Report To:	**Community Health & Care Partnership Sub Committee**	**Date: 25 August 2011**
Report By:	**Robert Murphy Corporate Director Inverclyde Community Health & Care Partnership**	**Report No: CHCP/35/2011/HW**
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Subject:	**Audit Scotland Review of CHP's – Inverclyde CHCP Position**	

1.0 PURPOSE

1.1 To apprise members of the position of Inverclyde CHCP in respect of the Audit Scotland Review of CHCPs (report published 2nd June 2011), and specifically the key messages within it.

1.2 To clarify the arrangements of Inverclyde CHCP in respect of the key findings of the above review, and offer commentary on action required to be taken.

1.3 The Sub-Committee is asked to note the report and commend the strong arrangements that have been established for Inverclyde CHCP and the work of its Senior Management Team.

2.0 BACKGROUND

2.1 The NHS Reform (Scotland) Act 2004 required NHS Health Boards to establish Community Health Partnerships (CHPs) to bridge the gap between primary and secondary healthcare; and also between health and social care.

CHPs were expected to co-ordinate the planning and provision of a wide range of primary and community health services, both directly managed community health services and services provided by NHS external contractors (i.e. general practitioners, general dental practitioners, community pharmacists and optometrists).

2.2 The Act also set out the expectation that CHPs should have a strategic role in influencing how health and social care resources are used in their areas.

2.3 It is important to note though that the Act clearly did not change the statutory lead responsibility for community care that resides with local authorities. While the Act was accompanied by an "enabling framework", it explicitly did not place a statutory obligation on local authorities to participate in, contribute resources to, or deliver services through the CHP within their respective areas.

3.0 RECOMMENDATIONS

3.1 The Sub-Committee is asked to review the appended position statement for Inverclyde CHCP, as at July 2011, in respect of the key statements made in the Audit Scotland report, and make comment as required.

3.2 It is also recommended that members approve the actions noted in response to key areas of the report, particularly where action is requested of CHCPs/the Council or the Health Board.

3.3 The Sub-Committee should be reassured that locally, strong arrangements are in place and being nurtured; and that the CHCP has - and will continue - to evidence its attention to the success factors helpfully underscored within the substance of the full Audit Scotland Report.

3.4 The Sub-Committee is asked to note the report and commend the strong arrangements that have been established for Inverclyde CHCP.

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4.0 AUDIT SCOTLAND REVIEW

4.1 During 2009/10, Audit Scotland undertook a paper-based survey of Community Health Partnerships and Community Health and Care Partnerships in Scotland. The purpose of the survey was to provide a report that determined whether "CHPs were delivering what they were set up to achieve, including their contribution to shifting the balance of care, and improving the health and quality of life of local people". In addition the report that was produced makes comment on CHPs' governance and accountability arrangements and whether they are using their resources effectively.

The former Inverclyde Community Health Partnership participated fully in the audit, having provided the information requested during August 2010 (within the deadline set), during the period immediately preceding the formal establishment of the CHCP in October 2010.

4.2 The report was considered on the day of publication by the CHCP Senior Management Team, and soon after by the Extended Management Team with a view to creating the appended position statement.

4.3 It should be noted that the process of gathering the information for the survey was done over a very short space of time, with little flexibility in the format of how information was presented. Where information was held locally in formats different to the Audit Scotland format, these were rejected and subsequently reported by Audit Scotland as missing information.

5.0 KEY MESSAGES

5.1 The key messages from the report are summarised in the appendix to this paper, with a statement against each highlighting Inverclyde's position. Furthermore, all of the issues highlighted within the Report are reflective of the wider theoretical evidence-base, with the substance of the Report explicitly accepting the increasingly ambitious agendas and complex environment that CH(C)Ps have to operate and lead within, including that:

- Partnership working across organisational boundaries is complex due to differences in organisational cultures, priorities, planning and performance management, decision-making, accountability and financial frameworks.
- Performance reporting arrangements can be challenging as they need to account for various national and local performance monitoring systems and targets for the NHS and councils which are not necessarily aligned.
- Governance arrangements for integrated CHCPs are generally more complex because they need to take account of different lines of accountability and the existing corporate governance arrangements for both partners.
- Health inequalities are complex, with socio-economic factors such as low income, gender, social position, ethnic origin, age and disability increasing the risks of poor health.

