

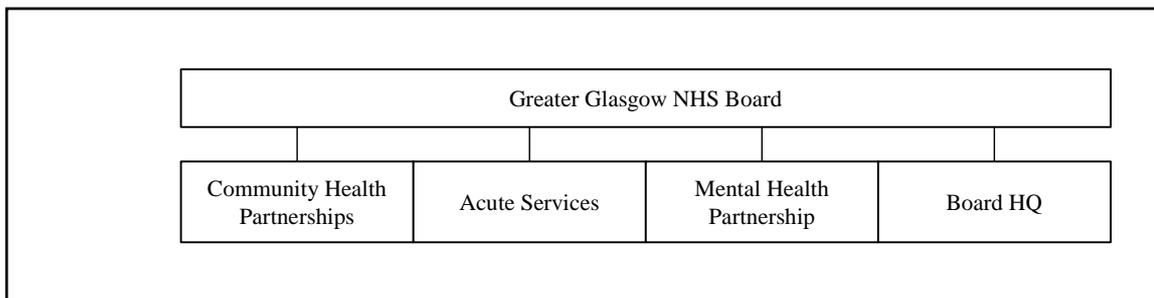
PARTNERSHIP FOR CARE: REFORMING THE NHS IN GREATER GLASGOW

A. BACKGROUND AND PURPOSE

1.1 The NHS Board and our partner Local Authorities have completed the required processes to conclude the organisational arrangements to move to implement the Partnership for Care White Paper following wide consultation. The purpose of this paper is to set out the top level structures within the new organisational arrangements. It is important to restate the background to the present position. Partnership for Care had a number of imperatives:

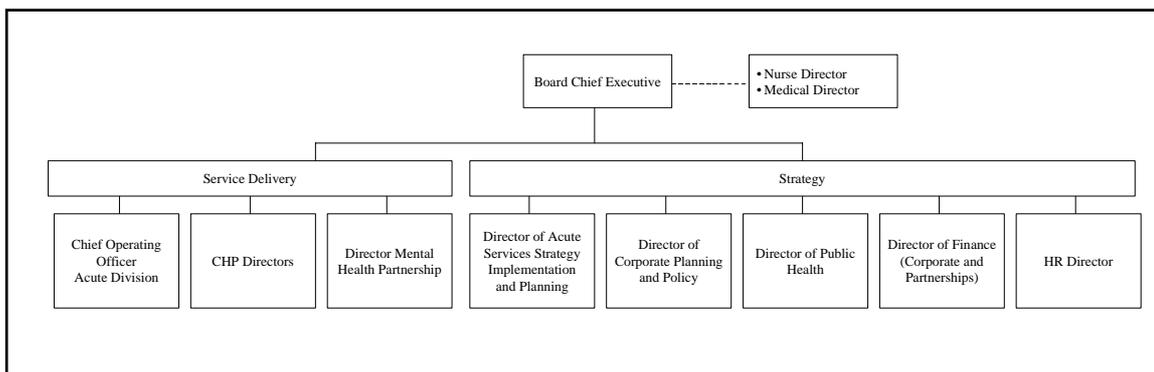
- abolishing NHS Trusts and creating a single system NHS;
- establishing CHPs as substantive partnerships with Local Authorities;
- improving health and narrowing the inequalities gap;
- securing better access and higher standards of care.

In order to meet these imperatives we intend to move to an organisational structure with four major management components.



1.2 The Greater Glasgow NHS Board will continue to be the board of governance within which the components of the organisation and its management arrangements operate. The NHS Board will have a detailed set of governance arrangements to ensure it can properly discharge its responsibilities and statutory functions. This will include a subcommittee structure covering health improvement, performance review, staff governance, involving people, audit, clinical and staff governance, research and ethics. In addition, non-Executive Directors of the Board will participate in CHP Committees and in the Mental Health Partnership Committee. These arrangements will ensure the Board meets its legal responsibilities for staff, clinical and corporate governance.

1.3 The top level management arrangements for this organisational structure is below. The detailed rationale for each element of the structure is described in **Sections B-E** of this paper.



It is proposed that the integrated CHP Directors for East Renfrewshire and East Dunbartonshire will report to the Board Chief Executive and relevant Local Authority Chief Executives. For Glasgow City there will be a lead Director for the NHS with a coordinating role on behalf of the Board Chief Executive.

- 1.4 The Board Nurse and Medical Directors will have key advisory responsibilities for the NHS Board and defined pan Glasgow responsibilities on behalf of the Board Chief Executive. They will be appointed, as at present, from the senior clinical leaders in the operational structures and their primary accountability will be within those structures.
- 1.5 This reorganisation is not only about major structural change - shifting from four NHS divisions and sixteen LHCCs into a single acute division and partnership arrangements for mental health, primary care and community services - but also about transforming the way we work, including, the integration of health and social care services, breaking down barriers between primary and secondary care, delivering services across Greater Glasgow, putting health improvement at the centre of the NHS.
- 1.6 In preparing this scale of change, it is important to state at the outset that NHS Greater Glasgow recognises the efforts of all its staff and is committed to harnessing their knowledge, skills and experience in delivering its responsibilities. While the vast majority of staff in their day to day jobs will be unaffected by the organisational changes, a significant number of staff in general, clinical and functional management positions are directly affected. We know that restructuring is an unsettling process and causes anxiety. Therefore, in implementing these changes we will treat our staff with fairness and equity in accordance with the Staff Governance Standard and the process outlined in **Section K** seeks to achieve this. The structure set out in this paper will give some more clarity to those staff affected about the future shape of the organisation and the intention is to move quickly, as set out in the timetable at the end of this paper, to communicate directly with those staff who are displaced by the new arrangements and to outline in more detail their options and the arrangements for filling posts.
- 1.7 The detail of the top level of the organisational structures is set out and explained in the following sections:

- B. Acute Services Division and Acute Services Review Implementation**
- C. Mental Health Partnership**
- D. Community Health Partnerships**
- E. Board Headquarters**

In addition, the sections outlined below describe how these different parts of the organisation will work together as a coherent single system. These sections cover:

- F. Planning**
- G. Performance Management**
- H. Health Improvement**
- I. Communications and Corporate Support**
- J. Clinical Leadership and Governance**

- 1.8 The sections outlined below cover implementation arrangements, the next steps and timing:

- K. Filling the Top Level Structure**
- L. Managing the Transition**

- 1.9 Finally, it is important in describing the context for this paper to underline that, as set out above, given the extent of organisational change and transformation which we are aiming to achieve, it is not possible to finalise detailed structures across the organisation, and at every level, in a single process. Therefore, the focus of this paper is setting out the top level organisational arrangements and our approach to establishing them. **Section K** sets out next stages to design and implement the further changes which will be required to conclude the totality of the reorganisation. It is also important to state that all staff within these structures who are employed by NHS Greater Glasgow, the single employer, will be assured of consistent and fair treatment and the observance of the NHS staff governance standard.

B. ACUTE SERVICES DIVISION AND ACUTE SERVICES STRATEGY IMPLEMENTATION

- 2.1 In looking at the options for a future structure for acute hospital services, the Board's Corporate Management Team first assessed the key challenges which this sector will face over the next decade. In implementing the Board's plan for modernising acute care within the city, for the next ten years, significant change in acute services will need to be delivered every year. Change needs, therefore, to be planned and delivered across Greater Glasgow. In addition, there was a recognition that the resources available to this sector need to be seen as a single pot, and not "owned" by separate Divisions. The consensus within the Corporate Management Team has been to propose a move to a single acute services structure, but with distinct operating and planning leadership.
- 2.2 In addition to the major challenge which implementation of the acute services strategy involves, we need to be satisfied that we will have an operational structure which will deliver on the national priorities, the key service imperatives and which will secure improved patient experience. In the years ahead, it is evident that shortening waiting times for assessment, diagnosis and treatment within the acute sector will remain a key plank of the Executive's policy for NHS Scotland. Successful delivery of these policy commitments will depend significantly on redesign of many aspects of current acute services provision which, in turn, will improve patients' experiences. There is an urgent need, therefore, to achieve stronger cross-city working in order to deliver these challenging targets. To support these processes of improvement, there are opportunities to consolidate a number of clinical support services into single, pan-Glasgow arrangements.
- 2.3 The proposed, single Acute Operating Division includes a discrete Directorate for Women's and Children's Services. That Directorate will bring together the present three separately managed Maternity Services, two separate Gynaecology Services and hospital Children's Services, presently based at Yorkhill. The Corporate Management Team saw a number of advantages of this model which are described in more detail below.
- 2.4 The development of CHPs will see a number of services presently managed by the Yorkhill Division managed by the CHPs. This will provide an important opportunity to achieve much stronger horizontal integration at local level alongside the capacity and responsibility to focus on inequalities and health improvement, with children as a top priority. The proposed arrangements, as they relate to the creation of CHPs, are set out in **Section D** of this paper.
- 2.5 There was strong support evident from the Board's Maternity Services consultation for the management of Maternity Services as a single structure. If that arrangement was as part of a separate Operating Division, it would involve separating Maternity Services from the other clinical services which are integral to their delivery, including anaesthetics, theatres and radiology. The inclusion of hospital children's services as a whole entity into this proposed Directorate ensures there is no similar separation for those Clinicians. In addition, it was evident also from the Maternity Services consultation that there are variations in Maternity Services

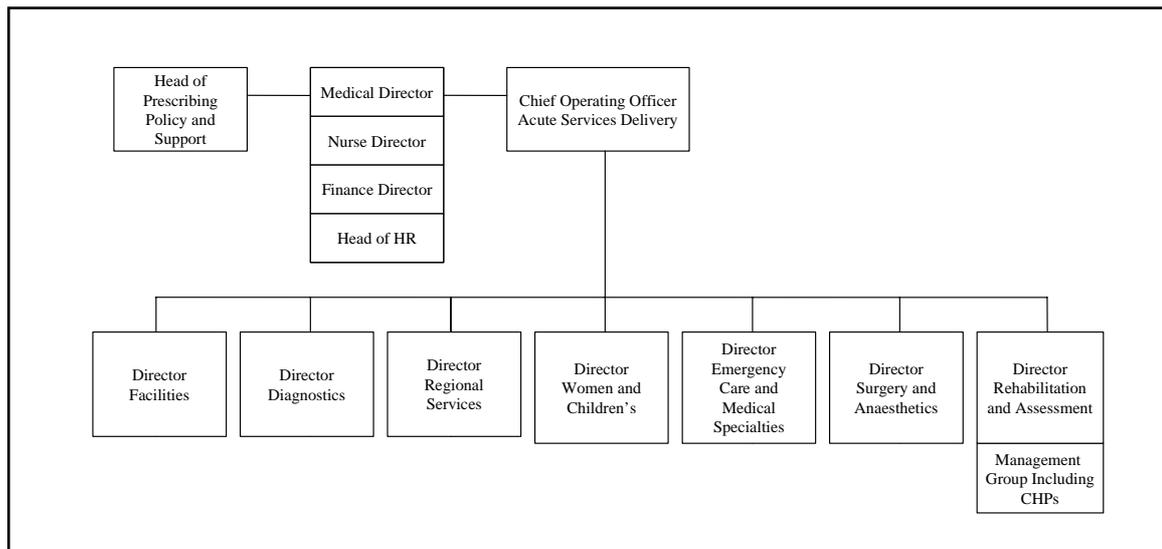
within Greater Glasgow currently, and variations also in the relationships between Maternity and Paediatric Services: these are difficult to justify and the Board recognised the need to have a consistent pattern of service delivery across Greater Glasgow.

