Key messages

Review of Community Health Partnerships

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

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Key messages

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. CHPs are statutory committees or subcommittees of NHS boards and were in place from 2006/07.

2. 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, community health services and community-based integrated teams, such as rapid response services to provide support to older people at home. NHS boards were also given flexibility to devolve any other function or service to the CHP.[1]

3. There are 36 CHPs in Scotland although this picture is continually changing.[2] There is at least one CHP in each NHS board area and one or more CHPs share the same geographical boundary with councils. The population covered by individual CHPs varies, from 19,960 people in Orkney to 477,660 people in Edinburgh City.

4. The number of older people in Scotland is projected to rise by 12 per cent between 2010 and 2015, with an 18 per cent increase in the number of people aged 85 and over.[3] This will increase demand for health and social care services at a time when public sector budgets will reduce in real terms.[4]

5. 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 the systems remain as they are now.[5] CHPs have been given an important role in facilitating better joined-up working to meet these challenges.

Our work

6. Our audit examined 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.

7. In the audit we:

- analysed published data on health and social care spending and health indicators
- reviewed relevant policy and other key documents, including governance, financial and performance information in NHS boards, councils and CHPs
- collected data from all CHPs on their governance arrangements, use of resources and performance management
- reviewed different aspects of joint working between health and social care in six CHPs.

Key messages

1 Since devolution, there has been an increased focus on partnership working between health and social care and across the public sector as a whole. Approaches to partnership working have been incremental, leading to cluttered partnership arrangements. CHPs were introduced with a challenging agenda. 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.

8. In 1999, GP-led Local Health Care Cooperatives (LHCCs) were established across Scotland to bring health and social care practitioners together to deliver services.[6] LHCCs were still in place when the Scottish Executive introduced the Joint Future Agenda in 2000 which encouraged a more formal approach to joint planning and resourcing between health and social care.

9. In 2003, the Scottish Executive used the Local Government in Scotland Act 2003 to establish community planning on a statutory basis.[7] 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.[8] Community Planning Partnerships (CPPs) were established as the key over-arching partnership and were expected to help coordinate

1 The Community Health Partnerships (Scotland) Regulations and Statutory Guidance, Scottish Executive, 2004.
2 This includes seven integrated CHPs and 29 health-only CHPs.
3 *2008-based National Population Projections*, Office of National Statistics, 2009.
4 *Departmental Expenditure Limit comprehensive spending review 2010 settlement*, Scottish Government, 2011.
5 Ibid.
6 In April 1999, 79 LHCCs were introduced across Scotland under the auspices of 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.
7 *Report of the Community Planning Working Group*, Convention of Scottish Local Authorities (COSLA) and the Scottish Office, 1998.
8 Organisations participating in community planning include NHS boards, enterprise networks, police, fire and rescue services, and the private and voluntary sectors.

other initiatives and partnerships and, where necessary, rationalise these.[9] CPPs are not statutory bodies.

10. Councils have a statutory duty to coordinate community planning and report 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 and provide information to the council on their contribution to enable the council to prepare its annual Single Outcome Agreement (SOA) report.

11. 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. The 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.

12. The 2004 Act also established CHPs which were expected to have devolved responsibility for providing certain community-based health services and a strategic role in influencing decisions on how health and social care resources are used in their areas. The Scottish Executive expected CHPs to build on the earlier progress of LHCCs and the Joint Future Agenda, working closely with CPPs.[10, 11] There have been a number of policies relevant to the development of CHPs (see paragraphs 15 to 22 of the main report).

13. 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. In many instances, NHS boards link with CPPs centrally and CHPs are not directly involved with the CPPs (see paragraph 23).

14. Broadly two different types of CHP have evolved in Scotland – a health-only structure and an integrated health and social care structure.[12] All CHPs, irrespective of type, are statutory committees or subcommittees of NHS boards and are therefore accountable to their NHS board. Integrated health and social care structures are partnership bodies and therefore have dual accountability to both the NHS board and relevant council.

15. There is no evidence of one structural approach being better than the other in moving services from hospital to the community or joining up frontline health and social care services. Partnership working depends on good local relationships, commitment and clarity of purpose, irrespective of structural arrangements. Even though CHPs are formal committees of NHS boards, councils also have a key role in working with their health partners to improve health and social care services (see paragraph 27 of the main report).

