that the particular needs of specific groups, such as people with learning disabilities or people with dementia, are identified and appropriately addressed.
28. In relation to capital planning, the consultation on the use of Joint Ventures to deliver primary care/joint premises raised the prospect of Strategic Services Development Plans (SSDPs)<sup>9</sup> agreed by local partners and a private sector partner being established to set out a vision for the development of primary and community care services to be supported by the joint venture.
29. Where SSDPs are established, whether in the context of joint ventures or not, they should become the key driver for local joint service delivery. These plans will include the capital and revenue consequences of the anticipated capital investment

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<sup>9</sup> Strategic Services Development Plans <http://www.scotland.gov.uk/consultations/health/cjvpc-00.asp>



required in an area to give effect to joint partner's service delivery and community plans. CHPs will have a critical role to play in focusing the NHS Board's strategy on developing the best infrastructure to support community based services and contributing to these plans.

### *Joint Future*

30. CHPs will have substantive partnerships with their local authority as the local focus for implementing Joint Future. They will have devolved authority from the NHS Board to progress the Joint Future agenda locally in the context of Extended Local Partnership Agreements. At a practical level they will have the potential to delegate functions (either way) under the Community Care and Health Act 2002<sup>10</sup> and to pool budgets and enter into joint management arrangements on a wide range of services.
31. The development of CHPs is an opportunity to serve communities better and to build on the joint working foundations developed under Joint Future. We expect local partners to continue to progress together Joint Future and the development of CHPs so as to maintain momentum in serving the community better.
32. The infrastructure for joint working is already firmly established and can be the basis for the evolution of CHPs as partners with local authorities. Therefore Extended Local Partnership Agreements, Local Outcome Agreements, Delayed Discharge Action Plans, Resource Transfer Agreements etc will be managed and further developed for the NHS Board through CHPs which are either individually or collectively coterminous with their local authority partners.
33. The existing governance and accountability arrangements e g though Joint Future Committees should be aligned to CHP arrangements for the furtherance of joint

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<sup>10</sup> Community Care and Health Act 2002  
<http://www.scotland-legislation.hmso.gov.uk/legislation/scotland/acts2002/20020005.htm>



planning, design, commissioning, resourcing and management of local services. CHPs will be responsible on behalf of the NHS Board for meeting the requirements of the Joint Performance Information and Assessment Framework (JPIAF) and in developing and monitoring joint Local Improvement Targets with their local authority partner.

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

#### *Children's Services*

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

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

36. These priorities build on the recommendations of *For Scotland's Children* and the report of the child protection review, *It's Everyone's Job to Make Sure I'm Alright*<sup>11</sup>. There should be a lead person within each CHP who takes responsibility for engaging with partners in the strategic planning of children's services and for the delivery of child health services.

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<sup>11</sup> It's Everyone's Job To Make Sure I'm Alright: Report of the Child Protection Audit and Review <http://www.scotland.gov.uk/library5/education/iaar-00.asp>



### *Drug and Alcohol Services*

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

**Schemes of establishment should:**

- define the desired outcomes and success factors for CHPs
- outline the range of services to be managed and/or co-ordinated by CHPs from day one and then outline how this will expand over time
- describe how Joint Future arrangements will be integral to and enhanced by CHPs
- describe how CHPs will contribute towards better integration of universal and targeted services for children and young people based on the detailed guidance to be produced in summer 2004
- indicate how CHPs will be involved in NHS Board and other strategic planning processes

### **Improving Health**

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



39. Under the Local Government in Scotland Act 2003<sup>12</sup>, local authorities have a statutory duty to facilitate the community planning process by which public services in an area are planned and provided in consultation with public bodies and with the community. Other agencies (including NHS Boards) have a statutory duty to participate in the community planning process. Consequently, NHS Boards should enable CHPs to take a wide perspective on health as being a state of physical, mental and social well-being and not merely the absence of disease and to act as enablers of improved health outcomes across a community, working very closely with all community planning partners. This will involve ensuring that the CHP has appropriate advice from specialist public health services and that the public health function has active networks that engage key CHP staff in agreeing priority areas of work that reflect local as well as national priorities.

#### *Community Benefits*

40. It is anticipated that CHPs, working with a range of local partners will fulfil this role by:

- supporting the delivery of the four pillars of *Improving Health in Scotland - The Challenge* and future health improvement strategies as part of the wider community planning process
- informing NHS Board health improvement priorities and action through ongoing needs assessment for local communities; focused on reducing inequalities;
- ensuring there is a focus for health promotion within their communities, working more closely with all partners e.g. Integrated Community Schools and Health Promoting Schools;
- bringing national and local priorities together and taking actions locally to improve the well being, life circumstances and lifestyles of local communities, especially the most disadvantaged communities;

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<sup>12</sup> Local Government in Scotland Act 2003 <http://www.scotland-legislation.hmso.gov.uk/legislation/scotland/acts2003/20030001.htm>



41. In addition, CHPs will support a health promoting health service by integrating health promotion throughout the work of the CHP. The objectives of a health promoting health service include:
- ensuring health promotion is an integral and sustainable part of health service delivery and organisational development
  - identifying areas of standard setting and encourage evidence based practice and quality health promotion
  - identifying how the health service can incorporate “Health for All” principles in its approach to health promotion and patient/client care
42. In practice, CHPs will impact on the health of local populations at various levels and over different time frames. CHP actions and involvement may be considered at 3 levels:
- individual practitioner actions
  - joint actions by partners to develop and deliver Joint Health Improvement Plans
  - informing and influencing community planning processes