2.6 With the Minister's decision now taken following the Maternity Services consultation, the Board must now drive forward rapidly the development of a new Children's Hospital. The physical planning of Children's Services will need, therefore, to be at the heart of the overall Acute Services Plan, given the Minister's requirement that Children's Services are relocated from the Yorkhill site in no more than five years from now, to be located alongside Adult Acute Services and Maternity Services. For all of these reasons we propose maternity and children's services should be in an integrated structure with the rest of acute services.

2.7 In developing the detail of this operational structure, we were concerned that change should not fracture the well established clinical and managerial relationships which have evolved in the existing three Divisions. We also wanted to ensure visible and decisive senior management on hospital sites. In order to work through how this could be achieved a multidisciplinary group was established, jointly chaired by the present North and South Divisional Chief Executives, to work through the detail of how this would be achieved in structures for the new Division. The group included clinical, planning, professional and managerial staff from across GGNHSB. The group established five key principles which informed the detailed structures included in the rest of this section. These were:

- Firstly, the new management arrangements should be built around pan-Glasgow clinical services but should also ensure local visibility and ownership. The creation of sector based management arrangements to support the large Directorates would secure strong local management within a large pan-Glasgow structure.
- Secondly, the new structures should seek to build on current successes but with the aim of having consistent managerial practices and approaches across the Directorates.
- Thirdly, management arrangements should not be internally focused. They should be built around the principle of structural devolution and accountability with appropriate co-ordination within an agreed performance management structure.
- Fourthly, the management arrangements should ensure that partnership arrangements are embedded at all levels.
- Finally, hierarchical structures and individual managerial lines of accountability and responsibility should be clearly articulated.

2.8 The essence of our proposal, which is shown in the schematic below, involves seven major Directorates, each led by a Director, with a substantial management team. In the case of the six Clinical Directorates, these teams will include a medical lead and Heads of Nursing, and for all Directorates, HR and Finance. The rest of the section provides a summary of the responsibilities and top level structure for each Directorate. The senior posts in each Directorate will have similar responsibilities. The senior clinical posts in the structure will include substantial protected time and appropriate remuneration. In the case of Associate Medical Directors we anticipate that these will require at least a half time commitment. For Clinical Directors the time commitment is likely to be a minimum of two sessions.



2.9 The creation of a single Director for each group of services brings a pan-Glasgow responsibility into the arrangements, ensuring that there is a single decision making point for each group of services: such an arrangement is presently lacking.

2.10 The major Directorates of emergency care and surgery and anaesthetics reflect the two most significant service priorities: to deliver high quality, effective and economic emergency care, and to continue to reduce waiting times. As the following detailed structures show, these largest clinical Directorates are underpinned with sector based General Managers. This arrangement combines a pan-Glasgow structure with strong local management and will also play a major part in ensuring the Acute Division works very closely with the Community Health Partnerships. Likewise, the sizable Facilities Directorate will have a strong sector based presence.

2.11 The posts of Medical and Nursing Directors may be full time if they also carry the NHS Board responsibilities.

2.12 **Rehabilitation and Assessment Directorate**

The proposed Rehabilitation and Assessment Directorate (RAS) will bring together the management of services which have strong inter-relationships and critical linkages to the related CHP services. This proposal was developed through detailed work around the organisation of older people's and physical disability services focused on ensuring we achieve an integrated whole system approach to assessment, rehabilitation and enablement for physically frail older, physically disabled and mentally ill older people.

The Directorate would manage the following acute services, the allied health professionals are those providing adult services:

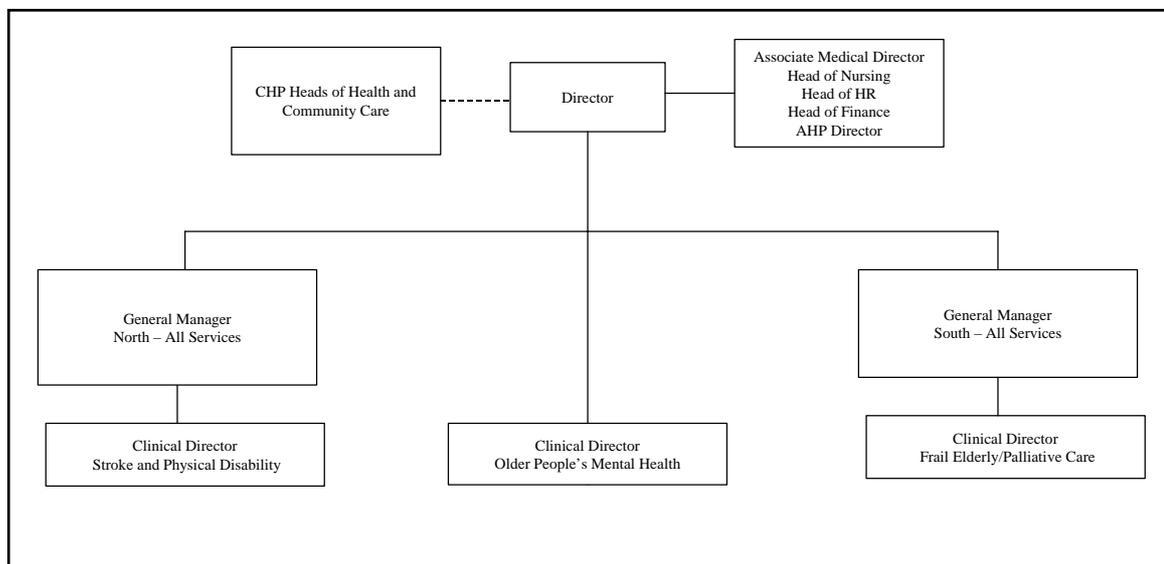
- stroke;
- frail elderly;
- palliative care;
- inpatient physical disability;
- WESTMARC;
- outpatient therapy;
- physiotherapy;
- dietetic and speech and language therapists;
- rehabilitation across the Acute Division.

In addition, the Directorate would manage a range of community services including palliative care, a number of specialist community disability services, pain services, continence advice, services to care homes and falls prevention.

Old age psychiatry is a critical link for this Directorate - although services will be managed within the CHPs, the Clinical Director for old age psychiatry will be part of the management team of the RAS.

To ensure strong connections to the CHPs, the Director will chair a management group including CHP Heads of Health and Community Care - who will manage similar services within CHPs and this group will lead the planning and policy development across Greater Glasgow for the populations and services outlined above.

Rehabilitation and Assessment Directorate



In addition, we are seeking agreement with Glasgow City Council to align their older people’s management and planning structures with citywide responsibilities, alongside this Directorate. This would create whole system health and social care cohesion. If we are able to agree the arrangement we would propose a small policy and planning function, jointly managed by the Glasgow City Council Head of Older People’s Services and RAS Director, to coordinate and support whole system planning, policy development and performance management with the direct engagement of the wider acute services planners and the planning and health improvement teams in the CHPs. The link to the MCNs and chronic disease management arrangements within the Acute Division will be particularly important. The RAS will host the MCN for stroke alongside its responsibilities for the delivery of stroke services.

2.13 Surgery and Anaesthetics

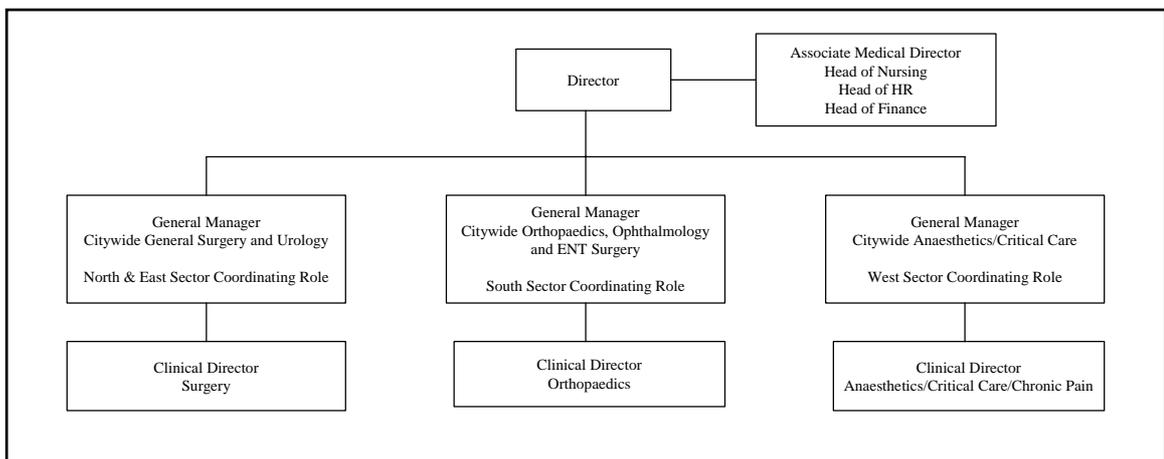
It is proposed that this Directorate should include: general surgery, including vascular and breast surgery; orthopaedics/trauma; and anaesthetics including critical care (with the exception of coronary care) and theatres. This Directorate should also include:

- ophthalmology;
- optometry;
- urology;
- ENT surgery;
- audiology;
- endoscopy.

Gynaecology should be in the Women’s and Children’s Directorate, as would paediatric anaesthesia. Neuroanaesthesia would be in Regional Services.

It is proposed that the smaller surgical specialties of ophthalmology, urology and ENT surgery, should have single pan-Glasgow general and medical management. In respect of each of the larger surgical specialties, in addition to a pan-Glasgow structure, there should be sector-based general management. The Directorate will also manage the community based Glasgow integrated eye service.

Surgery and Anaesthetics Directorate



2.14 Emergency Care and Medical Services

The proposed specialties to be included within this Directorate are:

- accident and emergency services;
- acute medicine;
- cardiology;
- respiratory medicine;
- renal medicine;
- gastroenterology;
- diabetes;
- infectious diseases;
- rheumatology;
- dermatology.

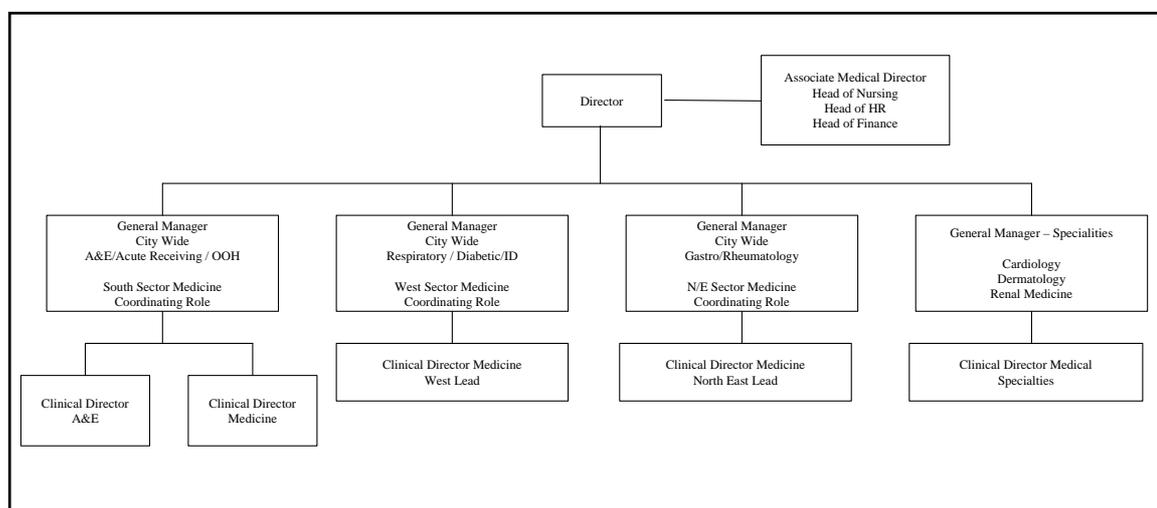
This Directorate will also manage the out-of-hours GP Service.

