

Greater Glasgow NHS Board

Board Meeting

Tuesday, 18th March, 2003

Board Paper No. 03/16

Chief Executive, GGNHS

PARTNERSHIP FOR CARE: SCOTLAND'S HEALTH WHITE PAPER

Recommendation: The Board is asked to:

- i) **receive this report on the Health Department's guidance on implementing the Health White Paper, Partnership for Care;**
- ii) **discuss the next steps in taking forward the plans for implementation.**

1. CONTEXT

- 1.1 The Minister for Health and Community Care launched the Health White Paper "Partnership for Care" on 27th February, 2003: copies have already been distributed to the members of the Board. Its main themes comprise: The Challenge of Health Improvement; The Importance of Listening to Patients; The Delivery of Consistent, Safe High Quality Care, supported by national standards and robust inspection arrangements, headed by NHS Quality Improvement Scotland and Audit Scotland; a significant emphasis on clinical reform and on service redesign; the continuing emphasis on partnership working with staff and the need to equip staff with the tools and skills necessary to deliver high quality care: it concluded with arrangements for strengthening unified NHS Board working through a move to single NHS organisations, with clear lines of accountability.
- 1.2 Within the last week, the Chief Executive of NHS Scotland has issued guidance on the steps necessary to implement the White Paper. That guidance is set out in the Health Department letter NHS HDL (2003) 11 entitled: "A Framework for Reform: Devolved Decision Making – Moving Towards Single System Working". That guidance also was issued to members of the Board earlier in the week: this paper, therefore, aims to focus on the key elements within the Chief Executive's guidance and on the processes of implementation which the NHS Board is charged with taking forward.

2. A SUMMARY OF THE OBJECTIVES WITHIN THE GUIDANCE

2.1 The guidance is designed to meet five central objectives:

- To help NHS Boards bring forward proposals no later than April, 2004 to dissolve NHS Trusts as separate legal entities, and for their functions, staff and assets to transfer intact to new Operating Divisions of NHS Boards;
- To set out a duty on NHS Boards to implement decentralised approaches to local decision making that give real influence to frontline staff;
- To ensure that all NHS Chief Executives have appropriate cross-system, regional or national leadership roles;
- To make clear that NHS Boards have an explicit duty to participate in effective and proactive regional and national service planning;
- To provide pragmatic guidance on limited changes in the membership of all NHS Boards.

The ensuing sections of this paper deal with these objectives in more detail.

3. MOVING TO UNITARY NHS ORGANISATIONS

3.1 The proposals set out in the White Paper are the next steps in a direction which was set out in the two previous White Papers, viz "Designed to Care" (1997) and "Our National Health: A Plan for Action, A Plan for Change" (2000). The aim is to consolidate the arrangements based on 15 NHS Boards, with minimal structural change and an increased level of devolution and delegation to frontline staff. The key themes underlying the proposals are corporacy, integration, decentralisation, service redesign and patient focus.

3.2 NHS Boards which operate with NHS Trusts are required to bring forward simple, practical proposals as soon as possible, but no later than April, 2004, to enable the Trusts in these areas to be dissolved, with the Trusts' functions, staff and assets transferring intact to new Operating Divisions of the NHS Board. This evolutionary approach is designed to allow NHS leaders to concentrate on supporting improvements in patient care in order to take forward the key national priorities which are set out within the White Paper.

3.3 Within the new Operating Divisions, real management authority is to be devolved to local level: frontline staff must be empowered and supported to plan and deliver services within a framework of clear strategic direction and rigorous performance management. The guidance makes clear also that the dissolution of Trusts, which can be achieved using existing legislation, will have no substantive impact on the employment of staff, since employers' obligations will transfer directly to the respective NHS Board. The guidance sets out a framework which the proposals for change should reflect: that framework is attached as an annex to this paper.

Key issues: It is possible that Ministers will wish to see the single system working arrangements in place by April, 2004. That timescale would require launch of the public consultation paper in August, 2003 with decisions by the NHS Board by December, 2003.

