Greater Glasgow NHS Board

Board Meeting

Tuesday 20th May 2003 **Board Paper No. 2003/33**

DIRECTOR OF PLANNING
AND COMMUNITY CARE
CHIEF EXECUTIVE

WHITE PAPER – PARTNERSHIP FOR CARE

Recommendation: The NHS Board endorse:-

- **the proposed development process for Community Health Partnerships**
- **arrangements to begin to establish a Service Redesign Committee**
- **the proposal to establish a Performance Review and Resources Committee**

1. Purpose

1.1 The NHS White paper – Partnership for Care sets out a series of imperatives for the NHS in Scotland including:-

- supporting and empowering frontline staff and patients as change leaders.
- service integration with redesign and quality as key drivers.
- a step change in health improvement and closing the inequalities gap.
- strengthening partnership with Local Authorities and communities.
- a wider range of services in community settings.
- involving and listening to patients.
- achieving better outcomes for patients.

A series of organisational changes are proposed in the White Paper to deliver these imperatives and NHS Boards are required to deliver a number of actions including:-

- developing proposals for the transition to Community Health Partnerships (CHP's).
- establishing a Service Redesign Committee

In addition, the White Paper reinforced the need for cross system, unified working and clear arrangements for corporate governance, including performance management.

The purpose of this paper is to set out proposals to move forward these three important strands of implementing Partnership for Care.

Section 2: Community Health Partnerships

Section 3: the Service Redesign Committee

Section 4: the Performance Review and Resource Committee

2. Developing Community Health Partnerships

2.1 Background

The White Paper acknowledges the progress made by Local Health Care Co-ops in developing into responsive and inclusive organisations. It proposes their evolution into Community Health Partnerships, with an enhanced role in service planning and delivery. The proposition is that the Partnerships will:-

- ensure patients and a broad range of healthcare professionals are fully involved in service delivery, design and decisions.
- establish a substantive partnership with Local Authority Services.
- have a greater responsibility and influence in NHS resource deployment.
- play a central role in service redesign.
- act as a focus for integrating local primary and specialist health services.
- play a pivotal role in delivering health improvement.

2.2 National Objectives

NHS Boards are required to review the organisation and operation of their existing LHCC's, by early 2004, with these objectives in mind. Within the same timescale we are required to produce, with Local Authority partners, plans to ensure more effective working with social care in locality arrangements. A further requirement is that linked to the development of Community Health Partnerships NHS Boards are also required to work with Local Authorities to review how service planning and delivery can be better designed to meet community needs including:-

- maximising coterminosity of service provision and organisational boundaries.

- targeting funding at integrated services.
- empowering NHS and Local Authority staff who provide care with clear schemes of delegation.
- extending joint resourcing and management to mental health services from April 2004.

These imperatives are to be reflected in Local Partnership Agreements to include:-

- reduced bureaucracy and duplication.
- modern and integrated community services focused on natural localities.
- integrated community and specialist healthcare through clinical and care networks.
- organisations which support these changes in service delivery.

2.3 Glasgow Context

There are four key strands to our local context as it relates to Community Health Partnerships and the related imperatives for community health and Local Authority services set by the White Paper and Joint Futures policies.

- the level of development of LHCC's.
- relationships between NHS and Local Authorities.
- relationship between primary care and hospital services.
- health improvement.

The rest of this section briefly considers our situation in each of these.

2.4 LHCC Development

Greater Glasgow has 16 Local Health care co-operatives – covering populations ranging from 23,000 to 115,000. Our Co-ops are at different stages of development in terms of the key performance assessment requirements for LHCC's which are:-

- modernising and developing primary care services
- improving access for patients
- improving staffing and ways of working
- working with other agencies and secondary care
- improving infrastructure
- contributing to the Local Health Plan
- developing as organisations

The Primary Care Strategy reflects strong service improvement and change agendas – for chronic diseases, older people and mental health, which have been driven by LHCC's.

The key challenges for LHCC's have included:-

- responding to the challenge of service integration with Local Authorities.
- exercising greater influence on specialist services.
- developing capacity and infrastructure to handle a complex, expanding agenda.
- developing comprehensive approaches to health improvement.
- the population and geographies of current Co-ops.
- playing a more significant role in strategy development.
- achieving real community engagement.