As with the larger surgical specialties, it is proposed that Acute Medicine be managed by general managers on a sector basis. Again, three General Managers would combine the operational management of the sector with a lead strategic role for a citywide specialty. In this model, however, it is proposed that the General Manager would work not with a single Clinical Director

in setting the strategic direction but with one of three sectoral Clinical Directors for Medicine. This is being proposed on the basis that a single citywide Clinical Director for Medicine would be an excessive role for one individual; it would be challenging to combine this with ongoing clinical commitments. In addition, the main managerial focus on acute receiving lies principally at sector level and this will ensure that general and medical management resources are targeted appropriately. The final specialties of Clinical Directors and clinical leads will be defined to ensure cross specialty coverage.

Debate has taken place on whether Accident and Emergency Services and Acute Medicine should be integrated within a single general manager post. We acknowledge that these services would benefit from integrated management arrangements at that level. However, given the challenging agenda facing particularly A&E services in the next two or three years, we decided that these services should continue to have separate and dedicated medical management resources but with shared objectives and coordination within a single Directorate. The Directorate will also manage a number of community services including heart failure liaison and weight management.

Emergency Care and Medical Specialties Directorate



2.15 Regional Services

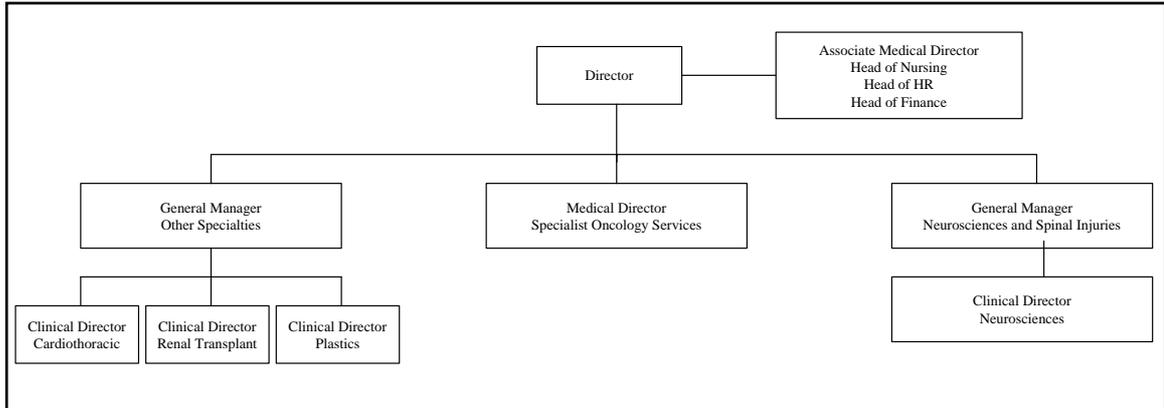
It is proposed that this Directorate should include:

- neurosciences (including all sub-specialties except neuroradiology);
- specialist oncology services (including haemato-oncology);
- plastic surgery and burns;
- cardiothoracic surgery;
- renal transplantation;
- oral and maxillofacial surgery.

The original proposition for Regional Services also saw Homoeopathy being managed within this Directorate. We believe further debate is required as to the best organisational home for homoeopathy. Comments on this point are welcome.

For oral health services, it has been concluded that a single oral health structure should bring together primary care, secondary care, public health, specialist health promotion and teaching and training, within the Acute Division either within this Directorate or as a stand alone Oral Health Directorate. Views on this issue are welcome.

Regional Services Directorate



Whilst it is not reflected in the above schematic, the Group did consider whether renal medicine and renal transplant should be managed together and if so, whether this would be in the Directorate of Emergency Care and Medical Specialties or, given the extent of West of Scotland income within renal medicine, in the Regional Services Directorate. This issue requires further consideration and comments are welcome.

2.16 Diagnostics Directorate

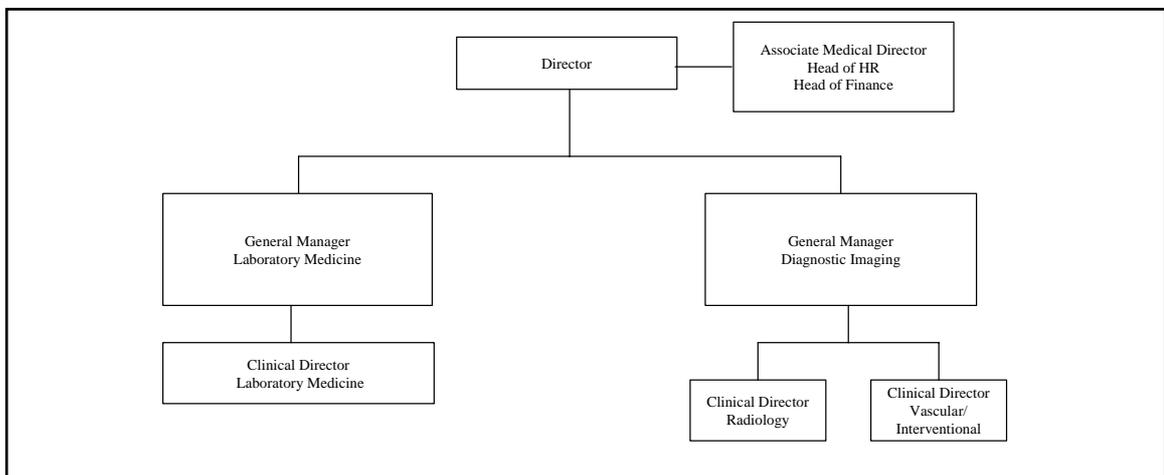
The proposal is that that this Directorate should include:

- all laboratory medicine including paediatrics;
- diagnostic imaging (including Beatson radiological services);
- vascular and interventional radiology.

In addition the Directorate will manage community based services for anticoagulation and breast screening and the cervical cancer screening programme.

The structure for the management of laboratory medicine within Glasgow have come from a separate process to review Laboratory Services. Amongst the recommendations from this Review was a proposal that paediatric laboratories would be managed within the overall laboratory Directorate but with distinct lead clinician roles for paediatric laboratory specialists. That is the arrangement we propose.

Diagnostics Directorate



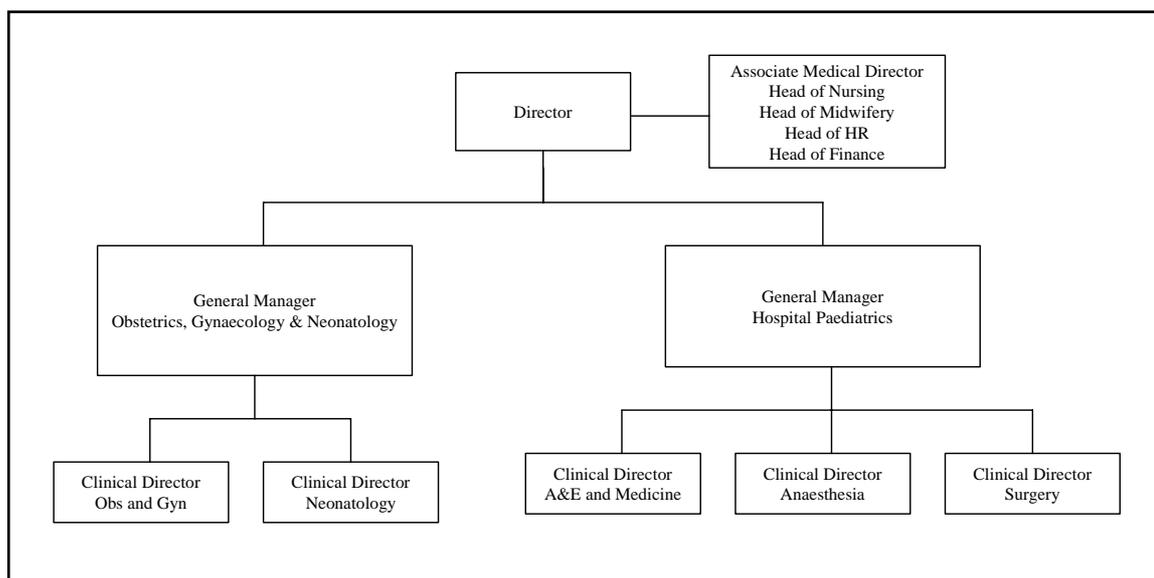
2.17 Women's and Children's Services

It is proposed that this Directorate should include:

- obstetrics;
- gynaecology;
- neonatology;
- paediatric medicine;
- paediatric surgery;
- paediatric accident and emergency services;
- paediatric anaesthetics;
- paediatric radiology.

The Directorate will manage the clinical services in the present three maternity hospitals, and the hospital services on the Yorkhill campus. The Directorate management team will include the specialist children's services managers who we propose will manage child and adolescent mental health and community child health within four of the CHPs. This and a network of clinical relationships, will ensure that vertical integration of hospital and community services is maintained and developed. The Head of Children's services for the Lead CHP, with overall responsibility for coordinating specialist community services will also be part of the Directorate management team.

Women's and Children's Services



2.18 Facilities Directorate

It is proposed that this Directorate should include:

- site maintenance for both acute and CHP facilities;
- hotel services;
- laundry;
- TSSU;
- supplies;
- transport;

- catering;
- telecommunications;
- waste management.

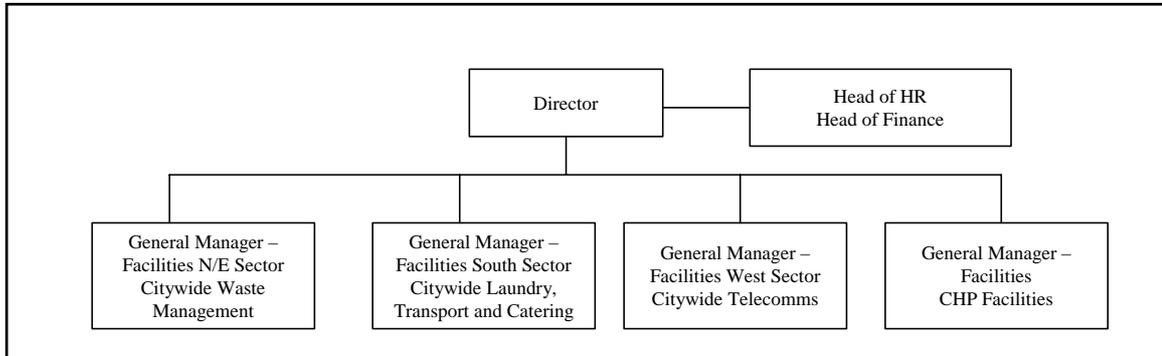
The focus of this structure would be to develop management arrangements that would provide site management to all premises within the single acute division. It is felt that this would be best achieved by maintaining the current sector arrangements representing north/east, south and west. It is proposed that the responsibility for site management be extended to cover all buildings within the boundary of an acute site. It is also proposed to site manage other CHP facilities, including Leverndale and Parkhead Hospitals, as a fourth sector within this Directorate.

A General Manager responsible for both facilities and site management would manage each sector. As with the other Directorates taking a combine citywide and sector management approach, it is proposed that each of the General Managers would also have responsibility for leading on a range of pan-Glasgow services.

It is acknowledged that strategic and professional direction for risk management, health & safety and fire and occupational health would be best provided from the HR function. However it has also been suggested that the daily reporting arrangements should be linked to the sector management structures, given the day-to-day operational risks that need to be managed.

