

# Review of Community Health Partnerships



Prepared for the Auditor General for Scotland and the Accounts Commission  
June 2011

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# Summary



CHPs were set up to help bridge the gap between primary and secondary healthcare, and between health and social care.



## Background

**1.** The NHS Reform (Scotland) Act 2004 required NHS boards to establish one or more Community Health Partnerships (CHPs) in their local area to bridge the gap between primary and secondary healthcare, and also between health and social care.<sup>1</sup> CHPs were expected to coordinate the planning and provision of a wide range of primary and community health services in their area. This includes GP services; general dental services; all community-related health services; mental health services; and community-based integrated teams, such as rapid response and hospital at home services. NHS boards were also given flexibility to devolve any other function or service to the CHP.<sup>2</sup>

**2.** Broadly two different types of CHP have evolved in Scotland – a health-only structure and an integrated health and social care structure. All CHPs, irrespective of type, are statutory committees or subcommittees of NHS boards and are therefore accountable to their NHS board.

**3.** Community Health and Care Partnerships (CHCPs) and Community Health and Social Care Partnerships (CHaSCPs) are integrated health and social care structures. There is no difference between them other than their name. These integrated CHPs are partnership bodies and therefore have dual accountability to both the NHS board and relevant council. We use the term CHPs in this report to cover both types of CHP, unless we specifically mean CHCPs and CHaSCPs, which we will then refer to as integrated CHPs.

**4.** There is at least one CHP in each NHS board area and one or more CHPs share the same geographical boundary with councils. There are 36 CHPs in Scotland although this picture is continually changing.<sup>3</sup> Membership of all CHP committees was defined by the Scottish Executive and must include key NHS stakeholders such as elected members of local councils, GPs and members of the local public partnership forum.<sup>4, 5</sup>

**5.** NHS boards and partners have established different CHP arrangements across Scotland, which means there are significant differences in the size, role, function and governance arrangements of CHPs. We discuss these differences in more detail in Parts 2 and 3 of the report.

**6.** Information on costs, activity and staffing for CHPs is limited although this is basic information needed to deliver effective and efficient services. In 2009/10, CHPs managed around £3.2 billion of health and social care expenditure, approximately 28,500 health and 5,300 social care staff, and other resources such as premises and equipment. This is an underestimate because not all CHPs provided us with information on budgets and staffing.<sup>6</sup>

**7.** The Scottish public sector is facing the tightest squeeze on budgets since devolution. The number of older people in Scotland is projected to rise by 12 per cent between 2010 and 2015 (from 881,000 in 2010 to 991,000), with an 18 per cent increase in the number of people aged 85 and

over (from 106,000 to 125,000).<sup>7</sup> This will increase demand for health and social care services. The Scottish Government has reported that the amount spent on health and social care services would need to increase by £3.5 billion by 2031 if systems remain as they are now.<sup>8</sup> CHPs have been given an important role in facilitating better joined-up working to meet these challenges.

## About the audit

**8.** The overall aim of our audit was to examine whether CHPs are achieving what they were set up to deliver, including their contribution to moving care from hospital settings to the community and improving the health and quality of life of local people. We also assessed CHPs' governance and accountability arrangements and whether CHPs are using resources efficiently. Given the move to integrate services, the report highlights issues for both NHS boards and councils to address.

**9.** We analysed published data on health and social care spending and health indicators. We reviewed relevant policy and other key documents, including NHS board, council and CHP governance, financial and performance information. We also carried out a data survey of all CHPs, collecting information on their governance arrangements, use of resources and performance management.<sup>9</sup> This is the first time this information has been reported in one place.

**10.** In addition, we looked in more detail at different aspects of joint

1 Not all CHPs were established in 2004 – some were not in place until 2006.

2 *The Community Health Partnerships (Scotland) Regulations and Statutory Guidance*, Scottish Executive, 2004.

3 This includes seven integrated CHPs and 29 health-only CHPs.

4 CHP committees must include the CHP general manager, a GP, a nurse, a medical practitioner who does not provide primary medical services, a councillor or officer of the local authority, a staff representative, a member of the public partnership forum, a community pharmacist, an allied health professional, a dentist, an optometrist and a member of the voluntary sector carrying out services similar, or related, to the NHS board.

5 Prior to September 2007, the Scottish Administration was referred to as the Scottish Executive. It is now called the Scottish Government. When dealing with the earlier period this report refers to the Scottish Executive but in all other instances it refers to the Scottish Government.

6 Mid Highland CHP was unable to provide social care expenditure for 2009/10. Health staff are excluded for Borders, and Orkney as this information was not available. Social care staff are excluded for Borders, Dumfries and Galloway, Moray and Orkney CHPs as this information was not available.

7 *2008-based National Population Projections*, Office of National Statistics, 2009.

8 *Reshaping Care for Older People*, Scottish Government, March 2010.

9 The former five Glasgow City CHCPs submitted a partial data survey return with high-level data on overall budgets, costs and staff numbers only.

working between health and social care in six CHPs. We reviewed the:

- circumstances leading to the dissolution of the five Glasgow City CHCPs and the transition to a single, health-only CHP covering the Glasgow City area
- CHP model in Fife
- CHCP model in East Renfrewshire
- governance and operational arrangements within Western Isles CHaSCP
- management and benefits of Clackmannanshire's pooled budget arrangements for its integrated mental health service
- unique devolved responsibilities at Argyll and Bute CHP. This CHP manages all health services and associated budgets.

**11.** We took account of an independent study commissioned by the Scottish Government which looked at the early progress of CHPs, published in May 2010, as well as the government's response to the study which was published in November 2010.<sup>10</sup>

**12.** Appendix 1 outlines membership of our Project Advisory Group. A self-assessment checklist for NHS boards and councils; a policy summary and further information on our methodology can be found on our website: [http://www.audit-scotland.gov.uk/work/health\\_national.php](http://www.audit-scotland.gov.uk/work/health_national.php)

**13.** This report is structured into four main parts:

- Setting the scene (Part 1)
- Governance and accountability (Part 2)

- How resources are used (Part 3)
- Impact on the health and quality of life of local people (Part 4).

### Key messages

- Since devolution, there has been an increased focus on partnership working between health and social care and across the public sector as a whole. CHPs were set up in 2004 with a challenging agenda. They are statutory NHS bodies and were expected to provide certain community-based health services, bridge the gap between primary and secondary healthcare services, and contribute to improving joint working between health and social care. However, these responsibilities did not come with the necessary authority to implement the significant changes required. There are two types of CHP – a health-only structure and an integrated health and social care structure. Irrespective of structure, partnership working depends on good local relationships, a shared commitment and clarity of purpose.
- Approaches to partnership working have been incremental and there is now a cluttered partnership landscape. CHPs were set up in addition to existing health and social care partnership arrangements in many areas. This has contributed to duplication and a lack of clarity of the role of the CHP and other partnerships in place in a local area. There is scope to achieve efficiencies by reducing the number of partnership working arrangements and simplifying performance reporting.

- Partnership working for health and social care is challenging and requires strong, shared leadership by both NHS boards and councils. Differences in organisational cultures, planning and performance and financial management are barriers that need to be overcome. CHPs' governance and accountability arrangements are complex and not always clear, particularly for integrated CHPs. There are some key principles that all partners should follow to improve joint working (Exhibit 5, page 15).
- A more systematic, joined-up approach to planning and resourcing is required to ensure that health and social care resources are used efficiently. There are very few examples of good joint planning underpinned by a comprehensive understanding of the shared resources available. The Scottish Government is developing an integrated resource framework which aims to provide better information on how health and social care money is spent. There are still difficulties in sharing information but some progress has been made in sharing premises.
- Enhancing preventative services and moving resources across the whole system require effective joint working. NHS boards, councils and CHPs have a key role to play in this but it is not possible to identify individual organisation's contributions. We reviewed performance against indicators where we expected people to benefit from new ways of working. While there is variation among CHPs against a range of performance indicators, limited progress has

10 *Study of Community Health Partnerships: Social research*, Scottish Government, 2010; *Community Health Partnerships: Delivering better outcomes and use of joint resources*, Scottish Government, 2011.

been made at a Scotland-wide level. For example, delayed discharges are starting to rise again after a period of steady reduction, and multiple emergency admissions for older people are increasing. In addition, there has been mixed progress in reducing emergency admissions for people with long-term conditions such as angina and chronic obstructive pulmonary disease.

### Key recommendations

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
- 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
- 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
- progress the eCare agenda to help address local barriers to sharing information for planning and service delivery purposes.

NHS boards and councils should:

- work with the Scottish Government to streamline existing partnership arrangements to secure efficiency and effectiveness and ensure they add value
- put in place transparent governance and accountability arrangements for CHPs and update schemes of establishment and other governance documents to ensure these are accurate
- have a clear joint strategy for delivering health and social care 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
- 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
- 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

- 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
- use the Audit Scotland checklist, located on our website, to help improve planning, delivery and impact of services through a joined-up approach.

# Part 1. Setting the scene



CHPs were established in 2004 with a challenging agenda.





## Key messages

- Since devolution, there has been an increased focus on partnership working between health and social care and across the wider public sector as a whole. Approaches have been incremental leading to a cluttered partnership landscape. CHPs were set up in 2004 with a challenging agenda. They were expected to provide certain community-based health services, bridge the gap between primary and secondary healthcare services, and improve joint working between health and social care. However, these responsibilities did not come with the necessary authority to implement the significant changes required.
- There are 36 CHPs in Scotland, varying in size and structure. There are two types of CHP – a health-only structure and an integrated health and social care structure. We found no evidence that either model is more successful in moving services from hospital to the community or joining up frontline health and social care services. Partnership working requires strong, shared leadership from both NHS boards and councils.

**14.** In this chapter, we discuss the:

- history of joint working between health and social care services
- key policies and priorities influencing CHPs
- number, size and geographical location of CHPs

- different structural approaches to managing health and social care across the UK.

### **Over the last decade there have been a number of approaches to improve how the NHS and councils work together**

**15.** There have been a number of approaches to improve joint working between health and social care and a focus on partnership working across the public sector as a whole since devolution. However, the different attempts have had varied success. Approaches to partnership working have often been incremental which has led to the current position where there is a complex and uncoordinated set of partnership arrangements across Scotland.

**16.** In 1999, GP-led Local Health Care Cooperatives (LHCCs) were established across Scotland to bring health and social care practitioners together to deliver services.<sup>11</sup> LHCCs were still in place when the Scottish Executive introduced the Joint Future Agenda in 2000. This encouraged a more formal approach to joint planning and resourcing between health and social care. In 2001, the Scottish Executive set up a Joint Future Unit (JFU) to support local NHS board and council partnerships to progress joint working. The JFU provided detailed guidance and tailored support to local partnerships to establish governance and operational arrangements for the joint management and resourcing of services. By 2003, each council area had its own Joint Future Partnership Group which was responsible for the oversight of joining up health and social care services for their local population.

**17.** The Scottish Executive used the Local Government in Scotland Act 2003 to establish community planning on a statutory basis.<sup>12</sup> The role of community planning is to bring together public sector and other organisations to develop a coordinated approach to identifying and solving local problems, improving services and sharing resources.<sup>13</sup> Community Planning Partnerships (CPPs) were established as the key over-arching partnership and were expected to help coordinate other initiatives and partnerships and, where necessary, rationalise these.<sup>14</sup> CPPs are not statutory bodies.

**18.** Councils have a statutory duty to coordinate community planning in their areas and report annually on overall progress in improving services and outcomes for local people. NHS boards and a number of other public sector bodies have a statutory duty to participate in community planning and provide information to the council on their contribution to enable the council to prepare its annual Single Outcome Agreement (SOA) report (Exhibit 1, overleaf). In 2008, Scottish ministers gave CPPs the lead role in tackling health inequalities.<sup>15</sup> An important part of community planning is to engage with local communities so they can contribute to how services are planned and to support them to contribute to their own well-being. This is also an important feature of health policy in Scotland.

**19.** Around the same time that community planning was introduced on a statutory basis, major changes in the NHS were also being planned separately under the NHS Reform (Scotland) Act 2004. Since 2000, the NHS has been moving towards integrated management of acute and primary care services. The 2004

11 In April 1999, 79 LHCCs were introduced across Scotland under the former Primary Care Trusts (PCTs) to deliver a wide range of primary and community health services and promote joint working with councils and the voluntary sector. The average LHCC included 12 general practices and covered a population of around 60,000.

12 The impetus for community planning came in 1998 when the Scottish Executive and the Convention of Scottish Local Authorities (COSLA) produced guidance to steer councils in the development of Community Planning Partnerships: *Report of the Community Planning Working Group*, COSLA and the Scottish Office, 1998.

13 Organisations participating in community planning include NHS boards, enterprise networks, police, fire and rescue services, and the private and voluntary sectors.

14 <http://www.scotland.gov.uk/Topics/Government/PublicServiceReform/community-planning>

15 *Equally Well: Report of the Ministerial Task Force on health inequalities*, Scottish Government, June 2008.

Act abolished separate acute and primary care trusts and NHS boards were required to manage both primary and acute health services under a single system. As part of the Act, the Scottish Executive also introduced CHPs as committees or subcommittees of NHS boards.

CHPs replaced the previous LHCCs and were to bridge the gap between primary and secondary healthcare, and between health and social care. CHPs were also expected to coordinate the planning and provision of primary and community health services in their area.

**20.** There are a number of key legislation and policy developments that have been instrumental in supporting partnership working in the public sector and, more specifically, joined-up working between health and social care (Exhibit 1).

## Exhibit 1

### Summary of the main legislation and policies to support partnership working across the public sector and better joined-up working between health and social care

There were a number of policies relevant to the development of CHPs.

Date	Policy/legislation	Summary
January 2001	Scottish Executive's Response to the Report of the Joint Future Group	Scottish ministers set up a Joint Future Group to bring forward recommendations to improve partnership working between health and social care and to secure better outcomes for people who use services and their carers. The Scottish Executive accepted the majority of the group's recommendations in its response.
March 2002	Community Care and Health (Scotland) Act 2002	This Act increased the flexibility for NHS boards and councils to work together to improve outcomes for people by enabling them to delegate functions and make payments to each other. The Act also introduced the Joint Future Agenda to take forward the Joint Future Group's recommendations. Joint Future partnerships between NHS boards and councils were expected to have in place Local Partnership Agreements setting out their arrangements for joint resourcing and joint management for older people's services by April 2002. This was extended to cover other community care services by 1 April 2003.
February 2003	Partnership for Care, Scottish Executive, February 2003	This White Paper included proposals to increase patient-centred care. It called for the establishment of CHPs to bridge the gap between primary and secondary healthcare and between health and social care.
February 2003	The Local Government in Scotland Act 2003	This Act provided a statutory framework for the community planning process to ensure a long-term commitment to effective partnership working with communities and between local authorities and other key bodies and organisations. It also made provision for ministers to issue guidance about participation in community planning.
March 2003	<i>Community Planning Guidance</i> , Scottish Executive, 2003L	This guidance sets out the Scottish Executive's priorities and advice on certain aspects of partnership working for public sector bodies. The guidance is illustrative and is not intended to cover all aspects of activity in relation to community planning.
June 2004	NHS Reform (Scotland) Act 2004	This Act abolished separate primary care trusts and acute trusts and created unified NHS boards to manage the NHS under a single system. It also required NHS boards to establish one or more CHPs as a subcommittee of the NHS board to cover the whole geographical area of the board. One or more CHPs in a board area together share the same geographical boundary with councils.

Date	Policy/legislation	Summary
October 2004	The Community Health Partnerships (Scotland) Regulations 2004 and Statutory Guidance	The regulations included nine priorities for CHPs (Exhibit 2, page 10). They also required NHS boards to set out detailed arrangements for their CHPs in board-wide schemes of establishment. The guidance stipulated certain management and operational arrangements for CHPs, including committee membership, appointments process and conduct of committee proceedings.
May 2005	<i>Building a Health Service Fit for the Future: National Framework for Service Change</i> , Scottish Executive, May 2005	This policy set out a new approach for the NHS which focused on more preventative healthcare and treatment delivered more quickly and closer to home. The policy identified a key role for CHPs in shifting the balance of care and delivering health improvements according to local needs.
November 2005	<i>Delivering for Health</i> , Scottish Executive, September 2005	The Scottish Executive's action plan for implementing the National Framework for Service Change recommendations.
April 2007	Scotland Performs – A national performance framework, Scottish Government, 2007	As part of the Scottish Budget Spending Review 2007, the Scottish Government introduced a national performance framework to track progress towards its overarching purpose 'to create a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable economic growth'. Scotland Performs included a number of performance targets for the public sector to work towards, in the form of 15 national outcomes and 45 national indicators.
November 2007	Concordat between the Scottish Government and local government, Scottish Government, 2007	The concordat agreement changed the relationship between the Scottish Government and councils. It gave councils more local flexibility in the way they spend the money received from the Scottish Government. This was largely achieved through the removal of a substantial number of ring-fenced funding streams. Initially councils were required to develop a Single Outcome Agreement (SOA) outlining the strategic priorities, expressed as local outcomes, for the council area. From 2009/10 onwards, CPPs were required to be fully involved in developing and agreeing the SOAs. This established SOAs as the main framework for aligning public sector activity towards agreed priorities.
December 2007	<i>Better Health, Better Care</i> , Scottish Government, December 2007	This set out the Scottish Government's vision and five-year action plan for the NHS. It gave CHPs lead responsibility for working with their partners to move more care out of hospitals and into the community.
May 2010	NHSScotland Quality Strategy – putting people at the heart of our NHS, Scottish Government, May 2010	This strategy builds on the Better Health, Better Care strategy. It set three quality ambitions to support the Scottish Government's aim of delivering the best quality healthcare to people in Scotland. It also identified the need for effective joint working between health and social care to move more services from hospitals to the community.

