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18 July 2002

Dear Colleague

COMMUNITY HEALTH PARTNERSHIPS

Partnership for Care, the Health White Paper, outlines the direction of travel for the health service in Scotland and lays strong emphasis on partnership, integration and service redesign. These principles will be at the heart of the development of new Community Health Partnerships where I foresee a central role for primary care teams, working in new ways with hospital services and at community level with Local Authorities.

Community Health Partnerships will seek to bridge the divide that has existed for too long between primary and secondary care and between health and social care. By devolving resources and decision making to frontline staff we will enable health and social care professionals to look at the whole picture of care from a patient's point of view. I believe this is essential for achieving shifts in the balance of care and for developing new models of care that meet patient's needs.

The NHS Reform (Scotland) Bill, recently presented to Parliament, provides the legislative framework to ensure that NHS Boards establish Community Health Partnerships as an effective basis for the delivery of local healthcare services. There is strong support for their development and I now seek your views on how they may be organised and work within NHS Boards and with other partners. Your responses will help inform any practical measures including guidance that may be needed to support the development of Community Health Partnerships. At the same time I will be considering the potential evolution of the Primary Care Modernisation Group to provide a national focus for the development of Community Health Partnerships.

MALCOLM CHISHOLM

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COMMUNITY HEALTH PARTNERSHIPS

CONSULTATION PAPER ON GUIDANCE

INTRODUCTION

1. The aim of this consultation paper is to seek views from within the NHS and from other relevant partners (especially Local Authorities and the voluntary sector) about the establishment of Community Health Partnerships (CHPs), as outlined in the White Paper *Partnership for Care*¹ and in the *Partnership Agreement*²

2. The NHS Reform (Scotland) Bill 2003³ provides the legislative framework to ensure NHS Boards devolve appropriate resources and responsibilities for decision making to frontline staff, and establish CHPs as an effective basis for the delivery of local healthcare services (Appendix 1). There is strong support for the development of CHPs but no definitive view and differing perspectives about the way they will be organised and work within NHS Boards and with other partners. The responses to this consultation paper will help us frame any practical measures, including guidance, that may be needed to support the development of CHPs.

3. The Scottish Executive's policy is that care should be delivered as close to home as possible, and that frontline staff should have the opportunity and resources to support the delivery of that objective. *Partnership for Care* emphasises that the vast majority of health care is delivered by community based professionals and that these staff also have an expanding role in health improvement. CHPs are therefore a key building block in the modernisation of services, with a vital role in partnership, integration and service design.

4. In the context of the partnership between CHPs and Local Authority community care services, we continue to emphasise the implementation of the Joint Future agenda in accordance with the "Next Steps" milestones for integration issued jointly by the Executive, NHSScotland and COSLA on 28th February 2003. The opportunity to progress integrated

¹ Scottish Executive, *Scotland's Health White Paper: Partnership for Care (2003)*
<http://www.scotland.gov.uk/library5/health/pfcs-00.asp>

² Scottish Executive, *A Partnership for a Better Scotland: Partnership Agreement (2003)*
<http://www.scotland.gov.uk/library5/government/pfbs-00.asp>

³ Scottish Executive, *The NHS Reform (Scotland) Bill 2003*
<http://www.scottish.parliament.uk/bills/index.htm#6>

working both within the NHS and with Local Authorities and other partners should not be missed.

5. In respect of child health and children's services, CHP development will be consistent with the agenda for better integrated services for children set by *For Scotland's Children*.⁴

6. We will continue to engage with Local Authorities on policy development to ensure that CHPs develop their full potential, and provide integrated responses to the communities they serve. CHPs will need to work closely with community planning partners to ensure the delivery of the health improvement agenda.

7. The proposals in this consultation paper build on the recommendations of the report of the LHCC Best Practice Group *Connecting Communities with the NHS*⁵, and of the report of the Primary Care Modernisation Group *Making the Connections*⁶. There was extensive consultation before the publication of both these reports which fed into the "Review of Management and Decision Making in the NHS", undertaken in the latter half of 2002.

