

## Health and Community Care

# Study of Community Health Partnerships

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Community Health Partnerships (CHPs) were established by NHS Boards as the key mechanism through which all primary and community based services are planned and delivered. They became operational in 2005. The Scottish Government commissioned this study in February 2009 to consider the early progress CHPs have made, identify factors which have facilitated or possibly hindered progress and identify ways in which CHPs' capacity and capability can be improved to maximise their potential.

## Main Findings

- The statutory guidance published to support the development of the CHPs stated that it did not expect a “one size fits all” approach and this has proved to be the case. There is great variation across the CHPs in terms of population size served, structures and the nature of relationships with key bodies. This local variation is broadly seen as a strength by those who participated in the research.
- The structure and development of CHPs have been and are constantly evolving to respond to local changes and need. Some of the CHPs have undergone major redesign since establishment while others have been involved in more gradual change.
- Relationships are central to the way in which each CHP has developed. These include relationships with the Health Board, the local authority and the Community Planning Partnerships (CPPs). The other relationships that are important in how the CHPs conduct their work are with the voluntary sector, the public, secondary care and with independent contractors, especially GPs. The levels of interaction in all these relationships vary considerably across the CHPs.
- CHPs have made significant progress towards Shifting the Balance of Care. In terms of health improvement and reducing health inequalities, while there are good examples of activities undertaken, the study found that there is still much work to be done.
- Other reported achievements included improved partnership working, linking health and social care, listening and responding to local needs, the redesign and development of services and improved access and availability for service users.
- Key facilitators identified in CHP progress included the qualities of the CHP management team, engagement with key stakeholders, the tradition of close partnership working with the local authority and leadership from key individuals such as the Health Board Chief Executive and the Chair of the CHP Committee.
- The key challenges and barriers to progress were seen as relationships (where these are working less well) with the health family and with the local authority, issues to do with structures and governance (size and composition of committees, potential duplication with other groups working on health and social care, clarity of role and purpose), the challenges of tackling health inequalities and resources.
- In order to maximise the CHPs' capacity and capability, further work is needed to strengthen governance and structures and to affirm the role of CHPs as facilitators across the horizontal patient pathway from community, primary to secondary care and back again.

## Background

The National Health Service Reform (Scotland) Act 2004 came into force in September 2004, and provided for each Health Board to establish Community Health Partnerships (CHPs). Health Boards were required to produce Schemes of Establishment for the CHPs which came into operational existence in 2005 (with the exception of Orkney and Western Isles which came into existence in 2006 and 2007 respectively).

The Scottish Government issued statutory guidance to assist in the establishment of the CHPs. The guidance made it very clear that the Scottish Government did not expect all the CHPs to be the same: there is *“no one size fits all”*. However it stipulated that in order to allow Health Boards to devolve functions and powers, all CHPs would be either committees, or sub-committees, of a Health Board.

## The Research

The Scottish Government’s Health Analytical Services Division commissioned, on behalf of the Primary and Community Care Directorate, a study of CHPs in February 2009.

The research aims were to consider the early progress CHPs have made in relation to key areas of responsibility, identify the factors which have facilitated or possibly hindered progress and identify ways in which the CHPs capacity and capability can be improved to maximise their potential.

## Methods

The study comprised a three-stage research process: the first stage involved all 40 CHPs and built a picture of the perceptions of a number of stakeholders about how CHPs have progressed; the second stage involved six CHPs and examined in more depth how CHPs were operating and how they have addressed a number of key responsibilities and functions. The final stage engaged a range of stakeholders, most of whom had taken part in the initial stages of the research, to discuss and validate the study’s findings and contribute to developing the way forward.

## Findings

There is great variation across the 40 CHPs with a complexity of relationships and structures. For example, whilst all CHPs are committees or subcommittees of the Health Board, there are variations to the model, with eight Community Health and Care Partnerships and three Community Health and Social Care Partnerships.

## Context

The CHPs have successfully developed at a time of significant change in terms of new policies and ways of working. In particular the advent of Single Outcome Agreements (SOAs) has changed the relationship between national government and local authorities and has led to a greater emphasis on the role of CPPs. There is varied interaction between the CHPs and CPPs, ranging from very close involvement where the CHP is the Health and Wellbeing arm of the CPP, to attendance by the CHP General Manager/Director at CPP meetings to a few CHPs where the link is still evolving.

## Purpose

Study participants described the purpose of the CHPs in a variety of ways. Some saw the main purpose as being about facilitating partnership working; others described it in terms of operational service delivery, either within the primary and community care setting or between health and social care services; while for others the key purpose was in terms of achieving better outcomes for patients.