Source: Audit Scotland, 2011

**21.** The 2004 statutory guidance set CHPs a challenging agenda. The guidance required them to focus on nine broad priorities to move care from hospital settings to communities where appropriate, and for the integration of health and social care (Exhibit 2).

**22.** Since CHPs have been in place, community planning and, more specifically, health and social care policy, have continued to develop and the expectations of what CHPs should do have become wider and more complex. However, the Scottish Government has not updated the 2004 statutory guidance for CHPs to reflect these changes although it has committed to do this after we publish our report.<sup>16, 17</sup> The role and responsibilities of each of the CHPs in Scotland vary and in many areas they have evolved in response to changes in policy, the economic climate and other local circumstances (see Part 3 for further details).

#### There are 36 CHPs, each with different local arrangements

**23.** At November 2010, there were 29 CHPs and seven integrated CHPs although this picture is continually changing (Exhibit 3). There were 30 CHPs and ten integrated CHPs when we started our fieldwork in June 2010.

**24.** The size of the population covered by individual CHPs varies, from 19,960 people in Orkney to 477,660 people in Edinburgh City. Highland and Fife have more than one CHP covering the council area.

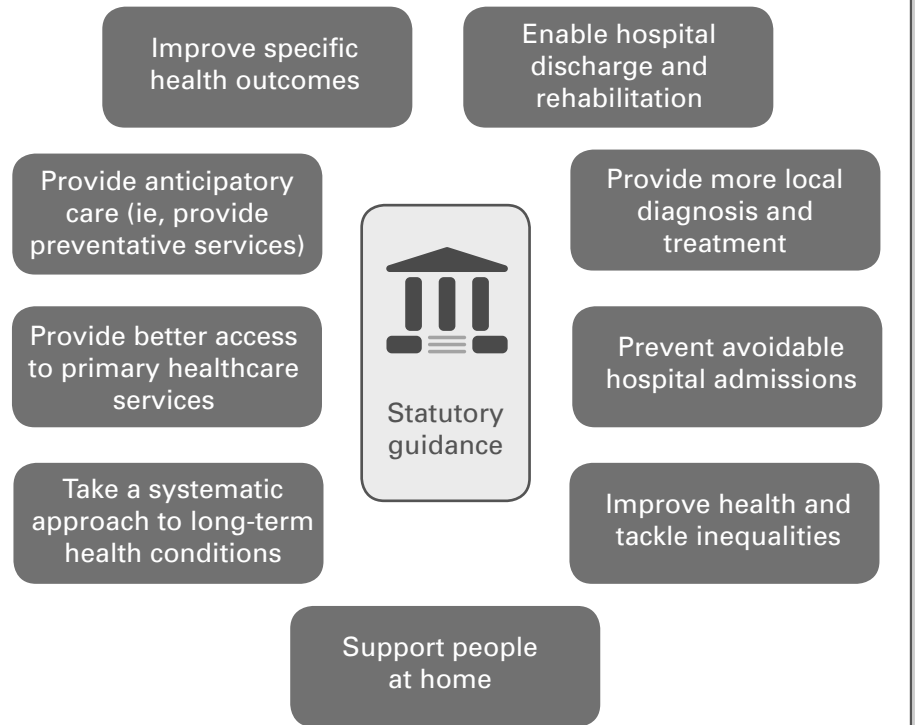
#### Health and social care are managed differently across the UK

**25.** Health and social care services are managed differently across the UK but they face the same

### Exhibit 2

#### Summary of 2004 statutory guidance for CHPs

The statutory guidance for CHPs focused on nine priorities.



Source: *Community Health Partnerships Statutory Guidance*, Scottish Executive, 2004

major challenges of an increasing demand for services while budgets are reducing. Each country is taking different approaches to bring health and social care together aimed at making best use of resources and improving care (Exhibit 4, page 12).

**26.** The UK Government's White Paper, *Liberating the NHS*, sets out proposals for reforming the NHS in England. These include abolishing primary care trusts by 2013 and giving GPs responsibility for commissioning services, while local authorities will take on responsibility for health improvement. If implemented, the proposals would significantly change the role of GPs in England. The UK-wide General Medical Services (GMS) contract would need to be

reviewed to take account of this. This may have future implications for Scotland and the rest of the UK.

#### There is no evidence that one structural approach is better than another

**27.** A recent study looked at three approaches to joining up health and social care in England. It concluded that it is possible to integrate services without organisations changing how they are structured, but effective local leadership and a commitment to develop partnership working over a sustained period is needed. The report also highlighted that although health and social care are delivered through single organisations in Northern Ireland, there are still

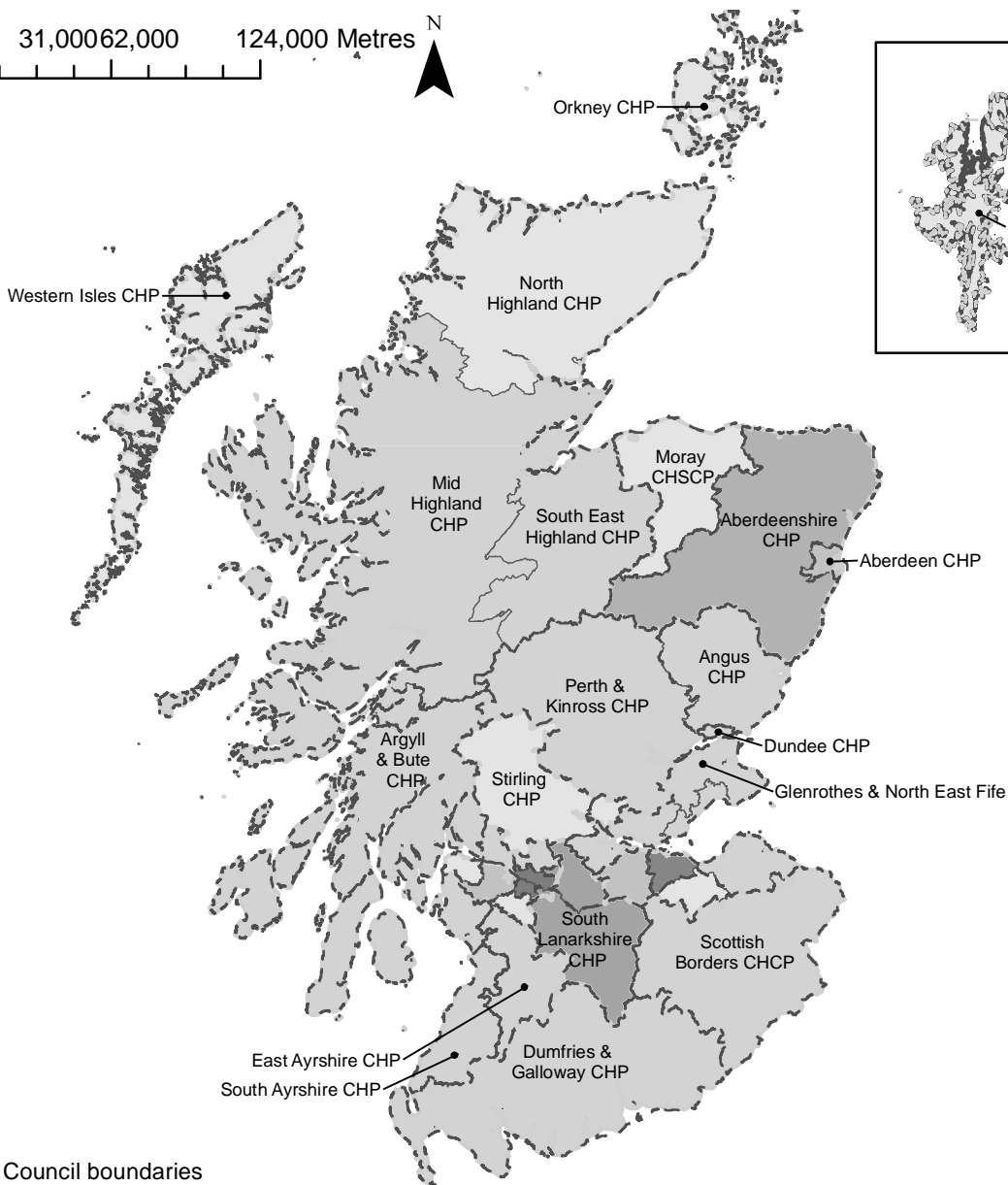
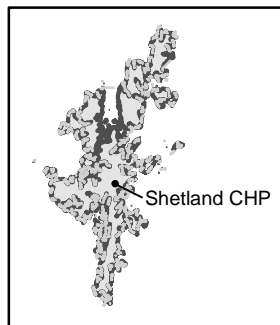
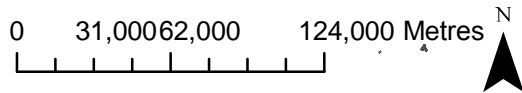
<sup>16</sup> *Community Health Partnerships: Delivering better outcomes and use of joint resources*, Scottish Government, 2010.

<sup>17</sup> The Scottish Government has issued guidance on various service areas for the attention of CHPs, including guidance on integrated mental health services and on improving the health and well-being of people with learning disability and/or autistic spectrum disorder.

**Exhibit 3**

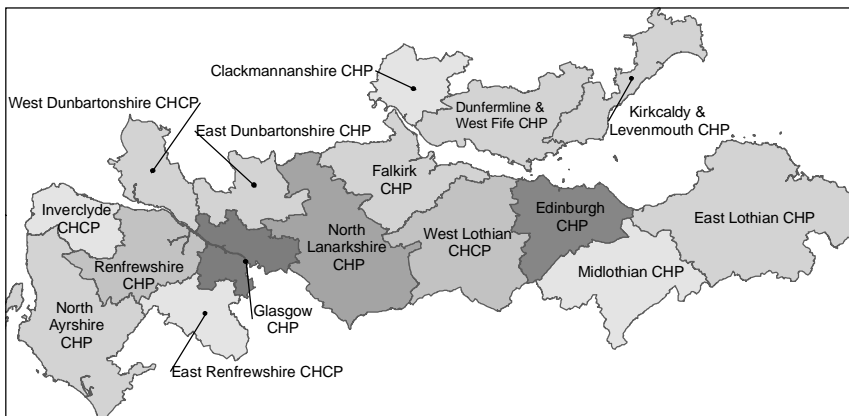
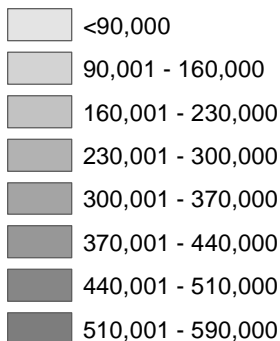
**CHP, NHS board and council boundaries**

CHPs share NHS board and council boundaries.



- Council boundaries
- Health board boundaries

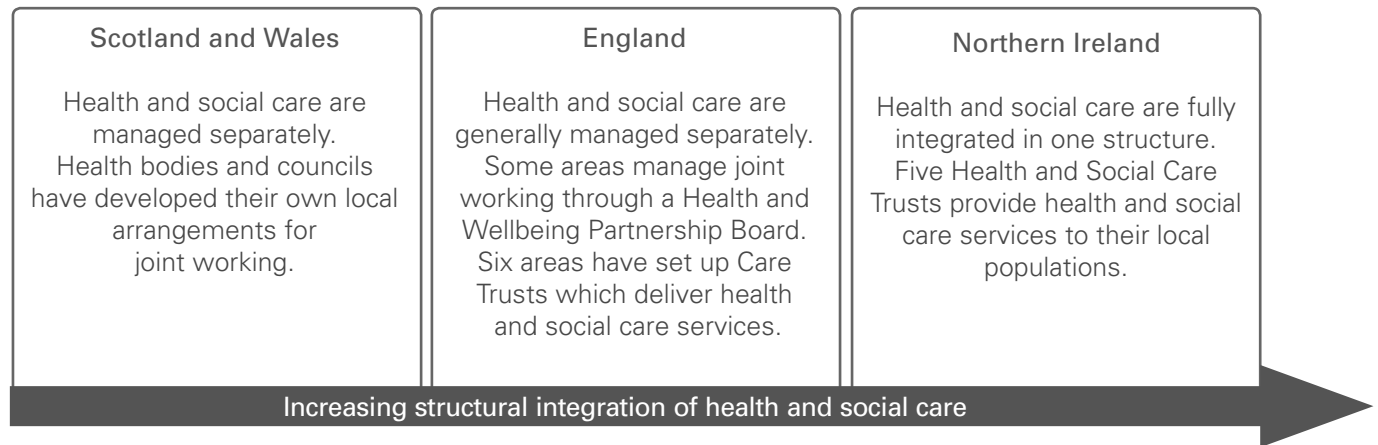
**2009 Population**



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**Exhibit 4****UK health and social care structures**

Different approaches to joining up health and social care have been taken across the UK.



Source: Audit Scotland, 2011

difficulties with a lack of integrated team working between staff who provide health and social care.<sup>18</sup> These messages from the rest of the UK resonate with the findings from our fieldwork. We found no evidence of one structural approach being better than the other in moving services from hospital to the community or in joining up frontline health and social care services (see Parts 2, 3 and 4).

18 *Integrating Health and Social Care in England: Lessons from Early Adopters and Implications for Policy*, Health Services Management Centre, University of Birmingham, 2010.

# Part 2. Governance and accountability



Governance and accountability arrangements for CHPs are complex and not always clear.



## Key messages

- Partnership working between two or more organisations is challenging due to the need for clear accountability arrangements to each partner and differences in organisational cultures, planning and performance and financial management.
- Good governance is important to ensure decision-making is clear and appropriate and that public money is properly accounted for. There are some key principles that all partners should follow to improve joint working.
- CHPs' governance and accountability arrangements are complex and not always clear, particularly for integrated CHPs. Schemes of establishment do not always reflect what is happening in practice. Few CHPs and councils have comprehensive partnership agreements in place for delegated or joint services.
- NHS boards and councils have yet to develop a joined-up approach to workforce planning. It is not always clear what partners are trying to achieve through joint posts and in many instances partners need to improve their arrangements for managing staff in joint teams.
- In many areas, CHPs were set up in addition to other existing health and social care partnership arrangements. This has contributed to duplication and a lack of clarity of the role of the CHP and other partnerships in place in the local area. There is scope to achieve efficiencies by reducing the number of partnership working arrangements, improving financial management and simplifying performance reporting.

28. In this chapter, we discuss:

- the key principles of good governance in public services as applied to partnership working
- CHP governance and accountability arrangements, including performance and workforce management arrangements
- links and potential duplication between CHPs and other health and social care partnerships, including CPPs.

### **There are some key principles that partners should adopt to improve joint working**

29. Governance in health and social care is essentially about making sure decisions are made in a clear and appropriate way to ensure that public money is properly accounted for, and that care is delivered to nationally set or locally agreed standards.

30. Good governance is critical to successful partnership working. It provides a framework for managing performance and risks, and ensuring accountability for securing efficiency and effectiveness. Partnership working across organisational boundaries is challenging due to differences in organisational cultures, priorities, planning and performance management, decision-making, accountability and financial frameworks. Strong leadership by NHS boards and councils is needed to improve how health and social care services are delivered and make best use of available resources. Successful partnership working can be achieved where partners adopt some key principles which we have drawn from various sources, including guidance, toolkits and published studies on partnership working, including our own work in this area (Exhibit 5).

### **Governance and accountability arrangements for CHPs are not always clear and need to improve**

31. The role, responsibilities and accountability arrangements for CHPs are not always clear. In addition, some important documents, such as standing orders and schemes of delegation, are out of date or inconsistent with the original schemes of establishment for CHPs. Many CHPs have evolved over time but few NHS boards have updated their schemes to reflect key changes since their inception. The statutory guidance requires NHS boards to obtain ministerial approval for key changes to the structure or functions of CHPs, but not all NHS boards have sought approval for changes.

32. Few CHP committees have a financial scrutiny role. Where CHP committees receive financial reports, there is often a lack of evidence of discussion or challenge on these. The frequency and content of financial reporting to NHS boards, CHP and council committees are variable. For example, frequency of reporting varies from monthly to quarterly; and not all reports provide sufficient explanation of actual or potential budget under/overspends, emerging cost pressures or reasons for moving money between budget headings. NHS boards and councils are ultimately accountable for public funds devolved or delegated to CHPs and need to strengthen financial monitoring and control of CHP budgets.

### **Performance reporting requirements for CHPs are overly complicated**

33. Effective planning and performance management underpins good governance. NHS boards are ultimately accountable for the strategic leadership of their CHPs and for agreeing joint local priorities and performance management arrangements for CHPs with their local council partners. Where integrated CHPs are in place, councils are also jointly responsible with their NHS partners for this.



**Exhibit 5****Good governance principles for partnership working**

There are several key principles for successful partnership working.