5.2 However, the Report and its recommendations do need to be set in context as it gives little analysis of the background to the creation of CHPs. For example the Report does not comment on the emphasis evident within the Scottish Executive's original Statutory Guidance for Community Health Partnerships that there was to be *no "one size fits all" approach:* individual NHS Boards and local authorities had to agree what best suited their needs; and while there were minimum requirements for devolvement of NHS resources and responsibilities, CHPs were always intended to evolve according to local circumstances.

As such, it was both wholly appropriate and indeed inevitable that the organisational arrangements for CH(C)Ps across Scotland would vary given the wide parameters set for NHS Boards; the legitimate discretion afforded to individual local authorities in relation to how they wished to pursue an integrated health and care service agenda; and the differing circumstances and priorities within local areas.

5.3 As a part consequence of this, the Report makes broad comparisons and generalisations across CH(C)Ps that have been given differing strategic mandates and service responsibilities as well as operating at differing points along an integrated health and social care journey. The Report does not provide any comparative analysis of CH(C)Ps against the evidence-base available on other models of community health and care service structures/models (e.g. the preceding local health care co-operative arrangements, the limitations of which are well established).

6.0 IMPLICATIONS

6.1 Legal: None

6.2 Finance: None

Cost Centre	Budget Heading	Budget Year	Proposed Spend this Report	Virement From	Other Comments

63 Personnel: None

6.4 Equalities: None

7.0 CONSULTATION

7.1 This report has been prepared to guide internal discussion, thus no consultation with the public or our wider CHCP staff group has taken place.

8.0 LIST OF BACKGROUND PAPERS

8.1 Audit Scotland Review of Community Health Partnerships (June 2011).

8.2 Inverclyde CHCP Joint OPR Submission May 2011.

8.3 Inverclyde CHCP Directorate Plan 2011/12.

8.4 Inverclyde CHCP Scheme of Establishment, October 2010

Audit Scotland Review of Community Health Partnerships – June 2011

Key messages	Inverclyde Position
CHPs' governance and accountability arrangements are complex and not always clear, particularly for integrated CHPs. There is scope to achieve efficiencies by reducing the number of partnership working arrangements for health and social care. Information on costs and staffing, financial management and performance reporting all need to be improved.	Streamlining of partnership arrangements had already begun prior to establishing the CHCP. Since establishment, key groups such as Staff Partnership Fora and Health and Safety Committees have also been developed to harmonised. The Clinical Governance Board will be developed to incorporate Care Governance and Quality Assurance across the full range of CHCP services. We are committed to continuously improving information on costs and staffing, financial management and performance reporting. Access to financial information is improving and will be further strengthened by the implementation of the SWIFT finance module in 2011/12, allowing for financial data and budget management to be linked to performance data more efficiently. Our access to performance data is continually improving and has significantly improved since the establishment of the CHCP, and via improvements in data management and reporting centrally from the health board.
The role, responsibilities and accountability arrangements for CHPs are not always clear. For example, important documents, such as standing orders and schemes of delegation are out of date or inconsistent with the original schemes of establishment for CHPs. In many areas, NHS boards' local delivery plans, CHPs' development plans and councils' social care service plans do not explicitly set out a joint vision, priorities, outcomes or resources for health and social care. Performance monitoring is not clearly linked to local strategies.	Standing orders and the Scheme of Delegation are up to date and in line with our SoE. The NHS Board has agreed to develop a Corporate Plan derived from the LDP, and our Directorate plan reflects that plan as well as the Council's Corporate Plan; our local priorities; intended outcomes, and our resources. We have explicitly articulated our CHCP vision and our performance monitoring and reporting arrangements, and have made progress in that regard via the most recent update to our CHCP Development Plan. We have begun to record health performance data on the Council's electronic performance management system (QPR) to facilitate integrated performance reporting. Similarly, council performance data is reported to the health board via the Joint Organisational Performance