Procurement and Sterile Services would both be managed within Facilities, with Glasgow-wide Heads of Service reporting to the Director.

Facilities Directorate



2.19 Other Key Functions

The Acute Division will manage a number of other functions on behalf of the whole of NHS Greater Glasgow. These include:

- prescribing policy and support - with a Head for this function reporting to the Division's Medical Director;
- clinical governance and support - as outlined in **Section J** of this paper.

2.20 Implementing the Acute Services Strategy, Service and Capital Planning

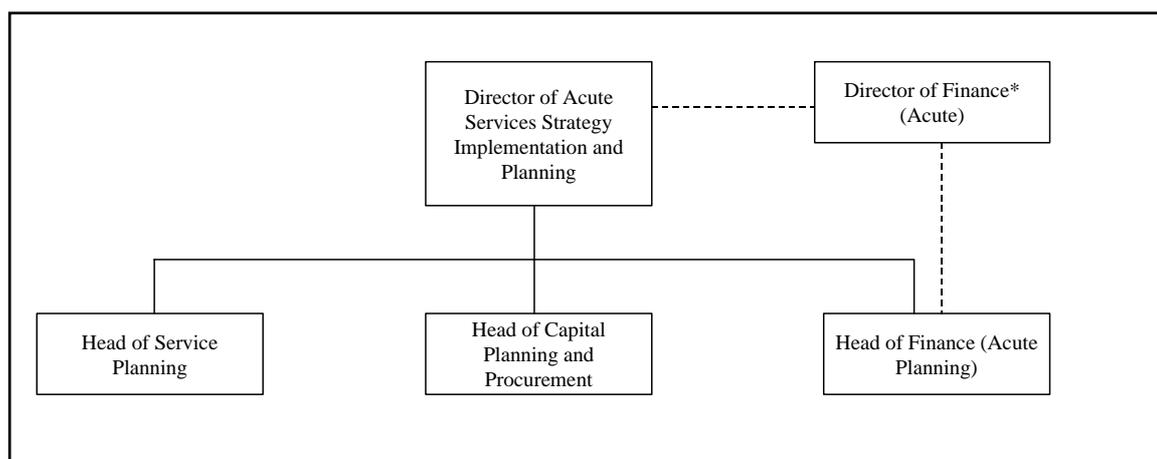
In the light of the demands of the Acute Services Review, action has already been taken to create an interim single Acute Planning Team, bringing together resources from the previously separate Operating Division and NHS Board structures. The team proposed in this section, to be led by a senior Director reporting to the Board Chief Executive, has five core responsibilities: to develop and enable the implementation of the detailed service change and capital plans required to deliver

the Acute Services Strategy; to develop annual Joint Service Plans with CHPs; to lead the development of the annual service and resources plan for acute services, including capacity planning and efficiency appraisal; to support the Division Chief Operating Officer in Divisional performance management routines; and, within the pan-Glasgow planning framework, to lead the development of the acute services components of the overall NHS Plan, ensuring that national and local priorities are fully reflected and, with Divisional Directors, followed through to detailed implementation plans.

In addition to these core responsibilities, this team will carry additional responsibilities to develop and manage implementation of the totality of the Board’s Capital Plan, working with the Mental Health Partnership and CHPs to ensure that plan properly reflects all capital priorities; to participate in a number of cross-cutting planning groups where acute services require to contribute expertise and deliver change programmes; to host the Managed Clinical Networks (MCNs) for Cancer and Coronary Heart Disease; and to take the lead on planning for chronic disease.

The team will work closely with the operational Directors of the Acute Division with a lead planner identified for each Directorate. The Chief Operating Officer and Strategy Director will work together to ensure that clear migration plans are developed and delivered for clinical services to deliver the implementation of the Acute Services Strategy. Similarly, they will agree an annual financial framework which reflects the imperatives of the Strategy.

The structure of this function is shown below.



In this structure the Director of Finance (Acute) reports to the Chief Operating Officer but also works with the Strategy Director to ensure coherent and coordinated financial planning and operational budgets.

C. MENTAL HEALTH PARTNERSHIP

3.1 This section describes the management structure for adult mental health services. After a long process of development and consultation, the Board approved the arrangements through which responsibilities for local, and more specialist, mental health services should be delivered, achieving an integrated service at local level but also ensuring whole system coherence.

3.2 There were several key components of those proposals:

- a Mental Health Partnership Committee including Local Authority Councillors, NHS Non Executives and CHP representatives;

- an Executive Team led by a Director with responsibility for ensuring there is a whole system approach to the planning and delivery of mental health services;
- mental health managers in each CHP accountable to the CHP Director for the delivery of all local mental health services but working as an integral part of the Mental Health Partnership Management Team to ensure there is a cohesive mental health system across the full range of services. Those local mental health services to include teams combining the functions of existing community and primary care mental health teams with social work teams;
- three of the CHP mental health managers with wider responsibility for area services including inpatient beds, and in particular the interface between CHP and pan CHP services, accounting to the Partnership Director for the management of area services.

3.3 A major objective in developing these arrangements was to deliver strong local accountability and connections, through the CHP, and to ensure there is a whole system coherence for mental health between services provided locally and those provided on a more aggregated basis (including inpatient beds).

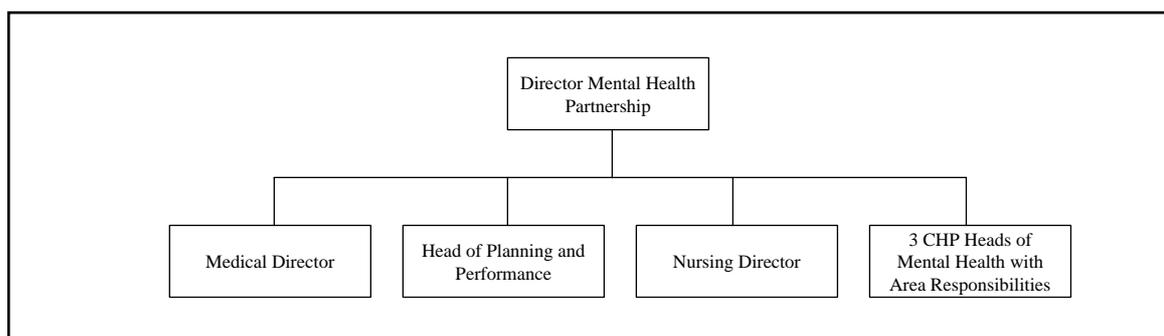
3.4 It is also important that CHPs are at the heart of decisions about the provision of these more aggregated services which are critical to providing effective local services.

3.5 The core functions of the Mental Health Partnership are:

- to manage Greater Glasgow wide services in partnership with CHPs;
- to ensure a whole system approach to the planning and delivery of mental health services;
- to ensure clear and consistent implementation of performance management arrangements, reflecting all aspects of health and Local Authority governance requirements;
- to provide effective managerial and professional leadership at all levels of the Partnership;
- to provide robust and safe arrangements for the management of mental health services with particular focus on balancing the risk to individuals to that of the community;
- to lead the development of health improvement and prevention strategies for mental health and wellbeing in partnership with CHPs.

3.6 Mental health services for older people will be managed in CHP structures but with clear arrangements for site management within the Mental Health Partnership. For child and adolescent psychiatry options for the management of inpatient services are under discussion. The top level partnership structure is shown below. We are in discussion with Local Authorities about how the top team can include a social care perspective.

3.7 As a transitional arrangement there will be a forensic services manager, reporting directly to the Partnership Director, with primary responsible to manage the development of the new medium secure unit, and over time to manage these services into the area responsibilities.



3.8 We are in discussion with Glasgow City Council about reporting relationships for the integrated learning disability and addictions services which presently have a line of accountability into the Primary Care Division. Any proposal would relate only to organisational reporting lines not the existing general management and structural arrangements. We need to ensure that NHS responsibilities including for inpatient services and staff, have a clear line of accountability into NHS governance structures.

D. COMMUNITY HEALTH PARTNERSHIPS

4.1 The Board set a clear policy framework for the development of Community Health Partnerships in Greater Glasgow.

4.2 In responding to the White Paper we established two fundamental aspirations:

- the massive potential for CHPs to deliver better services and decisions about their populations anchored in local accountability and responsibilities which connect wider health improvement with service delivery;
- CHPs as not simply a way of better managing and integrating NHS services but also as offering an organisation which can be:
 - a partnership with Local Authorities, integrating NHS and Local Authority services and driving a joint health improvement agenda;
 - a community planning partner.

4.3 We have developed these aspirations into seven key objectives for CHPs:

- real action on health improvement;
- focus on health of population as well as services and ensuring that a population perspective has clout corporately;
- delivering quality, effective and responsive personal care;
- driving externally provided services, quality and priorities;
- achieving staff and community influence, engagement and ownership;
- influencing and driving other local services;
- credibility with elected members.

4.4 In order to deliver these objectives we are aiming to establish CHPs to:

- be integrated and substantial organisations with strong accountability;
- be a local community planning structure;
- have substantial involvement of elected members;
- have significant health improvement capacity, equal to services element;
- be organisational structures with community and staff interest prominent;
- have structured links to housing, regeneration, employment.

4.5 Our aim has been to establish fully integrated CHPs which will bring together NHS and Local Authority responsibilities but retain clear individual agency accountability for statutory functions, resources and employment issues. It is a partnership organisation not a separate, new entity. The purpose of the CHP is to:

- manage local NHS and social care services;
- improve the health of its population and close the inequalities gap;
- play a major role in community planning;
- achieve better specialist care for its population;

- achieve strong local accountability through the formal roles for lead councillors and the engagement and involvement of its community;
- drive NHS and Local Authority planning processes.

4.6 The CHP will be characterised by:

- reduced bureaucracy and less duplication;
- modern and integrated community health and social care services focused on natural localities;
- integrated community and specialist health care through clinical and care networks;
- organisations which support achievement of service delivery;
- ensuring patients and a broad range of frontline health care professionals are fully involved in service delivery, design and decisions;
- shared governance and accountability with the Local Authority and substantial responsibility and influence in NHS resource deployment;
- a central role in service redesign;
- a pivotal role in delivering health improvement.

4.7 Priorities for development include:

- better care pathways for patients;
- a clear programme to tackle health inequalities;
- community involvement;
- realising the gains for patients of fully integrated local services;
- reduced bureaucracy and duplication;
- bringing a substantial population focus to the work of the whole of the NHS.

4.8 The rest of this section describes in more detail how integrated CHPs will operate: It is particularly important to emphasise that we will put in place processes to ensure CHPs work in a coordinated and coherent way where that is required, for example, in developing strategic service frameworks, or pan Glasgow chronic disease programmes. We are aiming to achieve a degree of consistency in CHP structures to ease their ability to work together at a number of levels. We expect CHP Directors and their Heads of Planning and Services to meet regularly on shared issues and priorities - including relationships with Acute Services. For the Glasgow City CHPs a single CHP Director will have responsibility to ensure coordination and joint working across the NHS.

4.9 Services Managed

For the NHS integrated CHPs will:

- Directly manage the following services:
 - health visitors;
 - district nurses;
 - relationships with primary care contractors;
 - mainstream school nursing;
 - local older people and physical disability services;
 - chronic disease management programmes and staff;
 - oral health action teams;
 - allied health professionals;
 - palliative care;
 - addictions and learning disability services;
 - local adult mental health and older people's mental health services.

- Hold budgets and contracts for the following services:
 - service level agreements for direct access to diagnostic and laboratory services;
 - primary care contracts;
 - prescribing;
 - health improvement and promotion.
- Participate in the management arrangements for the following services:
 - Greater Glasgow wide mental health services;
 - the Rehabilitation and Assessment Directorate of the Acute Division;
 - community midwifery services;
 - community planning;
 - hospital children's services.