Key principles	Features of partnerships when things are going well	Features of partnerships when things are not going well
<b>Behaviours</b>		
<p>Personal commitment from the partnership leaders and staff for the joint strategy</p> <p>Understand and respect differences in organisations' culture and practice</p>	<ul style="list-style-type: none"> <li>• Leaders agree, own, promote and communicate the shared vision</li> <li>• Leaders are clearly visible and take a constructive part in resolving difficulties</li> <li>• Be willing to change what they do and how they do it</li> <li>• Behave openly and deal with conflict promptly and constructively</li> <li>• Adhere to agreed decision-making processes</li> <li>• Have meetings if required but focus of meetings is on getting things done</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of leader visibility in promoting partnership activities (both non-executive and executives)</li> <li>• Be inflexible and unwilling to change what they do and how they do it</li> <li>• Adopt a culture of blame, mistrust and criticism</li> <li>• Complain of barriers to joint working and do not focus on solutions</li> <li>• Take decisions without consulting with partners</li> <li>• Have numerous meetings where discussion is about process rather than getting things done</li> </ul>
<b>Processes</b>		
<p>Need or drivers for the partnership are clear</p> <p>Clear vision and strategy</p> <p>Roles and responsibilities are clear</p> <p>Right people with right skills</p> <p>Risks associated with partnership working are identified and managed</p> <p>Clear decision-making and accountability structures and processes</p>	<ul style="list-style-type: none"> <li>• Roles and responsibilities of each partner are agreed and understood</li> <li>• Strategies focus on outcomes for service users, based on analysis of need</li> <li>• Have clear decision-making and accountability processes</li> <li>• Acknowledge and have a system for identifying and managing risks associated with partnership working</li> <li>• Agree a policy for dealing with differences in employment terms and conditions for staff and apply this consistently to ensure fairness</li> <li>• Review partnership processes to assess whether they are efficient and effective</li> </ul>	<ul style="list-style-type: none"> <li>• Roles and responsibilities of each partner are unclear</li> <li>• Unable to agree joint priorities and strategy</li> <li>• Lack of clarity on decision-making processes</li> <li>• Partnership decision-making and accountability processes are not fully applied or reviewed regularly</li> <li>• Risks are not well understood or managed through an agreed process</li> <li>• Deal with differences in employment terms and conditions for staff on an ad hoc basis</li> </ul>

Continued overleaf

Key principles	Features of partnerships when things are going well	Features of partnerships when things are not going well
<b>Performance measurement and management</b>		
<p>Clearly defined outcomes for partnership activity</p> <p>Partners agree what success looks like and indicators for measuring progress</p> <p>Partners implement a system for managing and reporting on their performance</p>	<ul style="list-style-type: none"> <li>• Understand the needs of their local communities and prioritise these</li> <li>• Have a clear picture of what success looks like and can articulate this</li> <li>• Have clearly defined outcomes, objectives, targets and milestones that they own collectively</li> <li>• Have a system in place to monitor, report to stakeholders and improve their performance</li> <li>• Demonstrate that the actions they carry out produce the intended outcomes and objectives</li> </ul>	<ul style="list-style-type: none"> <li>• Prioritise their own objectives over those of the partnership</li> <li>• Unable to identify what success looks like</li> <li>• Fail to deliver on their partnership commitments</li> <li>• Do not have agreed indicators for measuring each partner's contribution and overall performance or do not use monitoring information to improve performance</li> <li>• Unable to demonstrate what difference they are making</li> </ul>
<b>Use of resources</b>		
<p>Identify budgets and monitor the costs of partnership working</p> <p>Achieve efficiencies through sharing resources, including money, staff, premises and equipment</p> <p>Access specific initiative funding made available for joint working between health and social care</p>	<ul style="list-style-type: none"> <li>• Integrate service, financial and workforce planning</li> <li>• Have clear delegated budgetary authority for partnership working</li> <li>• Identify, allocate and monitor resources used to administer the partnership</li> <li>• Understand their service costs and activity levels</li> <li>• Plan and allocate their combined resources to deliver more effective and efficient services</li> <li>• Assess the costs and benefits of a range of options for service delivery, including external procurement</li> <li>• Have stronger negotiating power on costs</li> <li>• Achieve better outcomes made possible only through working together</li> </ul>	<ul style="list-style-type: none"> <li>• Do not integrate service, financial and workforce planning</li> <li>• Unable to identify the costs of administering the partnership</li> <li>• Deliver services in the same way or change how services are delivered without examining the costs and benefits of other options</li> <li>• Have duplicate services or have gaps in provision for some people</li> <li>• Plan, allocate and manage their resources separately</li> <li>• Fail to achieve efficiencies or other financial benefits</li> <li>• Unable to demonstrate what difference the partnership has made</li> </ul>

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

**34.** 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, and performance monitoring is not clearly linked to local strategies.<sup>19</sup>

**35.** Performance reporting arrangements for CHPs are burdensome as they need to take account of different national and local planning and performance monitoring systems and targets which have been developing over time. This means that there is a risk that the different requirements may overlap and are not always aligned (Exhibit 6). At a local level, CHPs have different performance reporting arrangements and the content of performance reports to CHP committees, NHS boards and councils is also varied. In some instances, councils do not receive performance reports from CHPs. This needs addressed, particularly where integrated services are in place or where councils have delegated services and budgets to CHPs. While some CHP committees consider performance reports on an exception basis, others receive detailed performance information against a range of national and local performance targets. There is also a lack of evidence of discussion or challenge on performance reports at many CHP committee meetings.

#### **Governance arrangements for joint working are generally weak**

**36.** Guidance on good governance for joint services recommends putting in place formal partnership agreements which detail joint financial and other resource arrangements.<sup>20</sup> However, we found that NHS boards and councils do not always have agreements in place covering services which the council has delegated to

### **Exhibit 6**

#### **Planning and performance management frameworks**

CHPs need to take account of a range of overlapping national and local targets and systems that are not always aligned.

The five national priorities set out in the national performance framework, Scotland Performs	Scotland Performs was set up as part of the 2007 spending review. It aims to measure the contribution of public sector bodies to the Scottish Government's five strategic priorities which are working towards a wealthier and fairer, smarter, healthier, safer and stronger, and greener Scotland.
National Community Care Outcomes Framework	This framework sets out 16 outcome measures under six themes: satisfaction; access; support for carers; quality of assessment, care planning and review; identifying and supporting those at risk of admission to hospital; and shifting the balance of care to support more people at home for longer, promoting self-care rather than reliance on professionals, and providing necessary services and support closer to people's own homes. The framework is voluntary and there is no requirement to report progress to the Scottish Government. NHS boards and councils have set up a national group which from 2010 has begun collating information to allow them to benchmark their performance.
Outcomes and impact measures set out in the Shifting the Balance of Care Improvement Framework	This framework identifies eight broad impact areas that, if delivered, may help shift the balance of care from acute to community settings.
Single Outcome Agreements (SOAs)	SOAs are agreements between the Scottish Government and Community Planning Partnerships (CPPs) which set out how each CPP will work towards improving outcomes for the local people in a way that reflects local circumstances and priorities and national priorities. CPPs can use national indicators where locally relevant, and draw on a menu of local outcome indicators. However, local partners agree their own performance indicators and therefore benchmarking local performance is not always possible.
NHS boards' Local Delivery Plans (LDPs) and HEAT targets	NHS Health improvement, Efficiency, Access, Treatment (HEAT) targets are a core set of ministerial objectives, targets and measures for the NHS as a whole. Each NHS board prepares an LDP on an annual basis which sets out how it plans to meet these targets and measures.

Source: Audit Scotland, 2011

<sup>19</sup> Prior to the introduction of Single Outcome Agreements, partners were required to produce a single Joint Health Improvement Plan for their areas. The Scottish Executive monitored and benchmarked local performance against key indicators set out in the national Joint Performance and Information Assessment Framework (JPIAF). The JPIAF was discontinued in 2006/07.

<sup>20</sup> *Governance for Joint Services: Principles and Advice*, Audit Scotland, COSLA and Scottish Government, 2007.

the CHP.<sup>21</sup> 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.

**37.** Governance arrangements for integrated CHPs vary but 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 are making decisions outwith their levels of delegated authority and that decision-making is slow.

**38.** Internal auditors carried out a review of financial management and budgetary control and a review of procurement at the previous Glasgow City integrated CHPs. Internal auditors also reviewed the governance arrangements for Western Isles integrated CHP. In all cases, auditors found weaknesses in joint governance arrangements such as a lack of clarity on financial management processes including budgetary control, and evidence of decisions being taken outwith the authority of the integrated CHPs. NHS Western Isles has since reported that work is under way to address the issues identified in the internal audit report. However, NHS Greater Glasgow and Clyde disagreed with the findings of its internal auditors.<sup>22</sup> NHS board and council partners in some areas cited the complexity and risks in relation to integrated structures as key factors in their decision to set up a health-only CHP.

**39.** NHS Greater Glasgow and Clyde had a vision of developing integrated CHP arrangements with its council partners in each area. Glasgow City Council was one of the first councils to sign up to the approach and together the board and the council set up five integrated CHPs within Glasgow. However, problems from the outset have led to the dissolution of the integrated arrangements (Case study 1).

#### **Joint workforce planning for health and social care staff is limited**

**40.** There are significant gaps in workforce information at a CHP level which mean that CHPs are generally unable to demonstrate whether they are planning and managing their workforce efficiently. Not all CHPs were able to provide us with details of the number of staff working within the CHP. Information available from 38 of the 40 CHPs in place at the time of our fieldwork shows that in total they manage approximately 28,500 healthcare staff and 5,300 social care staff.<sup>23</sup> Of these 38 CHPs, seven did not provide a breakdown of the number of each type of NHS staff, such as nursing, medical and pharmacy staff deployed within the CHP. Four of the 23 CHPs which have responsibility for certain council services did not provide information on the numbers of council staff working within the CHP.

**41.** Many CHPs were unable to provide details of vacancies, turnover and sickness absence rates for key staff groups. Eighteen CHPs were unable to provide their sickness absence rates for nurses and midwives, allied health professionals

and administrative staff, which are the largest staff groups.<sup>24</sup> For those CHPs which provided details of sickness absence levels, rates for nurses and midwives ranged from 3.9 per cent to 9.7 per cent. All CHPs except Shetland, that provided information on sickness absence had levels above the four per cent HEAT target in 2009 for nurses and midwives.<sup>25</sup>

**42.** The number and skill mix of health and social care staff required are likely to change in the future in response to planned service changes. NHS boards and councils generally have their own separate workforce plans. NHS board and council workforce plans were frequently underdeveloped, particularly in relation to community health and social care staff. East Renfrewshire's integrated CHP is the only area which has a joint workforce plan covering all health and social care staff. Nine CHPs reported that they are carrying out joint workforce planning with councils for certain joint services, such as mental health or older people's services.<sup>26</sup> A further four CHPs reported that they are currently working with the council to develop a joint approach to workforce planning.<sup>27</sup> However, NHS board and council workforce plans do not provide sufficient information to assess whether joint workforce planning for services has been fully integrated within their overall separate workforce plans. NHS boards and councils need to develop a joined-up approach to workforce planning for health and social care staff to ensure that they have the staff they need to deliver local services in the future.

21 The formal agreement may be between the NHS and council but it should always stipulate the role and responsibilities of the CHP.

22 A joint management response was prepared for one of the two internal audits of Glasgow City integrated CHPs but does not set out the areas of disagreement with the audit findings.

23 CHPs manage a range of NHS staff including: 1,086 medical and dental staff, 15,339 nurses and midwives, 3,537 allied health professionals, 286 health scientists, 202 personal and social care staff, 3,275 people in administrative services and 1,618 other therapeutic and support staff. CHPs also manage staff employed by the council including: 1,852 in social or personal and social care, 176 in administrative services, 17 allied health professionals and 326 in support roles. Not all CHPs could provide these breakdowns, so these figures will not equal the total numbers of staff reported above.

24 Where sickness absence information was not provided this may have been because it was not held in the format requested.

25 NHS Health improvement, Efficiency, Access, Treatment (HEAT) targets are a core set of ministerial objectives, targets and measures for the NHS as a whole.

26 The nine CHPs carrying out joint workforce planning for certain services are Clackmannanshire, Falkirk, Moray, South East Highland, North Lanarkshire, South Lanarkshire, Edinburgh, Dundee and Shetland.

27 The four CHPs developing a joint approach to workforce planning are Inverclyde, West Dunbartonshire, Angus, Perth and Kinross.

## Case study 1

### Glasgow City

NHS Greater Glasgow and Clyde and Glasgow City Council worked together to develop a scheme of establishment for five integrated CHPs covering the city and both signed up to this approach in 2005. However, the integrated CHPs were dissolved in 2010 and a number of wider lessons can be drawn:

- NHS Greater Glasgow and Clyde and Glasgow City Council approved the Scheme of Establishment which included the shared vision for the five integrated CHPs but it did not provide clear details of all services and budgets which were to be devolved by each partner to the integrated CHPs.
- NHS Greater Glasgow and Clyde and Glasgow City Council did not put in place a partnership agreement, joint financial framework or joint scheme of delegation.
- There was tension between the NHS board and council corporate strategies. For example, the council was restructuring its departments and functions which involved centralising some services and functions, whereas NHS Greater Glasgow and Clyde expected that the integrated CHPs would have devolved responsibility for both community-based health and social care services and budgets.
- NHS Greater Glasgow and Clyde devolved responsibility for all primary and community care services and budgets to the integrated CHPs. However, the council did not do this for all social care services.

In 2010, Glasgow City Council appointed Sir John Arbuthnott to carry out an independent review of the integrated CHP arrangements and asked for recommendations to be made to help the partners to strengthen their arrangements. Sir John Arbuthnott's report identified fundamental problems with governance arrangements, such as the lack of a clear strategy or formal agreement on what services and functions will be delivered through the integrated CHPs and the absence of a joint financial framework. His report made a number of recommendations for proceeding with a revised integrated CHP structure. Initially both partners agreed to work together to resolve their difficulties but later dissolved the integrated CHPs as they were unable to reach agreement on key issues.

Following the dissolution of the five integrated CHPs, a new single health-only model for Glasgow was implemented from 1 November 2010. Around the same time the integrated CHPs were being dissolved, Glasgow City Council was examining the feasibility of working with community planning partners to introduce a city-wide approach to planning and allocating resources for local services with all public sector partners to deliver jointly agreed outcomes. At the time of our fieldwork, work on this was at early stages of development.

Source: Audit Scotland, 2011

## Different terms and conditions complicate joint working

**43.** At the time of our fieldwork, three NHS boards and five councils had appointed a joint primary and community health and social care director, although since then a further NHS board and council have also appointed a joint director. Thirteen NHS boards and 25 councils have jointly appointed a range of senior staff, including service managers. The majority of jointly appointed CHP staff are responsible for managing staff employed by both partner organisations working within an integrated service. Jointly appointed staff are generally employed by one organisation and will therefore have one contract of employment. However, they will carry out duties on behalf of both organisations and are therefore accountable to both organisations.

**44.** Arrangements for managing joint appointments in CHPs can be complex as a result of different lines of accountability and staff policies and procedures in the two partner organisations. In 2004, the Scottish Government commissioned the Office for Public Management to develop a joint appointments guide to help partners develop their local arrangements.<sup>28</sup> However, 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.<sup>29</sup>

**45.** CHPs reported difficulties as a result of the different employment terms and conditions for NHS and council employees and in particular different salary scales for staff carrying out similar work and different policies on redundancy. This was identified as an issue for both jointly

28 *The joint appointments guide: A guide to setting up, managing and maintaining joint appointments between health organisations and local government in Scotland*, Office for Public Management, 2004.

29 This includes Aberdeenshire, Inverclyde, Orkney and Western Isles.

appointed staff and other staff working within integrated services.

**There is scope to rationalise the number of partnership arrangements for health and social care**

**46.** Many CHPs were set up in addition to existing partnership arrangements, and NHS boards and councils have not taken the opportunity to review and rationalise these existing partnership arrangements for health and social care. For example, in 15 council areas, Community Planning Partnerships (CPPs) have established health and well-being thematic partnership groups in addition to the CHP committee. CHPs and CPPs need to link effectively to ensure a coordinated approach to joining up health and social care and health improvement. Councils and NHS boards have joint responsibility to make this happen.

**47.** In some areas, NHS boards, CHPs and councils are not aware of the full range of partnership activity that their organisations are involved in or how these relate to, and are different from, the CHP. The cluttered partnership arrangements have contributed to a lack of clarity or duplication in roles and functions between the CHP and other partnerships (Exhibit 7 and Case study 2). 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 (see Part 3 for more details). Twelve CHPs and partners have tried to achieve this through integrating the CHP committee with their CPP's health and well-being partnership group. This reduces the risk of duplication between the CHP and CPP. NHS boards and councils should be clear that their local partnership working arrangements add value.

## Case study 2

### Fife

Fife has a population of 363,460 which is served by three separate CHPs: Kirkcaldy and Levenmouth CHP (population of 97,123); Glenrothes and North East Fife CHP (population of 124,153); and Dunfermline and West Fife CHP (population of 142,184). NHS Fife and Fife Council had combined health and social care expenditure of £759 million in 2009/10.

Partnership working arrangements between health and social care in Fife are complex. At a strategic level, there are three main bodies and there is a risk of overlapping roles and responsibilities:

1. Fife Health and Wellbeing Alliance is the health thematic partnership group within the CPP. It is responsible for providing a strategic lead for improving health and well-being and reducing health inequalities in Fife and delivering the health and well-being elements of Fife's community plan. Its membership is made up of senior representatives from NHS Fife, Fife Council and Council for Voluntary Service (Fife).
2. A separate Joint Health and Social Care Partnership Board has responsibility for strategic planning between health and social care. Members of this group are made up of representatives from NHS Fife and Fife Council. The Health and Social Care Partnership is technically two separate committees (one being a Fife Council committee and the other an NHS Fife committee) which meet simultaneously four times a year.
3. A Partnership Management Group has been established which sits underneath the Joint Health and Social Care Partnership Board. The Partnership Management Group is made up of senior representatives of the NHS board and council with responsibility for the oversight of health and social care partnership development and activity.

The three CHPs in Fife have an operational rather than strategic role. NHS Fife and Fife Council established three Local Management Units (LMUs) which are responsible for joint working between NHS Fife and Fife Council at an operational level and delivering and managing integrated care services within their localities. The LMUs were set up on the same geographical basis as the three Fife CHPs and Fife Council's operating structure. However, the council has since reorganised to a Fife-wide operational structure.