#### *Individual Practitioners*

43. The potential contribution to health improvement of all those providing health and care for local people has been recognised by a wide range of professional groups and partners organisations and highlighted in recent strategies.
44. Day to day interactions between a patient or service user and individual practitioners is a health improvement opportunity. By bringing together all professionals and their partners a CHP provides a focus for matching the knowledge those health professionals and other partners have about patient and public needs, life styles and life circumstances with the opportunity to redesign services to address individual and community needs. For example, to tackle the life circumstances of families on a low income requires the involvement of a range of professionals. When mothers are given Welfare Food tokens, there is an opportunity at that time to put health education on



diet, physical activity, smoking etc in the context of employment, income and benefit. The National Demonstration Project<sup>13</sup> “Starting Well” is currently evaluating this approach.

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

#### *Partners in Action - Joint Health Improvement Plans*

46. CHPs will be a powerful new vehicle to shape Joint Health Improvement Plans (JHIPS). JHIPS set out objectives, strategies and actions for each partner organisation, within the community planning partnerships, to improve health and reduce inequalities within their local populations. These plans are in turn reflected in local health plans developed by each NHS Board and subject to annual performance assessment. CHPs can ensure actions identified in JHIPS are based upon the best evidence of action that will, in turn, result in delivery of health improvement for the community.
47. Reducing health inequalities and closing the opportunity gap underpins *Improving Health in Scotland – The Challenge* and for individuals must be a core principle underpinning the work of CHPs. As CHPs work within and across communities they must identify and address the specific needs of the full range of community needs such as the low income groups, homeless people, asylum seekers, minority ethnic groups and travellers, people with HIV/AIDS or children with complex health needs, and work in partnership to address their needs.

#### *Community Planning*

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<sup>13</sup> The National Demonstration Project <http://www.scotland.gov.uk/library3/health/nhdp-00.asp>



48. Set within the overall community planning framework, CHPs will be effectively positioned to promote health improvement among local communities and to ensure there is an effective, innovative and accountable community basis for health improvement activity and strengthened relationships with all partners to reduce health inequalities and promote social justice within and across local communities.
49. In developing their role within community planning frameworks CHPs will make a valuable contribution to achieving the Executive's Closing the Opportunity Gap objectives, health targets and health improvement outcomes e.g. in relation to smoking cessation, breastfeeding and coronary heart disease mortality.
50. They will also contribute to achieving the Community Planning Partnership's targets and to closing the gap between disadvantaged and excluded communities and the whole population. In particular, CHPs should play an active role in the integration of Social Inclusion Partnerships and Community Planning Partnerships and in the development and delivery of the partnership's Regeneration Outcome Agreement, especially as it relates to improving health.
51. One of the aims of community planning is to set an overarching partnership framework. This should help to co-ordinate other initiatives and partnerships and also to rationalise and simplify a cluttered landscape. Therefore it will be important for NHS Boards to agree with local partners the contribution of CHPs to community planning arrangements.

### *Resources*

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



53. It will be important for NHS Boards and local authority partners to decide how resources, including specialist expertise, will best be deployed to enable CHPs to contribute effectively to the collective responsibility for health improvement. CHPs will need to effectively deploy and lead its health improvement workforce which may include public health practitioners, some health promotion staff, connections to local authority health improvement and environmental health officers as well as the wider workforce, most notably public health nurses but including all clinicians.
54. For example, it would not be appropriate in terms of economies of scale, critical mass and the need for specialist expertise for each CHP to have its own fully fledged public health function. Directors of public health and local authorities will need to establish effective managed public health networks with CHPs in order to ensure that CHPs have access to public health expertise and resources and are able to influence the department's priorities based on identified local need and that effective two way communication exists between the CHP and public health department.
55. In addition to developing the contribution that individuals may make to health improvement, CHPs also need to be aware of the wide range of financial and other resources distributed to community planning partners. In agreeing a community plan and targets to take it forward, community planning partners will want to identify resources to achieve the agreed aims.
56. CHPs will also need to understand how a variety of health improvement resources flow within the NHS, local authority and voluntary sector systems and what the CHP involvement/role will be in adding value and helping to prioritise resources against outcomes for health improvement activity. This means removing wherever possible barriers to sharing funding to ensure that resources are used for the benefit of local people regardless of which partner has "nominal" budgetary responsibility.
57. CHPs may also use their collective local knowledge to take advantage of opportunities such as the integration of Community Planning Partnerships and Social



Inclusion Partnerships, the New Opportunities Fund, Healthy Living Centres<sup>14</sup>, and Integrated Community Schools Quality of Life monies to support health improvement work locally.

58. CHPs will need to have the right links into national drivers for change and strategic support. NHS National Education Scotland<sup>15</sup>, NHS Chairs and Chief Executives, Directors of Public Health and NHS Health Scotland<sup>16</sup> and COSLA<sup>17</sup> will have an important role to play in supporting the evolution of new ways of harnessing expertise, sharing evidence into practice and fostering networking across agencies.