	Review process.
Performance reporting arrangements for CHPs can be challenging as they need to take account of the various national and local performance monitoring systems and targets for the NHS and councils which are not necessarily aligned. At a local level, CHPs have different performance reporting arrangements and the content and frequency of performance reports to CHP committees, NHS boards and councils are also varied. This needs to be addressed, particularly where they have integrated services in place or where they have delegated services and budgets to CHPs.	The frequency and content of local performance reports should be determined by the requirements and imperatives of our CHCP Committee, rather than by Audit Scotland. Significant improvements have been made in integrating the management of performance data and the reporting of these data to the respective organisations. Systems and processes are being merged to facilitate this, as far as possible within the confines of information governance.
Few CHP committees have a financial scrutiny role and the frequency and content of financial reporting to NHS boards, CHPs and council committees varies. Not all reports provide sufficient explanation of reasons for budget under spends, overspends or emerging cost pressures. There is also a lack of evidence of discussion or challenge at many CHP committee meetings on finance and performance reports.	Detailed financial reports are submitted to our CHCP Committee, and are discussed from a scrutiny perspective.
Guidance on good governance for joint services recommends that formal partnership agreements are in place which detail joint financial and other resource arrangements. However, NHS boards and councils do not always have agreements in place covering services which the council has delegated to the CHP. Where agreements are in place, these do not always cover all financial and other joint resourcing arrangements between partners. This is a potential risk to NHS boards and councils in case of dispute at a later date or in the event of relationships deteriorating.	Formal partnership agreement is in place.
Governance arrangements for integrated CHPs are generally more complex because they need to take account of different lines of accountability and the existing corporate governance arrangements of both partners. There are increased risks that there is a lack of transparency in how decisions are taken, people make decisions outwith their levels of delegated authority and that decision-making is slow.	We believe that our governance arrangements are robust, but we will consider, with the SMT, EMT and Committee Members, the presumption of increased risk of lack of transparency in how decisions are taken.

Joint workforce planning and arrangements for managing joint health and social care staff is generally underdeveloped. Around a fifth of the 25 CHPs which have joint appointments still do not have protocols or processes to deal with all aspects of performance management, grievance and disciplinary matters and differing employment terms and conditions.	We are considering the option of honorary contracts being established for managers with both health and social work staff. A process is being developed for the recruitment on a joint basis of staff to the CHCP.
In 15 council areas CPPs have established health and well-being thematic partnership groups in addition to the CHP committee.	The Health Inequalities Outcome Delivery Group (HIODG) for the SOA Outcome 5 (tackling health inequalities) scopes work that can benefit from the additionality afforded by a CPP approach. The CHCP Committee focuses on workstreams that are the sole responsibility of the CHCP. If the CHCP subsumes the HIODG portfolio, there is a risk that partners will regard health inequalities as solely the CHCP's responsibility rather than this being shared.
The cluttered partnership arrangements have led to a lack of clarity or duplication in roles and functions between the CHP and other partnerships. There is a lack of information on the time and overall cost to each organisation of their partnership activity but there is scope to achieve efficiencies by streamlining and reducing the number of partnership arrangements.	Streamlining of partnership arrangements had already begun prior to establishing the CHCP and continues within CPP arrangements as well as interfaces with the Council; NHS Board; voluntary sector; public engagement and Acute sector partners.
A more systematic, joined-up approach to planning and resourcing is needed to ensure that health and social care resources are used efficiently. This should be underpinned by a comprehensive understanding of the shared resources available. National work is under way to improve this. To date, few CHPs have been able to influence how resources are used across the whole system. At a CHP level, information on resources, including on staff, is not well developed. GPs indirectly commit significant NHS resources but are not fully involved in decisions about how resources are used.	CHCP arrangements will ensure a more systematic, joined-up approach to planning and resourcing. We will work with the NHSGGC Board to developing a clearer understanding of the level of resources committed by GPs, and how they can be more directly involved in Board and CHCP decisions, although we do have an active GP Forum and Professional Executive Group which afford engagement opportunities for our GP partners. Work has begun to improve the availability of resources information to inform planning on an integrated basis – a good example of this is in relation to our work on Reshaping Care for Older People where an inputs analysis is being taken on an iterative basis to track change linked to outcomes for people. Similar work in relation to mental health and addictions had begun pre CHCP and has further been strengthened since.