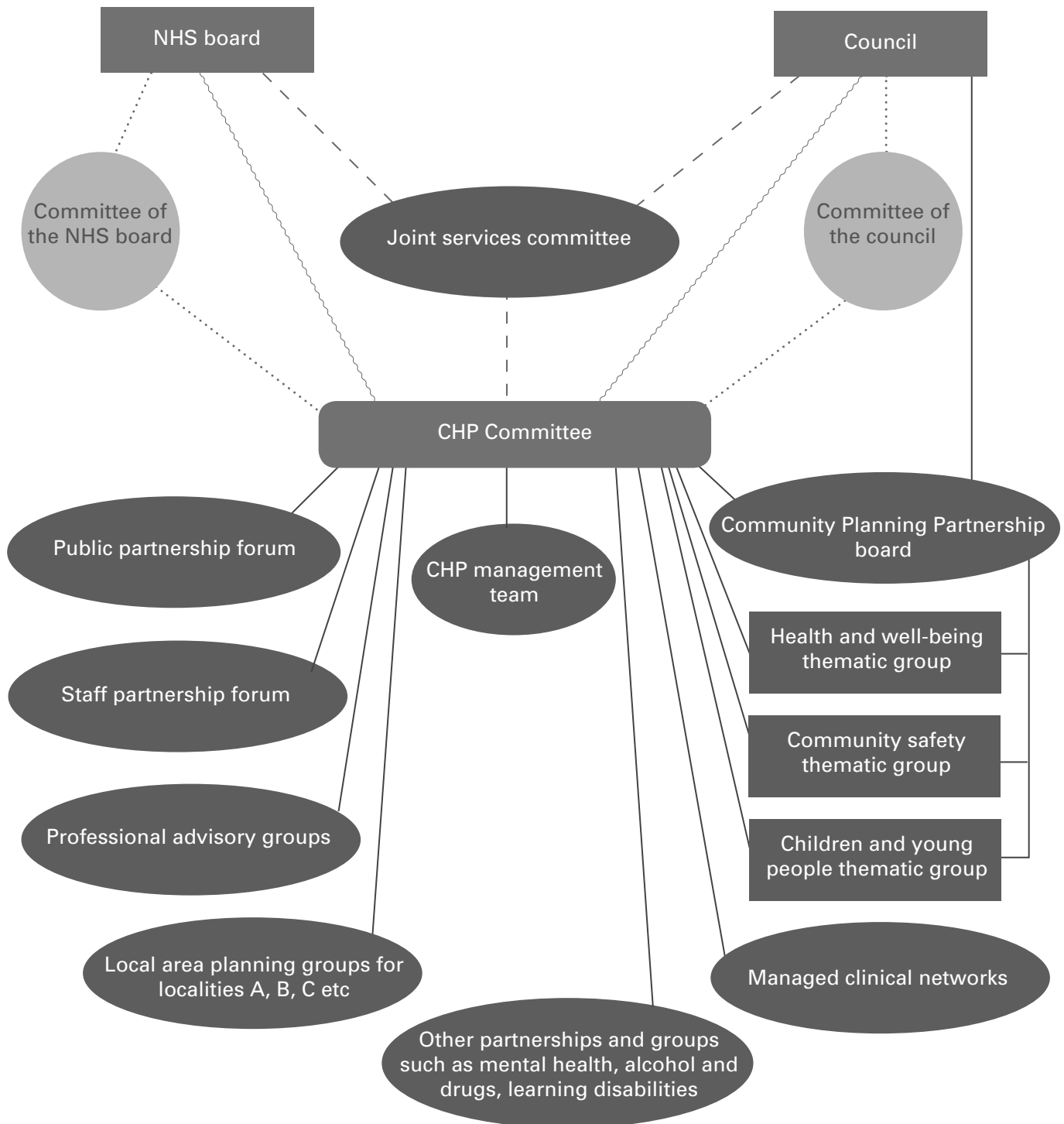
The three CHPs in Fife manage certain primary and community healthcare services for their local population, although each of them individually coordinates particular Fife-wide services. For example, Kirkcaldy and Levenmouth CHP coordinates managed clinical networks, mental health, rheumatology, rehabilitation, sexual health and nutrition and dietetics for the whole board area.

Source: Audit Scotland, 2011

**Exhibit 7**

An example of how CHPs link to other health and social care partnership arrangements

There are a number of potential local partnership arrangements with which CHPs need to link.



Note: The three broken lines (dots, dash and wavy) represent different possible lines of accountability. The solid lines represent joint working links between different groups.  
 Source: Audit Scotland, 2011

**48.** Eight NHS boards carried out an options appraisal to help develop their local arrangements before establishing a CHP.<sup>30</sup> These appraisals varied in content and in the extent to which the NHS board involved key stakeholders in setting up their local arrangements, including councils, the voluntary sector, private care providers and the general public. East Renfrewshire integrated CHP invested time in working with partners to be clear about the role and function of the CHP from the outset. In addition, clear leadership and personal commitment by NHS non-executives, elected members in the council and senior staff in both organisations enabled the NHS board and council in East Renfrewshire to achieve an integrated CHP and streamline partnership arrangements (Case study 3).

**49.** In areas with a small population and where NHS boards, councils and CPP boundaries are coterminous, the introduction of a CHP can further complicate partnership arrangements. We reviewed the CHP arrangements in Western Isles and found that the NHS board, CHP and council were unable to identify a clear role for the CHP to facilitate better joined-up health and social care services (Case study 4).

**50.** The three island councils (Shetland, Orkney and Comhairle nan Eilean Siar) have commissioned the Centre for Scottish Public Policy to examine options for public sector reform, bringing council, health and other public services into a single public body for each island authority. This is still at a very early stage. The initial aim is to determine whether the concept of a single public authority would have any merit or applicability.

### Case study 3 East Renfrewshire

The East Renfrewshire integrated CHP committee has a clear purpose and a joint vision, strategy and outcome measures for health and social care services for the local area. Clear leadership has enabled the committee and management team to develop a partnership ethos and culture and ensure committee members are fully informed of their role, responsibilities and the needs of their local communities so that they can make informed decisions. The NHS board and council have streamlined their partnership arrangements, dissolved the Joint Future Partnership Group and designated the CHP as the thematic health and well-being group of the CPP. The CHP leads community planning in relation to health and well-being for the local population. Committee meetings are well attended.

The NHS board and council have appointed a joint CHP director and other joint service managers. This has enabled East Renfrewshire Council to achieve recurring efficiencies of £350,000 each year. The integrated management structure has helped to improve joint planning and delivery of services. The NHS board and council have also introduced a joint performance management framework.

Source: Audit Scotland, 2011

### Case study 4 Western Isles

The Joint Improvement Team (JIT) helped NHS Western Isles and Comhairle nan Eilean Siar Council to develop their integrated CHP arrangements in 2006. The Western Isles population is just over 26,000 and the NHS board and council combined expenditure on health and social care in 2009/10 was £90 million. The initial role, vision and governance structure for the integrated CHP are set out in the Scheme of Establishment although these arrangements have not been fully implemented. When the integrated CHP was being set up, a number of other joint health and social care groups and partnerships were already in place and the NHS board and the council did not take the opportunity to rationalise these. As a result, the role and purpose of the CHP committee and other partnership groups have become increasingly blurred.

The CHP committee is large with 26 members, most of whom are also involved in other partnership groups. Attendance at CHP committee meetings is consistently poor. Although Western Isles CHP is intended to be an integrated structure, the NHS board and council have their own separate managers and health and social care services are managed separately. There is also a lack of capacity within the CHP management team to carry out joint planning and performance management for health and social care.

Source: Audit Scotland, 2011

30 Although NHS Highland conducted an options appraisal, this did not include the Argyll and Bute area which was formed at a later date. In addition, NHS Grampian did not complete an initial options appraisal but subsequently did for the Moray area only.



## Recommendations

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
- 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
- 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.

NHS boards and councils should:

- work with the Scottish Government to streamline existing partnership arrangements to secure efficiency and effectiveness and ensure they add value
- put in place transparent governance and accountability arrangements for CHPs and update schemes of establishment and other governance documents to ensure these are accurate
- have a clear joint strategy for delivering health and social care 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.

# Part 3. How resources are used



There is scope to make more efficient use of existing resources.



## Key messages

- In 2009/10, NHS boards and councils spent a total of £13 billion on health and social care. CHPs have limited influence on the allocation of resources across the whole system. They directly manage only 26 per cent of total spending and there is variation in the services for which they are responsible.
- A more systematic, joined-up approach to planning and resourcing is required to achieve better use of resources. There are very few examples of good joint planning between NHS boards and councils underpinned by a comprehensive understanding of the shared resources available. The Scottish Government is developing an integrated resource framework which aims to provide better information on how health and social care money is spent. At a CHP level, information on resources, including staff, is not well developed. There are still difficulties in sharing information but some progress has been made in sharing premises.
- 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 GPs engaging with CHPs. 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 in 2009/10, 12 CHPs overspent their prescribing budgets.

**51.** In this chapter, we provide context on the total spending on health and social work in Scotland and then go on to consider:

- the extent to which there is a joint understanding of costs and activity
- progress in agreeing joint planning and resourcing of health and social care, including sharing information and assets between NHS boards and councils
- the extent to which GPs influence overall health spending and activity levels; and engagement between CHPs and GPs
- the variation in services and budgets that CHPs manage.

**In 2009/10, £13 billion in total was spent on health and social work but CHPs have little influence over how this is used**

**52.** Scottish public sector spending on health and social work increased in real terms from £11 billion in 2005/06 to £13 billion in 2009/10, accounting for approximately 37 per cent of the total Scottish Government budget in 2009/10.<sup>31</sup> The NHS in Scotland spent a total of £10 billion in 2009/10, which is equivalent to £1,873 per head of population but this varied across the country from £1,541 in NHS Forth Valley to £2,602 in NHS Western Isles.<sup>32</sup> Only a relatively small part of this total NHS budget is devolved to CHPs (paragraph 80).

**53.** Social work expenditure in Scotland was around £3 billion in 2009/10, which is equivalent to

£544 per head of population but this varied significantly among councils.<sup>33</sup> Older people's services accounted for 45 per cent of Scotland's social work expenditure (£1.3 billion).<sup>34</sup> CHPs have limited responsibility for managing social care budgets (Exhibit 13, page 34).

**54.** The Scottish Executive expected CHPs to facilitate joint planning and resourcing between health and social care resources in their local areas to deliver more efficient and effective services.<sup>35</sup> However, while some CHPs have a strategic role, others are wholly operational, responsible for delivering specific services and have little influence over setting overall health and social care priorities and deciding on how resources are used across the whole system.

**National work is under way to get a better understanding of costs and activity to make better use of resources**

**55.** A more systematic, joined-up approach to planning and resourcing is required to achieve better use of resources for health and social care. NHS boards and councils do not have sufficient understanding of their service costs and how these are 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) project which aims to address this. If successful, the IRF should help CHPs, NHS boards and councils to prioritise and align their resources to support changes in how care is provided.

**56.** The first phase of the IRF involves NHS boards and councils mapping their patient and locality level cost and activity information for health and

31 *Scottish Health Service Costs R100T*, ISD Scotland 2010; *Scottish Local Government Financial Statistics*, Scottish Government, February 2011; *Scotland's Budget Documents 2009-10*, Scottish Government, 2009.

32 *Scottish Health Service Costs R100T*, ISD Scotland, 2010.

33 *Scottish Local Government Financial Statistics*, Scottish Government, February 2011.

34 *Ibid.*

35 *The Community Health Partnerships (Scotland) Regulations 2004 and Statutory Guidance*, Scottish Executive, 2004.

adult social care. This aims to provide a picture of how resources are being used across their populations. 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.

**57.** The second phase of the project involves NHS and council partners in four test sites (Highland, Tayside, Lothian, and Ayrshire and Arran). NHS boards, CHPs and councils in the test sites are developing protocols for shifting resources both within the NHS, and between the NHS and council. Alongside this, the Scottish Government has appointed consultants to undertake an evaluation of this work which is due to be completed in 2012. Work is at early stages in the test sites, although NHS Highland and Highland Council have agreed to work towards implementing new arrangements for commissioning community care services (paragraph 67).

### There is limited progress in the joint funding of services

**58.** The Scottish Government's shifting the balance of care policy requires NHS boards to work with councils to move some services out of hospital into the community and nearer to the service user's home. CHPs have a key role in working with NHS boards, councils, GPs and other health and social care organisations to achieve this.

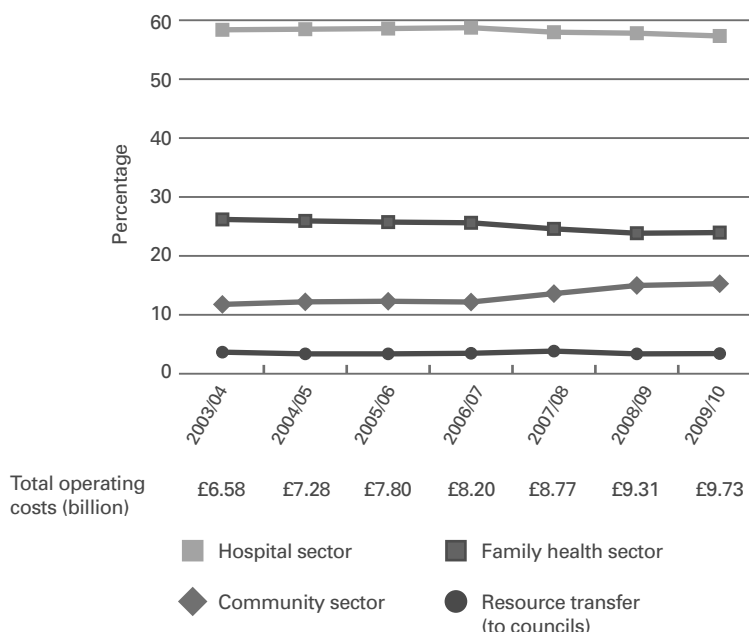
**59.** Overall, there has been a slight increase in the percentage of total NHS resources being spent in the community between 2004/05 and 2009/10. But there has been no change in the percentage of NHS resources transferred to councils for social care services during this same period (Exhibit 8).

**60.** Resource transfer has been a source of tension between the NHS and councils for several years due to a lack of transparency or agreement about how the resource transfer

### Exhibit 8

#### Percentage of total NHS operating costs by sector

There has been a slight percentage shift in NHS spending from the hospital and family health sectors to the community sector but the percentage of resource transfer to councils has remained almost static.



Source: ISD Scotland, 2011

amount is calculated. The Scottish Government and COSLA began reviewing the existing guidance in 2009 with the aim of resolving this tension. They expected to provide further guidance on resource transfer to NHS boards, CHPs and councils in 2010. The guidance was introduced in January 2011, and included a commitment to providing an annual uplift to the resource transfer amount, to be agreed nationally each year. The Scottish Government and COSLA anticipate that this commitment will resolve the tension but it is too early to comment on whether this has happened. Given the slow progress in resolving differences in relation to resource transfer, NHS boards and councils are unlikely to move quickly towards more integrated budgets.

### There are two approaches to joint funding that can be adopted

**61.** There are two types of joint funding approaches that NHS boards and councils in Scotland use: aligned

or pooled budgeting. Each approach has advantages and disadvantages (Exhibit 9). In Scotland, the most common joint funding approach is aligned budgeting.

**62.** Whichever approach to the funding of services is chosen it is important that NHS boards, CHPs and councils focus first on what they are trying to achieve through joining up their services. Clarity about this should help in choosing the most appropriate approach to the joint funding of services.

**63.** We found only one example of a genuine pooled budget in Scotland – Clackmannanshire's integrated mental health service (Case study 5, page 28). Pooling budgets requires significant trust between organisations and a jointly agreed vision for services. Pooled budgets can allow more flexibility and a faster response to individual user needs, but setting them up can be

**Exhibit 9****Joint funding of services**

There are two main approaches to joint funding of services.

	Characteristics	Benefits	Drawbacks
<b>Aligned budget</b>	<ul style="list-style-type: none"> <li>Partners align resources to meet agreed aims and spending and performance are monitored jointly</li> <li>More commonly adopted where partnerships are less mature or where there are legal obstacles to creating a pooled budget</li> </ul>	<ul style="list-style-type: none"> <li>Less bureaucratic in the short term</li> <li>Partners retain ownership of their own budget management</li> <li>Formal agreements are not required</li> <li>Can be an interim step to a pooled budget</li> </ul>	<ul style="list-style-type: none"> <li>Slower decision-making as each partner follows its own procedures</li> <li>Less likely to generate trust or overcome cultural differences between partners</li> </ul>
<b>Pooled budget</b>	<ul style="list-style-type: none"> <li>Each partner contributes funds to a pool which is used to deliver agreed outcomes. One partner is responsible for accounting and arranging the audit of the pooled budget</li> <li>Pooled budgets are more likely where there is a tradition of successful joint working</li> </ul>	<ul style="list-style-type: none"> <li>Service delivery and expenditure is based on users' needs rather than financial contributions</li> <li>Can be a more flexible and streamlined use of resources</li> <li>Faster decision-making and flexibility to redesign services</li> </ul>	<ul style="list-style-type: none"> <li>More complex because formal agreement setting out financial and associated arrangements required</li> <li>Can be perceived as more of a risk because of loss of identity of pooled funds</li> </ul>

Source: Audit Scotland, summarised from: *Guidance to local areas in England on pooling and aligning budgets*, Department for Communities and Local Government, March 2010; and *Means to an end: Joint financing across health and social care*, Audit Commission, 2009

more complicated and resource intensive than aligning budgets in the short term.<sup>36</sup>

**64.** In England, the use of pooled budgets is more common. The Audit Commission identified a number of benefits from pooling budgets in England which have led to improved joint working (Exhibit 10, page 29).<sup>37</sup>

**65.** In 2008, the UK Government launched its Total Place initiative in 13 pilot areas across England. The initiative aims to take a whole-area approach to local public services with local agencies working together to

improve services and outcomes and to reduce waste and duplication. The experience of pilot areas involved in the Total Place initiative found that effective pooling or aligning of budgets across a geographical area or across previously separate funding streams can help deliver better services at less cost.<sup>38</sup> But they also recognised the difficulties that local partners commonly encounter in combining resources. For example, pooled budgets are sometimes used where aligned budgets could be more effective, or pooled budget arrangements are not implemented effectively.<sup>39</sup>

### The Scottish Government is supporting local pilots to improve joint resourcing

**66.** A Change Fund to help joint working between NHS boards and councils was announced as part of the 2011/12 Scottish budget. In 2011/12, £70 million has been made available to NHS boards and councils to implement local plans for making better use of their combined resources for older people's services. The Change Fund is expected to continue for up to four years, providing short-term funding to facilitate shifts in the balance of care and influence decisions on overall health and social care spend on older people's care. NHS boards and

<sup>36</sup> *Pooled budgets: A Practical Guide for Local Authorities and the National Health Service*, Chartered Institute of Public Finance and Accountancy (CIPFA), 2009.