**Schemes of establishment should describe:**

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

### **Organisational Arrangements**

59. NHS Boards must have a clear governance framework within which all organisational arrangements must fit. CHPs will be actively involved in NHS Board strategic planning and also provide leadership for the co-ordination, planning, development and provision of services for their communities and they will be held accountable for the delivery of those services and for the use of all devolved resources. NHS Board Chief Executives remain the accountable officer for the use of all NHS Board resources.

60. Therefore the governance and management arrangements (including the scheme of delegation) of a CHP must reflect the scope of devolved functions and responsibilities

<sup>14</sup> Healthy Living Centres <http://www.ohn.gov.uk/ohn/partnerships/hlc.htm>

<sup>15</sup> NHS National Education Scotland <http://www.nes.scot.nhs.uk/>

<sup>16</sup> NHS Health Scotland <http://www.hebs.scot.nhs.uk/>



and be based around a flexible management and decision making framework which can respond to the aims and key objectives outlined in the schemes of establishment. In particular it will be important to ensure that local authority partners are actively involved in agreeing local arrangements to reflect their role in jointly providing and/or managing a range of local services.

61. Organisational arrangements must reflect the fact that CHPs will:

- directly manage and provide some services;
- lead the co-ordination and direct the delivery of some services;
- coordinate the delivery of some services as part of a managed network

#### *Governance*

62. In developing local governance and management arrangements NHS Boards must also build on one of the main aims of *Partnership for Care* which is to empower front-line staff and key stakeholders so that they can take decisions on the use of resources and the provision of services in the community. The effectiveness of each CHP will depend on the input of the staff and the partnerships, networks and joint working arrangements it develops within the NHS and with local authorities and other agencies.

63. The most effective way of clearly devolving functions and resources from the NHS Board to a CHP in a sustainable and accountable manner, is to establish each CHP as a separate committee or sub committee of the NHS Board in accordance with paragraph 10 of The Health Boards (Membership and Procedure) (Scotland) Regulations 2001.<sup>18</sup> Boards will only be able to establish a CHP once Scottish Ministers have approved their scheme of establishment.

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<sup>17</sup> COSLA website [www.cosla.gov.uk](http://www.cosla.gov.uk)

<sup>18</sup> The Health Boards (Membership and Procedure) (Scotland) Regulations 2001, SSI 2001/302.  
<http://www.scotland-legislation.hmso.gov.uk/legislation/scotland/ssi2001/20010302.htm>



64. Establishing the CHP as a committee or sub committee of the NHS Board will enable NHS Boards to devolve functions and powers to them within a scheme of delegation and a clear accountability framework, which will ensure that decisions are made as near as possible to the frontline. In line with the aspirations of *Partnership for Care*, the CHP committee or sub committee shall consist of frontline staff and other key stakeholders, who are best placed to assess the health care requirements of local communities.
65. The role and responsibility of the CHP committee or sub committee will be to drive service improvement locally and to ensure the effective delivery of the functions devolved to the CHP as described in the scheme of establishment and scheme of delegation. The NHS Board should have confidence that the people they appoint to the CHP will work together with other team members in the interests of the CHP and the people they serve.
66. In order to reflect the commitment to empower frontline staff and key stakeholders, and to ensure that services are patient focused, the regulations will state that a CHP committee or sub committee must comprise, **as a minimum:**
- a general medical practitioner
  - a general manager
  - a nurse
  - a pharmacist
  - a dentist
  - an allied health professional
  - a clinician from the acute/specialist sector
  - an optometrist
  - a representative of staff
  - a member or officer of the local authority
  - a member of the public partnership forum
  - a member of the voluntary sector
-



67. Boards may wish to have more than one of the above on the committee or sub committee and may choose to include other members. In particular, local authority membership should be commensurate with their substantive partnership arrangements with the CHP.
68. In deciding who should sit on the CHP committee or sub committee the NHS Board should discuss and agree with professions/relevant groups and partner organisations an appropriate way of choosing that person. Each person will have a responsibility to work corporately and together to achieve the objectives of the CHP. They should also be able to put forward any views that their profession or group has on how to improve health and services.
69. All members of the committee or sub committee will have equal status and membership and will broadly reflect the make up of the CHP staff and partnerships. The draft regulations provide that where a question relates to services delegated to the CHP by virtue of Community Care and Health (Scotland) Act 2002, those members present and voting who represent any local authority shall collectively have half the available votes.
70. NHS Boards must ensure that individuals are supported to fulfil their role and that they are enabled to fully participate in the work of the CHP. NHS Boards will be required to draw up Standing Orders in line with Regulation 9 (1) of The Health Boards (Membership and Procedure) (Scotland) Regulation 2001.

### *Management*

71. CHPs will be expected to put in place management arrangements for the entire CHP in line with their capacity to take on new roles and responsibilities. The aim will be to encourage local innovation and commitment and to develop approaches that may be worthy of adoption elsewhere.