8. The "Review of Management and Decision Making in the NHS" had a particular focus on LHCC development and the implementation of the Joint Future agenda. The conclusions, reflected in *Partnership for Care*, mirror closely the creation of, and more formal role for CHPs working in substantive partnership with Local Authority services.

9. Comments on this consultation paper may be sent by 12th September 2003 to:

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⁴ Scottish Executive, For Scotland's Children Report
<http://www.scotland.gov.uk/library3/education/fcsr-00.asp>

⁵ Scottish Executive, *Connecting Communities with the NHS* (2001)
<http://www.show.scot.nhs.uk/lhcc/Latest News Docs/bestpracticefinalreport.pdf>

⁶ Scottish Executive, *Making the Connections: Developing Best Practice into Common Practice* (2002)
<http://www.show.scot.nhs.uk/sehd/publications/mcbp/mcbp-00.htm>

BACKGROUND

Local Healthcare Co-operatives

10. CHPs are intended to evolve from Local Health Care Co-operatives (LHCCs). LHCCs were established following the 1997 White Paper *Designed to Care*⁷ and are not statutory bodies. They are voluntary associations of primary health care professionals who come together, along with other partner agencies such as Local Authorities, to consider the planning and delivery of NHS services to meet the assessed needs of patients and local communities. LHCCs are currently supported through the operational management arrangements of Primary Care Trusts or NHS Boards.

11. The non-statutory arrangements for LHCCs have operated satisfactorily in that they have fostered the development of informal organisations which have become increasingly important in the planning and delivery of local services. Many LHCCs have already evolved into multi-professional and multi-agency organisations with active community involvement. In many places they have very successfully brought together **all** who work in primary and community settings to plan and deliver improved services, working as partners and as teams.

12. However, while LHCCs have generally made good progress in developing into responsive and inclusive organisations that play a key role in the planning, development and delivery of services, this has not been consistent across Scotland. CHPs will build on the very best practice in LHCCs and will have a more consistent and central role in delivering health outcomes and patient benefits for local people.

COMMUNITY HEALTH PARTNERSHIPS

What will they do?

13. The overall purpose and focus for CHPs is on actions that: support the improvement of the health of local communities; provide service benefits for local people; and involve them in decisions that affect the planning and delivery of health care and health services for their communities. The policy intention is to enable CHPs to have a more direct and

⁷ The Scottish Office, *Designed to Care: Executive Summary*
<http://www.scotland.gov.uk/library/documents/1/execsumm.htm>

strengthened role in service planning and delivery, with a clearer focus on health benefits and outcomes for patients and more integrated responses to the needs of local communities. The general function of a CHP is to co-ordinate, for its area, the planning, development and provision of those services which it is the duty of the NHS Board to provide, or secure the provision of, with a view to improving those services. This means CHPs will:

- work as a key NHS partner with Local Authorities and others, such as the voluntary sector, in relation to community planning to tackle priority health issues; and in developing and delivering joint approaches to local health and social care services for all ages;
- directly influence NHS Board level strategic planning, priority setting and resource allocation;
- plan primary and community based services with delegated authority from the NHS Board to deliver services in the way that best fits the needs of local people;
- create and strengthen local networks and partnerships with hospital and specialist practitioners and teams to deliver integrated health services.

14. In fulfilling these roles CHPs will have a responsibility to work corporately within the local NHS system and agreed accountability frameworks.

Q. Do you agree with these overall roles?

Focus on Health Outcomes - Community Benefits

15. It is envisaged that CHPs will contribute to the improvement of the health of local communities by strengthening relationships with all partners to ensure a community focus for health improvement. They will be a powerful new vehicle to inform joint health improvement plans (JHIPs) and support the delivery of, community planning partnership objectives at a local level.