<sup>37</sup> *Means to an end*, Audit Commission, 2009.

<sup>38</sup> The UK Government launched its Total Place initiative in 2008 in England which aimed to put citizens at the heart of service design and improve how agencies work together to improve outcomes and eliminate waste and duplication. Thirteen pilot sites were set up bringing together local authorities, primary care trusts, fire authorities, police authorities, and a wide range of third sector organisations and service delivery bodies.

<sup>39</sup> *Total Place: a whole area approach to public services*, HM Treasury, 2011.

## Case study 5

### Clackmannanshire's pooled budget

NHS Forth Valley and Clackmannanshire Council established an integrated mental health service in 2003 before the CHP was established. The NHS board and council set up a pooled budget for the service which they expected to help speed up service redesign. No additional funding was provided to set up the new arrangements. The council is responsible for managing the pooled budget on a day-to-day basis and preparing financial reports on the use of the pooled budget. The NHS board and council have a service specification and pooled budget agreement in place to manage this arrangement. The pooled budget agreement states that the NHS board and council should include a memorandum account of the pooled budget within their annual accounts. Although the council's annual accounts comply with this requirement, the NHS board's accounts do not.

The NHS board, council and CHP reported a number of benefits as a result of the pooled budget. They feel that the pooled budget has helped them to radically change how services are delivered by creating a single referral process for people to access the service and reshape their workforce by changing the skill mix of staff. NHS Forth Valley and Clackmannanshire Council have also achieved modest recurring efficiency savings and a reduction in inappropriate referrals. Since 2003, the number of people receiving a service has increased from 500 to 2,000. But the type of support they receive has changed, with more focus on early intervention support such as support groups, self-help worksheets, stress workshops, self-help and counselling. There has also been a 35 per cent reduction in people receiving psychiatric services.

Source: Audit Scotland, 2011

councils were required to provide details of their overall combined resources for older people's services in order to access the funding, and plans were submitted to the Scottish Government in March 2011.

**67.** Alongside the Change Fund, the Scottish Government is providing support to NHS boards and councils to improve their joint planning and resourcing arrangements, including work with the IRF test sites. For example in Highland, the NHS board and council have examined a range of options and approved ambitious plans for integrating community-based health and social care services. Their approach is based on the North East Lincolnshire Care Trust model of integration between health and adult social care in England. In Scotland,

the approach is referred to as the lead agency model, and essentially means that one partner will delegate responsibility to the other for certain services. The delegating partner will also transfer agreed resources such as budgets, staff and assets to the lead agency which will pool with its own resources to manage the integrated service.

**68.** It is proposed that NHS Highland will be the lead agency for adult community care services and Highland Council will be the lead agency for the provision of children's services. Detailed planning is under way with a view to potentially implementing these new arrangements in April 2012.<sup>40</sup> This lead agency pilot is at an early stage of development and there are significant risks in relation to the

scale, complexity and timescale of planned changes and these need to be carefully managed. Audit Scotland will continue to monitor this through our local audit work.

### Limited sharing of information remains a barrier to improving services

**69.** Good information-sharing between health and social care staff is needed to manage services effectively and provide the best integrated service for individual service users. However, there are long-standing barriers to sharing information between health and social care and few areas have resolved these completely. These barriers include differences in approaches to handling information, particularly personal and sensitive information to meet data protection legislation; issues about the confidentiality of medical information in particular; and incompatible systems for sharing information electronically.

**70.** The Single Shared Assessment (SSA) process aims to provide users of health and social care services with faster access to the services they need by coordinating access to services through one lead professional.<sup>41</sup> The SSA should reduce the need for different health and social care professionals to collect the same information from service users several times. A lead professional coordinates documents and shares appropriate information, coordinates all contributions, and produces a single summary assessment of need. By March 2006, all areas should have been carrying out the SSA electronically. However, although all areas in Scotland are now using SSA forms, many areas still have incompatible IT systems which prevent them from sharing the SSA electronically. A recent inspection report found that SSA forms are still not capturing risks well and there is limited input from health professionals.<sup>42</sup>

40 *Joint Report by Chief Executive, The Highland Council and Chief Executive, HC/NHS/1/10*, NHS Highland, 16 December 2010.

41 Single Shared Assessments were introduced in 2002, initially for older people. This was later extended to all community care groups.

42 *Improving Social Work in Scotland: A report on SWIA's Performance Inspection Programme 2006-09*, Social Work Inspection Agency, March 2010.

**Exhibit 10****Benefits of pooled budgets in England**

Pooled budgets have helped strengthen joint working between health and social care in England.

**Oxfordshire**

A pooled budget was set up to establish an integrated approach for continuing care. Partners reported that this has enabled them to introduce a single assessment process for end-of-life care and reduced disputes and tensions between partners about funding for continuing care.

**North East Lincolnshire Care Trust Plus**

A pooled budget was used to establish an integrated approach for continuing care. The pooled budget linked both NHS and council funding with the contracts for the mental health service and care home. The Trust reported that the pooled budget has reduced transaction costs and simplified management arrangements.

**West Sussex Primary Care Trust and West Sussex County Council**

Partners used pooled budgets for their integrated learning disability and mental health services. Previously these budgets had been managed separately. The Trust reported that the pooled fund was crucial in improving user outcomes and helped deliver certain national targets. It also reported that it provided greater predictability in managing budgets which had been previously poorly managed financially.

Source: *Means to an end*, Audit Commission, 2009

**71.** The Scottish Executive set up a national eCare programme in 2006 to address the barriers to sharing information about people. Fourteen Data Sharing Partnerships (DSPs), aligned to NHS board areas, have since been set up. Each DSP has agreed an Information Sharing Protocol which specifies exactly how, and in what circumstances, information may be shared to comply with legislation. However, NHS boards, CHPs and councils in the four IRF test sites have reported continuing problems in sharing information.

**72.** DSPs were also given responsibility for implementing a new

eCare system which was developed to allow NHS boards, CHPs and councils to share information electronically for SSA purposes.<sup>43</sup> However, by March 2010, only four NHS boards and four councils were connected to eCare and five other boards had plans to connect to the system at that time.<sup>44, 45</sup>

**There is scope to share more assets**

**73.** Each part of the public sector has traditionally planned and managed the use of its own assets, such as buildings, land, equipment and IT systems, independently of other sectors. Although this is still predominately the case, 20 CHPs and 20 councils reported that they are

making progress through co-locating some CHP and council services.<sup>46</sup> Where this is happening CHPs are reporting efficiency savings and improved service delivery. In addition, 20 CHPs reported that they have joint community equipment stores with councils.<sup>47</sup> In the majority of cases, however, formal arrangements, such as partnership agreements or joint asset management plans and registers to manage shared assets, have not been put in place.

**74.** Previous Audit Scotland reports found that while there are a few good examples of NHS and social work staff sharing premises, public sector bodies need to work together more to make more efficient use of their assets.<sup>48</sup> However, the Scottish Government is providing £1 billion investment for a Hub initiative which aims to improve collaboration and joint working between public sector bodies through shared accommodation.<sup>49</sup> Funding has already been approved for a number of joint premises for health and social care, including a new Health and Care Village in Aberdeen worth £21 million in which NHS Grampian, Aberdeen City Council and Grampian police staff will be based.

**GPs indirectly commit significant NHS resources but there is not yet full engagement between CHPs and GPs**

**75.** GPs are independent contractors and provide services to the NHS through the General Medical Services (GMS) and Primary Medical Services (PMS) contracts. Together these contracts accounted for approximately £729 million (7.5 per cent) of NHS spending in Scotland in 2009/10.<sup>50, 51</sup>

43 The 14 DSPs are coterminous with NHS board boundaries. Organisations involved include NHS bodies, the police, and councils' education, housing and social work departments, and voluntary sector partners.

44 Written answer to parliamentary question S3W-32169, 18 March 2010.

45 NHS Tayside, NHS Grampian, NHS Ayrshire and Arran, NHS Western Isles, North Ayrshire Council, Aberdeenshire Council, Angus Council and Comhairle nan Eilean Siar were connected to eCare by March 2010. The five other NHS boards planning to connect to eCare at March 2010 were Fife, Highland, Forth Valley, Borders, and Dumfries and Galloway.

46 The former five Glasgow City integrated CHPs also reported that some health and social care services had been co-located before they were dissolved.

47 Edinburgh, East Lothian and Midlothian share a joint equipment store; similarly for the three CHPs in Fife the joint equipment store is board-wide.

48 *Asset management in the NHS*, Audit Scotland, 2009; and *Asset management in local government*, Audit Scotland, 2009.

49 *Management of the Scottish Government's capital investment programme*, Audit Scotland, 2011. The Scottish Futures Trust is leading the Hub initiative on behalf of the Scottish Government. Scotland is divided into five hub territories that, when combined, aim to deliver around £1 billion of community infrastructure. Councils, health boards, police and fire services are expected to work together with the private sector to deliver these assets.

50 There are two types of contract: GMS and PMS contracts. The majority of contracts between NHS boards and GPs are GMS contracts.

51 *Scottish Health Service Costs R100T*, ISD Scotland, 2010.

However, using data from IRF mapping, the Scottish Government estimates that GPs indirectly influence at least four times this total as a result of their individual clinical decisions.<sup>52, 53</sup> It is therefore crucial that GPs and other independent contractors such as dentists, opticians and pharmacists are fully engaged in service changes with the whole health system, including CHPs.

**76.** The majority of CHPs reported to us that GPs and other independent contractors were generally good at engaging on relevant issues.<sup>54</sup> But a recent report from the Royal College of General Practitioners found that CHPs in some areas have not gained the support of GPs.<sup>55</sup> Recent research commissioned by the Scottish Government also reported variation in the extent of CHP engagement with GPs and other independent contractors. It concluded that the reason for this was due to a lack of shared vision and priorities between CHPs, GPs and other independent contractors.<sup>56</sup> The interviews we carried out with key stakeholders for this audit supports the findings in these two reports. However, the British Medical Association (BMA) also reported to us that in many areas GPs are engaging directly with NHS boards rather than with CHPs due to the lack of influence CHPs have over how resources are used. The BMA also highlighted a wider issue about the lack of involvement of other medical professionals in service planning and resource allocation. However, we did find some examples of good engagement between CHPs and GPs (Case study 6).

**77.** There is significant variation in GP prescribing, referral patterns and associated costs both within and across CHPs in Scotland. From analysis of initial IRF mapping, the Scottish Government concluded that there is significant variation in

### Case study 6 70 Per Cent Group

The 70 Per Cent Group is a group of GPs in Highland who have organised themselves to work with the NHS board, CHPs and council on service changes to support a shift in resources from hospitals to community settings. The South East Highland CHP manager is responsible for managing the contract on behalf of NHS Highland.

The 70 Per Cent Group's first initiative was to set up a community-based dermatology service where GPs treat the majority of benign skin excisions rather than these patients being treated in hospital. NHS Highland has a Service Level Agreement (SLA) with the group which runs from December 2009 until November 2012. The SLA requires GPs to reduce their outpatient referral rates for skin diagnosis and treatment by 30 per cent and includes criteria for quality assurance. For example, GPs must provide evidence of qualifications and experience, patients must have good access to services within 18-week waiting time limits. The NHS board also requires satisfaction surveys to be carried out annually. The SLA cost is £140,000 per annum but if the group fails to meet the target reduction in referrals then the NHS board introduces financial penalties.

NHS Highland reports that the community-based service has delivered faster outpatient appointments for people with suspected malignant melanomas or other skin cancers and moved the diagnosis and treatment of skin lesions closer to the patient's home. The waiting list for GP referrals for an outpatient appointment reduced from 475 in June 2009 to 258 in November 2010. An unexpected benefit has been a reduction in the volume of work and shorter waiting list for the visiting plastic surgery service.

In the first seven months, the group achieved a 40 per cent reduction in outpatient referrals. NHS Highland estimates that the service has generated savings of £136,000.<sup>1</sup> The service is funded primarily from short-term funding. But from April 2011, Raigmore Hospital will be responsible for funding the service by releasing resources from the dermatology service. The group is now working with the NHS board, council and CHPs on a range of other local service redesign initiatives.

Note: 1. Savings are estimated using the IRF tariff. However, the actual savings will be lower as this does not take account of fixed costs of the existing acute based dermatology service.  
Source: Audit Scotland, 2011

expenditure and inequitable access to services as a result of GPs' clinical decisions. This indicates variability in efficiency of resource use. The majority of CHPs have introduced a range of local protocols and systems to attempt to influence and monitor GP prescribing and referral decisions. But despite this, they are generally unable to identify reasons for the significant variation. Where they have

identified reasons for inappropriate variation, CHPs may not have sufficient leverage through contracts with GPs to control this effectively.

### **There is significant variation in the services and budgets that CHPs manage**

**78.** The statutory guidance sets out a clear expectation that CHPs will

<sup>52</sup> This includes expenditure on unplanned admissions, prescribing, diagnostics, new outpatient referrals and emergency department attendances.

<sup>53</sup> *Integrated Resource Framework Newsletter*, Scottish Government, September 2010.

<sup>54</sup> Audit Scotland data survey, 2010.

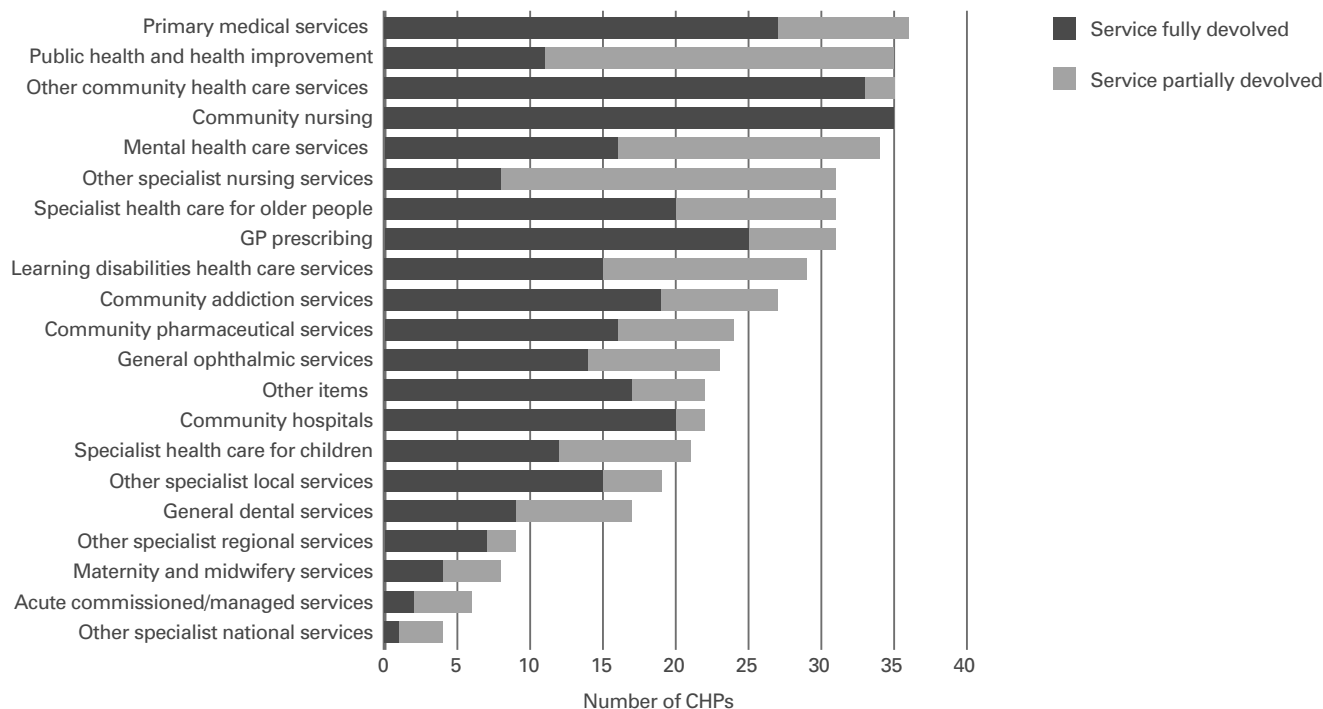
<sup>55</sup> *Time to Care: Health Inequalities, Deprivation and General Practice in Scotland*, RCGP Scotland Short Life Working Group Report, December 2010.

<sup>56</sup> *Study of Community Health Partnerships*, Scottish Government Social Research, 2010.



**Exhibit 11****Summary of NHS services devolved to CHPs in 2009/10**

There is variation in the extent to which NHS boards have devolved services to CHPs to manage.



Source: Audit Scotland, 2011

directly manage and provide some community healthcare services and they should have devolved budget responsibility for those services.<sup>57</sup> However, 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 (Exhibit 11). 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 (Case study 7, overleaf).<sup>58</sup>

### CHPs are managing increasing amounts of NHS money each year

**79.** CHP managers and finance staff are generally involved in setting CHP budgets. However, financial planning is generally short term using an incremental budgeting approach and there is a lack of evidence that CHP budgets are linked to priorities.