The migration to Community Health Partnerships must build on the strengths of LHCC's but recognise that CHPs could be significantly different entities, with much greater resources, autonomy, responsibilities, and the quid pro quo, accountability, than current LHCC arrangements.

2.5 NHS and Local Authority Relationships

We work with six local authorities, only two of which are coterminous. The key drivers of our work have been:-

- integrating local service delivery.
- creating devolved local planning and delivery structures.
- developing a "joined up" approach to health improvement through Local Health Improvement Plans.
- fully engaging locally based NHS staff through LHCC's, and Local Authority Staff through area based structures.
- engaging local community and voluntary sector interests.

Our current position on these drivers is different with each Local Authority. With Glasgow City we have a number of programmes of service integration in hand – including for older people, addictions and mental health – similarly we have, or are moving to, single planning arrangements for main client groupings. However, locality planning structures, covering the 9 area social work teams and 12 LHCC's, are at an earlier stage of development.

With East Dunbartonshire, we have agreed, in principle, full integration with a single Head of Health and Social Care. With West Dunbartonshire, South Lanarkshire and East Renfrewshire we have different approaches to integration but consistently strong locality planning processes with full LHCC engagement. For Children's services, the integration agenda is generally less well developed.

In addition, we have increasingly formalised partnership arrangements with Local Authorities – characterised by a number of joint NHS/Authority Sub Committees and formal structures within community planning partnerships.

Our approach to developing Community Health Partnerships needs to reflect these different local circumstances, re-energise and reinforce the objects we have been pursuing with Local Authorities – particularly around service integration – the requirements for which are restated by the White Paper and the associated recent guidance "Joint Futures; the Next Steps". Picking up the Children's services agenda should be a critical dimension.

2.6 Primary Care and Hospital Services

This White Paper, and the one which preceded it, emphasise the need for clinical and service networking between community and hospital services. Our situation on this dimension has a number of elements.

- there is a strong programme of chronic disease management driven from primary care, but developed in partnership with Acute hospitals, covering a number of key disease areas.
- for older people, acute hospital clinicians are heavily involved in the service planning process – informing cross system service change.
- clinical fora are in place with each of the acute Trusts and Yorkhill. These have led to a number of clinical service changes but not a fully comprehensive programme of service redesign across specialist and community services.
- For mental health – there is good cross hospital/community working simplified by consistency of clinical staffing in the two settings which is less obviously achievable for acute general hospital clinicians.

In developing Community Health Partnerships we need to take the opportunity to consider again how the relationships between community and specialist care can be constructed to deliver service change driven by a population focus and local priorities. This is critically linked to the service redesign and innovation agenda outlined in more detail in Section 3 of this paper.

2.7 Health Improvement

Greater Glasgow has one of the worst health records and widest health inequalities in the UK. Activity to improve our populations health has always been a major focus of the work of the NHS, increasingly allied with Local Authorities, as they develop their health improvement focus and capacity. In parallel, the appointment of public health practitioners to LHCCs has strengthened their focus on this work and created local resources to tackle health improvement. However, it is arguable that we have not yet achieved within the NHS and Local Authorities the full integration of decision making on service delivery with a drive for health improvement or wide ownership of health improvement responsibility among front line staff.

The White Paper and Scotland's Health Challenge put even greater emphasis on tackling the causes of ill health across a range of settings and most particularly in local communities. In developing Community Health Partnerships – which will be the primary vehicle for the NHS to relate to Local Authorities and communities we need to consider how the heath improvement focus of the Partnerships is maximised and the potential of local responsibility for health improvement and service delivery being integrated into a single structure is realised.

2.8 **Moving to CHP's**

The White Paper is not detailed or prescriptive in it's proposition about Community Health Partnerships. Reflection on our local context should form an important part of the debate about what we want to achieve in moving to CHPs. Set out below are proposals on how we might organise that debate.

These proposals are intended to achieve an approach to the development of Community Health Partnerships in Greater Glasgow characterised by:-

- a highly inclusive process, recognising the wide range of stake holders who should shape the Partnerships and have a role in them.
- a coherent, Board wide policy framework committed to the key aims of the White Paper, including maximum devolution, a strong health improvement focus and moving to substantive partnerships with Local Authorities.
- Evolution of existing LHCC arrangements in a way which maintains primary care commitment and the existing momentum for change and development within Co-ops.
- coherence with other critical policy imperatives including implementing the Joint Futures agenda, rising to the "Health Improvement Challenge" and bridging the divide between primary and secondary care.
- significant dialogue and influence for each Local Authority on the development of CHP's in their area.
- recognising the potential impact on a wide range of staff of these changes and ensuring a partnership approach.