4 DEVOLUTION OF POWERS: SCHEMES OF DELEGATION FROM NHS BOARDS TO AND WITHIN OPERATING DIVISIONS

- 4.1 The White Paper introduced a new duty on NHS Boards to put in place devolved systems of decision-making. On the dissolution of NHS Trusts, NHS Boards will devolve duties and responsibilities for service delivery to new Operating Divisions. The guidance states that this is to be achieved by converting the current Trust Management Teams into Committees of the NHS Board, to be known as Divisional Management Teams.
- 4.2 As with other Committees of the NHS Board, the schemes of delegation which set out the responsibilities of the Operating Divisions will take the form of Standing Orders. The devolution of powers direct from NHS Boards to Operating Divisions is intended to ensure that Divisional Management Teams are as flexible as the Trust Management Teams which they will replace. These new arrangements are intended to ensure also that NHS Boards preserve their status as strategic Boards of governance and that they are not unnecessarily drawn in to day-to-day management issues.
- 4.3 While the guidance sets out an expected pattern of migration from Trust Management Teams to Operating Divisions, it does leave some flexibility with NHS Boards to determine the organisational structures which are required to deliver local services. Thus, NHS Boards may consider developing arrangements in ways that are different from the suggested model, provided that there is agreement achieved locally on this and that benefits of the different arrangements proposed can be demonstrated. The guidance stresses, however, that it is crucial that an appropriate balance should be maintained between the need to avoid the disruption frequently associated with organisational change and the over-riding aim of securing tangible benefits for patients. Any variant proposals will require the prior approval of the Health Department before they are submitted to Ministers for consideration.

Key issues: The NHS Board needs to determine whether the expected pattern of migration to Divisional Management Teams will deliver the priorities within the White Paper. Formal schemes of delegation need to be prepared both between NHS Boards and Operating Divisions and within Operating Divisions. These are likely to be required to form part of the consultation papers issued.

5 A REPOSITIONING OF NHS SCOTLAND MANAGEMENT

- 5.1 The White Paper aims to bring about a material repositioning of NHS Scotland management to reflect its critical importance in working with Clinicians to enable service change and clinical reform. Working within unified NHS systems, Divisional Chief Executives will have key cross-system leadership roles in the drive to integrate, redesign and develop patient centred services. These leadership roles will include the following:
- pursuing the redesign of services, with patient focused solutions which will enable Clinicians and patients to lead service redesign;
 - supporting the development of Local Health Care Co-operatives (LHCCs) as they evolve into Community Health Partnerships;
 - supporting the further development of Managed Clinical Networks and other Clinical and Care Networks, to ensure that they are resourced to bridge organisational boundaries in the systems across which they operate;

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- playing a full part in discharging the new duty of regional (and national) planning;
- achieving the best-fit possible with other services provided locally, including those provided by Local Authorities and other Partner Agencies.

NHS Boards must ensure that all Chief Executives carry appropriate cross-system, regional or national leadership roles.

5.2 A New Duty of Regional (and National) Planning

Leadership in regional and national service and workforce planning is a vital component of the NHS Scotland reform agenda. With increased specialisation in aspects of Acute Services, allied to the legislation which governs the hours of work of doctors and other professionals, urgent and sustained progress must be made in planning and implementing services which need to be provided for populations greater than those of individual NHS Board areas.

5.3 The guidance stresses also that other Executives with key clinical leadership roles, such as Directors of Public Health, Directors of Nursing and Medical Directors, have particular roles to play in ensuring that coherent regional planning arrangements are taken forward proactively. Similarly, it emphasises the particular role of Directors of Finance in ensuring that the financial planning and resource allocation framework facilitates rather than inhibits regional service planning and implementation.

5.4 Support for Clinical Leadership

A major thrust of the White Paper is the need to promote the involvement of Clinicians in planning and implementing improved services for patients through service redesign. As a key part of this process, all NHS Boards are required to establish a Service Redesign Committee. These Committees should include a broad range of local clinical leaders, together with members drawn from each LHCC or Community Health Partnership in the NHS Board area. Consideration should be given also to involving Lay Members.

5.5 To support clinical redesign at local level, each NHS Board will be required to develop a Change and Innovation Plan. Additional funding will be made available to support the implementation of these Plans: Service Redesign Committees will make a key contribution to their development and delivery. Further guidance on this issue is promised in due course.

Key issues: Chief Executives and other senior members of the Executive Teams are already taking leadership roles across the local NHS system, in respect of the roll out of the acute services plan and other key areas, including Workforce Planning.

Further rigour needs to be built in to the “rules of engagement” on regional planning, to avoid some of the current impediments to progress.