NHS boards and councils do not have sufficient understanding of their service costs and how this is influenced by activity levels to make informed decisions about how they allocate their combined available resources. The Scottish Government is leading a national Integrated Resource Framework (IRF) which aims to address this.	We will work with our IRF data when it received by the CHCP (this was due June 2011, but is not yet available).
The first phase of the IRF involves NHS boards and councils mapping cost and activity information for health and adult social care to provide a picture of how resources are being used for their local population. All NHS boards, except NHS Shetland, completed initial mapping of their cost and activity information by March 2011. However, progress by councils is variable and needs to improve.	Awaiting Inverclyde IRF data, as noted above.
There is significant variation in the extent to which NHS boards have devolved services and budgets to CHPs although most are responsible for a number of core primary and community health services. This ranges from the three CHPs in Ayrshire which do not directly manage services but influence how health and social care services are planned and resources used in their area – through to Argyll and Bute CHP which is the only CHP to manage all community and acute health services.	It is unclear why Audit Scotland regard this variation as problematic. The level of devolution is constantly changing and that is, rightly, based on local landscape and circumstances. Inverclyde CHCP would rank as one of the integrated CHCPs with the highest level of devolution to manage services, particularly since inpatient mental health services were devolved in April 2011.
GPs and clinical professionals are not yet fully involved in service planning and resource allocation. The lack of influence CHPs have over overall resources is a barrier to better engagement with GPs. This needs to be addressed because GPs influence a large proportion of the NHS budget as a result of their clinical decisions – an estimated £3 billion of NHS spending in 2009/10. There is significant variation in GP referral and prescribing patterns, and 15 CHPs overspending against their GP prescribing budget in 2009/10.	GPs are not a homogeneous group. The vast majority of them wish only to be clinicians and focus on individual patient's care needs and are only concerned re planning issues when they impact, either positively or negatively, on their patients. Initiatives need to take cognisance of this, identify some structures which will provide a representative function and utilise the opportunities afforded by QP QOF, the change fund etc. Addressing this deficit will raise questions regarding the availability and validity of data used and also of the budget setting process. Our recent OPR process did reflect significant improvements in reducing the prescribing costs of the CHCP, and further work is planned to deliver on the rational prescribing targets in 2011/12. In additional significant work has been done to work with GPs in

	relation to prescribing patters, their compliance with formulary medication and the prescribing of antidepressant medication. This has involved good joint working between the GP community and CHCP employed staff.
NHS boards, councils, GPs and other health and social care providers need to work together to move some services out of hospital into the community and nearer to the service user's home. CHPs have a key role to play. However, while some CHPs have a strategic role, others are wholly operational, responsible for delivering specific services and have little influence in setting overall health and social care priorities and deciding on how resources are used across the whole system.	This cannot be achieved by CH(C)Ps alone but rather, needs to be driven at Board level. The model proposed by Audit Scotland would require acute services to be part of CH(C)Ps, which would in turn require significant re-organisation and review of SoEs and governance arrangements.
Overall there has been a slight increase in the percentage of total NHS resources being spent in the community between 2004/05 and 2009/10. But there has been no change in the percentage of NHS resources transferred to councils for social care services during this same period. It is not possible to carry out a more detailed review of activity because of poor information on community health services and data systems have not kept pace with changes to how services are being delivered.	Applies to health-only CHPs
At a CHP level, information on resources is not well developed. There are significant gaps in workforce information which means that CHPs are generally unable to demonstrate whether they are planning and managing their workforce efficiently. Many CHPs were unable to provide details of vacancies, turnover and sickness absence rates for key staff groups.	The former Inverclyde CHCP provided all of the requested information to Audit Scotland and we are now working on developing processes which will allow us to take information from both parent organisations to enable us to provide robust and meaningful performance reports for the CHCP.
There are some significant, long-standing and complex health and social care issues in Scotland which no partner can tackle on its own and which need action across the whole system. CHPs are not always able to demonstrate their specific contribution to improving the health of local people or shifting services from hospitals to community settings.	We can demonstrate some of the high level improvements but have historically started from a low baseline re health inequalities in Inverclyde. Shifting services out of hospitals needs to be driven at Board level, or else the IRH would need to be transferred to the CHCP. people or shifting services from hospitals to community settings.

