Glasgow Centre for Population Health

BRIEFING PAPER 4 *CONCEPTS SERIES*

Policy Background to Community Health Partnerships and Community Health and Care Partnerships

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SUMMARY

Community Health Partnerships in Scotland bring the NHS and local authorities closer together in developing joint working practices, but there is a longer history of integrated working stretching back to pre-1974. Some NHS Board and Council areas have taken a further step in creating joint management structures, and there are opportunities for learning about similar models of working from recent experience in Children's Trusts in England. This short paper provides a brief outline of the development of the policy context leading to the current configuration of Community Health Partnerships and Community Health and Care Partnerships in Scotland.

INTRODUCTION

Community Health Partnerships (CHPs) were introduced in Scotland in *Partnership for Care*[1] as part of an ongoing programme of NHS reform and represented a step towards greater integration between the NHS and local authorities, building on the previous primary care structures of Local Health Care Co-operatives. In a small number of areas, health boards and local authorities have established Community Health and Care Partnerships (CHCPs) which have fully integrated some services into a common management structure similar to Care Trusts created in England in 2002. Collaboration between, and integration of, health and social services have a long history spanning different degrees of working together and apart, but the last two decades have seen concerted efforts to merge health and social care structures and functions. This briefing paper explores the policy background to the development of CHPs and CHCPs in Scotland, tracing the move towards integration between health and social services.

COLLABORATING FOR HEALTH

Early integration

Integration of health and social care is not a new phenomenon. From the end of the 19th Century public health departments were created in local authorities to provide hospital, primary and community care services and were overseen by Medical Officers of Health (MOsH). For example, in the period between the first and second world wars public health departments in local authorities had a remit to provide maternal and child welfare services; school medical services; TB clinics and treatment; infectious disease, ear, nose and throat and VD services; health centres; regional cancer schemes; and to run the old Poor Law hospitals[2].

The MOsH domains of prevention, family practitioners and hospital services were transferred to the NHS in 1974 although local government retained social care and environmental health services. The 1974 split is believed by some commentators to have had a long-lasting impact on the ability of health and social care services to work together[3].

Together again

One of the first specifications for the move back to working together came in the 1990 *NHS and Community Care Act*[4], which required local authorities to produce community care plans in partnership with health boards and other local agencies. The main objective of this Act was to keep people who needed care in their own homes rather than in institutions, but it also sought to create a “mixed economy of care” which was chiefly aimed at involving voluntary and private sector service provision to meet the growing need for care for older people.

The requirement for health boards and local authorities to work more closely together was developed further in 1997 by *Designed to Care*[5], one of the new Labour administration’s early White Papers. It introduced a modernisation programme for the NHS in Scotland of dismantling the internal market and working towards a system of integrated care. Primary care services were to do this through restructuring into Local Health Care Cooperatives (LHCCs) whose objectives included providing services to patients, working with public health to plan for meeting the defined health needs of the LHCC population, clinical governance, and developing population-wide approaches to health improvement and disease prevention[5]. LHCCs were to work in association with independent health service contractors but the policy also set out moves towards working in partnership, and integration between primary care and both acute and social care services. They also introduced the need for primary care to begin to take a population approach to improving health as well as to deliver services to individual patients.

Integration of health and social care

The move towards integration between health and social services in Scotland began in earnest through the Joint Future initiative, taken forward by the Joint Future Group, set up by the Scottish Executive in 1999[6]. The Group was tasked to find ways of improving joint working to deliver modern and effective person-centred services, to identify options for charging for home-based care, and sharing good practice. The focus was initially to be on older people, but eventually to move on to other client groups, including children. The Group produced a number of recommendations in 2000, including:

- Local authorities (social work and housing only), health boards, NHS Trusts and Scottish Homes should draw up local partnership agreements, including a clear programme for local joint resourcing and joint management of community care services collectively or for each care user group individually.
- Agencies locally should have in place single, shared assessment procedures for older people and for those with dementia by October 2001, and for all client groups by April 2002.
- The Scottish Executive should, by 2002, offer a strategic lead on the development of community care information, information sharing and systems integration[6].