**80.** The amount of NHS money that CHPs manage is increasing each year (Exhibit 12, page 33). In 2009/10, CHPs managed approximately £2.9 billion of NHS expenditure compared to approximately £875 million in 2005/06. This is not a complete picture because a number of CHPs were unable to provide details of their overall NHS

budgets or expenditure for one or more years since 2005/06.<sup>59</sup>

**81.** In 2009/10, 18 CHPs reported overspends against their NHS budgets compared to 12 in 2008/09. At the time of our fieldwork, 11 CHPs projected an overspend on their 2010/11 NHS devolved budget.<sup>60</sup> This indicates pressure on NHS budgets devolved to CHPs or weaknesses in financial control.

**82.** GP prescribing and community nursing budgets were by far the most frequently overspent budget each year. Twenty-three CHPs were responsible for GP prescribing budgets of £577 million in 2009/10 – 12 CHPs overspent their prescribing

57 *Community Health Partnership statutory guidance*, Scottish Executive, October 2004.

58 NHS Ayrshire and Arran has appointed a healthcare director for integrated care and partnership services, responsible for directly managing a range of NHS board-wide services and budgets. The service budgets are set and managed on an NHS board-wide basis, although some services are delivered through locality teams aligned with CHP and council boundaries. There are Locality Officer Groups for children's and adults' services within each CHP structure which are made up of senior NHS board and council officers whom are responsible for all health and social care services. These groups provide a forum for joint planning across the whole system.

59 The 2005/06 and 2009/10 figures are not directly comparable because 13 CHPs were not in place in 2005/06, therefore they did not incur expenditure for the year. This includes Argyll and Bute, East Dunbartonshire, East Glasgow, East Renfrewshire, Edinburgh, Inverclyde, North Glasgow, Orkney, Renfrewshire, South East Glasgow, South West Glasgow, West Dunbartonshire and West Glasgow CHPs. A further seven CHPs were unable to provide details of their expenditure in 2005/06: North Lanarkshire, South Lanarkshire, East Lothian, Midlothian, West Lothian, West Lothian, Shetland and Western Isles.

60 Orkney integrated CHP had the highest overspend of almost four per cent of its overall NHS budget in 2009/10.

budgets in 2008/09 compared with 15 CHPs in 2009/10.<sup>61</sup> However, pressures in prescribing budgets pre-date the establishment of CHPs. Twenty-eight CHPs were responsible for managing community nursing budgets of £155 million in 2009/10 and 16 of those CHPs reported an overspend against this budget.

#### **Few councils have delegated responsibility for social care services to CHPs**

**83.** There is significant variation in councils' approaches to delegating social care services and budgets to CHPs. Although there were 11 integrated CHPs, only East Renfrewshire's integrated CHP had full delegated responsibility from the council for all social care services and budgets in 2009/10.<sup>62</sup> A number of other councils delegated specific social care services to a further 21 CHPs in 2009/10 but only 14 of these CHPs had the delegated budget responsibility for the services. This means that seven CHPs were responsible for the day-to-day service provision of council social care services but councils retained control over service budgets (Exhibit 13, page 34). Of those CHPs with delegated budget responsibility for services and which provided information on budgets and actual expenditure in 2009/10, only one CHP reported a minor budget overspend.

#### **Not all CHPs know their management and administration costs**

**84.** NHS boards account for their administration costs at community sector levels and do not go down to individual CHP level. Between 2004/05 and 2009/10, records show an increase in spending on community administration costs by 34 per cent in real terms from £150 million to £200 million.<sup>63</sup> Community administration costs decreased as a percentage of the overall NHS board community operating costs from 14.9 per cent to 13.5 per cent during this period. However, as there are

### **Case study 7** **Argyll and Bute**

The Argyll and Bute area was redefined within NHS Highland's boundary and the Clyde area was brought within Greater Glasgow and Clyde's boundary in 2006 when NHS Argyll and Clyde was dissolved. NHS Highland inherited a budget deficit of £4.9 million from the former NHS Argyll and Clyde; however, there is also a potential additional deficit amount due to cross-boundary flow of patients which NHS Highland and NHS Greater Glasgow are still disputing. NHS Highland ring-fenced the £4.9 million deficit within the Argyll and Bute area which meant Argyll and Bute CHP became responsible for making savings to eliminate the budget deficit over a four-year period when the budget was devolved to the CHP. In 2009/10, Argyll and Bute CHP's budget for health services was £171 million, which is equivalent to 31 per cent of NHS Highland's total annual budget. The CHP has broken even against its NHS devolved budget each year and met its annual targets for reducing the deficit and overall efficiency savings targets of £1.5 million in 2007/08, £3 million in 2008/09 and £3 million in 2009/10.

NHS Highland expected the devolved budget arrangements to lead to stronger local control over services and faster progress in moving care from hospitals to more community-based. But so far there has been no major change in the balance of services between hospitals and the community. However, there has been small-scale movement of certain services to the community, for example, on the Cowal peninsula ten long-term elderly care beds have been closed. Some resources were released from the closure of the beds and re-invested to provide community care aimed at keeping older people in their own homes and avoiding admissions to hospital and care homes.

NHS Highland, Argyll and Bute CHP and council representatives reported difficulties in releasing funding from acute services to support a shift in care to the community. Changes to services have usually been initiated using short-term funding from the Scottish Government. The no redundancy policy in the NHS is reported to have contributed to a slower pace of change, as both small and large-scale closures to hospitals mean that staff have to be re-deployed. Argyll and Bute CHP and Argyll & Bute Council identified this as a major challenge because there are few suitable alternative employment opportunities within the local area and significant travel and re-skilling of the workforce would be required. The CHP also reported that changing the terms and costs of its SLA with NHS Greater Glasgow and Clyde for the provision of acute services is another barrier to shifting services to the community.

The CHP and council are currently developing joint plans for larger-scale service redesign, including shifting 70 per cent of hospital-based dementia services to the community. The CHP has commissioned consultants to prepare a business case for this, which is due to be completed in spring 2011 for approval by the NHS board and council. Argyll and Bute CHP and council identified a risk that the new service is more costly as it is unlikely that sufficient funding will be released from the closure of hospital beds to fund the new community-based services. NHS Highland, Argyll and Bute CHP and council will therefore need to consider the costs and benefits of the proposed service change before making a decision on whether to pursue the plans, once the business case has been prepared.

Source: Audit Scotland, 2011

61 Where there is more than one CHP in each area, sometimes they jointly manage the GP prescribing budgets or one of the CHPs manages the prescribing budget on behalf of all CHPs.

62 Orkney integrated CHP became fully operational in 2010/11 and has responsibility for all council social care services.

63 The 2004/05 figure has been inflated from £132 million to show the real terms cost.

**Exhibit 12**

Total NHS expenditure by CHPs for devolved services for which they control the budget between 2005/06 and 2009/10  
CHP expenditure has increased between 2005/06 and 2009/10.

NHS board	CHP	Actual expenditure (£ million)				
		2005/06	2006/07	2007/08	2008/09	2009/10
NHS Borders	Scottish Borders	0	0	0	0	0
NHS Dumfries and Galloway	Dumfries and Galloway	74	78	80	83	84
NHS Fife	Dunfermline and West Fife	21	24	31	31	38
	Glenrothes and North East Fife	20	23	22	24	26
	Kirkcaldy and Levenmouth	41	48	53	58	61
NHS Forth Valley	Clackmannanshire	6	6	37	39	41
	Falkirk	29	41	32	44	46
	Stirling	24	27	28	34	34
NHS Grampian	Aberdeen	31	33	38	58	82
	Aberdeenshire	46	48	54	59	60
	Moray	218	227	231	234	246
NHS Greater Glasgow and Clyde	East Dunbartonshire	N/A	INA	38	38	38
	East Glasgow	N/A	INA	86	84	89
	East Renfrewshire	N/A	INA	41	42	41
	Inverclyde	N/A	N/A	50	49	51
	North Glasgow	N/A	INA	53	54	55
	Renfrewshire	N/A	INA	97	97	99
	South East Glasgow	N/A	INA	53	56	55
	South West Glasgow	N/A	INA	49	50	53
	West Dunbartonshire	N/A	INA	63	65	65
NHS Highland	West Glasgow	N/A	INA	79	80	79
	Argyll and Bute	N/A	150	160	167	171
	Mid Highland	34	35	37	60	34
	North Highland	33	35	36	41	43
NHS Lanarkshire	South East Highland	61	65	70	75	77
	North Lanarkshire	INA	INA	83	90	95
	South Lanarkshire	INA	226	277	288	310
NHS Lothian	East Lothian	INA	INA	63	66	65
	Edinburgh	N/A	N/A	225	226	236
	Midlothian	INA	INA	55	59	61
	West Lothian	INA	INA	90	90	94
NHS Orkney	Orkney	N/A	N/A	N/A	N/A	16
NHS Tayside	Angus	66	80	89	93	95
	Dundee	98	111	130	135	139
	Perth and Kinross	74	90	99	103	104
NHS Shetland	Shetland	INA	INA	INA	0.2	0.2
NHS Western Isles	Western Isles	INA	22	20	23	23
<b>Total</b>		<b>875</b>	<b>1,370</b>	<b>2,652</b>	<b>2,793</b>	<b>2,908</b>

Notes: 1. We have used expenditure rather than budget information because we were advised at project-scoping stage that budget information would not be available from CHPs for earlier years.

2. Moray integrated CHP contains GP prescribing figures and independent contractor spend for the whole of NHS Grampian. South Lanarkshire CHP contains independent contractor spend for the whole of NHS Lanarkshire.

3. Some CHPs host board-wide services on behalf of other CHPs within the NHS board area.

4. Clackmannanshire CHP was unable to provide any expenditure information for community-based healthcare services in 2005/06 and 2006/07, therefore the expenditure for these years reflects expenditure on independent contractor services only.

5. Excludes the three CHPs in NHS Ayrshire and Arran which do not directly manage any services.

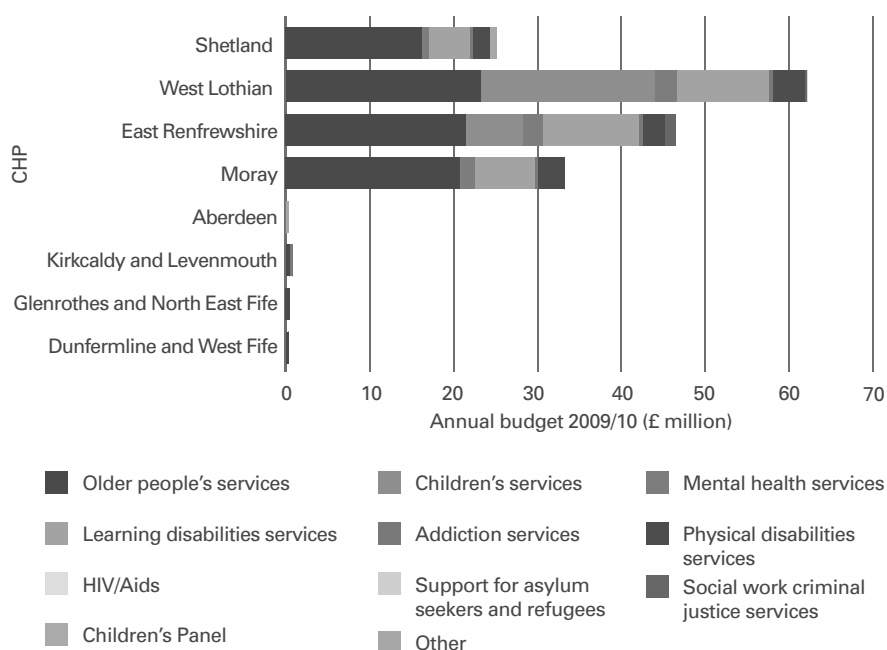
6. INA denotes the information was not available. N/A denotes not applicable as the CHP did not exist at this time.

Source: Audit Scotland, 2011

### Exhibit 13

#### Services and budgets delegated to the CHP by councils in 2009/10

Councils have delegated social care services and budgets to CHPs in some areas.



#### Notes:

1. Figures will be an underestimate because a number of CHPs were unable to provide details of their budgets for the services they manage. Orkney integrated CHP manages all council social care services and budgets; however it was not fully operational until 2010/11.

2. The former five integrated CHPs in Glasgow City managed combined total delegated budgets of £142 million in 2009/10. This is not included in the exhibit because a breakdown of this was not available showing the service budgets managed by each of the five CHPs.

3. Figures for Shetland and West Lothian CHPs are gross, rather than net.

Source: Audit Scotland, 2011

inconsistencies in how administration costs have been categorised between years, figures should be considered with caution.

**85.** In this context, CHPs are generally unable to provide details of their overall annual management and administration costs for all years since their establishment. Where CHPs provided information, there was significant variation in what they included within these amounts and few areas included organisational overheads. It is therefore not possible to use this information to compare how much each CHP spends on management and administration.

### Recommendations

The Scottish Government should:

- work with NHS boards, councils, ISD and other key stakeholders to improve systems for collating community health and social care activity and cost data<sup>64</sup>
- progress the eCare agenda to help address local barriers to sharing information for planning and service delivery purposes.

NHS boards and councils should:

- 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
- 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
- ensure that budgets are devolved in a transparent and structured way
- work together to continue to develop the IRF to help plan how resources are used in the local area
- work with NHS boards, CHPs and councils to review the scope for sharing assets including staff, buildings, equipment and IT
- 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.

<sup>64</sup> Information Services Division (ISD) is part of NHS National Services Scotland (NHS NSS). ISD provides national health statistics and other intelligence to support NHS bodies to improve planning and delivery of health services in Scotland.

# Part 4. Impact on the health and quality of life of local people



Organisations have to work together to enhance preventative services and move resources across the whole system.



## Key messages

- Tackling health inequalities in Scotland is a complex issue which no single body can solve on its own. There have been some successes, for example, in the reduction of low birth-weight babies, although there is less success in reducing drug and alcohol-related hospital admissions. Enhancing preventative services and moving resources across the whole system require effective joint working. CHPs have a key role to play in this but it is not possible to identify their individual contribution.
- While there is variation among CHPs against a range of performance indicators, limited progress has been made at a Scotland-wide level. For example, delayed discharges are starting to rise again after a period of steady reduction and multiple emergency admissions for older people are increasing. In addition, there has been mixed progress in reducing emergency admissions for people with long-term conditions such as angina and chronic obstructive pulmonary disease (COPD). CHPs have contributed to improving the health of local people but it is difficult to identify the overall impact they have made.

### **There are some significant and complex issues that no single partner can solve on its own**

**86.** There are some significant, long-standing and complex 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 the balance of care to community settings. However, we looked at their performance against a range of indicators to which we would expect CHPs to contribute through changes to services, for example, long-term conditions and services for older people.

**87.** This chapter looks at progress in:

- moving services to the community and joining up health and social care services
- improving performance in a range of indicators where CHPs should have a significant role
- tackling health inequalities.

### **There has been no large-scale shift in the balance of care despite this being a key priority since 2000**

**88.** Progress in moving services from hospital to the community and joining up frontline health and social care services is slow despite this being a key Scottish Government priority since 2000 and significant support and investment being made to drive this forward. CHPs were expected to contribute significantly to the 'shifting the balance of care' agenda. The Shifting the Balance of Care Improvement Framework was introduced in 2009. It identifies eight broad areas for work that will support progress in this area; and 48 impact changes for monitoring improvement.<sup>65</sup> However, the framework has limitations; for example, some work areas and impact measures are intangible, such as 'enhancing carers' capacity'. Others give a misleading picture of the direction of travel if considered in isolation; for example, improved care in the community could result in the average inpatient bed days increasing because only patients with severe illness reach hospital.

**89.** All CHPs have worked with NHS boards, councils and other health and social care providers to set up local initiatives focused on supporting older people and those with long-term conditions such as COPD, asthma, diabetes and angina. There is no evidence of a significant shift in the balance of care, although this may be because of a lack of information on community activity and data systems not keeping up with changes in the way that services are delivered (Part 3). But there is evidence of learning through piloting different approaches and, where these have been successful, rolling the approach out to a larger number of people. Similarly, there is evidence of CHPs learning from different approaches in other areas, both in Scotland and other parts of the UK.

**90.** A number of CHPs are able to show slight reductions in the number of emergency hospital admissions for particular client groups since initiatives were set up. However, many initiatives were set up using short-term funding rather than from savings released from acute hospitals. The focus of these changes appears to be on providing more community-based services but there is often a lack of analysis of the overall effect on costs as a result of service changes (Exhibit 14).

**91.** NHS boards, CHPs and councils are making use of telecare to support people at risk of admission to hospital and reduce the number of delayed discharges. Telecare is the remote or enhanced delivery of care services to people in their own home or in a community setting by means of telecommunications and computerised service. Examples of telecare include a monitoring sensor, which triggers a response from a call centre to provide help when someone has fallen, and a device that will alert someone to a particular hazard, such as the water level in a bath.

<sup>65</sup> The eight work areas are: maximise flexible and responsive care at home with support for carers; integrate health and social care and support for people in need and at risk; reduce avoidable unscheduled attendances and admissions to hospital; improve capacity and flow management for scheduled care; extend scope of services provided by non-medical practitioners outside acute hospital; improve access to care for remote and rural populations; improve palliative and end-of-life care; improve joint use of resources (revenue and capital).

**Exhibit 14****Examples of local initiatives aimed at shifting the balance of care**

CHPs have set up a range of local initiatives aimed at shifting the balance of care, particularly for long-term conditions.