2 Partnership working is challenging and requires strong, shared leadership by both NHS boards and councils. There are several key principles for successful partnership working that all partners should apply. CHPs' governance and accountability arrangements are complex and not always clear, particularly for integrated CHPs. There is scope to achieve efficiencies by reducing the number of partnership working arrangements for health and social care. Information on costs and staffing, financial management and performance reporting all need to be improved.

16. Partnership working across organisational boundaries is challenging due to differences in organisational cultures, priorities, planning and performance management, decision-making, accountability and financial frameworks. Successful partnership working can be achieved where strong, shared leadership between NHS boards and councils is in place. Partners should adopt key principles which we have developed from various sources, including guidance, toolkits and published studies on partnership working, as well as our own work in this area (Exhibit 1).

17. The role, responsibilities and accountability arrangements for CHPs are not always clear. For example, important documents, such as standing orders and schemes of delegation are out of date or inconsistent with the original schemes of establishment for CHPs.[13] In many areas, NHS boards' local delivery plans, CHPs' development plans and councils' social care service plans do not explicitly set out a joint vision, priorities, outcomes or resources for health and social care. Performance monitoring is not clearly linked to local strategies.

18. Performance reporting arrangements for CHPs can be challenging as they need to take account of the various national and local performance monitoring systems and targets for the NHS and councils which are not necessarily aligned.[14] At a local level, CHPs have different performance reporting arrangements and the content and frequency of performance reports to CHP committees, NHS boards and councils are also varied. Councils do not always receive performance reports from CHPs. This needs to be addressed, particularly where they have integrated

9 http://www.scotland.gov.uk/Topics/Government/PublicServiceReform/community-planning
10 CHPs replaced the former LHCCs.
11 The Community Health Partnerships (Scotland) Regulations and Statutory Guidance, Scottish Executive, 2004.
12 We use the term CHPs in this document to cover both types of CHP, unless we specifically mean integrated structures, which we will then refer to as integrated CHPs.
13 The statutory guidance for CHPs required NHS boards to produce a Scheme of Establishment for CHPs in their area, setting out details of their role, governance and operational arrangements.
14 This includes HEAT targets, Single Outcome Agreements (SOAs), Community Care Outcomes Framework, Scotland Performs and Shifting the Balance of Care impact measures.

Exhibit 1

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
Behaviours		
Personal commitment from the partnership leaders and staff for the joint strategy Understand and respect differences in organisations' culture and practice	• Leaders agree, own, promote and communicate the shared vision • Leaders are clearly visible and take a constructive part in resolving difficulties • Be willing to change what they do and how they do it • Behave openly and deal with conflict promptly and constructively • Adhere to agreed decision-making processes • Have meetings if required but focus of meetings is on getting things done	• Lack of leader visibility in promoting partnership activities (both non-executive and executives) • Be inflexible and unwilling to change what they do and how they do it • Adopt a culture of blame, mistrust and criticism • Complain of barriers to joint working and do not focus on solutions • Take decisions without consulting with partners • Have numerous meetings where discussion is about process rather than getting things done
Processes		
Need or drivers for the partnership are clear Clear vision and strategy Roles and responsibilities are clear Right people with right skills Risks associated with partnership working are identified and managed Clear decision-making and accountability structures and processes	• Roles and responsibilities of each partner are agreed and understood • Strategies focus on outcomes for service users, based on analysis of need • Have clear decision-making and accountability processes • Acknowledge and have a system for identifying and managing risks associated with partnership working • Agree a policy for dealing with differences in employment terms and conditions for staff and apply this consistently to ensure fairness • Review partnership processes to assess whether they are efficient and effective	• Roles and responsibilities of each partner are unclear • Unable to agree joint priorities and strategy • Lack of clarity on decision-making processes • Partnership decision-making and accountability processes are not fully applied or reviewed regularly • Risks are not well understood or managed through an agreed process • Deal with differences in employment terms and conditions for staff on an ad hoc basis