In respect of evidencing a shift in the balance of care; our change fund is being heavily performance managed to allow us to show on a short term and longer term basis what improvements have been made, specifically |

in respect of the shift in the balance of care. In respect of tackling health and social issues; it is difficult to track improvements ins health and social status over short periods of time to meet the requirements of those who seek to understand the results of inputs on a short term basis. We have put in place a range of new measures that should help address this, but it should be acknowledged that the impact of our intervention may not be fully felt for a generation Our recent Organisational Performance Review report demonstrates where significant impact has been made from a service delivery point of view in respect of health and social inequalities, particular in respect of tobacco and child healthy weight.	Whilst the number of emergency hospital admissions has risen in Inverclyde (in common with most areas) once vulnerable people are known to us, we work hard to avoid repeat admission, using tailored support, developed using SPARRA data. As a result, in Inverclyde there has been a reduction in the number of older people with two or more emergency hospital admissions from 876 in 2009/10 to 834 during 2010/11. This equates to a reduction in the number of actual admission episodes from 2,308 to 1,696 respectively. CHCP arrangements have allowed us to take a more rounded approach to identifying and supporting those older people who have already had an emergency admission, with a view to preventing future admissions if possible. A strategic framework approach is being developed locally for Long Term Conditions and via the change fund for older people. It is in these areas that we see the most impact in emergency admissions. There is some evidence of analysis that has been done linked to key projects (such as the COPD telehealth pilot) but work to embed research and analysis as core is required, and has started via our Clinical Improvement Steering Group.
A number of CHPs are able to show slight reductions in the number of emergency hospital admissions for particular client groups in their area since initiatives were set up. However, many initiatives were set up using short-term funding rather than from savings released from acute hospitals and there is often a lack of analysis of the overall effect on costs as a result of service changes.	
There are signs that the delayed discharge position is beginning to get	In Inverclyde, during most months we continue to successfully meet the

worse. For example, between April 2008 and January 2011, total delayed discharges increased from 434 to 790. Seasonal fluctuations do not fully account for this as total delayed discharges were 30 per cent higher in January 2011 than in January 2010. There is a similar picture for delayed discharges of over six weeks.	challenge of zero delayed discharges, based on the national definition, providing a good foundation for us to face the challenge of reducing the number of bed days lost to delayed discharges.
Despite initiatives aimed at supporting older people to stay at home longer, emergency admissions for older people increased in three-quarters of CHP areas between 2004/05 and 2009/10. Over the same period, there was also an increase in the number of older people admitted to hospital as an emergency on more than one occasion in-year in Scotland.	It is very difficult to verify this statement as during the timeframe specified, health service arrangements in Inverclyde varied from being part of the former NHS Argyll & Clyde; being part of the newly formed NHS Greater Glasgow & Clyde (from 2006); having the Local Health Care Co-operative in place; the setting up of the CHP in 2007, and then finally the CHCP in 2010. These different arrangements employed different measurement definitions so it is unlikely that the report is comparing like with like with regard to Inverclyde. Our Change Fund Plan does however place specific emphasis on reducing emergency hospital admissions in respect of older people, in recognition that such a reduction is in line with the preferences of our older people. Also, evidence shows that avoiding hospital admission where possible leads to faster recovery and overall improved outcomes.
Between 2004/05 and 2008/09, the number of emergency admissions for people with ambulatory care sensitive conditions grew in Scotland, although this varies for individual conditions across CHPs. For example, rates of emergency stays for people with angina decreased in approximately two-thirds of CHPs; rates increased in around half of CHPs for people with asthma and people with diabetes complications; while rates increased in most CHPs for people with COPD. There is no single CHP which is performing well on all indicators that we looked at as part of the audit.	The issues about data consistency and comparability noted above also apply to this issue; however we are developing a strategy on long term conditions which will pick up on these key issues. We have high prevalence of the 4 main long term conditions (Asthma, Diabetes, COPD and Chronic Heart Disease), and resultant issues with hospitalisation despite a continually improving picture in terms of what we have on offer in community services.
CHPs have a key role in developing preventative health services. Since they were established the percentage of mothers smoking during pregnancy decreased in all but four CHP areas. Over the same period, the percentage of babies being exclusively breastfed at eight weeks increased in three CHP areas and decreased in 26 CHP areas. Between 2004-06 and 2007-09, hospital admission rates for alcohol-	In line with most other areas, Inverclyde saw a small reduction in the percentage of mothers smoking during pregnancy from 21.5% from October 2009 – September 2010, to 20.9% from January – December 2010 (annualised percentages are used due to low absolute numbers). We also saw a small improvement in breastfeeding rates from 15.4% to 15.8%. For the same period, there was a slight reduction in hospital