One description of the role CHPs play was as *“adaptors”* or linking agents between the different organisations, departments and sectors involved. This *‘linking’* role facilitated better understanding between the different organisations and can be visualised as acting horizontally across different areas of vertical service provision to help broker joint working and, where appropriate, integration.

## Progress

CHPs can play a key role in Shifting the Balance of Care, which emphasises health improvement and anticipatory care, providing more continuous care and more support closer to home.

The CHPs have made good progress in relation to Shifting the Balance of Care. This includes shifting to more preventive work for example on the development of long term conditions strategies and anticipatory care initiatives. It includes shifting the balance in terms of who delivers services for example with new posts such as health and social care assistants to allow for more provision of services at home. Within hospitals, examples include using staff such as physiotherapists, where appropriate, to reduce the burden on consultants. It also includes shifting the balance in terms of the location of services with greater emphasis on local service delivery and on developing multi-agency facilities.

There has also been progress in relation to health improvement. There are many examples of activities to improve health, for example around smoking cessation, obesity, tackling alcohol and drug misuse. However there was a sense from those interviewed that there is still a lot to do in this area and that it requires time to embed positive outcomes.

Similarly, in terms of reducing health inequalities, there are examples of some CHPs working well to tackle the wider social determinants of health such as employability, housing and homelessness. There are also examples in some CHP areas of multi-agency work to tackle inequalities for specific sections of the community, such as work with young people to address anti-social behaviour. However, in general study participants thought there was much more work to be undertaken in this area.

## **Achievements**

The most commonly reported achievement was working with other bodies and building good working relationships across the health family and externally. Another achievement in some CHPs was linking health and social care, although it was recognised that this had been challenging at the start due to differences in culture and staff.

The CHPs in many areas have made the health service more understandable and accessible for local people, facilitating a level of engagement that was not seen previously. For most CHPs the Public Partnership Forum has been central to this engagement.

The range of people involved in the CHP Committee was seen as assisting in the service redesign that has taken place for example around long term care provision, care at home and community nursing. This service redesign has in turn improved access and availability for service users.

## **Facilitators of progress**

The most frequently noted facilitator of CHP progress was the qualities of the CHP management team which were described as enthusiastic, committed, motivated, talented and engaged in delivering better health outcomes for their populations.

CHP progress was also helped in areas where there was a pre-existing tradition of partnerships working as there were established structures and well-developed relationships. Good leadership, by Health Board Chief Executives or CHP Committee Chairs was also important in supporting CHP staff and encouraging buy-in from wider partners and health colleagues and endorsed the significance of the CHP.

Other facilitators included: co-terminosity with local authority locality boundaries as well as with other agencies' boundaries; co-location of staff; being an integral part of the CPP; political buy-in from elected members; positive engagement with GPs; and strong links with the voluntary and community sectors.

## **Challenges and barriers**

The challenges and barriers were often the opposite side of the coin from the facilitators. For example in some areas relationships had been problematic, with different parts of the health family, and/or with the local authority and other external agencies. In particular a commonly acknowledged challenge for the CHPs was the difficulty in engaging effectively with GPs.

There were challenges relating to the structures and governance of the CHPs ranging from the size of the Committee in some areas to the need for greater clarity about the role of the CHP in others. There was a sense that there may be duplication across the various partnerships and bodies working on health and social care issues.

Resources were another challenge: in terms of the current financial constraints linked to potential tensions between the Health Board and local authority about the share of spending towards CHP activity.

## **Suggestions for forward action**

The full report provides suggestions for future action for Health Boards, local authorities, CPPs, CHPs and national bodies including COSLA and the Scottish Government. These suggestions are based around the need to review and strengthen CHP governance and structures, the importance of affirming the CHP role across the horizontal patient pathway and to review and build on progress already made. It is suggested that each Health Board and CPP should consider the study's findings and relate these to their own local circumstances so that specific issues for action in each area can be identified.

## **Conclusion**

Despite the challenges raised during the study, many of those interviewed thought that the CHP in their area was working well and that they would continue to build on the progress that has been made so far. The overall sense is that the CHPs are ready to move onto the next chapter of their development.

This document, along with full research report of the project, and further information about social and policy research commissioned and published on behalf of the Scottish Government, can be viewed on the Internet at: <http://www.scotland.gov.uk/socialresearch>. If you have any further queries about social research, please contact us at [socialresearch@scotland.gsi.gov.uk](mailto:socialresearch@scotland.gsi.gov.uk) or on 0131-244 7560.