Continued overleaf

Key principles	Features of partnerships when things are going well	Features of partnerships when things are not going well
Performance measurement and management		
Clearly defined outcomes for partnership activity Partners agree what success looks like and indicators for measuring progress Partners implement a system for managing and reporting on their performance	• Understand the needs of their local communities and prioritise these • Have a clear picture of what success looks like and can articulate this • Have clearly defined outcomes, objectives, targets and milestones that they own collectively • Have a system in place to monitor, report to stakeholders and improve their performance • Demonstrate that the actions they carry out produce the intended outcomes and objectives	• Prioritise their own objectives over those of the partnership • Unable to identify what success looks like • Fail to deliver on their partnership commitments • Do not have agreed indicators for measuring each partner's contribution and overall performance or do not use monitoring information to improve performance • Unable to demonstrate what difference they are making
Use of resources		
Identify budgets and monitor the costs of partnership working Achieve efficiencies through sharing resources, including money, staff, premises and equipment Access specific initiative funding made available for joint working between health and social care	• Integrate service, financial and workforce planning • Have clear delegated budgetary authority for partnership working • Identify, allocate and monitor resources used to administer the partnership • Understand their service costs and activity levels • Plan and allocate their combined resources to deliver more effective and efficient services • Assess the costs and benefits of a range of options for service delivery, including external procurement • Have stronger negotiating power on costs • Achieve better outcomes made possible only through working together	• Do not integrate service, financial and workforce planning • Unable to identify the costs of administering the partnership • Deliver services in the same way or change how services are delivered without examining the costs and benefits of other options • Have duplicate services or have gaps in provision for some people • Plan, allocate and manage their resources separately • Fail to achieve efficiencies or other financial benefits • Unable to demonstrate what difference the partnership has made

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

services in place or where they have delegated services and budgets to CHPs (see paragraphs 33 to 35 of the main report).

19. Few CHP committees have a financial scrutiny role and the frequency and content of financial reporting to NHS boards, CHPs and council committees varies. Not all reports provide sufficient explanation of reasons for budget underspends, overspends or emerging cost pressures. There is also a lack of evidence of discussion or challenge at many CHP committee meetings on finance and performance reports.

20. Guidance on good governance for joint services recommends that formal partnership agreements are in place which detail joint financial and other resource arrangements.[15] However, NHS boards and councils do not always have agreements in place covering services which the council has delegated to the CHP.[16] 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.

21. Governance arrangements for integrated CHPs are generally more complex because they need to take account of different lines of accountability and the existing corporate governance arrangements of both partners. There are increased risks that there is a lack of transparency in how decisions are taken, people make decisions outwith their levels of delegated authority and that decision-making is slow (see paragraphs 36 to 39 of the main report).

22. Joint workforce planning and arrangements for managing joint health and social care staff is generally underdeveloped.[17] 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 (see paragraphs 40 to 45 of the main report).[18]

23. CHPs replaced the former LHCCs. However, at a local level, many CHPs were set up in addition to existing partnership arrangements and NHS boards and councils have not taken the opportunity to rationalise them. For example, in 15 council areas CPPs have established health and well-being thematic partnership groups in addition to the CHP committee.

24. The cluttered partnership arrangements have led to a lack of clarity or duplication in roles and functions between the CHP and other partnerships. There is a lack of information on the time and overall cost to each organisation of their partnership activity but there is scope to achieve efficiencies by streamlining and reducing the number of partnership arrangements (see paragraphs 46 to 50 of the main report).

3 A more systematic, joined-up approach to planning and resourcing is needed to ensure that health and social care resources are used efficiently. This should be underpinned by a comprehensive understanding of the shared resources available. National work is under way to improve this. To date, few CHPs have been able to influence how resources are used across the whole system. At a CHP level, information on resources, including on staff, is not well developed. GPs indirectly commit significant NHS resources but are not fully involved in decisions about how resources are used.

25. NHS boards and councils do not have sufficient understanding of their service costs and how this is influenced by activity levels to make informed decisions about how they allocate their combined available resources. The Scottish Government is leading a national Integrated Resource Framework (IRF) which aims to address this.

26. The first phase of the IRF involves NHS boards and councils mapping cost and activity information for health and adult social care to provide a picture of how resources are being used for their local population. All NHS boards, except NHS Shetland, completed initial mapping of their cost and activity information by March 2011. However, progress by councils is variable and needs to improve.