72. It is anticipated that there will be an increasing range of joint services provided by the NHS, local authorities and other partners. CHP governance and management arrangements should reflect this joint responsibility and joint funding arrangements.
73. It is anticipated that CHPs, in discussion with their local authority partners, will agree specific local arrangements for reaching decisions on the planning and delivery of jointly managed and jointly resourced services (e.g. community care services). These agreements on joint services must be based on an equal partnership. This arrangement should be reflected in the Standing Orders. If the local authority does not delegate functions to CHPs under the Act then existing arrangements for decision making (e.g. under Joint Future Committees) would apply. This is to assist local partners seeking high levels of integration.
74. In developing local management and governance arrangements the aim will be to streamline and integrate as far as practicable local decision making processes and to set CHPs within an explicit accountability framework. This framework is designed to reduce bureaucracy and avoid duplication and to enable and encourage local partners to rationalise existing “aligned” arrangements. This approach could facilitate the functions of the Joint Future Committee being incorporated within the framework of the CHP committee, and so streamline local partnership arrangements.
75. CHPs will require highly effective leadership and management at all levels. We expect each CHP to have a chairperson and general manager appointed by the NHS Board and to put in place arrangements to ensure that there is appropriate clinical and professional leadership.

#### *Chairperson*

76. The chairperson will be responsible for chairing the CHP committee or sub-committee and for developing the CHP as a truly multi-disciplinary and multi-agency partnership with a clear focus on the needs and aspirations of the local communities which they are set up to serve. This role will require very skilled leadership to create



and sustain effective working relationships across a number of organisations and between professional groups.

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

#### *General Manager*

78. The general manager will be the NHS officer on the CHP committee or sub-committee and will be directly accountable to the NHS Board Chief Executive or Division Chief Executive for the overall management and use of resources of the CHP. The general manager must ensure that the views of managers (including general practice managers) are taken into account and reflected at CHP management team discussions.

#### *Leadership*

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

#### *Clinical leadership*

80. Mechanisms must be put in place to ensure effective clinical leadership of the work of the CHP and this should be led by the CHP management team. An overall clinical



lead/director for each CHP should be identified. Their responsibilities should include ensuring that:

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

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

82. In addition, consideration should be given to identifying a clinical lead within the CHP for national clinical or Ministerial priorities i e mental health, child health etc. and for overseeing the population health improvement focus of the CHP. In some circumstances or in some clinical areas this may not be practicable or desirable, in which case schemes of establishment should describe how clinical leadership for these services will be provided to the CHP.

### *Professional Leadership*

83. NHS Boards should ensure that effective professional leadership is available to all the clinical and non clinical professions working within the CHP in order to support the effective delivery of services and promote innovative and safe professional practice.

84. Professional leadership should be available wherever possible within the CHP, with effective lines of communication and accountability to the appropriate Director at Division or NHS Board level. These arrangements should be clearly described within



schemes of establishment and should take account of the principle of devolution of responsibility and decision making to CHPs.

85. NHS Boards, in discussion with the relevant professional groups, should take the opportunity to review the relationship of CHPs to existing professional advisory structures to take account of the evolution of CHPs. In particular they will need to review the LHCC Professional Committee in light of the development of CHPs.

*Summary of Organisational Arrangements*

86. It will be critical to the success of CHPs that those fulfilling all key roles and positions within the CHP have the confidence of both local stakeholders and the NHS Board and that they are selected on the basis of competency and not only professional status. In addition, it will be critical for CHPs to have the necessary range of identified support services such as finance, human resources, information technology, estates and planning to be able to deliver their functions. This will require a whole NHS system response.
87. NHS Boards will need to consider the impact of the establishment of CHPs on their wider organisational arrangements and ensure that there is appropriate migration of skills and resources into CHPs to reflect their significance and responsibilities. As joint working develops with local authorities then there may be potential for wider discussions locally about the most effective use of staff resources and skills. CHPs and local authorities should ensure that effective patient centred arrangements are in place to address cross boundary needs.

**Schemes of establishment should:**

- provide details of the membership and organisational arrangements of CHP committees (cross ref to next section of guidance);
- describe the initial management and decision making framework for the CHP;
- describe how CHPs fit in with the overall structure of the NHS Board;
- describe plans for the replacement of the LHCC Professional Committee;



- describe arrangements for professional and clinical leadership within CHPs including lines of accountability; and
- describe how CHPs will have access to support services

### *Size and Geographical Coverage*

88. CHPs must be fit for purpose and match local authority boundaries. This means that the organisational boundaries of one or more CHPs must be coterminous with the local authority boundary. In entering into these arrangements each CHP must ensure that there are arrangements in place to address the needs of their local communities. Organisational boundaries will not cut across natural flows of people into health services.
89. Ensuring that CHPs relate to local authority boundaries or clear sub divisions of boundaries will enable more effective integration of the planning and delivery of health and social services for local communities. Where there are multiple CHPs within one local authority boundary then an appropriate mechanism should be found to enable CHPs to work corporately within the relevant community planning partnership arrangements. It is essential that the development of CHPs is considered with reference to existing and proposed arrangements for the planning and delivery of multi agency services at local or community level.
90. In determining the size of each CHP, NHS Boards working with all stakeholders and partners should aim to reduce bureaucracy and achieve economies of scale in delivering improved health outcomes and benefits to patients. They should also take into account: the critical mass of patients required to deliver cost effective local services; the availability and capacity of partners to plan and manage services; the need to avoid duplication of activities; and the impact of any physical or geographical constraints.
91. It is expected that CHPs will have a minimum population size of around 50,000 unless there are significant local reasons otherwise. There will be no absolute



maximum population size but CHPs must be able to reflect the needs of communities and specific localities and engage effectively with frontline staff.