2.9 **Proposed Next Steps**

To achieve these objectives we propose 3 strands of activity:-

- establishment of a Board Wide Steering Group, bringing together the representatives of the main interests to take responsibility for leading the development and implementation of CHP'S. Membership should include LHCC representation from the professional advisory committee, key PCT staff representatives from public health, health promotion and planning at GGNHSB and of acute and Children's services.

- an early event, under the auspices of the Steering Group to bring together a range of frontline staff to contribute their thoughts at the formative stage of developing our approach.

- early engagement with each Local Authority and it's LHCCs to ensure they influence and inform overall development of CHPs and, particularly, the development and implementation of the CHP(s) for their area. This is probably best achieved through existing joint structures.

The proposed Steering group, and work with individual Local Authorities, would need to bridge across to Lanarkshire and Argyll and Clyde Health Boards development and implementation processes for those areas which are covered by more than one NHS Board. CHP's offer a real opportunity to achieve more coherent local services across Board boundaries, coterminous with Local Authorities.

These proposals reflect initial discussions with LHCC interests, Local Authorities and the Primary Care Trust: The objective is that they should enable us to bring forward detailed proposals for the pattern, scope and organisation of Community Health Partnerships by the end of 2003 enabling formal consultation in the early part of 2004. The work of the steering group will need to link into the wider processes to consider future operational arrangements across the Glasgow NHS – a fully developed CHP model could have significant implications for other structures.

It is critically important that during this development phase we maintain the momentum of progress led by LHCC's and in our work by Local Authorities.

3. Service Redesign & Innovation Committee

3.1 Background

The Health White Paper included a very strong, cross cutting focus on service redesign.

There is a clear intention that:

- frontline staff should be leaders of the change process
- service change should be driven from the patient's perspective and grounded in everyday patient experience.

NHS Boards are expected to coordinate redesign activity by putting in place service redesign programmes and developing a Change and Innovation Plan that is specific, prioritised and resourced. Plans must:

- demonstrate active participation by patients and leadership by clinicians.
- challenge traditional boundaries of service delivery.
- develop sustainable services.

- ensure information systems support changing patterns of care.

The SEHD will create and distribute a Change and Innovation fund to NHS Boards where a satisfactory Change and Innovation Plan is in place. There is a specific requirement on NHS Boards to establish a Service Redesign Committee as a focal point for this work. The SEHD proposition is that these Committees link to the Area Clinical Forum and will include members drawn from the new Community Health Partnership. The stated objective is to ensure that there is strong clinical input input to the development and delivery of Change and Innovation plans.

The local arrangements set out above are to be underpinned by national support for service redesign through the work of the newly created Centre for Change and Innovation (CCI). The CCI will provide practical support and expertise to help the NHS in Scotland improve the way in which care is provided for patients.

3.2 Current Position

Within the NHS in Greater Glasgow there are wide ranging and significant programmes of activity which meet many of the aspirations of the White Paper that redesign and modernisation should be at the core of the delivery of healthcare.

Significant examples include:-

- the Primary Care Strategy – putting innovative services into local communities and new resources into primary care.

- clinical planning groups leading service change for heart disease and stroke.

- a radical Information Strategy, well into implementation.

- Modernising Mental Health – shifting the balance of care and implementing new clinical services.

- managed clinical networks for cancer developing programmes of service change.

- integrated and highly accessible sexual health services at the Sandyford Iniative.

- integrated older peoples services with Local Authorities.

3.3 **Proposed Next Steps**

It is proposed that we move to establish a shadow Service Redesign Committee, chaired by a Board non executive and including membership from professional advisory structures and staff partnership arrangements. Given the plethora of redesign, change and innovation already occuring across the NHS in Greater Glasgow, it is proposed that the shadow committee should, in it's initial phase – between now and autumn 2003 – focus on:-

1. considering and signing off our 2003/04 Change and Innovation plan which enables us to draw down our share of the Innovation fund. This plan is required to demonstrate:-

   - active participation by patients and leadership by clinician
   - challenge to traditional service boundaries
   - sustainable services
   - information systems supporting changing patterns of care.

