1 Purpose of the Report

To propose revised management arrangements for Edinburgh Community Health Partnership (ECHP).

2 Recommendations

The Sub Committee is asked to consider and approve the following recommendations;

2.1 To move from the current management teams (hosted services, care of the elderly, community, allied health professionals and five Local Health Partnerships (LHPs)) to a reduced number (hosted services, care of the elderly, community, allied health professionals and two sectors).

2.2 To consolidate the existing 5 LHPs management resources into two teams; North and South Edinburgh.

2.3 To preserve the current GP engagement arrangements based on established boundaries, albeit with reduced meeting frequency.

2.4 To recognise the importance of the GP/Community Nursing interface and strengthen this through ‘clusters’ of Community Nursing teams aligned with GP practices. (As per Chief Nurse paper in June 2010.)

2.5 To note that the restructuring will help the CHP to address the longstanding deficit in its management costs.

2.6 To ask for a further timetabled implementation process which would see the new structure fully implemented by 31st March 2011.

2.7 To agree that there are benefits in terms of structural clarity, focus on resources and communication, to recognising the CHPs two major responsibilities as Service Delivery (and Redesign) and Tackling Inequalities.
2.8 To note that the Scottish Government have indicated they have no concerns with what is proposed and do not anticipate that the changes will require ministerial approval.

3 Discussion

3.1 The current CHP management arrangements for LHPs are built on the previous configuration of LHCC boundaries. These were kept as the CHP was established, partly for continuity and partly because they were well recognised and effective local structures.

3.2 The LHPs role of providing ‘general management’ to their local area has been overtaken by strong functional management structures and by the efficiencies presented by Edinburgh wide approaches to many issues.

3.3 The 5 LHP management teams no longer have either the role or staff once associated with a localised general management arrangement.

3.4 What is therefore proposed is to combine the resources of the five LHPs to establish two teams; North and South. This would give two sectors of the City which could relate well to the three CEC departments with which the CHP works closely (Adult Social Work, Children and Families, and Services for Communities) without needing to define a precise boundary.

3.5 It would also fit with existing north/south arrangements in the CHP such as North & South PPFs and North and South mental health teams, along with resources such as Leith CTC and Astley Ainslie Hospital which clearly relate strongly to a North-South alignment.

3.6 It is proposed that the North and South Teams both have the capacity to manage the dual role of effective service delivery and tackling inequalities.

Service Delivery

3.7 The ‘Service Delivery’ side of the CHPs responsibility is largely a functional and single-agency approach, i.e. day-to-day delivery of primary and community care and hospital services. This activity is supported by well established joint planning mechanisms where longer term planning and decisions needs to be made jointly. In addition, joint teams such as the PREPARE Team and the Access Practice have well developed joint management arrangements.

3.8 The CHP is largely able to determine effective service delivery management arrangements, through joint planning mechanisms where relevant and make the necessary operational links with partners.

3.9 ECHP has an established hosted services management team managed by an Assistant General Manager. The focus of attention is around Astley Ainslie Hospital and also includes satellite units such as the Lanfine Unit at Liberton Hospital and the Robert Ferguson Unit at the Royal Edinburgh Hospital. In addition, this management team covers a range of Lothian wide ‘hosted’ services including rehabilitation and sexual health.
3.10 The management of other hospital sites: Corstorphine Hospital, Ellen’s Glen, Ferry field and Findlay House is through the Chief Nurse with support from the Hospitals team.

3.11 In addition Allied Health Professional services (physiotherapy, podiatry, occupational therapy, speech and language therapy and dietetics) are managed city-wide by the Allied Health Professions Manager.

3.12 Following review, it is proposed that these arrangements are retained by the CHP.

3.13 LHCC and LHP structures have worked well for Edinburgh in the past both as ‘operational units’ and as networks of colleagues with common geographical boundaries for their responsibilities. It is clear however, that the interaction and joint work between primary care and the managed services is not as well supported as it once was.

3.14 Community nursing services are the mainstay of the CHP services provision alongside our hospital services. To an extent, some of our innovation and redesign in this field was effected and influenced by the (national) Review of Nursing in the Community. We now have the opportunity to refocus locally on the design and functioning of the extended Primary Care Team.

3.15 The detailed arrangements to support this outline were subject to a paper by the Chief Nurse (June 2010), but the basic assumption relating to the management structure is that each current LHP area will form 2-4 operational units for the purposes of organising the delivery of community nursing services.

3.16 In Service Delivery terms therefore, each of the two new North & South management teams would provide a co-ordinating function between approximately 7 community nursing clusters and associated Primary Care Teams, the adult and older people’s mental health teams and AHP services, alongside a range of other specialist delivery functions such as the IMPACT service.

3.17 One of the other advantages of the proposed Service Delivery focus is the opportunity to promote effective working with acute service colleagues who have struggled, at times, to engage with five LHPs. The North-South management units should be better positioned to take advantage of these opportunities, particularly as redesign across clinical pathways takes place.

3.18 In addition, the north and south teams will be better placed to take Edinburgh wide lead roles for the whole CHP on common issues such as health and safety, medical records, risk management, business continuity planning etc.

3.19 This North-South management team structure will give a stronger focus for current LHP staff and create an agenda focussed on the delivery of services largely within our operational control.
Inequalities

3.20 In contrast to Service Delivery, the ‘inequalities’ side of the ECHP’s responsibility must be addressed on a multiagency basis, working closely with CEC, the voluntary sector, local communities, and other partners.

3.21 When designing management arrangements to address inequalities responsibilities, the CHP must therefore fashion its structure together with key partners to be effective.