**Schemes of establishment should:**

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

## **Working in Partnership**

### *Engaging Local Communities*

92. CHPs will be required to maintain an effective and formal dialogue with their local communities through the development of a local public partnership forum for each CHP. Whilst these forums will be a mechanism by which the CHP maintains this formal dialogue this should not be their only mechanism for engaging with local communities.
93. The relationship between CHPs and their local communities should be based on the following principles:
  - the duty placed on NHS Boards to involve and consult the public will apply to CHPs and any current or future national guidance or standards for public involvement should underpin the work of CHPs;
  - wherever possible CHPs should seek to use or tap into local authority, voluntary sector and other existing public involvement mechanisms;
  - public partnership forums should have a formal role in the decision making processes of CHPs but this must not compromise their “independent voice”;
  - the role of the Scottish Health Council locally will be to monitor and support the development of the public partnership forum and to ensure that it operates effectively in accordance with standards developed by the Council, and according to standards for community engagement currently being developed by Communities Scotland, COSLA and other partners



*Role and benefit of public partnership forums*

94. There will be two main roles for public partnership forums. The first will be to ensure local people are informed about the range and location of services and information which the CHP is responsible for, and to engage local service users and carers in discussion about how to improve services and information to enable CHPs to respond to the needs, concerns, and experiences of patients, carers and families. This will mean engaging local people in issues concerning the nature, design and quality of service delivery and outcomes. This will help to inform the work plans of CHPs and to determine local priorities for service improvement.
95. The second role will be to support wider public involvement and to seek to make public services more responsive and accountable to citizens and local communities. This will require CHPs to engage with community involvement and consultation structures such as local authority area committees, community councils, citizen's panels, community planning. Public partnership forums will be able to link in with local involvement mechanisms in relation to health improvement and service planning issues.

*How will public partnership forums work?*

96. In order to fulfil these dual roles, and to build on good local approaches and the work of local user/carer groups, we envisage public partnership forums as virtual groupings which will not have a fixed, formal membership or identity. They will bring together existing local groups and networks of patient groups, voluntary organisations, interested individuals and others with the key role of considering and informing the CHP on specific issues.
97. Local systems should agree the best arrangements to deliver the public involvement function of CHPs, recognising that the public partnership forum alone will not necessarily enable CHPs to fulfil the statutory duty to involve.



98. Public partnership forums should engage with their local communities through existing networks of patient/user and carer groups and community care forums on how their views are taken into account in the work of CHPs and to ensure that the views expressed through the public partnership forum have a wider validity. They should also develop strong links with the Scottish Health Council locally, reporting areas of concern or where there is a need for support.
99. Each CHP should reserve a place on the CHP committee for a public partnership forum member to be filled through a fair and open appointment process with advice from the Scottish Health Council locally. Those appointed should be able to represent the views of the wider patient and public interest rather than their individual interests.
100. Mechanisms should be put in place to enable a two way dialogue on a regular basis between the wider public partnership forum and those people attending the CHP committee. Formal involvement on the CHP committees must not compromise the “independent voice” of the public partnership forum members.
101. Members of the public partnership forum should agree what is expected of them with the CHP and draw up a working agreement to reflect the local arrangement. Clear terms of reference for public partnership forum members should reflect their responsibility to ensure that the work of the public partnership forum is fully shared and communicated with local groups and that the issues, concerns and priorities of local groups are fed into the work of the CHP. The Scottish Health Council locally should support CHPs and public partnership forums in drawing up the terms of reference.
102. Public partnership forum members will require proper administrative support, training and development to enable them to fulfil the role envisaged for them on the CHPs and this should be funded by the NHS Board through a delegated budget to each CHP.
103. CHPs will be expected either to commission the administration for the public partnership forum, including any support they need, through a tendering process for



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

*Links to joint planning partnerships*

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

105. NHS Boards are committed to developing local sustainable frameworks for Patient Focus and Public Involvement, and should aim to ensure that public partnership forums add value and complement local community planning processes.

*The Scottish Health Council*

106. The proposed role of the Scottish Health Council and its local advisory council was set out in the consultation paper, *A New Public Involvement Structure for the NHSScotland*.<sup>19</sup> These proposals are currently being further developed by an implementation team. The role of the Scottish Health Council in relation to CHPs and public partnership forums is to:

- provide a quality assurance role in terms of whether or not NHS Boards are effectively carrying out their statutory duty to involve the public through the work of public partnership forum members on the CHP committee and other patient and public involvement activities carried out locally;
- provide a source of advice and support to CHPs in the development of their public partnership forum and agreeing any arrangements;

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<sup>19</sup> *A New Public Involvement Structure for the NHSScotland*  
<http://www.scotland.gov.uk/library5/health/npis-00.asp>



- provide a source of advice and support to public partnership forum members on a range of involvement methodologies, tools and techniques and help to identify and support their training and development.