4.10 Health Improvement

In terms of Health Improvement we are constructing CHPs as “health” organisations resourced and responsible for making a difference to the health of their population and reducing inequalities and as partners in working with other organisations to improve health.

This means:

- CHPs will lead the locally based health improvement effort, covering life circumstances and lifestyle action;
- a senior officer will have responsibility for leading health improvement within the CHP;
- the CHP will be developed as a public health organisation embedded within the NHS and Local Authority;
- the facilitation and integration of community involvement will be core to the CHP through a Public Partnership Forum;
- CHPs will lead the “health” contribution to local community planning;
- CHPs will have specialist health improvement resources bringing together staff from the LHCC, health promotion and local government forming a specialist health improvement team, supporting the public health orientation and activity of a wide range of non specialist CHP staff;
- CHPs will produce an annual health improvement and inequalities plan delivering on NHTSGG wide priorities but also reflecting local circumstances and a full partnership with local government;
- CHPs will contribute to the development and delivery of regeneration outcome agreements;
- all of the CHP management team will have responsibility for health improvement in their area, supported by the specialist resources. This connection of service delivery and health improvement will drive a focus on addressing inequalities by targeting resources and services. In addition, service delivery will reflect the imperatives of health improvement. Rather than prevention and inequalities being squeezed out by the imperatives of health and social care delivery we intend to see service delivery driven by the imperative to prevent ill health and improve health.

4.11 The wider reorganisation of the NHS in Greater Glasgow will enable CHPs to have a wide range of further specialist support for their work from health promotion and public health staff.

4.12 Local Authority Services

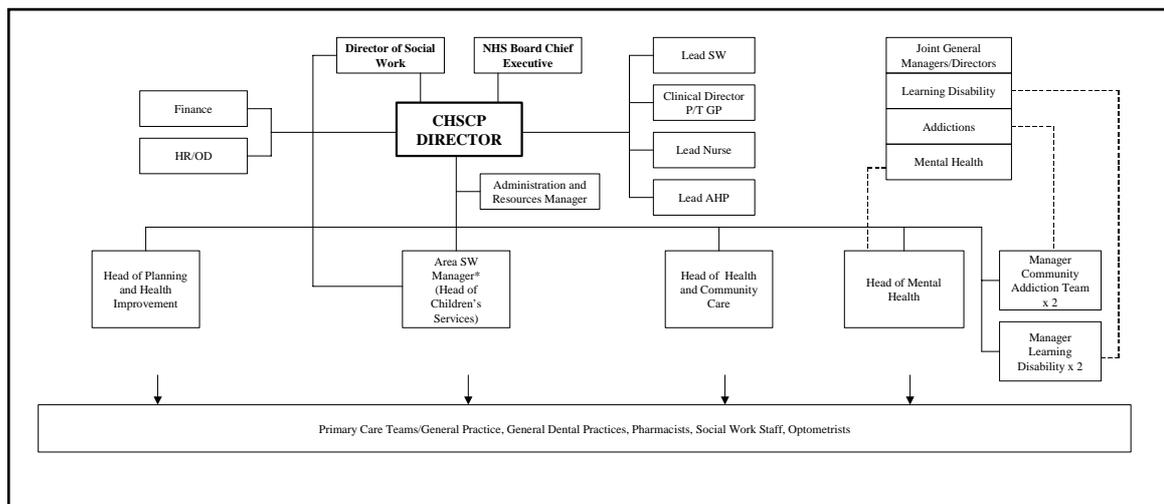
For the Local Authority - integrated CHPs will manage local social care services including children and families; addictions, older people and disabilities.

Individual schemes of establishment set out substantial delegation of Local Authority social work services into the CHP to match the high level of NHS delegation outlined above.

4.13 Management Structures

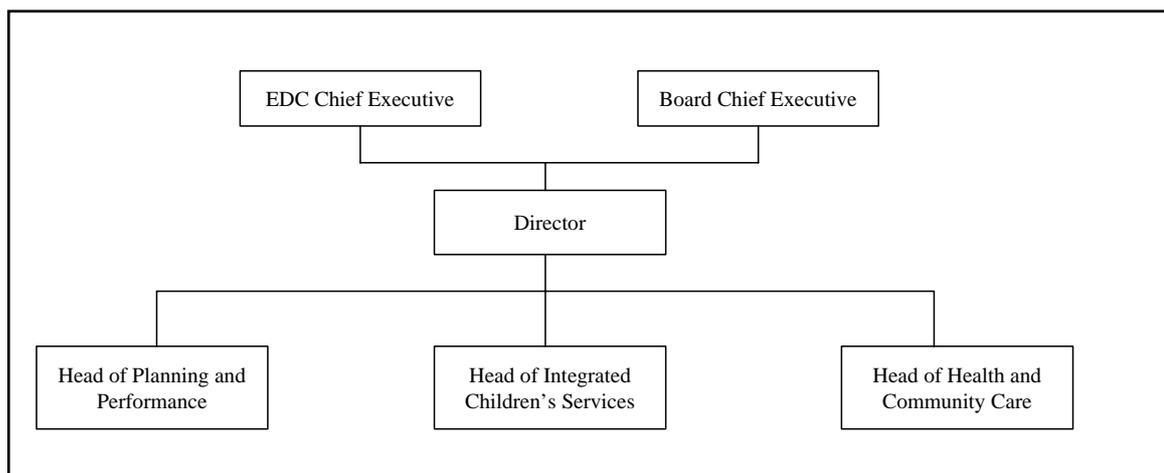
We have reached agreements with East Dunbartonshire, Glasgow City (and East Renfrewshire - subject to final Council approval) to establish fully integrated CHPs. Management structures are being finalised but at headline level the structures for the agreed integrated CHPs are set out below.

Glasgow City



One Glasgow CHP Director will act as Coordinating Director for the NHS. That CHP will include a Head of Primary Care Support in its structure.

East Dunbartonshire



4.14 For the East Renfrewshire CHP we will debate the top level structure with the Council following the approval of the scheme of establishment at the end of this month.

4.15 For the health service joint CHP covering West Dunbartonshire - the structure is being finalised with Argyll and Clyde NHS Board and will include a single Joint Director, Heads of Mental

Health, Planning and Health Improvement and either a single Head of Primary Care and Community Services, or that post with a separate Head of Children's Services.

4.16 A short summary of the potential responsibilities and key relationships for posts is set out below.

4.17 Joint Director. The core responsibilities for these posts will include:

- strategic leadership of the CHP across range of its responsibilities including the development and delivery of a comprehensive CHP plan;
- establishment of the CHP as a coherent organisation particularly achieving:
 - an effective management team and committee arrangements;
 - a PEG which fully engages local professionals at the heart of the CHP;
 - strong relationship with community and voluntary organisations;
 - strong relationships with local elected members;
- leading the development and implementation of change programmes to improve services and more effectively tackle inequalities;
- ensuring the CHP delivers effective high quality services which meet required standards of practice and governance;
- substantial role in corporate management and planning of the Local Authority and Greater Glasgow NHS;
- ensuring the CHP works effectively with other Council departments and other parts of the NHS, including the Acute Division and Mental Health Partnership;
- managing the CHP within the policy and performance frameworks established by the two parent bodies;
- taking a lead role across CHPs for a series of key strategic issues.

4.18 Head of Children's Services. The core responsibilities of these posts will include:

- the delivery of NHS and Local Authority children's services provided in the CHP area;
- driving a programme of service integration across children's services;
- developing programmes to improve the health of children and tackle inequalities;
- developing effective relationships with other Council services including education;
- contributing to the development of the new learning communities;
- the effective delivery of criminal justice social work services in the CHP and connecting those activities into the other responsibilities of the CHP;
- effective child protection across the CHP's activities;
- for four posts, managing specialist community children's services.

4.19 Head of Mental Health. The core responsibilities of these posts will include:

- managing all local mental health services;
- developing and delivering a programme of mental health improvement and prevention;
- driving a programme of service integration;
- participating in the management arrangements for the Mental Health Partnership;
- for three posts, managing inpatient and area wide mental health services

4.20 Head of Planning and Health Improvement. These posts will lead the team responsible for planning and health improvement activity within the CHP. The core responsibilities of these posts will include:

- ensuring that planning and health improvement expertise supports the CHP at all levels;
- contributing to a wide range of planning activities outside the CHP;

- delivering the CHP annual plan, in line with Local Authority and NHS requirements, including a financial plan;
- developing the annual joint plan with hospital services and the Mental Health Partnership;
- ensuring the CHP has a comprehensive programme of health improvement activity reflected in a detailed plan, including tackling inequalities;
- performance management within the CHP and connecting to Local Authority and NHS performance management routines.

The planning and health improvement team will include a lead senior specialist in health improvement with designated responsibilities in relation to professional leadership and participation in Glasgow wide networks.

4.21 Head of Community Health and Care. These posts will be responsible for:

- manage services for older people, including mental health services and services for adults with a physical disability and carry lead responsibility across the CHP for relationships with primary care contractors and for effective programmes of chronic disease management;
- for the improvement of care pathways between acute and local services;
- for driving the integration of services.

4.22 In addition to the management structure outlined above, the establishment of a Professional Executive Group for each CHP - bringing together a wide range of frontline staff to work with the management team will ensure a strong professional and clinical voice within the CHP.

4.23 It is important to restate that these arrangements define the management arrangements for the current pattern of services. There will be a fully engaging process to develop service change proposals to deliver the further integration of services for the benefit of patients which CHPs will enable us to achieve.

4.24 For children's services, we have proposed for wider discussion, that four CHPs will be designated as managing CHPs for specialist community children's services. This means they will have within their children's services management arrangements, an additional NHS specialist services manager post and clinical leads to manage the specialist children's community services which are too small to be managed in every CHP. We also propose that a single CHP will manage very small services and take a lead role for co-ordinating policy, strategy and professional development across all specialist community children's services. That CHP would include in its structure a clinical director for each of community child health and child and adolescent mental health.

4.25 Each CHP will have a part-time Clinical Director who is a GP.

4.26 For primary care support we will establish a senior management post within one CHP to take responsibility for a range of functions to all CHPs including:

- administer requirements of regulatory and legislative frameworks;
- practice communications and distribution;
- contract specification, data collection and monitoring;
- practice guidelines, development and advice;
- data processing for screening, call and recall systems;
- performance, payment and verification systems;
- facilities support and compliance with standards.

4.27 We have not yet concluded arrangements for the Rutherglen and Cambuslang area and therefore we are not in a position to propose a structure to cover that area.

4.28 Primary Care Division Functions

Finally, the process to finalise the responsibilities for the present Primary Care Division functions has been concluded. Attachment One to this paper sets out the detail of the conclusions of that process. Key points from those outcomes are:

- a number of services will be managed within the Acute Division but provided within community settings. This further emphasises our commitment to move away from internally focused acute services and build strong relationships between primary and secondary care;
- we are proposing lead CHPs for a number of important responsibilities and services which cut across NHS Greater Glasgow. We will develop arrangements to ensure that these additional responsibilities are properly resourced and have the appropriate connections to wider NHS interests;
- for key contractor support functions we need to ensure that the proposed single lead arrangements are properly resourced, durable and work across the CHPs to continue to provide highly effective support to primary care contractors.