There is an urgent need to put in place the Service Redesign Committee if it is to play a material role in the first Change and Innovation Plan.

6. THE ROLE OF NHS CHIEF EXECUTIVES IN SINGLE SYSTEM WORKING

6.1 The role of NHS Board Chief Executives will be broadly unchanged: the major difference is that, instead of discharging responsibility for implementation through separate statutory bodies, this responsibility will be discharged through Operating Divisions of the NHS Board. Similarly, the role of Divisional Chief Executives will match closely the current role of Trust Chief Executives. Divisional Chief Executives will continue to be accountable for their budget, for the performance of their organisation and for leading the work of the Divisional Management Team. Divisional Chief Executives will work closely with the Chair of the Divisional Management Team, as they currently do with the Chair of the Trust Management Team.

6.2 Two changes flow from the move to single NHS organisations. First, Divisional Chief Executives will not be appointed formally as accountable officers, but they will still have primary accountability for their budgets, and will still be liable to be summonsed to give evidence to the Parliament. Secondly, the Chief Executive of the NHS Board will have overall accountability for the performance management of the whole NHS system, and there will therefore be a direct line of accountability from Divisional Chief Executives to the NHS Board Chief Executive.

6.3 The Circular stresses that these formal changes will not affect the status, authority or autonomy of Divisional Chief Executives. Other members of the former Trust Executive Teams will fulfil the same roles as before but as part of the Divisional Executive Team. They will continue to report to the Divisional Chief Executive.

6.4 Relationships Among NHS Chief Executives

The Health White Paper and the Health Department Guidance highlight the importance of corporate working among Chief Executives. All Chief Executives in the NHS Board area must operate as a strong, unified team, providing leadership in agreed areas across the local NHS system, with specific operational results being delivered by Divisional Chief Executives and their Executive Teams. As part of the steps to ensure that Chief Executives carry the confidence of the wider NHS system, a key part of the assessment of the effectiveness of the Chief Executive Team will be '360°' appraisal of each other against the key behaviours for effective leadership. This is designed to ensure a balanced leadership team that is able to work together effectively in an atmosphere of mutual support.

6.5 The NHS Board Chief Executive will be responsible for performance assessment of Divisional Chief Executives in consultation with the Chair of the Divisional Management Team. The NHS Board Chair and the Remuneration Sub-Committee will be the 'reviewers' in this process. The NHS Board Chair and the Remuneration Committee will be responsible for the appraisal and review of the performance of the NHS Board Chief Executive.

Key issues: The relationship between Chief Executives should further be formalised by the early establishment of a Board level Executive Team.

The Board's Remuneration Committee is already aiming to move substantially for the performance year 2003\04 towards the arrangements set out in the guidance.

7 CHANGES TO MEMBERSHIP OF NHS BOARDS

7.1 The current composition of Greater Glasgow NHS Board comprises twenty-three Directors: fifteen are Non-Executive members; eight are Executive members. The guidance sets out a number of changes which are proposed to the membership of NHS Boards as follows:

- creation of a new Non-Executive position for the Chair of the LHCC Professional Committee;
- creation of the new Executive position of NHS Board Medical Director;
- transfer of Trust Chief Executive positions to Divisional Chief Executive positions;
- replacement of the Trust Chair positions by an equivalent number of Lay Member positions;
- the possibility to create additional Lay Member positions to compensate for the loss of Trustees on Trust Management Teams, with up to two such positions created for each Trust to be dissolved, subject to the prior agreement of the Health Department.

7.2 Appointment of Chairs of LHCC Professional Committees to NHS Boards

The Chair of the LHCC Professional Committee currently sits on the Area Clinical Forum. In turn, the Chair of the Area Clinical Forum is a full member of the NHS Board. It is proposed that the Chair of the LHCC Professional Committee should have automatic membership of the NHS Board. As Board members, Chairs of LHCC Professional Committees will be expected to play a key role in the transition from LHCCs to Local Health Partnerships.

7.3 Appointment of Medical Directors of NHS Boards

A Medical Director will be appointed to a new position on each of the fifteen NHS Boards. The Medical Director will be a local Divisional Medical Director appointed to serve as a full member of the NHS Board. This appointment is intended to complement the role of the NHS Board Nurse Director, first introduced in June, 2002, and to emphasise the importance attached to placing Senior Clinicians at the heart of local decision-making.