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

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

### *Resources*

109. Significant national investment and support has already been made to improve the quality of NHS Boards' partnerships with patients, carers and communities. NHS Board's have a duty to support and fund public involvement and this is reflected in the statutory duty which is being created. NHS Boards should build on the significant good practice already in place within their communities e.g. Managed Clinical Networks; redesign models, local Health Council work, community planning. Where necessary, they should redirect or pool existing resources with other partner organisations to deliver this statutory duty, including providing the support needed by the public partnership forums.

**Schemes of establishment should outline how:**

- each CHP will be supported to develop the capacity and capability to effectively involve local communities
- each CHP will discharge its responsibility to involve and engage patients, carers and communities
- how these arrangements will fit with other existing or proposed arrangements for consulting with people about public services in the area covered by each CHP



- the CHP will fund and provide support for each public partnership forum
- members of the public partnership forum will be appointed to the CHP with advice from the Scottish Health Council locally.

### ***Linking Clinical and Care Teams***

110. Clinicians and their teams work more closely together when there are clear benefits for their patients and if it is in their professional and organisational interests to develop new ways of working. CHPs will be well placed to deliver benefits for patients and professionals as outlined on pages 6-7, by creating opportunities for much closer working and inter-dependency between all health and social care professionals and teams and they will have the means to support professionals in developing new ways of working.
111. CHPs will be a focus for bringing clinical and care teams together to work as part of a single local health system acting as the focus for integrating health and social care services at a local level, building on the range of clinical and quality standards already available. They will have a pivotal role in enabling clinicians and other health and social care professionals to share local service delivery problems, make decisions on the solutions and to implement those decisions locally.
112. The traditional view of primary care, secondary care and social care should change over time as professionals working within and across these areas remove barriers to joint working and design alternative models of care delivery based around patient pathways that are adapted to suit local circumstances. This is already happening in some chronic disease areas such as diabetes where allied health professionals such as podiatrists and dieticians are working with general medical practitioners and consultants to provide more integrated care for patients in their local community.
113. CHPs will be expected to deliver care along a continuum based wherever possible on evidence and, most importantly, provided by the most appropriate professional regardless of historical job/role profile.



114. This means **all** health and care professionals are stakeholders in the work of the CHP as they work together to make patient pathways of care smoother, more accessible, less complicated and less subject to delays. For example, improving information and services for people with mental health problems at a local level will have real spin-offs in terms of reduced admissions to hospital.
115. It will require all clinicians and other professionals to align their skills, knowledge and experience to serve patients and local communities differently. It is happening already. For example, community pharmacists have already demonstrated the benefits for frail elderly of reviewing the medication of patients who have been identified by social work staff as having problems with their medicines. CHPs should deliver direct benefits for patients by strengthening working arrangements and relationships between clinical and care teams particularly in areas where there are service pressures or problems.

#### *Managed Clinical and Care Networks*

116. CHPs will encourage clinicians, managers and other professionals to work together as part of an integrated health system, using managed clinical and care networks to design services and care pathways to enable more specialist treatment to be available in community facilities. Working together as part of networks of clinicians and with other professionals will be a critical aspect of the way in which CHPs operate.
117. Where managed clinical networks exist they will have a lead role in design, quality assurance, improved access and agreed pathways of care and potentially agreeing new investment and improved information for patients and the public. CHPs will need to be fully involved in the work of these networks and be accountable for those elements of service delivery agreed with the networks.
118. CHPs will be well placed to redesign services to better meet the needs of their communities. They should have sufficient devolved responsibility to enable services to be redesigned as well as having influence over the way that specialist services are



deployed. In particular, they should be clear about how they see the need for services to be provided and developed so that this can form part of local discussions by Medical and Clinical Directors at the job planning stage with consultant colleagues.

119. More generally CHPs will be positioned to use the opportunities and flexibilities offered by the 3 main strands of Pay Modernisation as a vehicle to develop new and innovative approaches by different professionals to service delivery. To be effective in service redesign they should be fully involved in the work of NHS Board service redesign committees.

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

121. The Chief Executive of the NHS Board will remain accountable for clinical governance. NHS Boards will be required to put in place clear governance arrangements for clinical issues within and across CHPs and this should be described in the schemes of delegation. Each CHP committee will be accountable through the general manager for clinical governance and the clinical lead will be responsible for developing and implementing the local arrangements. Local arrangements should identify the person responsible in each area for clinical governance.

122. CHPs will require effective and timely information in order to fulfil their clinical governance role and to ensure a consistent assessment of needs and the effective sharing of information between professionals and staff across agencies, for example, in relation to child protection or other children’s services.

123. CHPs will need to consider the most effective way of ensuring that clinicians are supported to enable their active involvement in the work of the CHP. This means



developing innovative ways of providing equitable backfill for clinical staff and providing a strong focus on protected learning and educational opportunities.