E. BOARD HEADQUARTERS

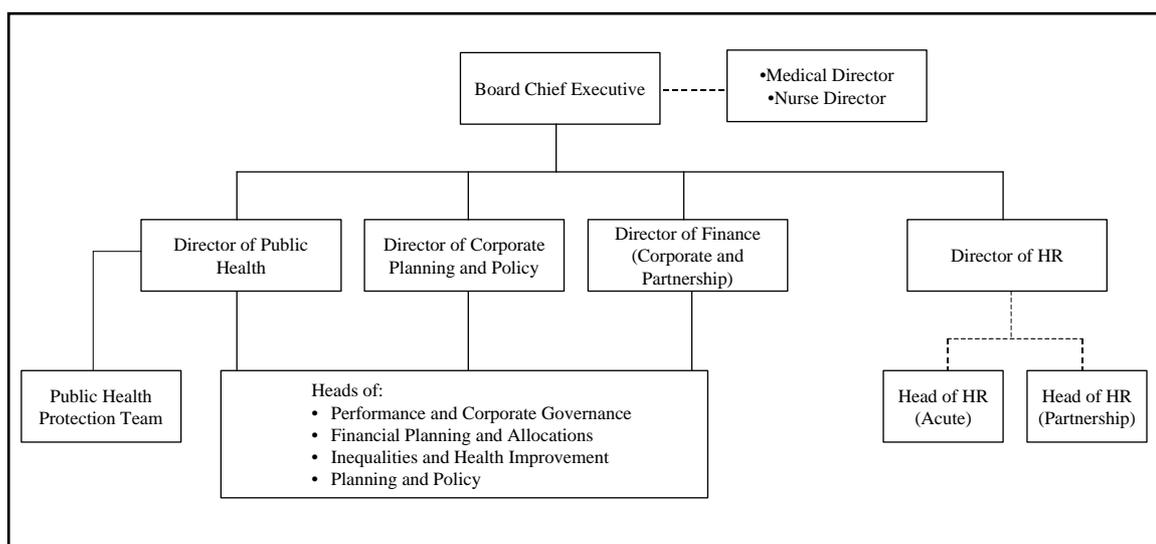
5.1 The proposed structure for Board Headquarters shown in the schematic below reflects the four key responsibilities which need to be discharged. These are:

- leadership of policy and planning;
- strategic leadership for reducing inequalities and improving health;
- resource allocation;
- performance management and corporate governance.

5.2 The need for change from the present arrangements has a number of drivers.

- We are creating CHPs as public health organisations, charged not simply with managing services but also with the responsibility to tackle inequalities and improve the health of their population. CHPs will be substantive partnerships with Local Authorities, fully integrated into community planning structures and embedded within local communities.
- We will have a number of other new NHS management arrangements, for example, for older people and mental health. We have the opportunity to design these elements of our organisation to drive health improvement and tackle inequalities as well as manage service delivery. This will enable us to ensure that decisions about priorities, service organisation and development are driven by a population and public health perspective and that prevention and early intervention have a central place in more parts of the NHS system.
- It is clear that NHS Boards should mainly concentrate on strategic leadership and performance management, devolving decision making as far as possible.
- All of this means that a number of the responsibilities which have been discharged by the Primary Care Division and our Directorates of Planning, Health Promotion and Public Health will be vested in other parts of the NHS organisation and that requires structural change.

- There is a gathering momentum to our work with Local Authorities which requires us to move from joint and coordinated approaches to greater synchronisation of our activity. This is an issue for service delivery, planning and health improvement and social justice activities.
- We need to do much more to extend the importance of improving health and tackling inequalities right across the work of the NHS in Greater Glasgow. While we can point to many successful activities and partnerships which have contributed to this agenda there is no doubt that we can do more, and that reflecting these imperatives in the organisational changes will give us the opportunity to achieve better results for our population.



- 5.3 The challenge in responding to these drivers is to create systems for planning, policy and health improvement which ensure the Board sets, delivers and accounts for clear priorities across its responsibility but action and responsibility is embedded in CHPs, the Acute Division and Mental Health Partnership.
- 5.4 Through the arrangements outlined above we will create integrated teams working on our major responsibilities rather than separate Directorates. The teams covering performance and corporate governance, financial planning and allocation, planning and policy and health improvement and inequalities are only one part of the NHS system which carries these responsibilities. These small teams will relate to and work with other parts of the NHS to coordinate and pull together these strands of activity to ensure the Board's corporate responsibilities, including a comprehensive Local Health Plan, action on inequalities and ensuring policy is implemented, are delivered. The detailed structural arrangements and what the changes will mean for planning, public health and health promotion staff are currently being finalised. There will clearly be significant change for senior managers but for most other staff any change will be around management arrangements and organisational home. The staff presently working in these three Directorates will have skills and experience which will be central in all parts of our new organisation.
- 5.5 The Board's Human Resources Director will work with HR professionals and managers across the NHS and our Partnerships to develop and implement consistent frameworks for staff, workforce and related issues. The senior HR post shown above for Partnerships will be line managed by the Boards HR Director while the acute post will be line managed by the Acute Division's Chief Operating Officer. More details on these arrangements are included in section I of this paper.

- 5.6 Communications and Board Administration, which are core parts of the HQ structure, will report through a nominated Director.
- 5.7 In order for the Board Chief Executive to discharge his responsibilities in a highly devolved structure we intend to create systematic and sophisticated management processes to bring together the top teams from across the organisation. These processes will also ensure that the service delivery leaders are able to contribute to policy and strategy. Similarly, we would expect functional HQ Directors, including the Board Nurse and Medical Directors to formalise ways of working, collegiately with their counterparts from the operational organisations.
- 5.8 The principal relationship between Board HQ and the service delivery organisation will be through the planning and policy process outlined in the next section of this paper. The Board Chief Executive will set objectives for and manage the personal performance and development of his direct reports at HQ and in the service delivery organisations. Apart from the arrangements for a single HR post outlined above, there will be no other line management arrangements between HQ and operational Directors, but the systems of performance management and corporate reporting outlined later in this paper will operate on behalf of the Chief Executive across NHSGG.

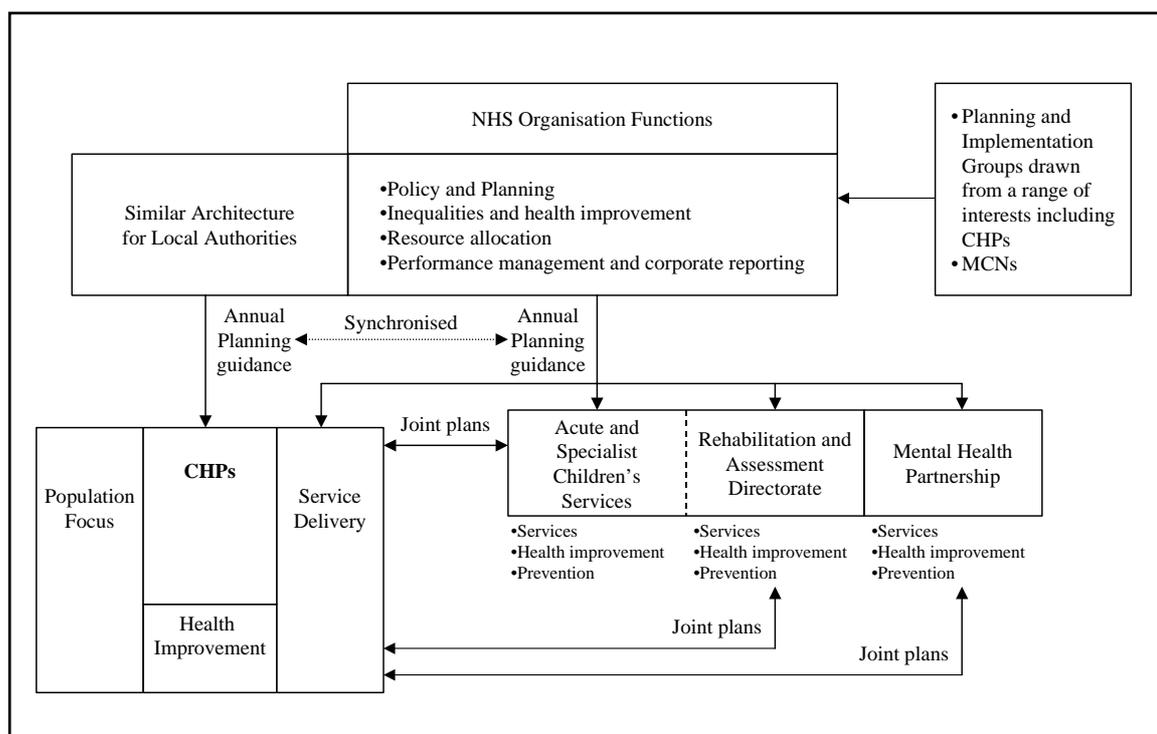
F. PLANNING

- 6.1 Our proposed reorganisation devolves the responsibility to plan for services and health improvement to each component part of our organisation. The Acute Division, the Mental Health Partnership and the Community Health Partnerships will all have responsibilities for planning. To hold together such a disseminated system, and ensure the Board meets its obligations, a more sophisticated planning system is required. This section briefly outlines how that system will operate. At headline level, the key components are outlined below:
- 6.2 Formal NHS wide planning guidance issued annually but with a three year overview:
- that guidance to be developed by the network of planning staff, throughout the organisation, co-ordinated from Board HQ;
 - the guidance setting out clear priorities and resource assumptions within which each part of the organisation will be required to produce its own annual plan;
 - those annual plans will describe their contribution to the GGNHSB wide policies and priorities, their local issues and priorities and a detailed financial plan;
 - for CHPs the planning guidance will be co-ordinated with each Local Authority. CHPs, the Acute Division and Mental Health Partnership will be expected to produce joint plans which will cover shared responsibilities. These will include rehabilitation and enablement, chronic disease management, diagnostic support, unscheduled care and other identified priorities.
- 6.3 To ensure a consistent and joined approach to particular patients, diseases, health challenges and priorities for NHS Greater Glasgow we will establish a coherent and coordinated network of planning groups across the range of our responsibilities. To establish this network, we will review the totality of our present planning groups as we establish our new organisational arrangements. The revised planning groups will be populated from across NHSGG and their leadership and coordination will be embedded within the roles and responsibilities of senior posts from the appropriate part of the NHS structure. For example, we would expect the Director of the Rehabilitation and Assessment within the Acute Division to lead planning for older people and physical disability bringing together colleagues from CHPs.
- 6.4 In terms of corporate responsibilities, this planning infrastructure will be co-ordinated by Board HQ but leadership roles, clinical input and planning support will come from a range of parts of

the organisation. For example, the Acute Division will lead on chronic disease planning but working with CHP planning teams. For children’s services, CHPs will have a lead role but will need to work with the Acute Division.

- 6.5 Importantly, we will ensure through the planning guidance that CHPs strike the balance between local flexibility and priorities and the need to participate in NHS Greater Glasgow wide planning arrangements. For particular specialist areas CHPs may take lead responsibility for planning – linked to arrangements to host particular services.
- 6.6 The resources presently embedded within Board Headquarters and the Primary Care Division will be deployed into each part of the organisation to provide planning capacity and expertise.

The points outlined above can be represented diagrammatically:



The structures set out in the earlier sections of this paper reflect the proposed planning system with planning capacity visible throughout NHS Greater Glasgow.

G. PERFORMANCE MANAGEMENT

- 7.1 Effective performance management will be the key to ensuring that the NHS Board can have confidence we are meeting our responsibilities and can account to the Scottish Executive and the people of Greater Glasgow. The development of a new approach to performance management to underpin our reorganisation needs to reflect important changes to the context in which we work.
- 7.2 Dealing first with the national context. There is an increasing expectation that the NHS should be subject to more systematic examination and accountability. This is a strong theme of the “Partnership for Care” White Paper and it is clear from recent Ministerial interventions that there will be a greater degree of focus on the demand for evidence that the NHS is improving against a backcloth of increased expenditure. This will mean much greater focus on tangible outcomes.