By this time, LHCCs were also beginning to put in place joint working arrangements. A survey in 1999 of LHCCs across a third of the Health Boards in Scotland found that local working between LHCCs and social work, particularly in relation to community care, had developed substantially since the introduction of LHCCs (LHCC Best Practice group, 2000). This finding influenced the objectives of the next re-structuring of LHCCs as they were further developed into CHPs, outlined in the 2003 White Paper *Partnership for Care*[1].

Partnership for Care outlined that LHCCs were to evolve into CHPs, but the new bodies would have statutory underpinnings instead of being voluntary groupings, and would be part of the NHS Boards. CHPs were to establish a substantive partnership with Local Authorities (social work, housing, education and regeneration), patient involvement through establishing Patient Partnership Forums for patients and staff, have more devolved budgetary responsibilities and a duty to promote health improvement. The White Paper also required health boards to work with local authorities to ensure more effective working with social care in appropriate locality arrangements, and to integrate the management of primary and acute services.

Legal duties for NHS Boards and Local Authorities to work in partnership were imposed by both *The Local Government in Scotland Act 2003* [8] and the *NHS Legislative Reform Bill* [9] *of 2004*, both of which gave the NHS and other public bodies a “duty to participate” in the community planning process.

Integrating management

Some NHS Boards and Local Authorities including Greater Glasgow NHS and Glasgow City Council took the decision to create fully integrated Community Health and Care Partnerships (CHCPs)[10]. CHCPs brought together primary care and social work services under a single management structure, with associated accountability and governance arrangements. They also proposed substantial involvement of elected members and intended to develop further structured links to housing, regeneration and employment.

CHCP aims for integration are similar to those of England's Care Trusts, which were introduced in 2002 to bring together existing staff from health and social care services within one local organisation, and were to be governed by a mixture of local councillors, health managers and patient and user representatives[11]. Different models of Care Trusts could be developed, but it was envisaged that they would focus on commissioning and providing services for older people and mental health services initially. Since then, a number of Children's Trusts have been developed on the Care Trusts model, and pathfinder Children's Trusts were evaluated in 2004. The evaluation reported that integration and collaboration was said to have been facilitated by joint training, maintaining a stable workforce, commitment to integration at all levels and a history of joint working. Barriers were identified where there were complex service interfaces, insufficient funding, lack of time, changes in management personnel and problems recruiting and retaining staff[12].

Health improvement and health inequalities

In addition to having an increasingly central role in integration of services locally as they matured into their partnerships, the CHPs also aimed to have a stronger role in health improvement and in reducing health inequalities. Collaboration through partnership working was regarded as an important focus for this work. For example, the *CHP Statutory Guidance*[13] for establishing CHPs stated that health improvement should include:

- Population health
- Influencing Boards through needs assessment
- Working with disadvantaged communities
- Health promotion
- Taking a wide perspective on health
- Working with partners
- Improving well-being, life circumstances and lifestyles especially in disadvantaged communities.

These approaches reflect Scottish public health and health improvement policy currently enacted through *Towards a Healthier Scotland* [14] and *Health Improvement – The Challenge* [15], and suggests that health improvement, as a development from health promotion, is increasingly understood as a partnership activity between health, local authority, voluntary and community sectors, rather than residing only in the "health" domains of policy and practice.

The CHP guidance also states that the approach to addressing health inequalities should also be to work in partnership to address the different needs of community groupings[13]. However, there is otherwise a lack of clarity as to what is expected of CHPs themselves or in partnership in relation to addressing health inequalities, although targets for reducing health inequalities are included as a section in the Scottish Executive's regeneration policy, *Closing the Opportunity Gap* [16].

Community Planning is the mechanism by which regeneration policy is delivered and is now the key overarching partnership framework for co-ordinating the planning and development of public service provision, including the health sector. The statutory basis for Community Planning in Scotland is *The Local Government in Scotland Act 2003* which, as mentioned above, also gave the NHS and other public bodies a "duty to participate" in the community planning process. Therefore, CHPs and Community Planning Partnerships (CPPs) are linked through legislation and policy in a similar way as for local authorities, although to date they remain under separate accountability mechanisms.

CONCLUSION

An historical perspective on integration of health and social care suggests that the current configuration of CHPs and CHCPs appears to be part of an ebb and flow of joined up and separate working and managerial practices. It is clear that we can learn from previous and parallel developments about configurations that offer the best opportunities for effective working practices, and that, in turn, the current experience should also be captured in order to inform future developments.

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