124. Developing the relationships between community and acute/specialist clinicians will be key to the success of a CHP and a prerequisite for effective integration of services. Therefore CHPs should promote joint working between clinicians and closer integration of clinical and care teams and:

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

**Schemes of establishment should outline:**

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



### *Involving Staff*

125. CHPs provide an opportunity to build on successful partnership working locally and evolve existing arrangements to support all frontline staff whilst recognising that CHPs are partnership organisations that represent different employer interests.
126. CHPs will be expected to ensure staff are treated as full partners in decisions that affect the planning and delivery of services in line with the objectives set out in *Partnership for Care* and the NHS staff governance standard. This priority given to staff involvement must be reflected in the organisational arrangements of CHPs where a staff representative will be a full member of the CHP committee.
127. CHPs will be responsible for delivering a range of services. Some of these services will be delivered by NHS employees and some by independent contractors and their employees. It will be a requirement to ensure that the staff governance standard is implemented for all NHS staff working within a CHP. Section X of the National Health Service (Scotland) Act 1978, as inserted by section Y of the National Health Service Reform (Scotland) Bill, requires Boards to put in place and keep in place arrangements for the purpose of improving the management of staff and for monitoring such management.
128. In addition, CHPs will be expected to strive to develop common/complementary employment practice frameworks for non NHS employed staff working within CHPs (such as staff working in general practice) that meet staff governance and employment law requirements. CHPs should seek to commend best practice to all employers within the CHP, for the benefit of all employees and in turn for the benefits of patients and carers.
129. NHS Boards and area staff partnership forums will be expected to put in place local staff partnership arrangements that will ensure that there is effective local implementation, through CHPs, of the staff governance standard on behalf of the Staff Governance Committee of the NHS Board. As Joint Future arrangements evolve through greater partnership working and joint service arrangements with local



authorities, then staff partnership arrangements should evolve to reflect the changing requirements.

**Schemes of establishment should:**

- describe the arrangements for involving staff in the work of CHPs and highlight how staff governance principles will be delivered

**Working with Local Authorities**

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

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

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

133. Maintaining the impetus on developing integrated working flowing from Joint Future and *For Scotland's Children* should remain central to these new arrangements. Boards are already working with local authority partners to build on their Extended Local Partnership Agreements by producing plans aimed at ensuring more effective working with social care in appropriate locality arrangements. Joint Children's Services Plans and resources through the Changing Children's Services fund have



encouraged more co-ordinated arrangements for joint planning and delivery across children's services between the NHS, local authorities and other partners.

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

**Schemes of establishment should describe:**

- the nature of working relationships between the CHPs and local authorities

***Working with the Voluntary Sector***

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

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

137. In developing CHPs, NHS Boards will be required to discuss and agree with their local Council of Voluntary Services on how the views and experience of the voluntary sector locally may be built into the organisational arrangements of each CHP.

**Schemes of establishment should:**



- outline the arrangements for involving the voluntary sector in CHPs

## **Building Workforce Capacity**

### *A Shared Culture*

138. CHPs are intended to be flexible and innovative organisations, free from unnecessary bureaucracy and administrative burdens. They should operate within a shared culture based on partnership and team working. They will have a key role in unlocking the potential of all professionals and staff by providing a forum for independent contractors and all staff working in health and social care to come together to support health improvement and develop local services.
139. Within this shared culture CHPs will be encouraged, wherever practicable, to promote joint learning opportunities within the NHS and also with local authorities and voluntary sector.
140. This shared culture should reflect the need for CHPs to take a proactive and positive approach to engaging with the people they serve and to demonstrate that they have listened to, understood and acted upon their views. This approach at a local level will be supported by new arrangements nationally and locally under the umbrella of the Scottish Health Council.
141. We envisage CHPs acting as the focus for local networks for sharing good practice and encouraging links into research activities and national organisational learning. In particular, CHPs will be encouraged to use networks being developed by the Scottish School of Primary Care,<sup>20</sup> NHS Health Scotland,<sup>21</sup> COSLA and Public Health Departments, both as sources of evidence on which to base improvements and as mechanisms to generate locally important questions and to get them answered. NHS

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<sup>20</sup> Scottish School of Primary Care <http://www.sspc.uk.com/>

<sup>21</sup> NHS Health Scotland <http://www.hebs.scot.nhs.uk/>



Quality Improvement Scotland<sup>22</sup> and the Care Commission<sup>23</sup> will also play an important role in informing the work of CHPs.

### *Developing Roles*

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

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

144. CHPs will be able to use the opportunities provided by Pay Modernisation<sup>24</sup> across the NHS (e g Agenda for Change and Primary Medical Services) to facilitate service redesign and role development, maximising the contribution of all health professionals to benefit local communities.

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

146. The new GMS contract introduces far reaching and fundamental changes to the way in which primary care works. Supported by 33% increase in investment it will

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<sup>22</sup> NHS Quality Improvement Scotland <http://www.nhshealthquality.org/nhsqis>

<sup>23</sup> Care Commission <http://www.nationalcarestandards.co.uk/>



provide improved quality of care for patients and better working conditions for staff. It offers important levers for change across the whole of the NHS and in better chronic disease management for patients, better access to services for patients, a wider range of services in primary care and improved infrastructure.

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

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

### *Workforce Development*

149. CHPs will also play an important role in local workforce planning and development to support new models of care and service delivery. In particular they will:

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

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<sup>24</sup> Primary Medical Services <http://www.show.scot.nhs.uk/sehd/paymodernisation/>



150. CHPs should agree their specific role in supporting workforce planning and development locally and have access to appropriate expertise and support to help them fulfil this role.

*Development Plans*

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

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



- develop workforce capacity to deliver the range of community based services and in particular developing competences in relation to health improvement within the wider workforce to enhance and support the work of public health practitioners.