7.3 In addition to this perceived change of emphasis it is clear that:

- the SEHD intend to set explicit performance requirements across a wider range of NHS responsibilities, most particularly in relation to tackling inequalities where the following indicators are likely to feature in the new planning guidance:
 - reducing teenage pregnancy;
 - reducing coronary heart disease and cancer mortality;
 - reducing smoking in pregnancy;
 - reducing suicides;
 - reducing adult smoking;
- an increasing focus on national inspection regimes - NHSQIS is already in play, joint inspection of children's services is being piloted and a new social work inspectorate is in implementation.

7.4 In terms of local context, in addition to the need to respond to the national position outlined above the local context as we move to full implementation of Partnership for Care has a number of important elements which need to inform our approach to developing a performance framework for the future. These elements include:

- the abolition of NHS Trusts with their status as separate legal entities and related statutory duties;
- our aim to establish single system working with a high degree of devolution and without excessive centralisation but which has clear lines of accountability and a systematic reporting to enable a small HQ focused on the strategic leadership of four core activities:
 - tackling health inequalities and health improvement;
 - policy and planning;
 - resource allocation;
 - performance management and corporate governance;
- the creation of operational arrangements characterised by the need for joint working, collaboration and partnership between different parts of the NHS system;
- formal partnership arrangements with Local Authorities characterised by more significant delegation to shared organisational arrangements;
- our objective is to embed responsibility for improving health and tackling inequalities throughout the operation of the NHS and coupled with a much stronger corporate focus on these areas of activity.

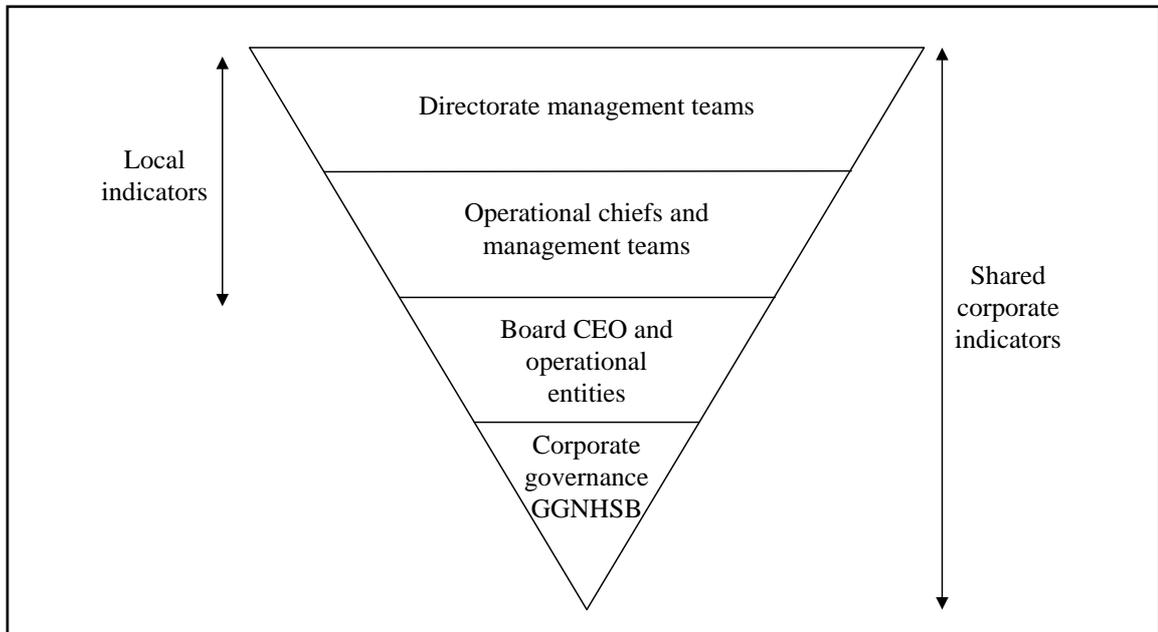
This context requires us to design a performance framework which is a significant step up from the present arrangements and we have established a number of principles which will inform that detailed work. These are:

7.5 Our performance framework and management should:

- ensure that NHSGG is delivering on local and national priorities and is able to demonstrate that is the case;
- ensure that we are focused on improving services and health outcomes and are able to demonstrate those improvements;
- be embedded at all levels of NHSGG not just HQ;
- inform forward planning and prioritisation by creating a feedback loop from present activities;
- enable the NHS Board to discharge its governance responsibilities for the full range of NHS activities;
- foster a culture where there is creative tension and challenge to the status quo within an agreed framework;

- performance reporting and management arrangements should not be seen as hierarchical or controlling. We need to foster commitment throughout the NHS system to a systematic and coherent approach to the way we work which enables us to evaluate our effectiveness and improve effectiveness at every level.

7.6 These proposed principles are diagrammatically represented as below:



Each tier needs clearly defined indicators and performance management routines - the suggestion is that - given we intend to create significant planning capacity level in the operational organisations that functionality has responsibility for coordinating the derivation of corporate indicators in partnership with the HQ team developing local indicators with the operational teams, and ensuring coordinated reporting cycles.

7.7 In considering performance measures we would develop indicators under three key headings:

- Service delivery:
 - user focused;
 - efficiency and effectiveness;
 - safe.
- Health gain:
 - inequalities and social justice;
 - improvement.
- Finance:
 - performance to budget;
 - resource utilisation.

The process of developing and annually reviewing the planning guidance set out in Section F of this paper would include explicit requirements for performance measures.

7.8 A fundamental purpose of these arrangements is to ensure that while promoting a highly devolved structure we can systematically ensure we are delivering on our obligations and where that is not the case identify and implement corrective action.

7.9 These outline proposals are reflected in the described organisational structures and will be included in the job descriptions as indicated. It is particularly important to be clear about the role of the HQ performance management function. That function will:

- pull together the key indicators emerging from the planning and policy processes and take an overview of their comprehensiveness in terms of national and local requirements;
- ensure that information is available and collated to report on the indicators and each indicator has a clear reporting timeline;
- deliver reports for performance management routines including the NHS Board and its subcommittees and the annual reviews with SEHD;
- ensure that exception reporting is robust to highlight to the Board Chief Executive on significant variances;
- relate to the SEHD in terms of annual accountability review preparation, PAF and other national reporting;

Performance management will be a function at a number of different points in the NHS organisation.

H. HEALTH IMPROVEMENT

8.1 A primary objective of Partnership for Care was to give greater priority to improving health and narrowing the inequalities gap - objectives which have always been at the heart of the work of the NHS in Greater Glasgow. In these proposals for restructuring we are embedding responsibilities and resources for health improvement at all levels of the organisation:

- establishing a new health improvement subcommittee of the NHS Board;
- creating CHPs as public health organisations with the responsibility to tackle inequalities and improve the health of their population as well as managing services;
- developing every part of our organisation including the Acute Division and Mental Health Partnership to have the responsibility and skills to drive health improvement in their area;
- responding to our review of progress on implementing policies to tackle inequalities by establishing a Board HQ function and creating capacity and expertise in each part of the organisation to improve our performance.

8.2 Our aim is to embed widely a public health approach with four characteristics right across the organisation. These are:

- a focus on improving the health of populations, with high priority given to promoting good health and preventing disease, illness and injury;
- a wide view of health - encompassing mental and social aspects as well as physical - and positive (well-being and fitness) dimensions as well as ill-health;
- a wide view of what affects health - including life circumstances as well as lifestyles;
- an emphasis on team working and partnerships - across professional groups, between agencies and with communities and the public at large.

Proposals for the reorganisation of public health and health promotion to support this approach are being finalised. We are also keen to establish a shared health improvement function with Glasgow City Council to provide drive and support across the five Glasgow City CHPs.

I. COMMUNICATIONS, CORPORATE SUPPORT, FINANCE AND HUMAN RESOURCES

- 9.1 The Communications Teams from each of the Divisions across NHS Greater Glasgow have already been brought together into a single critical team under the Board's Director of Communications. This includes responsibility for "Involving People" and for Ministerial and Parliamentary correspondence as well as for media relations and staff communication. No further change is proposed.
- 9.2 A small group has reviewed corporate support functions to consider how our present Divisional arrangements can migrate into the new organisational structure. Considering the work of that group we have concluded that the responsibility for the leadership and coordination of the group of functions set out below should be discharged within the Board HQ structure. These functions all have close interaction with the Directors of the Board and related governance arrangements, including the clinical governance role of the Board's Medical Director and are all issues which relate to the Board's status as the single legal entity for the NHS in Greater Glasgow.
- Administration and secretariat for Board and Subcommittees;
 - corporate governance;
 - appointments processes;
 - Board wide consultations;
 - Ethics Committee administration;
 - complaints policy system management and reporting;
 - Freedom of Information request administration;
 - legal claims.
- 9.3 For the purposes of this first phase reorganisation it is proposed that the Board retains a Head of Board Administration leading the function with the responsibilities outlined above. Thereafter, we will be establishing a network of responsibility across the organisation for the elements of these functions which should be discharged outwith HQ. CHPs, the Mental Health Partnership and the Acute Operating Division will require corporate support to discharge their particular responsibilities and it is proposed that this functionality and related structures are designed for inclusion within the second phase of the reorganisation. This will include the migration of primary care support functions into a single lead CHP including a senior management post to oversee those arrangements which is included in this first phase.
- 9.4 For Finance, we have already defined and established integrated financial accounting across NHSGG. Senior finance posts are shown in each part of the structure and will be finalised for the second phase of this reorganisation. For this first phase we propose two Finance Director posts. One Director of Finance (Corporate and Partnership) accountable to the Board's Chief Executive, will be responsible for the Board's strategic responsibilities including financial planning, resource allocation, financial governance and corporate financial reporting. The post would also have the lead financial role for NHS aspects of the Community Health and Mental Health Partnerships. The second post, Director of Finance (Acute Services) would report to the Chief Operating Officer of the Acute Division but also work closely with the Director of Acute Strategy. The responsibilities of that post would include developing costing methodology, cross boundary flow income, financial support to the capital plan, revenue planning, budget setting, financial management and reporting for acute services and the financial framework for the ASR. Both posts would participate in performance management for their areas of responsibility. The postholders will work in partnership and divide responsibilities for financial governance and operational financial services.
- 9.5 For Human Resources, we propose two senior HR posts, one covering acute services and reporting to the Chief Operating Officer of the Acute Division and one reporting to the HR

Director covering the NHS responsibilities in relation to all Partnerships. The acute post will also act as the HR lead for one of the Acute Divisions Directorates, which will all have senior HR leadership reporting into the Director. The rationale for the reporting line to an HQ Director for the Partnership post is the need to ensure consistency and coordination across our integrated structures and the potential of 8 or 9 partnerships do not enable alternative reporting structures. In addition, it remains our expectation that we will agree with Local Authorities specific, joint HR support to Partnerships and the Board's HR Director needs to exercise a strategic lead in relation to the complexities of evolving Partnerships.

- 9.6 The second phase reorganisation will include further detailed structures for human resources, including shared service arrangements for recruitment and other functions.