7.4 The pool of potential applicants eligible to be appointed as NHS Board Medical Directors is limited to Medical Directors employed at Divisional (currently Trust) level in each NHS Board area. The Chairman of the NHS Board is responsible for taking forward the appointment process set out in the Health Department guidance.

7.5 Replacement of Trust Chair positions

Those NHS Board positions held *ex-officio* by Trust Chairs and which are not separately remunerated will cease automatically upon dissolution of Trusts. In order to maintain Non-Executive capacity in each NHS Board, an equivalent number of new Lay Member positions should be created on each NHS Board concerned: these new Lay positions will be filled by open public competition.

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7.6 Additional Lay Member Positions on NHS Boards

The Health Department and Ministers are prepared to consider applications from NHS Boards for the creation of additional Lay Member positions, where this is considered necessary to compensate for the reduction in overall Non-Executive capacity within each local NHS system following the loss of Trustee positions on dissolution of Trusts. A maximum of two additional Lay Member positions may be created for each Trust that is dissolved. Chairs of NHS Boards should submit proposals for any additional Lay Members to the Chief Executive of NHS Scotland in the first instance: the proposals must be justified in terms of the overall size and balance of the NHS Board.

7.7 Overall Size of NHS Boards

The total number of members of NHS Boards should be sufficient to ensure that Boards can carry out the functions required of them. These functions will include providing an adequate degree of scrutiny over all the component parts of their local NHS system, including membership of Committees. The overall number of members of NHS Boards should reflect a balance between the desire for inclusiveness and the need to ensure that the Board is of a manageable size, consistent with the effective discharge of business.

7.8 The arrangements set out in the guidance create a potential Board member complement in Greater Glasgow of thirty-three.

Key issues: The Chairman will take early action to secure the appointments of the Chair of the LHCC Professional Committee and the Trust Medical Director as NHS Board Directors.

The NHS Board needs to work through the scope and skills of Non-Executive responsibilities to inform debate about the complement of Non-Executives needed to deliver the functions required, consistent with maintaining a Board of a manageable size.

8 DIVISIONAL MANAGEMENT TEAMS

8.1 The current appointments of Trust Chairs and Trustees will cease automatically on dissolution of NHS Trusts. This will apply also to un-remunerated NHS Board positions held *ex-officio* by Trust Chairs. The position of Executive Members of the Trust Management Teams is different, since they are employees of NHS bodies. When Trusts are devolved, the Executive Members will automatically transfer to Divisional Management Teams and will become employees of the NHS Board, in common with all former Trust employees.

8.2 Current Appointments of Trust Chairs and Trustees

The contribution of Trust Chairs and Trustees has been greatly valued and their continued role until the dissolution of Trusts will be essential. Trust Chairs and Trustees whose positions cease on dissolution of NHS Trusts will be welcome to apply as candidates in open competitions for the new Lay Member positions which will be created on the local NHS Board. This will generally also apply to Trust Chairs (or Trustees) already serving a second term of appointment with the Trust, since a successful application to become a member of the NHS Board would constitute a new public appointment.

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8.3 Chair of the Divisional Management Team

The new Divisional Management Team will be Chaired by a Non-Executive Lay Member of the NHS Board. As the Divisional Management Team will, in formal terms, be a Committee of the NHS Board, its Chair will be appointed by the NHS Board rather than directly by Ministers, as currently happens with Trust Chairs.

8.4 The Chair of each Divisional Management Team will be expected to contribute at least two days per week in that role, in addition to the one day per week which is expected of all Lay Members of NHS Boards. In recognition of this, additional remuneration should be paid by the NHS Board to the Lay Member appointed to Chair each of the Divisional Management Teams.

8.5 Divisional Clinical Governance Committees

Trusts' current responsibilities for Clinical Governance will continue to be discharged at Operating Division level. The responsibilities of Trust Clinical Governance Committees will transfer therefore to Divisional Clinical Governance Committees. These Committees will be Committees of the Divisional Management Team and, in consequence, Sub-Committees of the NHS Board. The Divisional Clinical Governance Committees should be Chaired by a Non-Executive Member of the NHS Board. The Chair of the Divisional Management Team should not Chair the Divisional Clinical Governance Committee.