27. The second phase of the IRF involves NHS and council partners in four test sites developing protocols for shifting resources both within the NHS and between the NHS and council.[19] Work is at early stages in the test sites, although Highland Council and NHS Highland have approved ambitious plans to pilot a new lead agency approach for both adult community care services and for children's services.[20] Detailed planning is under way with a view to potentially implementing these new arrangements in April 2012.[21] 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

15 *Governance for Joint Services: Principles and Advice*, Audit Scotland, COSLA and the Scottish Government, 2007.
16 The formal agreement may be between the NHS and council but it should always stipulate the role and responsibilities of the CHP.
17 East Renfrewshire integrated CHP is the only CHP with a joint workforce plan for health and social care staff. Nine CHPs reported that they are carrying out joint workforce planning with councils for certain services and a further four CHPs are currently working with council partners to develop a joint approach to workforce planning.
18 This includes Aberdeenshire, Inverclyde, Orkney and Western Isles.
19 The test sites are Ayrshire, Highland, Lothian and Tayside.
20 The lead agency approach means 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 it will pool with its own resources to manage the integrated service.
21 *Joint Report by Chief Executive, The Highland Council and Chief Executive, HC/NHS/1/10*, NHS Highland, 16 December 2010.

changes and these need to be carefully managed. Audit Scotland will continue to monitor the lead agency approach through our local audit work (see paragraphs 55 to 57, and 67 to 68 of the main report).

28. There is significant variation in the extent to which NHS boards have devolved services and budgets to CHPs although most are responsible for a number of core primary and community health services. This ranges from the three CHPs in Ayrshire which do not directly manage services but influence how health and social care services are planned and resources used in their area – through to Argyll and Bute CHP which is the only CHP to manage all community and acute health services (see paragraph 78 of the main report).[22]

29. GPs and clinical professionals are not yet fully involved in service planning and resource allocation. The lack of influence CHPs have over overall resources is a barrier to better engagement with GPs. This needs to be addressed because GPs influence a large proportion of the NHS budget as a result of their clinical decisions – an estimated £3 billion of NHS spending in 2009/10. There is significant variation in GP referral and prescribing patterns, and 15 CHPs overspending against their GP prescribing budget in 2009/10 (see paragraphs 75 to 77 and paragraph 82 of the main report).

30. NHS boards, councils, GPs and other health and social care providers need to work together to move some services out of hospital into the community and nearer to the service user's home. CHPs have a key role to play. However, while some CHPs have a strategic role, others are wholly operational, responsible for delivering specific services and have little influence in setting overall health and social care priorities and deciding on how resources are used across the whole system.

31. Overall there has been a slight increase in the percentage of total NHS resources being spent in the community between 2004/05 and 2009/10. But there has been no change in the percentage of NHS resources transferred to councils for social care services during this same period. It is not possible to carry out a more detailed review of activity because of poor information on community health services and data systems have not kept pace with changes to how services are being delivered.

32. Resource transfer has been a source of tension between the NHS and councils for several years due to a lack of transparency or agreement in how the resource transfer amount is calculated. The Scottish Government and COSLA issued revised guidance on resource transfer to NHS boards and councils in January 2011. It is too early to say whether this has resolved the tension.

33. Given the difficulties around resource transfer, it is unlikely that NHS boards and councils will move quickly towards more integrated funding arrangements. Pooling budgets, for example, requires significant trust between organisations and a jointly agreed vision for services.[23] Pooled budgets can allow more flexibility and a faster response to individual user needs, but setting them up can be more complicated and resource intensive than aligning budgets in the short term.[24] We found only one genuine example of a pooled budget in Scotland.

34. In 2011/12, a £70 million Change Fund has been made available to NHS boards and councils to implement local plans to make better use of their combined resources for older people's services. The fund is expected to provide short-term funding to facilitate shifts in the balance of care and influence decisions on overall health and social care spend on older people. NHS boards and councils have provided details of their overall combined resources for older people's services in order to access the funding. Plans were submitted to the Scottish Government in March 2011.

35. At a CHP level, information on resources is not well developed. There are significant gaps in workforce information which means that CHPs are generally unable to demonstrate whether they are planning and managing their workforce efficiently. Many CHPs were unable to provide details of vacancies, turnover and sickness absence rates for key staff groups (see paragraphs 40 to 42 of the main report).

4 Enhancing preventative services and moving resources across the whole system require effective joint working between NHS boards and councils. CHPs have a key role to play. While there is variation among CHPs against a range of 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.