16. NHS Boards will be expected to develop CHPs that are able to:

- adopt a wide perspective on health as being a state of physical, mental and social well-being;
- act as holistic enablers of improved health outcomes across an entire community, working very closely with all community planning partners;
- ensure NHS Board health improvement priorities and activities are; based on a needs assessment for local communities; focused on reducing inequalities; linked to national priorities and are designed to improve the well being and lifestyles of communities;
- ensure there is a local focus for health education and promotion within their communities;
- deliver on the four pillars of *Improving Health in Scotland - The Challenge*⁸

Q. How can CHPs best work with community planning partners to support the health improvement agenda?

Focus on Service Outcomes - Patient and Carer Benefits

17. Radical service improvements can happen when people at the frontline are given the opportunity, skills and resources to do a better job. Many health services will increasingly be provided locally by a wide range of skilled staff working together as a team with other professions. This multi-disciplinary and multi-partner approach is essential for the provision of local, integrated and improved services for patients and carers. CHPs will be the main focus for service integration for local communities with particular emphasis on clinical priority areas and chronic disease management.

18. NHS Boards will be expected to support CHPs to develop:

- broader access to services in the community with wider and greater direct access to services such as allied health professionals, community pharmacy;

⁸ Scottish Executive, *Improving Health In Scotland: The Challenge* (2003)
<http://www.scotland.gov.uk/library5/health/ihis-00.asp>

- single shared assessment for access to professionals and services;
- wider access to information and services through public involvement and a greater understanding by the public of what they can receive;
- more local and flexible arrangements for diagnosis and service delivery;
- better management of demand and capacity - through increased levels of, and expanded opportunities for, triage and a focus on service redesign bringing stakeholders together around clinical priorities and deployment of resources;
- a central role in Managed Clinical Networks and other care networks;
- professional standards, and local standards of treatment, access and referral; and
- more integrated approaches to planning and delivering specialist care.

Q. Are these the right service outcomes and what indicators would we use to measure these outcomes?

WHAT IS A SCHEME OF ESTABLISHMENT?

19. NHS Boards are required to submit for approval by the Minister for Health and Community Care schemes for the establishment of CHPs which would cover the whole Board area (Appendix 1). This requirement will ensure that CHPs have the delegated powers and resources to deliver the intentions in *Partnership for Care* and *The Partnership Agreement*. Boards will be required to include within their scheme matters including the following:

- functions which will be delegated to CHPs and their role in the overall planning, development and provision of services for the area;
- number of CHPs;

- membership of CHPs;
- arrangements for the involvement of the public and patients;
- joint resourcing and joint management arrangements with Local Authorities; and
- associated financial arrangements.

20. The success of CHPs in harnessing widespread support from clinicians and staff will depend to a great extent on how effectively resources; decision making and operational support are devolved to the frontline. Schemes of establishment should therefore be developed through a bottom up inclusive process and demonstrate that the views of all stakeholders have been taken into consideration.

21. It is likely that most NHS Boards will have more than one CHP in their area. We will expect their schemes of establishment to cover all the areas contained within this guidance, however the details may vary across CHPs in line with local preferences and needs. For example, one CHP may undertake a specific function or provide a particular service on behalf of all CHPs in the same area.

WHAT CULTURE AND STYLE OF WORKING SHOULD UNDERPIN CHPs?

22. CHPs should operate within a shared NHS culture based on team working and service integration across the NHS and stronger partnerships with Local Authorities and the voluntary sector and other agencies and care providers. This shared culture will also reflect the need for CHPs to take a proactive and positive approach to engaging with the people they serve and to demonstrate that they have listened to, understood and acted upon their views. This approach at a local level will be supported by new arrangements nationally and locally under the umbrella of the Scottish Health Council and its local Advisory Councils.

23. CHPs are intended to be flexible and innovative organisations, free from unnecessary bureaucracy and administrative burdens. They will have a key role in unlocking the potential of all professionals by providing a forum for independent contractors and all staff working in

primary and community based care to come together to support health improvement and develop health services.

24. We envisage CHPs acting as the focus for local networks for sharing good practice and encouraging links into national organisational learning. In particular, CHPs will be encouraged to use networks being developed by the Scottish School of Primary Care, NHS Health Scotland, and Public Health Departments, both as sources of evidence on which to base improvements and as mechanisms to generate locally important questions and to get them answered.

25. We are seeking views in this consultation paper on the range of services, size, status, relationships and accountability of CHPs.

WHAT SERVICES WILL CHPs BE RESPONSIBLE FOR?