3.22 A paper agreed by the CHP Committee on 15th October 2008, ‘Strengthening our Approach to Inequalities’ began to set out a joint approach to tackling inequalities in the areas of the city where high proportions of households are classified as ‘deprived’.

3.23 In brief, the proposed structures build on the Neighbourhood Partnership structures to create opportunities for resources from Fairer Scotland Fund, Services for Communities, the NHS and voluntary organisationss to be better co-ordinated to pursue Single Outcome Agreement objectives for 8 geographically defined communities across the city.

3.24 Further discussion is required with CEC Services for Communities and CEC Corporate Services to determine the best arrangements to link Neighbourhood Partnerships, the proposed North and South Teams and the City Wide strategic partnerships which are part of, or relate to the Community Planning structures.

3.25 Whatever the outcome of further discussions it is clear that the role of our Public Health Practitioners (PHPs) remains key in ensuring ECHP plays a strong role in Community Planning and its central aspiration to reduce the impact of poverty.

3.26 Under these proposals, each of the PHP posts would have responsibility for supporting three Neighbourhood Partnerships in joint efforts to tackle inequalities. Each of the two teams (North & South) would have two PHPs based as part of the team.

3.27 One of the two teams would also include those other CHP staff whose posts are dedicated to tackling inequalities such as the Keep Well Manager and any ‘specialist’ PHP posts. In this way the CHP can establish a strong and recognisable Inequalities Team ensuring mutual support and much improved co-ordination of activity across the city.

3.28 In addition, the work of the Public Involvement Co-ordinators (PIC) has become increasingly focussed on inequalities topics. Within the two Public Partnership Forums (PPFs) the strengthening links with Neighbourhood partnerships are balancing the traditional focus on ‘how well are we delivering services’, towards ‘what can the NHS & Communities do in partnership’. Other work of the Public Involvement Co-ordinators is heavily skewed towards groups who either choose not to, or find it difficult to engage with PPFs and other public mechanisms for pro-active engagement with the
public. It is therefore recommended that these staff form part of the inequalities function.

4 Organisational Change

There are some Human Resources issues to be worked through when considering these proposals. These are noted below;

4.1 Whilst LHPs would effectively ‘disappear’ as management teams, Clinical Nurse Managers should consider their responsibilities as relating to 2, 3 or 4 clusters of GP practices and associated community nursing teams.

4.2 At a Core management Team on 6th September 2010 the options for physical location of the two teams was considered with a supporting paper. The meeting determined that the best option at this stage to progress the restructuring, was to secure a combined base on the Astley Ainslie site. Since that time attention has focussed on trying to secure use of Canaan Park building (formerly finance), which is currently vacant.

It should be noted that the list of staff below is not necessarily exclusive nor deterministic for example senior Allied Health Professional Managers have indicated that being based with the North and South Teams has advantages, as has the Carer Co-ordinator.

(1) North Team

Clinical Leads x2
Clinical Nurse Manager x2
Public Health Practitioner x2
Primary Care Pharmacist x2 (tbc)
Development Managers x2
Mental Health Clinical Nurse Manager x1

(2) South Team

Clinical Leads x2
Clinical Nurse Manager x2
Public Health Practitioner x2
Primary Care Pharmacist x2 (tbc)
Development Managers x2
Mental Health Clinical Nurse Manager x1

(3) Shared North-South Staff

Public Involvement Coordinators x2.5
Assistant General Manager x1
Inequalities Manager and Diversity Manager x2
Keep Well Manager x1
Administrative Support x8 (tbc)
4.3 This arrangement would re-establish strong and mutually supportive operational teams with built-in cover and support for what have been, in many cases, quite isolated posts. This arrangement would also bring together fragments of secretarial support into a co-ordinated team. This is important as many colleagues are not well supported with administrative back up which makes their day-to-day activities less efficient.

4.4 These changes would allow the CHP to reduce the number of Assistant General Managers from three to two and the number of Development Managers from five to four. The CHP has already reduced the numbers of Clinical Nurse Managers and Clinical Leads from five to four and these changes will allow the remaining staff to work more effectively.

4.5 Over time, if only one AGM is available to support both North and South Teams, then the role of the Development Managers becomes central to the co-ordination of the two teams in achieving the Service Delivery Objectives for the area. Whilst only four of the current five posts will be required in future, the current job descriptions will need to be revisited to ensure these staff have the necessary authority to co-ordinate a diverse team of colleagues.

4.6 Similarly, groupings of Primary Care Pharmacists will be made at the North-South level, allowing one of the current vacancies to be used for savings. Discussions are underway on how these senior staff might best be supported with a skill-mixed team.

4.7 There may be a small number of other posts which would see themselves better housed alongside colleagues with a South or North Edinburgh remit. It would be helpful, for example to have Health Promotion colleagues housed alongside the main part of the Inequalities Team.

4.8 The General Manager has been reassured by the senior official in the Scottish Government Health Department with responsibility for CHPs that the changes envisaged do not require ministerial approval.

5 Impact on Health Inequalities

5.1 The reorganisation of the CHP management arrangements is designed to create a strong focus on service delivery (and redesign) and to create a more coherent approach to Tackling Inequalities. The organisational outcome would be that the CHP would be able to clearly articulate;

* Management responsibilities for Tackling Inequalities.
* Partnership arrangements for Tackling Inequalities.
* Governance arrangements for Tackling Inequalities.
* Resources allocated.

6 Resource Implications

Initial Estimate of Management Savings; £200k
Initial expectation of necessary Investments: £20k

In addition the freeing up of space in various locations across the city through bringing together the LHP teams will create opportunities to accommodate clusters of community nurses in support of the CHP’s efficiency target on reducing costs of accommodation.

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