J. CLINICAL LEADERSHIP AND GOVERNANCE

- 10.1 We recognise the importance of clinical leadership if we are to achieve the ambitions which are the purpose of this reorganisation. We also recognise the concerns there have been that the abolition of Trusts and their successor Divisions, with the loss of a number of functional Directors, will dilute professional leadership. Throughout this paper we have outlined our proposals to ensure effective clinical leadership at a number of levels with strengthened arrangements to enable professional staff to contribute to the leadership of the NHS in each part of our new organisation. These strengthened arrangements include:
- senior medical roles across the Acute Division properly resourced and with protected time;
 - professional nursing leadership in every Acute Division clinical directorate;
 - the establishment of comprehensive Professional Executive Committees within CHPs;
 - resourced, professional leadership roles, including for general practice, within every CHP.
- 10.2 In addition, the assessment centre process, outlined later in this paper, will ensure that staff presently with functional, professional and specialist roles will be able to be considered for a wide range of posts in this new structure. We anticipate such staff will fill a number of the proposed senior management posts.
- 10.3 There is further work to do to set out our proposals about professional leadership roles in the rest of the organisation. The proposals we develop in the next few weeks will be shared as discussed to ensure we arrive at the right arrangements.
- 10.4 Clinical governance must be at the heart of decision making across NHSGG. A review of how this can be effectively achieved in our new organisation has been undertaken by Nursing and Medical Directors. Their detailed papers will form the basis of the comprehensive design of clinical governance across NHSGG but this section summarises our approach.
- 10.5 The Board Chief Executive has the ultimate responsibility for clinical governance but needs to establish robust, but devolved arrangements, to discharge that responsibility. We propose that the Directors managing clinical services will have responsibility for clinical governance, as at present. They will be required to establish and maintain effective arrangements for clinical governance. Each Director will be required to have a clinical lead for governance, appropriate multidisciplinary fora to review and develop governance arrangements and to produce an annual report.
- 10.6 We recognise that these arrangements will require support and coordination across NHSGG and we propose:

- a clinical governance support function;
- a comprehensive structure of clinical governance groups.

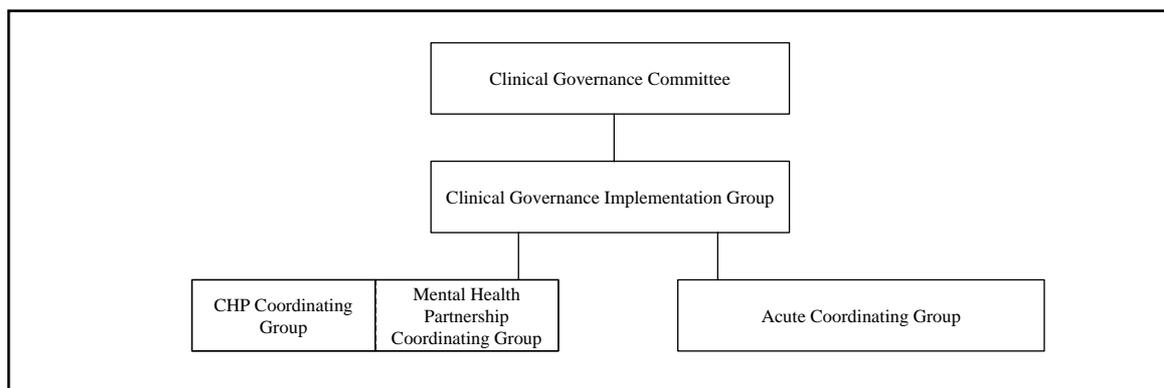
10.7 The clinical governance support function would bring together staff working in the following functions:

- risk management and critical incident review;
- clinical under performance;
- clinical audit;
- clinical governance;
- clinical effectiveness.

10.8 The unit would have a senior Head reporting directly to the Board’s Medical Director but also working with a clinical governance implementation group to ensure that the unit’s priorities and work programmes reflect the requirements of all parts of the NHS system. It is likely that the unit will have three teams - covering CHPs and the Mental Health Partnership, the Acute Division and pan Glasgow functions.

10.9 This will achieve the balance between the benefits of a single function, pooling skills and experience but enabling there to be strong relationships with organisational staff and a sense of ownership.

10.10 Under the Board’s Clinical Governance Committee we would establish the structures shown below:



The Clinical Governance Implementation Group would be chaired by the Board’s Medical Director and include the Head of the Clinical Governance Support Unit and Chairs of the three clinical governance groups. In addition it would involve other professional leads and the Board’s Nursing Director.

10.11 These headline arrangements, and the detailed work which underpins them, ensure a clear track of accountability, from Board level; appropriate managerial responsibilities and clinical leadership; and ensure efficient and coherent support across the system.

K. FILLING THE TOP LEVEL STRUCTURE

THIS SECTION IS SUBJECT TO PARTNERSHIP AGREEMENT AND AGREEMENT WITH LOCAL AUTHORITIES

- 11.1 This a major management restructuring and is also intended to be a transformation of the way the NHS in Greater Glasgow operates – as outlined in the first section of this paper. Our proposed arrangements to fill the top level structure need to reflect that as well as ensuring that there is a fair and transparent process in which our senior staff have opportunities to be considered for a range of posts appropriate to their grade, experience and skills. In addition, a process is required which can be joint with Local Authorities and where necessary with Argyll and Clyde NHS Board.
- 11.2 We have already established the following principles:
- the national organisational change policy and local policy on managing workforce change will apply;
 - these are based on the principle of “no detriment”, and no compulsory redundancy;
 - communication will take place with those directly affected as soon as possible when details of the organisational structure become clear;
 - the process for filling posts will be agreed with Trade Union representatives.
- 11.3 We therefore propose to develop detailed job descriptions and competency frameworks for the posts set out in the preceding structural schematics. The posts reporting to the Chief Executive require to be graded by the Central Evaluation Committee. Other posts in the new structure will be subject to local evaluation. Draft job descriptions for the posts reporting to the Chief Executive have been prepared and work is underway to prepare draft job descriptions for the other posts set out in the structure. The job descriptions for the Director posts in CHPs are being discussed with the Local Authorities and Argyll and Clyde NHS Board in relation to West Dunbartonshire and East Renfrewshire.
- 11.4 Thereafter we will identify the pool of staff in Greater Glasgow NHS and Local Authorities who are displaced by our reorganisation and are presently in posts operating at similar levels to those outlined in the earlier section of this paper. Those staff will be invited to participate in an assessment centre which will be externally designed and facilitated with the aim of providing detailed information on individuals’ skills and competencies to enable their matching to a particular post. For a small number of posts there may be a requirement for a further interview process to finalise an offer. In advance of the assessment centre each candidate will have an opportunity to express their preferences through an individual discussion. The assessment centre will include Associate Medical Director and Clinical Director posts.
- 11.5 When we have appointed to the top level posts, a similar process will apply to posts in structures throughout the rest of the organisation and those who are displaced from the next tiers of our current organisation. Our aim is to publish for discussion - in a similar way to this paper, those second phase structures by the end of May, although structures will only be finalised after the top level posts are filled.
- 11.6 In a reorganisation and transformation, the proposed assessment centre process has a number of strengths particularly given the number and range of posts and the number of individuals within the pool of staff affected:

- avoids multiple interviews which are time consuming for senior staff and difficult for candidates;
- enables those who have been appointed to the first wave of posts to participate in the matching for the second phase but with consistent information available on candidates for all posts;
- enables functional directors in areas where there are substantial reductions in posts to be considered for a wider range of posts at senior level;
- offers staff who have not been successful in the first process the opportunity to be considered for posts in the second phase with the potential to avoid further process;
- enables a single consistent and fair process which engages a number of Local Authorities;
- accommodates the fact that there will be staff displaced from functional posts in the first phase based on grade who can be offered opportunities in advance of detailed functional structures being concluded for phase two.

11.7 Beyond the principles outlined in this section, detailed proposals on how these arrangements will operate will be finalised during April in parallel to the conclusion of staff dialogue on this paper.

11.8 An indicative timetable is shown below:

Mid April	<ul style="list-style-type: none"> • Top level structure published for formal dialogue with staff
During April	<ul style="list-style-type: none"> • Develop job descriptions and get graded • Develop in Partnership detail of first phase displacement and assessment processes
Mid May	<ul style="list-style-type: none"> • Issue notices to first level of displaced staff including arrangements to fill top level posts
End May	<ul style="list-style-type: none"> • Finalise second level structures for formal dialogue with staff
Early June	<ul style="list-style-type: none"> • Develop in partnership detail of second phase displacement and assessment process • Assessment centre for top level posts
Mid June	<ul style="list-style-type: none"> • Appointments to top level structure concluded • External adverts for any posts not filled
End June	<ul style="list-style-type: none"> • Assessment centre for second phase.

L. MANAGING THE TRANSITION

- 12.1 This paper has set out how we will begin to move into our new organisational arrangements. The whole transition process will require careful co-ordination and management. We have given the commitment that the present organisation and governance structures will remain in place until we are confident that robust migration arrangements for services are in place. Following appointment to the top level structure, the Board Chief Executive will form and chair an Organisational Transition Group, with full time project support – establishing explicit senior leads for each element of the transition and ensuring the overall migration process is properly organised and managed.
- 12.2 This paper signals the move into our new organisation but change will proceed throughout 2005/06.

PROPOSED DISTRIBUTION OF PCD FUNCTIONS

PCD Services	Proposal or Process
GMS Challenging Behaviour Practice	Single CHP
Carers Development	Single CHP
Dietetics	Five CHPs
Continence Advisor	Rehabilitation Directorate, Acute
District Nursing OOHs	Four CHPs
Community Nursing Locum Service	Three CHPs
Asylum Seekers and Refugee Service	Five CHPs
Oral Health Action Teams	All CHPs
GMS Contract Monitoring and CDM	All CHPs with single central support structure in one CHP
Physical Disability Teams	Rehabilitation Directorate, Acute
AHP Care Homes Training Team	Rehabilitation Directorate, Acute
PMS Nursing Homes Care Team	Rehabilitation Directorate, Acute
Enhanced Home Care Project Management	Rehabilitation Directorate, Acute
Brain Injury Community Treatment	Rehabilitation Directorate, Acute
Allied Health Profession Stroke Team	Rehabilitation Directorate, Acute
Home Falls Prevention Team	Rehabilitation Directorate, Acute
GGILES Joint Store Central Support	Rehabilitation Directorate, Acute
GEMS NHS	Medical Directorate, Acute
Lymphoedema	Cancer Services, Acute
Palliative Care	Rehabilitation Directorate
Diabetic Retinal Screening	Lead CHP
Heart Failure Liaison Nursing	Medical Directorate, Acute
Breast Screening	Diagnostics Directorate, Acute
IM&T	Single GGNHSB system delivery model
Finance	Single GGNHSB system delivery model
HR - OD, Recruitment, Personnel and Workforce Planning	Single GGNHSB system delivery model
Estates	Single GGNHSB system delivery model
Back Pain Service	Rehabilitation Directorate, Acute
Breastfeeding Initiative	Lead CHP
Sandyford Initiative	Lead CHP
Integrated Eye Service	Surgical Directorate - integrated ophthalmic service
Community Dental Service	Single integrated structure - meeting 4 th March to conclude
Research and Development	Single GGNHSB system delivery model - link to clinical governance
Clinical Governance	Single GGNHSB system
Dental Directorate	Acute Division
Pharmacy Directorate and Medicines Management	Acute Division, Glasgow wide function
Central Contractors Support	Lead CHP
218 Service	Mental Health Partnership
Homelessness including Community Dental	Homelessness Partnership
Risk Management	Single GGNHSB delivery model - link to clinical governance
Pain Management	Rehabilitation Directorate, Acute

PCD Services	Proposal or Process
Glasgow Anti Coagulant Service	Diagnostics Directorate
Glasgow Weight Management Service	Medical Directorate
Community Older People's Teams	CHPs with link to Rehabilitation Directorate
Marie Curie Nursing Service	Single CHP