Project aim and client group	Intervention	Funding	Outcome indicators
<p><b>Community Claudication Clinics (NHS Lanarkshire)</b> Three clinics were established in 2005 to reduce waiting times for patients suffering from this debilitating condition which restricts a person's ability to walk due to pain.</p>	<p>GPs refer suitable patients to the clinics instead of to the vascular surgeon. Clinics offer patients an initial assessment and a range of services to suit their circumstances.</p>	<p>Set up with short-term funding from the Centre for Change and Innovation Community Outpatient Services Programme. The service was mainstreamed in 2008 and so is now funded from NHS Lanarkshire's annual budget allocation. The board has not identified the effect on overall costs from changing the service.</p>	<p>The clinics reduced the surgeon's waiting list by 478 patients during the first eight months of 2010. The service is also more tailored to people's specific needs.</p>
<p><b>Pulmonary Rehabilitation Programme (Angus CHP)</b> Angus CHP has set up a range of initiatives to support people living with COPD.</p>	<p>All COPD patients who are able to, attend a six-week pulmonary rehabilitation course. A housebound COPD service supports patients who are unable to attend.</p>	<p>The housebound COPD service has been mainstreamed since 2007. The NHS board has not identified the cost impact of changes to the COPD services.</p>	<p>The 2010 annual review of the housebound service shows there has been a reduction in hospital admissions and bed days among patients receiving the service.</p>
<p><b>STARS<sup>1</sup> (Dumfries and Galloway CHP)</b> STARS is a partnership between Dumfries &amp; Galloway Council and NHS Dumfries and Galloway. It provides rehabilitation support to people at risk of admission or when they are discharged from hospital to enable them to live independently or with minimal homecare support.</p>	<p>STARS service provides flexible rehabilitation care in people's own homes for a maximum of six weeks with frequent re-assessment of their needs. As people become more capable their care package is adjusted.</p>	<p>The NHS board and council have funded STARS from their annual budget allocations from the outset. Between July 2009 and March 2010, the service made a net saving of £77,000.</p>	<p>Between November 2009 and March 2010, 30 people (43 per cent) who received support from STARS needed no further care and 16 people (23 per cent) had a reduced care package. The service is currently developing systems to track people's progress.</p>
<p><b>Rural North West Forth Valley Partnership (Stirling CHP)</b> A pilot community-based rehabilitation service to provide quicker supported discharge from hospital and to avoid admission.</p>	<p>A multi-disciplinary team, working out of a GP surgery, provide a flexible service for four to six weeks aiming to improve people's ability and independence.</p>	<p>The Scottish Government Joint Improvement Team is providing funding for the project leader for two years. NHS Forth Valley and Stirling Council fund other staff from their annual budget.</p>	<p>This pilot service began in September 2010 and will run for a year before evaluation.</p>
<p><b>Carers Link (East Dunbartonshire CHP)</b> The CHP has an agreement with third sector organisation, Carers Link, to deliver a training and information programme aimed at increasing the capacity of carers.</p>	<p>Training and information for carers covers topics such as looking after yourself, stress management, money matters, the legislation maze, first aid, computing and the internet, and confidence and assertiveness.</p>	<p>Funding comes from existing resources rather than short-term programmes. It is not possible to quantify the cost impact of the programme.</p>	<p>Carers score how they feel on a baseline questionnaire covering areas such as health, confidence, information and life of their own. They repeat this after six months. Results showed carers felt better about their role and themselves in all areas.</p>

Note: 1. Short-Term Augmented Response Service Re-enablement Initiative.  
Source: Audit Scotland fieldwork, 2011.

**92.** Local telecare developments were mainly funded through a national Telecare Development Programme (TDP) which was in place between 2006 and 2010 and helped 21,796 new people access telecare. An evaluation of the TDP found that local initiatives were significantly better at avoiding unplanned hospital admissions than anticipated but failed to deliver the expected reduction in delayed discharges and care home admissions.<sup>66</sup> It is estimated that the telecare programme generated efficiency savings of approximately £48.4 million due to saved bed days, sleepover nights and home check visits.

### Delayed discharges and unplanned emergency admissions are increasing

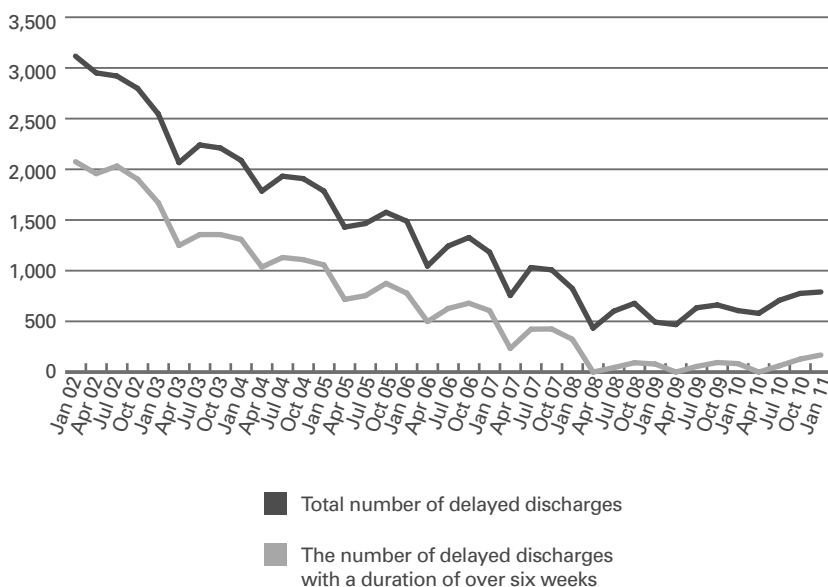
Delayed discharges are rising after a period of steady reduction

**93.** Inpatients are categorised as a 'delayed discharge' when they are clinically ready for discharge but are unable to leave the hospital because the other necessary care, support or accommodation for them is not readily accessible and/or funding is not available to purchase, for example, a care home place. It is essential that health and social care providers work together effectively to tackle delayed discharges effectively. This is a key priority area for CHPs and is the focus of many local initiatives (Exhibit 14).

**94.** The Scottish Executive launched a national plan to tackle delayed discharges in March 2002 and provided £20 million additional funding to support this work in 2002/03, which increased to annual funding of £30 million between 2003/04 and 2007/08.<sup>67</sup> NHS board and council local partnerships were given a ring-fenced allocation to achieve individually agreed targets in 2002/03. National targets were introduced from 2003/04 and local partnerships

### Exhibit 15 Delayed discharges

The number of patients in Scotland with a delayed discharge from hospital decreased from 3,116 in January 2002 to 434 in April 2008 but has since increased to 790 at January 2011. The number of delayed discharges over six weeks has also started to rise again after a period of steady reduction.



Source: ISD Scotland, 2011

received a further ring-fenced allocation to support this work until 2008/09.<sup>68</sup> Since then, the Scottish Government has provided £29 million to councils for delayed discharges as part of the local government financial settlement but this funding is no longer ring-fenced. From 2007/08 onwards, the target has been to reduce to zero the number of people with a delayed discharge of over six weeks and those in short-stay beds and sustain this performance.

**95.** Before the national plan was launched in March 2002, the total number of delayed discharges was 3,116. This reduced to 434 in April 2008.<sup>69</sup> Over the same period, the number of people being delayed by over six weeks reduced from 2,075 to zero. Although there has been significant progress, there have been

seasonal fluctuations in all years for both total delayed discharges and delays of over six weeks.<sup>70</sup>

**96.** There are signs that the position is beginning to get worse. For example, between April 2008 and January 2011, total delayed discharges increased from 434 to 790. Seasonal fluctuations may account for part of this increase but delayed discharges were 30 per cent higher in January 2011 than in January 2010.<sup>71</sup> This is a similar picture for delayed discharges of over six weeks. In the quarter to January 2011, delayed discharges of over six weeks increased by 102 per cent to 168 from 83 in January 2010 (Exhibit 15). NHS boards and councils need to ensure their strategies for managing delayed discharges are effective and sustainable.

<sup>66</sup> *An assessment of the development of telecare in Scotland 2006-2010*, Scottish Government Joint Improvement Team, October 2010.

<sup>67</sup> *Delayed discharges action plan*, Scottish Executive, 2002.

<sup>68</sup> From 2004, the target for NHS boards, CHPs and councils was to achieve a 20 per cent reduction in delayed discharges. In 2006/07, the target was to reduce all delays over six weeks by 50 per cent and free up 50 per cent of beds occupied by patients in short-stay beds.

<sup>69</sup> The total number of delayed discharges taken from the census in January 2002 was 3,116.

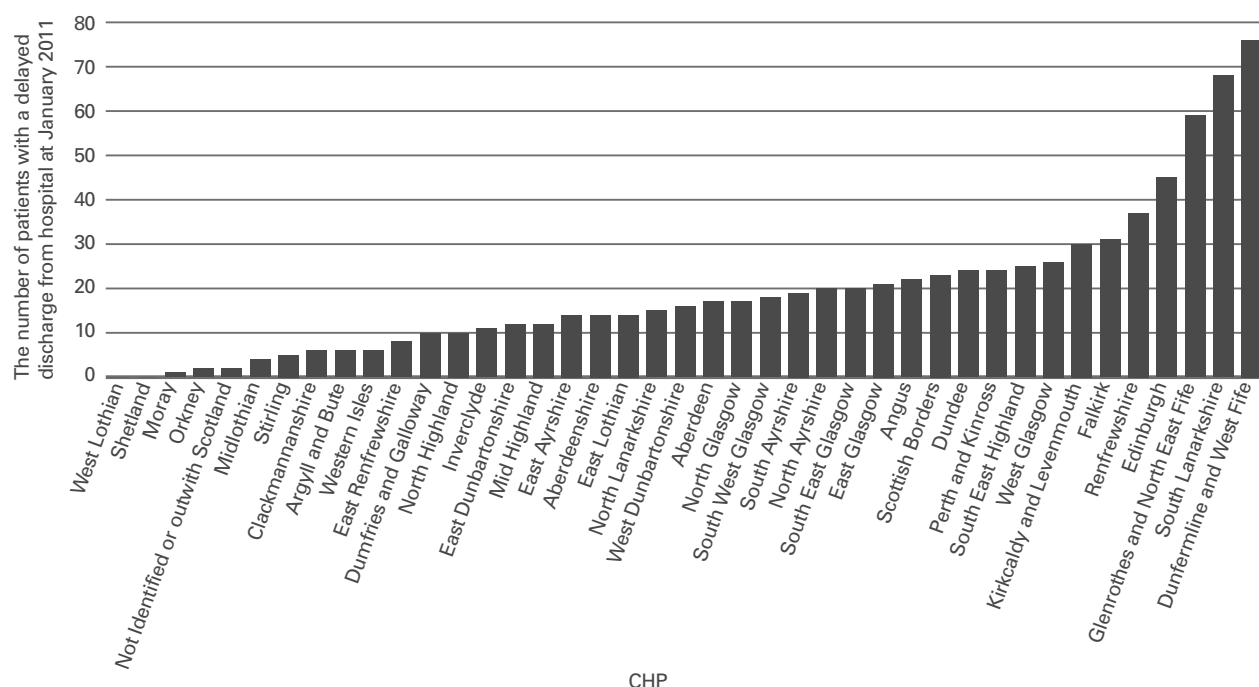
<sup>70</sup> Delayed discharges have typically been lowest at the census date in April each year and highest at the census date in October each year. The target of zero delayed discharges of over six weeks has been achieved in April each year between 2008 and 2010.

<sup>71</sup> The total number of delayed discharges at the census date in January 2010 was 606, increasing to 790 in January 2011.



**Exhibit 16****Delayed discharges across CHPs in Scotland**

The number of people experiencing a delay in leaving hospital increased in 17 CHPs between October 2010 and January 2011.



Note: The delayed discharges target is zero, therefore we have not used standardised rates to present the data.

Between October 2010 and January 2011, the number of delayed discharges decreased in 18 CHPs and stayed the same in four CHPs. Delayed discharges increased in the remaining 17 CHPs. The greatest decrease was 28 in Scottish Borders. The greatest increase was 41 in Dunfermline and West Fife.

Source: ISD Scotland, 2011

**97.** There are a number of potential reasons for recent increases in delayed discharges. But there are systemic issues which need to be addressed through better joint working between the NHS and councils. Reductions in public sector budgets may increase the challenge for NHS boards, CHPs and councils to work together effectively to achieve and sustain no delayed discharges.

**98.** In the last quarter recorded to January 2011, the number of delayed discharges increased in 17 CHP areas. At that time, Borders, South Lanarkshire, Glenrothes and North East Fife and Edinburgh City CHPs showed the highest number of delayed discharges overall. In Fife, all three CHPs are experiencing delays,

which indicates pressure across the whole system (Exhibit 16).

#### Emergency admissions to hospital for older people are rising

**99.** Despite national and local initiatives aimed at supporting older people to stay at home longer, emergency admissions for older people increased in Scotland between 2004/05 and 2009/10. The rate of emergency admissions for older people varies among CHPs, although emergency admissions for older people increased in three-quarters of CHP areas during this period. Similarly, between 2004/05 and 2009/10, there was an increase in the number of older people admitted to hospital as an emergency on more than one occasion in-year in Scotland. The rates of multiple emergency

admissions for older people increased in all but six CHP areas (Exhibit 17, overleaf).

#### There is mixed progress in the extent to which emergency stays in hospital are reducing for certain conditions

**100.** Ambulatory care sensitive conditions, including long-term conditions, are conditions for which admission to hospital is potentially avoidable through good-quality primary and preventative care.<sup>72</sup> CHPs have a key role in providing primary and preventative care to people with ambulatory care sensitive conditions.

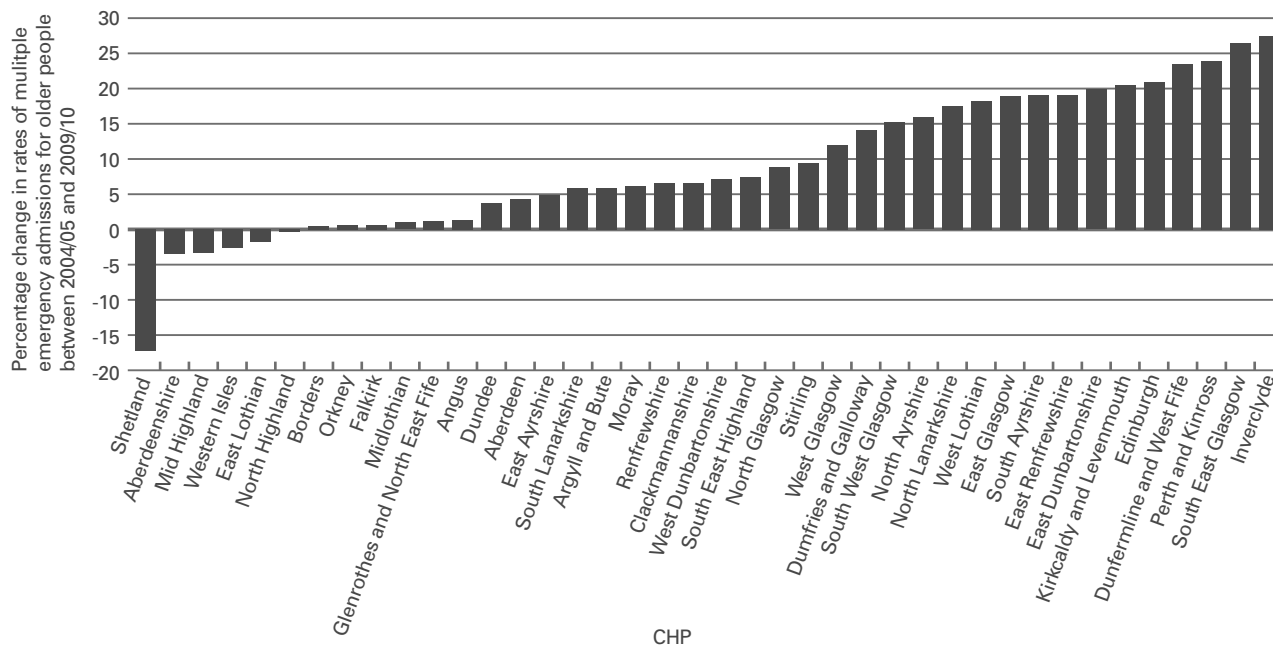
**101.** Between 2004/05 and 2008/09, the number of emergency admissions for people with ambulatory care sensitive conditions grew in Scotland, although this varies for individual

<sup>72</sup> Ambulatory care sensitive conditions include the following diagnoses: influenza and pneumonia; other preventable vaccine; asthma; congestive heart failure; diabetes complications; COPD; angina; iron deficiency/anaemia; nutritional deficiencies; hypertension; dehydration and gastroenteritis; pyelonephritis; perforated/bleeding ulcer; cellulitis; pelvic inflammatory disease; ear, nose and throat infections; dental conditions; convulsions and epilepsy; and gangrene.

## Exhibit 17

### Summary of trends of multiple emergency admissions for older people

Rates of multiple emergency admissions for older people increased in most CHPs between 2004/05 and 2009/10.



Note: In 2009/10, rates of multiple emergency admissions for older people were highest in East Glasgow (7,315 per 100,000 population) and South West Glasgow (7,008 per 100,000 population) and lowest in Moray (3,531 per 100,000 population) and Shetland (3,602 per 100,000 population).

Source: ISD Scotland, 2011

conditions across CHPs.<sup>73</sup> In 2008/09, rates of emergency stays for people with ambulatory care sensitive conditions were highest in East Glasgow and North Glasgow CHP areas and lowest in Aberdeenshire and East Dunbartonshire CHP areas.<sup>74</sup> This is at a time when money has been invested in GP contracts to improve services for people with long-term conditions.

**102.** Between 2004/05 and 2008/09, the number of emergency admissions in Scotland for people with angina decreased while emergency admissions increased for people with COPD, asthma and diabetes.<sup>75</sup> However these trends vary for each condition between CHPs over this period. For example, rates of

emergency stays for people with angina decreased in approximately two-thirds of CHPs (Exhibit 18); rates increased in around half of CHPs for people with asthma (Exhibit 19) and people with diabetes complications (Exhibit 20, page 42); and rates increased in most CHPs for people with COPD (Exhibit 21, page 42). There is no single CHP which is performing well on all indicators that we looked at as part of the audit.