26. NHS Boards will be expected to define the core NHS services and associated budgets to be managed by, **or play a full part in**, the CHP arrangements including any arrangements for pooling of budgets and delivery of services with other agencies. Currently across Scotland there are a range of services that are managed and/or co-ordinated by LHCCs including:

- the full range of independent contractor services;
- all community related health services including community nursing; allied health professionals; and any community based integrated teams (e g rapid response teams, hospital at home), voluntary services
- community based midwifery services
- community child health services;
- health promotion/health education;
- community mental health services (including psychology);

- learning disability;
- older peoples services;
- community access to a range of outpatient and diagnostic services;
- community resource centres/hospitals
- community assessment and rehabilitation
- drug and alcohol services
- sexual and reproductive health services.

27. NHS Boards must ensure that the services for which CHPs will be responsible are developed around maximum integration of primary and secondary care and strong management at a local level.

Q. What should the core services be?

28. CHPs should work in partnership within the NHS to promote service integration and redesign. CHPs will be the local focus for partnership with Local Authorities under the Joint Future agenda; they will have the potential to pool budgets and enter into joint management arrangements on a wide range of services. In addition, the Executive is currently consulting on how the NHS and Local Authorities can effectively plan and deliver better integrated services for children in their early years.

29. NHS Boards and their partners are invited to consider how to optimise the potential of joint working and provide an illustrative menu of what could be located/managed within a CHP. They should also highlight the liaison and co-ordinating role for CHP managers and leaders in relation to community care and other services not directly managed by the CHP.

WILL ALL CHPs BE THE SAME SIZE?

30. Ministers wish to see the development of CHPs that are fit for purpose. This means striking the right balance between flexibility and prescription in relation to the size, number and structure of CHPs.

31. We wish to encourage maximum alignment between CHPs and natural communities. At the same time NHS Boards must consider the minimum size needed to be able to deliver a wide range of primary and community based services for the local population based on the health and service outcomes in their proposed schemes.

32. NHS Boards are therefore asked to take into account the issues that currently constrain the delivery of more effective and integrated health care and health outcomes and configure their CHPs to minimise these constraints. Issues to be taken into account should include co-terminosity with Local Authorities or their internal administrative boundaries (which may themselves be the subject of adjustment), the critical mass of patients required to deliver cost effective local services, physical and human resources capacity and geographical constraints.

33. It will be important to ensure that CHPs maximise their potential and achieve economies of scale in delivering improved health outcomes and service improvements. For this reason, with the exception of the Island Boards or where there are particular local circumstances, it is anticipated that CHPs should have a minimum population size of around 50,000. There will be no absolute maximum population size but CHPs must be able to reflect the needs of communities and engage with frontline staff.

Q. What are your views on population size?

WHAT STATUS WILL CHPs HAVE?

34. CHPs will not be independent statutory bodies separate from NHS Boards, but they will have a more formal and consistent role within Boards, thereby providing those primary and community based clinicians and staff with a greater say in the design and delivery of local services.

35. While CHPs will wish to ensure they reflect the needs of localities, LHCCs as separate bodies will cease to exist

36. CHPs have critical functions to deliver and they must be enabled to deliver the agreed health and service improvements for their local population. In order to be empowered with delegated decision making power and resources, CHPs need to be formally part of the NHS Board. This paper recognises that for practical reasons in some areas across Scotland NHS Boards may wish to set up a primary care operating division in the first instance to enable a move towards single system working in line with previously issued guidance ([NHS HDL \(2003\) 11](#)). This HDL also requires such divisions to "delegate budgetary and decision-making powers to the appropriate level within their NHS system" such as CHPs. However, it will be possible for NHS Boards to establish CHPs as committees of the NHS Board at the appropriate time, if that would fit local circumstances better and improve the planning, development and delivery of services for local communities.

37. Providing CHPs with this status within the NHS Board would bring with it a significant profile and position within the NHS system, and empower them to respond to the needs of their local communities and at the same time play a full role in the range of NHS Boards activities.

Q. What effect will CHPs have on existing LHCC Professional Committees and the relationship with the Area Clinical Forum?