   And to reflect three key priorities:-

   - developing community health services
   - integration and managed clinical networks
   - producing definitive membership proposals to reflect that final role and remit

2. establishing a way of working which ensure the committee itself if not unwieldy and bureaucratic but is visible and accessible to a wide range of staff and patient interests

3. taking stock of existing redesign activity and establsihing where there are significant gaps, barriers and coordination issues.

This approach should enable the Board to sign off final proposals to establish a substantive committee in the Autumn of 2003.

4. Performance Review & Resources Monitoring Group

4.1 <u>Background</u>

The management of the performance of the NHS in delivering the commitments set out in national policy papers and in local health plans is a key responsibility of NHS Boards. The White Paper "Partnership For Care" which was launched by the Minister for Health and Community Care in late February, 2003 sharpened the focus on delivery of consistent, high quality care across NHS Scotland and spelt out an enhanced role for NHS Quality Improvement Scotland and Audit Scotland in monitoring the quality of clinical care and of other supporting services. Early indications from the discussions about the development of the Partnership Agreement and a Programme for Government are that this sharp focus will continue.

4.2 The Performance Assessment Framework and the Accountability Review

There are two principal vehicles by which the Scottish Executive Health Department monitors the performance of NHS Boards. The Health Department uses a detailed Performance Assessment Framework as a means of assessing the performance of NHS Board across seven key domains. Annually, the Health Department produces a set of detailed assessment charts for each NHS Board in late May. Boards are asked to undertake a self-assessment of this assessed performance, dealing by exception with performance "outliers", whether positive or negative. The output from this self-assessment then forms a material part of the agenda for the Annual Accountability Review meeting between the NHS Board and the Health Department's Management Team. Details of the Accountability Review process are included on another item of the agenda for the May Board meeting.

4.3 In its initial discussions about the implications of the White Paper, in a working seminar in late February and in considering the Chief Executive's paper at the March Board meeting, the NHS Board has already given some thought to how the Board can strengthen its performance management arrangements. In order that the Board itself can be assured that NHS Greater Glasgow is well positioned to meet the requirements related to the Performance Assessment Framework, the action plan agreed at the annual Accountability Review meeting and the ongoing monitoring of standards by the key external agencies mentioned above, this paper brings forward, from those earlier discussions, a firmer proposal to establish a Performance Review and Resources Monitoring Group.

4.4 Proposed Remit

It remains the role of the NHS Board itself to define and determine key strategic and policy issues. It is proposed that the Monitoring Group carries delegated responsibility on the NHS Board's behalf for the monitoring of organisational performance and of resource allocation and utilisation. It is recognised that individual domains within the Performance Assessment Framework, such as staff governance and clinical governance, are already covered by extant Committees of the NHS Board. Thus, in addition to ensuring that there is a co-ordinated overview of performance monitoring across all domains of the Performance Assessment Framework, this Group will concentrate in detail on those aspects of overall organisational performance which are not covered by existing Committees of the NHS Board.

4.5 Resources

The Group will have a key responsibility in the following areas:-

- Reviewing and approving the 5-year Financial Strategy as an integral part of the Local Health Planning process

- Approving annual financial allocations and investment plans as part of the update of the Local Health Plan.

- Monitoring in-year financial performance across NHS Greater Glasgow

- Approving, and monitoring thereafter, the annual capital expenditure programme

- Approving other key investment decisions, including decisions affecting the procurement of the acute services plan.

4.6 Organisational Performance

The Group will have a key responsibility in the following areas:

- Leading the setting of local priorities within the context of the Local Health Plan

- Monitoring the NHS Board's performance across the Performance Assessment Framework

- Monitoring the progress on implementing the action plan agreed at the annual Accountability Review meeting

- Monitoring specifically progress against key performance targets, including achievement of national and local waiting time guarantees and targets.

4.7 Potential Membership

The NHS Board Chairman is himself keen to Chair this key Committee. Potential membership of a Committee of up to ten members might include a spread of Non-Executive interests within the NHS Board, including the Employee Director, and a spread similarly of Executive representation from the NHS Board and NHS Trusts.

4.8 Detailed Working Arrangements

It is suggested that the detailed working arrangements are finalised following discussion at the NHS Board meeting. One potential model would see the Committee meet on a two-monthly cycle: however, the frequency of meetings should be determined in the context of the Board's overall review of its future working arrangements in taking forward the "Partnership For Care" White Paper.