Key recommendations	
	admission rates for alcohol related problems, from 12.6 per 1,000 population to 11.8. The Inverclyde rate however remains higher than the Scottish average. We have been unable to acquire data relating to drug-related hospital admissions to CHCP level due to low absolute numbers and the risk of being able to identify individuals from the data, so are unable to comment on Audit Scotland's assertion.
related problems increased in three-quarters of CHP areas, and drug-related hospital admissions increased in all but eight CHP areas.	
The Scottish Government should	
Work with NHS boards and councils to undertake a fundamental review of the various partnership arrangements for health and social care in Scotland to ensure that they are efficient and effective and add value.	CHCPs must be part of agreeing the methodology for this. There were significant limitations of the initial Audit Scotland Review of CHCPs where the data that was requested has impacted on the picture that has been reported and assumptions being made by Audit Scotland about operating models without any clear rationale or options appraisal.
Work with NHS boards and councils to help them measure CHP performance, including the effectiveness of joint working. This should include streamlining and improving performance information for SOA, HEAT and other performance targets to support benchmarking.	Inverclyde CHCP would welcome this.
Update and consolidate guidance on joint planning and resourcing for health and social care. This should cover the use of funding, staff and assets, to support NHS boards and councils develop local strategies for joining up resources across the whole system.	We await the Scottish Government's guidance on the next steps for the Integrated Resource Framework.
Progress the eCare agenda to help address local barriers to sharing information for planning and service delivery purposes.	Four NHS Boards are currently connected to eCare with another five in process. The Scottish Government needs to develop a clear national policy view and actively and practically support its implementation.
NHS boards and councils should:	
Put in place transparent governance and accountability arrangements for CHPs and update schemes of establishment and other governance documents to ensure these are accurate.	Our arrangements are up to date
Have a clear joint strategy for delivering health and social care	This action has been addressed through our Directorate Plan 2011/12

services which sets out roles and responsibilities, processes for decision-making and how risks will be addressed.	
Clearly define objectives for measuring CHP performance which reflect the priorities in the national guidance; agree what success looks like; and implement a system to report performance to stakeholders.	We are putting in place revised performance reporting systems through the QPR and our integrated OPR arrangements
Collect, monitor and report data on costs, staff and activity levels to help inform decisions on how resources can be used effectively and support a more joined-up approach to workforce planning. This should include information on current and future staffing numbers, and sickness and vacancy rates.	This will be covered by the CHCP's financial framework and routine workforce reports.
Improve CHP financial management and reporting information and ensure that financial reports are regularly considered by the CHP, NHS board and appropriate council committees. This should include any information on overspends.	This is already happening.
Involve GPs in planning services for the local population and in decisions about how resources are used and work with them to address variation in GP prescribing and referral rates.	Any such initiatives would need to avoid being tokenistic from the GP perspective and be outcome focused from a patient perspective. If it were to be other than this, work pressures and resourcing would mitigate against GP involvement.
Use the Audit Scotland checklist (which can be found at http://www.audit-scotland.gov.uk/work/health_national.php) to help improve planning, delivery and impact of services through a joined-up approach.	If this is the best tool available for our needs. There should be recognition of the new SCSWIS e-tool for self assessment which we favour locally.