38. The NHS Board will be the formal "Primary Care Organisation" in relation to the GMS contract but we see significant opportunity for CHPs to support the delivery of the new arrangements. For example, CHPs may play a central role in co-ordinating "enhanced services" and building on the opportunities presented by new contractual arrangements to forge pathways between community and hospital based care thereby releasing the potential of staff and teams to work in different ways for the benefit of local communities. They will also play an important role in influencing local workforce planning, working with regional workforce development groups and forging better links between service development and workforce capacity.

Q. What role do you envisage for CHPs in relation to workforce planning and development and the new contractual arrangements?

WHAT ARE THE ORGANISATIONAL ARRANGEMENTS FOR CHPs?

39. CHPs are required to have a range of functions as described above and this should be reflected in their organisational arrangements. They need to be able to operate at a strategic level in relation to their influencing role within NHS Boards and with partners, and ensure that all partners and staff, who are involved locally in the operational delivery of services, are included in the organisational arrangements. The make up of the CHP should reflect the total make up of the workforce in terms of professional backgrounds.

40. CHPs are expected to build on the best examples of LHCC partnership working across Scotland and this will require very high levels of leadership, management and support services. Taking these factors into account we envisage each CHP will have management arrangements that enable NHS Boards to delegate powers and resources. This may take the form of a CHP management team which should be large enough to include a range of skills, knowledge and experience but not so large as to be unworkable. It is envisaged that members of the CHP management team could be drawn from:

- Primary healthcare professionals
- Secondary healthcare professionals
- Local Authority services (especially social services to ensure development of joint approaches to meet agreed local health and social care)
- Users and carers
- Voluntary sector
- Other community planning partners
- Public health

41. Working within the above parameters, CHPs will have flexibility in determining the organisational arrangements to suit local circumstances. However, in order to ensure effective leadership and management of CHPs we propose a minimum of three formal positions - chair, lead clinician and general manager. It will be critical to the success of CHPs that those fulfilling these roles have the confidence of both local stakeholders and the NHS Board and that they are selected on the basis of competency and not only professional status.

Q. What are the most appropriate mechanisms for filling the formal roles on the CHP?

Q. Should a Public Partnership Forum member have a formal role within the CHP?

Q. Should the chair of the CHP be a non-executive?

Q. How can joint responsibility for outcomes across primary and secondary care be reflected in the management arrangements?

42. CHPs will require a range of identified support services such as finance, human resource, information technology, estates and planning to be able to deliver their functions. This requirement should also be reflected in the working arrangements of the CHP.

Q. What are your views on the proposed CHP organisational arrangements?

WHAT ARE THE KEY RELATIONSHIPS?

43. ***Clinicians*** - CHPs will work as part of an integrated health system both within a CHP and across the Board area. They will be the focus for integrating both primary and specialist health services at a local level, building on the range of clinical and quality standards already available. CHPs will be accountable for the clinical governance arrangements of the services they provide with a line of accountability to the NHS Board Chief Executive.

44. This means clinicians working together closely to make patient pathways of care smoother, more accessible, less complicated and subject to delays. It means clinicians and managers working together in Managed Clinical and care Networks and redesigning services

and care pathways to enable more specialist treatment to be available in community facilities. The working arrangements of CHPs should reflect the need to strengthen relationships between clinicians and support the promotion of an e-health culture.

45. Representatives from each CHP will be part of the Service Redesign Committee which will be critical in leading a whole system approach to service integration. They will also play a full part in Managed Clinical Networks where linked groups of health professionals and organisations from primary, secondary and tertiary care work together in a co-ordinated manner to ensure equitable provision of high quality, clinically effective services.

Q. How can primary care and specialist clinicians be most effectively brought together in the working arrangements of CHPs?

46. *Staff* - CHPs will be expected to ensure staff are treated as full partners in decisions that affect the planning and delivery of services and care in line with the objectives set out in *Partnership for Care* and the *Staff Governance Standard*⁹. CHPs provide an opportunity to build on successful partnership working locally and evolve existing arrangements to support all frontline staff whilst recognising that CHPs are partnership organisations that represent different employer interests.