**Schemes of establishment should:**

- outline the priority development areas for CHPs
- describe how they will develop leadership within and across CHPs
- describe how management support and expertise will be used to support CHPs
- outline how human resource and organisation development issues will be addressed

**Finance and Accountability**

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

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

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

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

- primary care investment funds
- funding for the enhanced services component of Primary Medical Services
- development funding for Primary Medical Services



- any further budgets to support the shift in the balance of care into the community
156. In relation to the drugs element of the unified budget, NHS Boards and CHPs should agree and indicate in the scheme of establishment arrangements for managing the prescribing budgets in the context of overall risk management.
157. CHPs must have access to resources without unnecessary filters within the organisation and they should have flexibility and powers of virement to enable them to use their devolved budgets/savings to greatest effect. They will be required to operate within NHS Board policy, planning and performance management arrangements; standing financial orders, audit and risk management systems and ensure actual expenditure is monitored against budget and corrective action taken if necessary.
158. All CHPs in a Board area will also be expected to work closely together to deliver jointly agreed health and service improvements and to address inequalities. They will require clear and integrated accountability arrangements and NHS Boards should agree with their CHPs:
- a CHP dimension to their local performance management framework in order to benchmark and monitor delivery of services and relationships with partners;
  - shared accountability and performance management arrangements within the NHS system for service outcomes and the use of resources; and
  - the nature of CHP reports on the planning, development and provision of services.
159. CHPs will be accountable, on behalf of the NHS Board, for the joint management and resourcing of services provided within the CHP area as agreed with local authority partners and other partners within the governance arrangements of the Local Partnership Agreement. This will include the responsibility for the delegation of functions and resources (under the Community Care and Health Act 2002), pooled and aligned budgets and joint i.e. single and shared management arrangements.



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

**Schemes of establishment should describe:**

- the range of services and associated budgets to be devolved to CHPs
- the joint health and social care budgets, joint resourcing and management frameworks
- the resources devolved to CHPs for developing their public partnership forums
- the % of the total NHS Board allocation to be devolved to CHPs
- the mechanisms for ensuring that CHPs have clear involvement in decisions on the use of existing resources both within a CHP and across the wider NHS system
- the mechanisms for ensuring CHPs have involvement in decisions on the use of **all** development funding
- how CHPs will influence the use of integrated funding streams, e g children
- the staffing, financial management and training and development support to enable CHPs to function effectively
- the areas of “earmarked” funding to be devolved to CHPs
- the level of devolved resource transfer funding and support finance
- the lines of accountability

**Schemes of Establishment**

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

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



163. All schemes should be developed through an inclusive process and demonstrate that the views of all stakeholders have been taken into account. Where a CHP is proposed which is coterminous with one local authority but spans more than one NHS Board area, then the NHS Boards concerned should agree the local CHP arrangements with the local authority and include the arrangements for that entire CHP in their respective schemes of establishment. It should identify the resources that each participating Board will put into that CHP.
164. Schemes must address all areas contained within this guidance and be with the Scottish Executive no later than December 2004. The schemes must include development plans that indicate how CHPs will be supported to deliver the health and services outcomes for which they have devolved responsibility.
165. Once schemes have been approved then NHS Boards will have a statutory duty to implement the schemes within 3 months of approval using the powers afforded to them under paragraph 10 of The Health Boards (Membership and Procedure) (Scotland) Regulations 2001.
166. If schemes are rejected because there is insufficient detail, or NHS Boards have failed to meet the requirements set out in this guidance, then schemes will be returned to the NHS Board with a requirement to resubmit them within a timescale to be determined by Scottish Ministers.
167. Once CHPs have been set up then NHS Boards will be able to extend the range of devolved functions without having to resubmit schemes for approval by Ministers. However, if a NHS Board wishes to substantially alter the nature or number of CHPs in its area then they should submit a new scheme to Scottish Ministers under section 4A(4)(a) of the National Health Service (Scotland) Act 1978, as inserted by section 2 of the National Health Service Reform (Scotland) Bill.



## CHECKLIST FOR SUBMITTING SCHEMES OF ESTABLISHMENT

168. NHS Boards, working in partnership with local authorities, will be expected to demonstrate within their schemes of establishment the nature and extent of devolution of responsibility for functions, services and associated funding to CHPs to enable them to deliver the aims and objectives set out in this guidance. In summary, NHS Boards will be required to include the following in CHP schemes of establishment:

- functions and services which will be devolved to CHPs;
- how CHPs will support improvements in the quality of local services;
- joint resourcing and joint management arrangements with local authorities;
- the role of CHPs in health improvement and community planning
- the role of CHPs in the planning and development of services for the area;
- number and size of CHPs and relationship to local authorities;
- membership of CHP committees
- arrangements for the involvement of the public, patients and carers through public partnership forums
- the role and responsibilities of CHPs in managed clinical and care networks and service redesign
- arrangements for staff involvement in the work of CHPs
- arrangements for involving the voluntary sector
- development plans for CHPs including management and leadership development
- how support services will support CHPs
- devolved budgets and associated financial arrangements
- the accountability arrangements within the NHS, and on a joint basis to the NHS and local authorities in relation to community planning and Joint Future
- the initial management and decision making framework
- how "buy-in" is being secured from frontline staff and other stakeholders