### Reducing health inequalities remains a major challenge in Scotland and CHPs have a key role

**103.** Health inequalities are complex. Socio-economic factors such as low income, gender, social position, ethnic origin, age and disability increase

the risks of poor health. Behavioural factors such as smoking, alcohol, drugs, poor diet, poor sexual health and low physical activity also increase the risk of health-related problems. Many of these factors are interlinked and further increase the risk of health problems.

**104.** A key function of CHPs is to 'tackle health inequalities, enhance anticipatory and preventative care, shift resources to community settings and provide a wider variety of services at local level'.<sup>76</sup> However, CPPs have the lead role in tackling health inequalities and so CHPs need to work closely with them.

<sup>73</sup> Between 2004/05 and 2008/09, the largest percentage increase in rates of emergency stays for people with ambulatory care sensitive conditions was in East Glasgow (30 per cent increase) and the largest percentage decrease was in East Lothian (two per cent decrease).

<sup>74</sup> Emergency hospital stay rates per 100,000 population were 2,698 in East Glasgow, 2,438 in North Glasgow, 1,341 in Aberdeenshire and 1,353 in East Dunbartonshire.

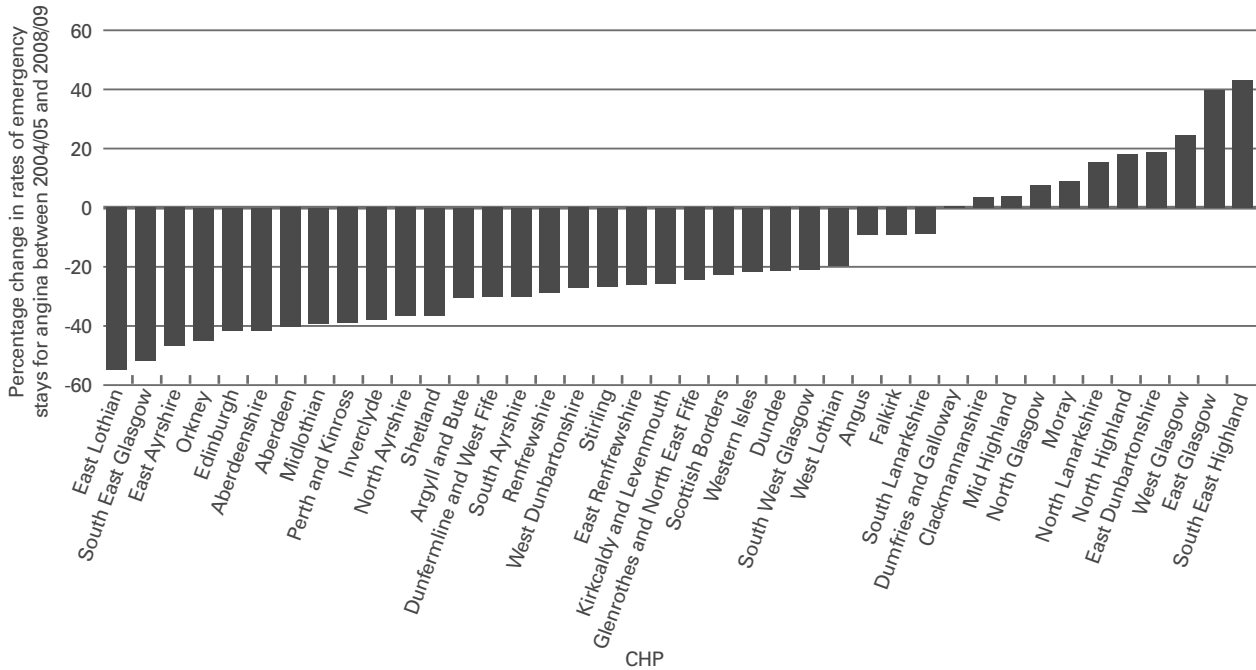
<sup>75</sup> Between 2004/05 and 2008/09, rates of emergency stays for people with COPD increased from 267 to 327 per 100,000 population, while rates of emergency stays for people with asthma have increased from 129 to 134 per 100,000 population and rates of emergency stays for people with diabetes complications increased from 91 to 95 per 100,000 population. In contrast, over the same period, rates of emergency stays for people with angina decreased from 190 to 151 per 100,000 population.

<sup>76</sup> *Better Health, Better Care Action Plan*, Scottish Government, 2007.

### Exhibit 18

#### Percentage change in rates of emergency stays for people with angina

Rates of emergency stays for people with angina decreased in around two-thirds of CHPs between 2004/05 and 2008/09.

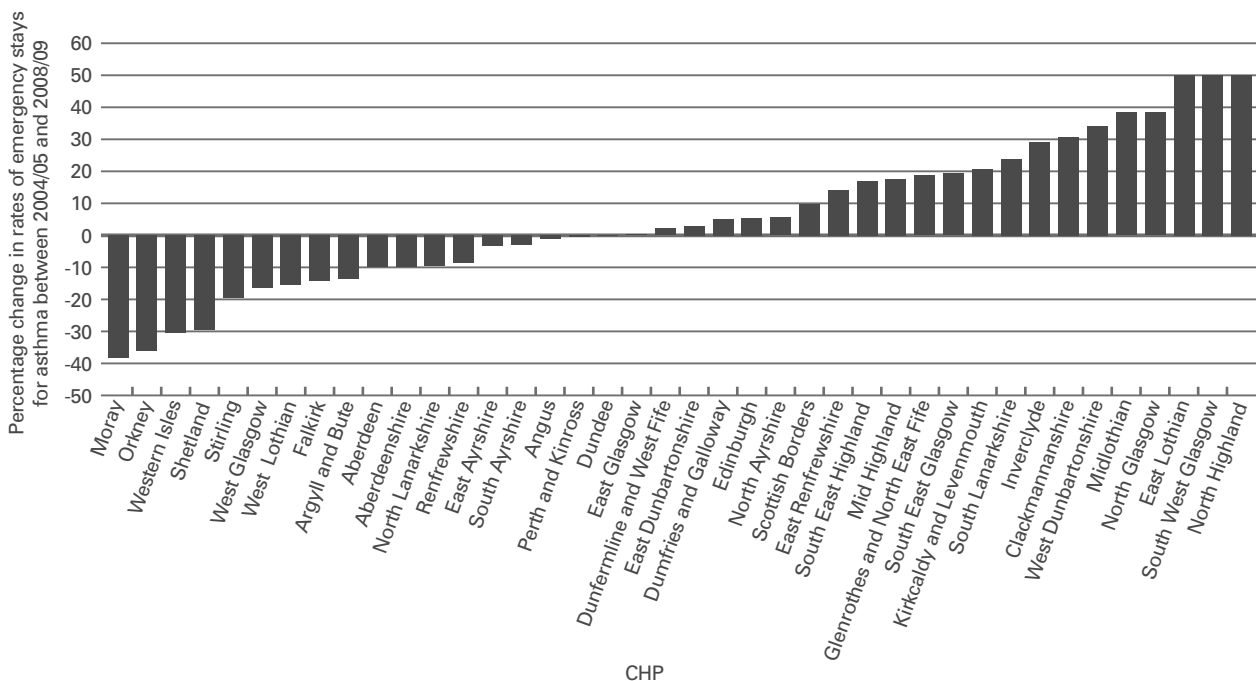


Note: Rates of emergency stays for people with angina in 2008/09 were highest in North Lanarkshire (252 per 100,000 population) and South East Highland (245 per 100,000 population) and lowest in Aberdeenshire (63 per 100,000 population) and South East Glasgow (68 per 100,000 population).  
Source: ISD Scotland, 2011

### Exhibit 19

#### Percentage change in rates of emergency stays for people with asthma

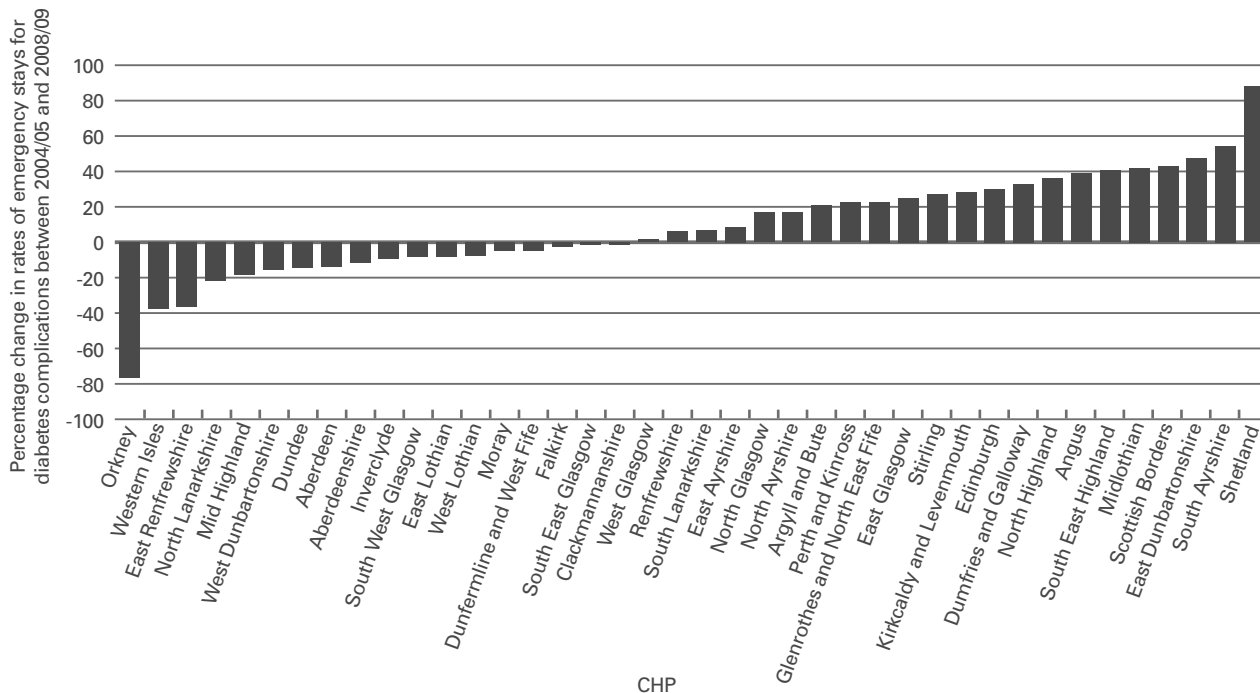
Rates of emergency stays for people with asthma have increased in around half of CHPs between 2004/05 and 2008/09.



Note: In 2008/09, rates of emergency stays for people with asthma were highest in South West Glasgow (249 per 100,000 population) and North Highland (189 per 100,000 population) and lowest in Shetland (55 per 100,000 population) and Orkney (75 per 100,000 population).  
Source: ISD Scotland, 2011

**Exhibit 20****Percentage change in rates of emergency stays for people with diabetes complications**

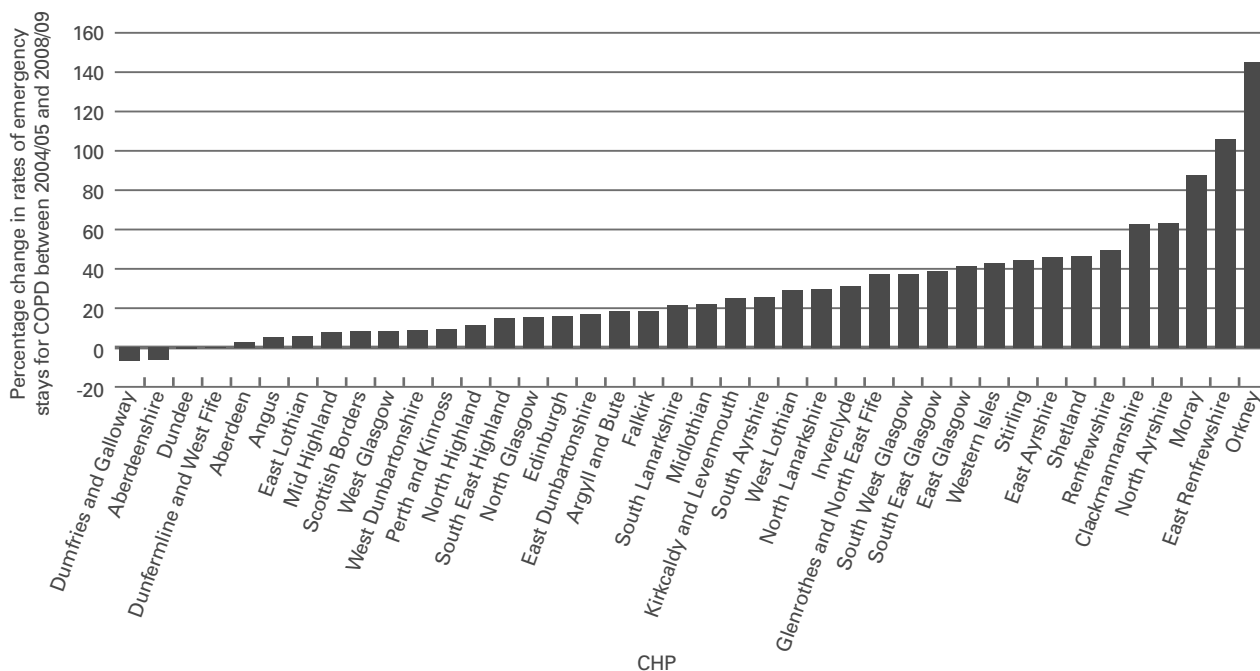
Rates of emergency stays for people with diabetes complications have increased in around half of CHPs between 2004/05 and 2008/09.



Note: Rates of emergency stays for people with diabetes complications in 2008/09 were highest in North Ayrshire (153 per 100,000 population) and Shetland (146 per 100,000 population) and lowest in Orkney (35 per 100,000 population) and East Dunbartonshire (53 per 100,000 population).  
Source: ISD Scotland, 2011

**Exhibit 21****Percentage change in rates of emergency stays for people with chronic obstructive pulmonary disease**

Rates of emergency stays for people with COPD increased in all but three CHPs between 2004/05 and 2008/09.



Note: In 2008/09 rates of emergency stays for people with COPD were highest in East Glasgow (765 per 100,000 population) and North Glasgow (622 per 100,000 population) and lowest in Shetland (100 per 100,000 population) and Aberdeenshire (160 per 100,000 population).  
Source: ISD Scotland, 2011

**105.** A Ministerial Taskforce published a report on health inequalities in 2008 which set recommendations for the Scottish Government and CPPs.<sup>77</sup> The Scottish Government and the Convention of Scottish Local Authorities (COSLA) published their *Equally Well* action plan in 2008 which sets out Scotland's key priorities for tackling health inequalities: children's very early years; cardiovascular disease and cancer; drug and alcohol problems and links to violence; and mental health and well-being.

**106.** Since the Ministerial Taskforce's baseline report in 2008, there has been indication of a slight reduction in health inequalities in some areas such as low birth-weight babies and first-ever hospital admission for heart attack. But there is also evidence of the health inequalities gap widening in other areas, including deaths from coronary heart disease.

**107.** We reviewed a number of health indicators aligned to priority areas to assess whether there has been any improvement since CHPs were established. We have selected 2004 as our baseline for assessing progress because CHPs were phased in from that time. We focused on those areas in which CHPs should make a contribution as primary and community healthcare providers. We found that between 2004-06 and 2006-08, the percentage of mothers smoking during pregnancy decreased in all but four CHP areas.<sup>78</sup> Over the same period, the percentage of babies being exclusively breastfed at eight weeks increased in three CHP areas but decreased in 26 CHP areas.<sup>79</sup> Between 2004-06 and 2007-09, hospital admission rates for alcohol-related problems increased in all but a quarter of CHP areas and drug-related hospital admissions increased in all but eight CHP areas.<sup>80</sup>

**108.** NHS boards and councils must ensure that they are working closely with the local population to improve the services they deliver and support local people to help improve health and meet social care needs, for example, supporting carers in the local area. There are cultural and resource implications for the public sector in working with local people, including training needs for staff and a different way of thinking about how services are planned and delivered. CHPs have a key role to play in taking this agenda forward.

### Recommendations

NHS boards and councils should:

- carry out options appraisals, including an assessment of the costs and benefits, before implementing service changes or initiating pilot projects
- work together to develop sustainable strategies to address delayed discharges and emergency admissions within the local area and ensure regular monitoring takes place.

<sup>77</sup> *Equally Well: Report of the Ministerial Task Force on health inequalities*, Scottish Government, June 2008.

<sup>78</sup> *2010 CHP Profiles*, ScotPHO, 2010. Four CHP areas have shown an increase in the number of mothers smoking during pregnancy: East Lothian, Edinburgh, Midlothian and Shetland.

<sup>79</sup> Due to the phased implementation of CHPs, breast feeding data was not available for all CHPs over this period.

<sup>80</sup> *2010 CHP Profiles*, ScotPHO, 2010.

# Appendix 1.

## Project advisory group membership

Audit Scotland would like to thank members of the project advisory group for their input and advice throughout the audit.

Member	Organisation
Ron Culley	Convention of Scottish Local Authorities
Graeme Dickson	Scottish Government
Joan Forrest	ISD Scotland, NHS National Services Scotland
Dr John Gillies	Royal College of General Practitioners
Lynne Hollis	NHS Directors of Finance Group and NHS Lothian
Alexis Jay	Social Work Inspection Agency
Kenny Leinster	Association of Directors of Social Work and South Ayrshire Council
Fiona McKenzie	NHS Chief Executives Group and NHS Forth Valley
Julie Murray	Association of Community Health Partnerships and East Renfrewshire CHCP
Robert Peat	Society of Local Authority Chief Executives and Angus Council
Sandy Watson OBE DL	NHS Tayside Board
Steven Wilson	NHS Quality Improvement Scotland

Note: Members of the project advisory group sat in an advisory capacity only. The content and conclusions of this report are the sole responsibility of Audit Scotland.

# Review of Community Health Partnerships

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