Q. How should local staff partnership arrangements evolve?

47. *Local Partners* - If CHPs are to serve their communities better, they need to work very closely with their local partners, and particularly Local Authorities and the voluntary sector. Some of the more developed LHCCs already have integrated approaches with these partners that can form the foundation for the greater expectations of CHPs.

48. Maintaining the impetus on developing integrated working flowing from the Joint Future agenda as set out in the "Next Steps" letter and *For Scotland's Children* should remain central to these new arrangements. Boards are already working with Local Authority partners to build on their Local Partnership Agreements by producing plans aimed at ensuring more effective working with social care in appropriate locality arrangements.

⁹Scottish Executive, Staff Governance Standard for NHSScotland Employees (2002)
<http://www.scotland.gov.uk/library5/health/sgss-00.asp>

49. CHPs should build on the success of Joint Future implementation and engage fully in the delivery of joint resourcing and joint management, and on single shared assessment across all of community care, but perhaps more significantly turn their attention to the new focus of developing joint services and joint outcomes across the range of care groups.

Q. How can we ensure that CHPs are an integral part of the delivery of the Joint Future agenda?

Q. What further opportunities do CHPs offer for partnership working?

50. *Patients and Public* - Amongst the key roles of CHPs will be ensuring that they maintain an effective dialogue with their local communities through the development of a local Public Partnership Forum (PPF). We expect these Forums to be as representative as possible. While CHPs will be accountable to the NHS Board, they will be responsible through their PPF to the communities for which they provide services.

51. A key aspect of a NHS Boards' CHP scheme of establishment will be its proposals for obtaining the widest possible representation on its PPF. We would expect any such proposals to have been developed with the active involvement of local stakeholders and to have the explicit endorsement of the local Advisory Council.

52. The PPF will be funded and supported administratively through the CHP. However, the Forum will receive professional support from, and work closely with the local office of the Scottish Health Council and its local Advisory Council, to strengthen the accountability of the CHP to the people it serves. These close links and complementary local mechanisms will ensure that the voices of patients, carers and communities are heard by the CHP and, through the mechanism of the Performance Assessment Framework and Accountability Reviews, on the national stage.

Q. Do you agree with the role proposed for the Public Partnership Forum?

Q. Do you agree with the proposed close link between the Public Partnership Forum and the local office of the Scottish Health Council?

53. **NHS Boards** - All CHPs in a Board area will be expected to work closely together and will be positioned within the NHS system to enable the delivery of jointly agreed health and service improvements. They will require clear and integrated accountability arrangements and NHS Boards should agree with their CHPs:

- a CHP dimension to their local performance management framework in order to benchmark and monitor delivery of services and relationships with partners – this process should feed into and out of the community planning process;
- shared accountability and performance management arrangements within the NHS system for service outcomes and the use of resources; and
- the nature of the reports to be provided by CHPs on the planning, development and provision of local services.

54. Devolution and delegation of decision making and responsibilities does not stop at CHP level and must be applied consistently through to the frontline.

Q. What do you see as the relationship between operating divisions and CHPs?

HOW WILL WE BUILD CHP CAPACITY AND CAPABILITY?

55. In order to deliver improved services and care for people, CHPs will require significant and sustained organisational and management development with effective leadership. NHS Boards are already reviewing the organisation and operation of their existing LHCCs to build a baseline for the development of CHPs. This review will enable NHS Boards to agree a broad development plan to support the evolution of CHPs. This development plan should be focused on actions that will **support the delivery of the health and service outcomes highlighted in their scheme of establishment**. Plans should reflect local priorities and take into account the following:

- the importance of support for those taking on leadership roles at a number of levels across the CHP, including planned induction and adequate backfill arrangements for those with ongoing clinical responsibilities;

- the need for management styles that increasingly support innovation and change and patient focus, public involvement building on the concept of interface managers to support clinical reform;
- meaningful involvement of staff and independent contractors to create a corporate identity for the CHP, achieved through for example, shared training, education, communication and a renewed focus on the benefits of a staff partnership forum which includes independent contractors;
- the links between CHPs and local Managed Clinical and Care Networks raising the prospect of employing shared network managers and redesign facilitators to support service improvements; and
- the need to develop workforce capacity to deliver the range of primary and community based services.