8.6 Other Former Trust Committees

Some former Trust Committees, such as the Audit Committee, will no longer be necessary following the dissolution of Trusts. NHS Boards will, therefore, be expected to review the Committee structures within their Board areas in order to determine how best to discharge the business of the local NHS system. Committees and Sub-Committees of the NHS Board should be populated from across the whole local NHS system, drawing upon the pool of experience and expertise that exists in each area. As before, all members of the NHS Board will be expected to play a full part in the work of Committees across the local NHS system.

Key issues: The exercise to scope the responsibilities of Non-Executive Directors across NHS Greater Glasgow needs to encompass the Non-Executive roles required within Operating Divisions.

In addition there will be new Board level structures, such as the Service Redesign Committee and the proposed Performance and Resources Committee for whose creation the external auditors continue to press.

9 BRIEF SUMMARY OF LEGAL STEPS TO TRUST DISSOLUTION

9.1 Dissolution of Trusts

Scottish Ministers must give prior authorisation for dissolution of each Trust, on receipt of formal application from the Chair of the Trust Management Team. Public consultation must then follow in relation to the dissolution of Trusts and the transfer of staff, property, rights and liabilities under the terms of the appropriate regulations. Consultation will generally be expected to last three months: when consultation is complete, the NHS Board must submit a report to the Minister within one month summarising the results of the consultation process.

9.2 Transfer of Staff, Moveable Property, Rights and Liabilities to NHS Boards

In addition to staff transfers, dissolution of Trusts necessitates the transfer, by order, of all moveable property, rights and liabilities from Trusts to the respective NHS Board. The guidance emphasises that staff transfer orders will have no substantive impact on the employment of staff, since the obligations of the employer will transfer directly to the respective NHS Board. In formal terms, the dissolution of Trusts will follow the principles set out in the National Organisational Change Policy Document.

9.3 Transfer of Heritable Property to Scottish Ministers

Within current legislations, it is not possible for NHS Boards to hold heritable property rather than Scottish Ministers. This means that the transfer of heritable assets must be made from the respective Trusts to Scottish Ministers. The guidance makes it clear, however, that this arrangement will not operate to the disadvantage of NHS Boards or Special Health Boards compared with NHS Trusts. Standard accounting treatment provides for NHS Boards' retention of all of the advantages of economic ownership of the assets in their respective NHS Board areas including, for example, the proceeds of sale of assets.

10 NEXT STEPS

- 10.1 This paper attempts to draw together a summary of the key points within the guidance and offers some early suggestions of key points for action on the part of the NHS Board. To that end, a brief comment has been offered at the end of each section of the guidance to highlight some of the issues which the NHS Board will require to discuss. The discussion at the Board meeting will give the opportunity to begin to plan a more detailed programme of work to take forward the continuing move towards single system working, while maintaining a sharp focus on the need to deliver the key challenges in improving health and delivering high quality care which the Health White Paper sets out.

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NHS Boards – key principles for single-system working

NHS Boards should retain their focus as **boards of governance**, embodying:

- a **corporate, inclusive approach** to collective decision-making,
- based on the principles of **partnership working** and **devolution of powers** to the front line of patient care.

NHS Boards should support **local leadership**, by:

- delegating **financial and management authority** as far as possible; and
- encouraging **locally responsive approaches** to service provision.

As **integral parts** of local NHS systems, well-defined **Operating Divisions** should have:

- **specific, delegated authority** to act within a defined remit without constant reference to the NHS Board;
- this must be backed up by clear, formal **schemes of accountability**;

Proposals should recognise the **complex interaction** between:

- **clinicians and other staff** who work directly with patients; and
- **common services** which support them in that task.

Responsibility and decision-making should be **devolved** to staff who are **directly involved** in delivering healthcare.

The design and development of services should be firmly grounded in the patient's **everyday experience of care** at **locality level**.

NHS Boards should continue to develop **sustainable frameworks** for **patient focus** and **public involvement**.

NHS Boards should build on the achievements of:

- **Local Health Care Co-operatives** as they evolve into **Community Health Partnerships**; and
- the **Joint Future** initiative

in a way which:

- engages with **Community Planning** partners; and
- **maximises population alignment** between LHCCs / Community Health Partnerships and social care.

Health services should be delivered **locally as far as possible**, but always consistent with providing **safe, sustainable** and **efficient** services to patients.

To achieve this, NHS Boards should: **promote, resource** and **actively manage** the development of:

- **Managed Clinical Networks** and other clinical and care networks;
- both **within** and **beyond** their local boundaries.