22 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. 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 who are responsible for all health and social care services. These groups provide a forum for joint planning across the whole system.

23 A pooled budget is a mechanism by which two or more partners contribute money to a pool which can be used to deliver agreed outcomes. Once the money is in the pool, one partner is responsible for accounting for the pooled budget and it is not possible to identify each partner's expenditure separately.

24 *Pooled budgets: A Practical Guide for Local Authorities and the National Health Service*, Chartered Institute of Public Finance (CIPFA), 2009.

36. There are some significant, long-standing and complex health and social care issues in Scotland which no partner can tackle on its own and which need action across the whole system. CHPs are not always able to demonstrate their specific contribution to improving the health of local people or shifting services from hospitals to community settings.

37. However, we looked at a range of performance indicators where we would expect CHPs to contribute to improvements. For example, all CHPs have worked with NHS boards, councils and other providers to set up local initiatives focused on supporting older people and those with long-term conditions such as chronic obstructive pulmonary disease (COPD), asthma, diabetes and angina.

38. A number of CHPs are able to show slight reductions in the number of emergency hospital admissions for particular client groups in their area since initiatives were set up. However, many initiatives were set up using short-term funding rather than from savings released from acute hospitals and there is often a lack of analysis of the overall effect on costs as a result of service changes (see paragraphs 90 to 92 of the main report).

39. The Scottish Executive launched a national plan to tackle delayed discharges in March 2002. Local partnerships between NHS boards and councils were given a ring-fenced allocation to achieve individually agreed targets in 2002/03. National targets were introduced from 2003/04 and local partnerships received a further allocation to support this work each year.[25, 26] From 2007/08 onwards, the target has been to reduce to zero the number of people with a delayed discharge and sustain this performance.

40. Before the national plan was launched in March 2002, the total number of delayed discharges was 3,116. This reduced to 434 by April 2008. 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.[27]

41. 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 do not fully account for this as total delayed discharges were 30 per cent higher in January 2011 than in January 2010.[28] There is a similar picture for delayed discharges of over six weeks.

42. Despite initiatives aimed at supporting older people to stay at home longer, emergency admissions for older people increased in three-quarters of CHP areas between 2004/05 and 2009/10. Over the same period, there was also an increase in the number of older people admitted to hospital as an emergency on more than one occasion in-year in Scotland (see paragraphs 93 to 99 of the main report).

43. Between 2004/05 and 2008/09, the number of emergency admissions for people with ambulatory care sensitive conditions grew in Scotland, although this varies for individual conditions across CHPs.[29, 30] For example, rates of emergency stays for people with angina decreased in approximately two-thirds of CHPs; rates increased in around half of CHPs for people with asthma and people with diabetes complications; while rates increased in most CHPs for people with COPD. There is no single CHP which is performing well on all indicators that we looked at as part of the audit (see paragraphs 100 to 102 of the main report).

44. 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.

45. CHPs have a key role in developing preventative health services. Since they were established the percentage of mothers smoking during pregnancy decreased in all but four CHP areas.[31] Over the same period, the percentage of babies being exclusively breastfed at eight weeks increased in three CHP areas and decreased in 26 CHP areas.[32] Between 2004-06 and 2007-09, hospital admission rates for alcohol-related problems increased in three-quarters of CHP areas, and drug-related hospital admissions increased in all but eight CHP areas (see paragraphs 103 to 108 of the main report).[33]

25 Between 2003/04 and 2006/07, 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.
26 From 2008/09, additional funding for delayed discharges has been included in the local government financial settlement but is no longer ring-fenced.
27 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.
28 The total number of delayed discharges at the census date in January 2010 was 606, increasing to 790 in January 2011.
29 Ambulatory care sensitive conditions, including long-term conditions such as asthma and diabetes, are conditions for which admission to hospital is potentially avoidable through good quality primary and preventative care.
30 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).
31 *2010 CHP Profiles*, ScotPHO, 2010. We have used the three-year rolling average 2004–06 and 2006–08.
32 Due to phased implementation of CHPs, breast feeding data was not available for all CHPs over this period.
33 *2010 CHP Profiles*, ScotPHO, 2010.

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 (which can be found at http://www.audit-scotland.gov.uk/work/health_national.php) to help improve planning, delivery and impact of services through a joined-up approach.

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