Q. What do you see as the development priorities?

WHAT ARE THE FINANCIAL ARRANGEMENTS?

56. Effective schemes of delegation and accountability frameworks will be crucial to the delivery of improved services through CHPs. NHS Boards will be expected to outline in their schemes of establishment how they propose to:

- ensure CHPs have clear and proportionate influence on the distribution of existing resources both within a CHP and across the wider system;
- devolve resources to CHPs and enable local flexibility in the use of budgets;
- ensure that actual expenditure is monitored against budget and corrective action taken if necessary;
- ensure the development of joint health and social care budgets and financial frameworks;

- enable CHPs to have a significant say on the use of all NHS Board development monies, including waiting times and delayed discharge monies; change and innovation funding and all integrated funding streams, for example, children;
- identify clear staffing and financial management support to enable the effective functioning of CHPs.

Q. Are the financial arrangements clear?

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

WHAT ARE THE MILESTONES?

58. NHS Boards should ensure that their schemes of establishment for CHPs are considered alongside their plans for the dissolution of Trusts (where guidance has already been issued), joint health improvement plans, and local plans to extend Joint Future. These processes are inextricably linked although the respective time scales for implementation may vary according to local circumstances. Ministers will wish to be assured that the schemes have been fully discussed with Local Authority partners and are in line with Joint Partnership Agreements.

59. NHS Boards should submit their schemes of establishment to the Minister for Health and Community Care by **[Date dependent on legislative timetable for the NHS Reform (Scotland) Bill]**. These schemes should be accompanied by broad CHP development plans to support the evolution of CHPs. Once these have been approved then NHS Boards may implement their schemes at different times depending on local circumstances. All NHS Boards should aim to have CHPs established across their area by **[Date dependent on legislative timetable for the NHS Reform (Scotland) Bill]**.

1. Community health partnerships

After section 4 of the 1978 Act insert—

"Community health partnerships

4A Community health partnerships

- (1) Every Health Board shall, within such period as the Scottish Ministers may specify, submit to them a scheme for the establishment of—
 - (a) a community health partnership for the area of the Board, or
 - (b) two or more community health partnerships for districts which, taken together, cover the whole area of the Board.
- (2) The general function of a community health partnership is to co-ordinate, for its area or district, the planning, development and provision of the services which it is the function of its Health Board to provide, or secure the provision of, under or by virtue of this Act, with a view to improving those services.
- (3) The Scottish Ministers may—
 - (a) approve (with or without modifications), or
 - (b) refuse to approve,a scheme submitted to them under subsection (1) or (4).
- (4) A Health Board—
 - (a) may, at any time,
 - (b) if so directed by the Scottish Ministers, must, within such period as they may specify,submit to the Scottish Ministers a new scheme under this section.
- (5) Regulations may make provision in relation to—
 - (a) the number of community health partnerships to be established for the area of a Health Board,
 - (b) the status, membership, procedures, staffing and expenses of a community health partnership,
 - (c) the form and content of, and the procedure in relation to, schemes under this section,
 - (d) the functions of a community health partnership and the exercise of those functions,
 - (e) such other matters with respect to community health partnerships as the Scottish Ministers think fit.
- (6) Regulations made in pursuance of subsection (5)(d) may, in particular, include provision—
 - (a) specifying functions of a Health Board which are to be exercised on their behalf by a community health partnership,

- (b) as to consideration by a community health partnership of matters relating to the planning, development and provision, in its area or district, of the services referred to in subsection (2),
- (c) as to the submission by a community health partnership to its Health Board of—
 - (i) advice and reports on the planning, development and provision, in its area or district, of such services,
 - (ii) annual reports on its activities,
- (d) as to consultation between a community health partnership and its Health Board,
- (e) with a view to securing that persons to whom such services are being or may be provided, and other persons having an interest in the provision of such services, are involved in, and consulted on, the exercise by a community health partnership of its functions."