

Greater Glasgow NHS Board

**Board Meeting
Tuesday, 21st December, 2004.**

Board Paper No. 04/63

Chief Executive, GGNHSB

**CONSULTATION PAPER:
“IMPLEMENTING PARTNERSHIP FOR CARE – THE NEXT STEPS”**

Recommendation: The Board is asked to:

- i) receive the enclosed consultation paper which sets out the next steps proposed in implementing “Partnership for Care”.
- ii) approve the issue of the paper, following consideration by the Board, to consultees, with comments to be returned by 4th February, 2005.

1. The purpose of this paper

- 1.1 This paper describes the next steps which the Board proposes to take in implementing “Partnership for Care” the health reform White Paper. “Partnership for Care” emphasized the importance of strengthening “single system” working within NHS Scotland following the dissolution of NHS Trusts. It introduced Community Health Partnerships as its major initiative, to be implemented from April, 2005. With that significant change in mind, the NHS Board has adopted for the current year a migration from the 4 previous NHS Trusts to 4 Operating Divisions which carried the same service delivery responsibilities.
- 1.2 During the past year, the Board has considered a number of substantial reports about aspects of the new organisational arrangements which are proposed from April, 2005. These have included three reports on Community Health Partnerships:
 - Community Health Partnerships: Boundary Proposals and Principles (January, 2004);
 - Community Health Partnerships - Outcome of Consultation on Initial Boundary and Service Proposals (April, 2004);
 - Community Health Partnerships - Update (October, 2004).

The Director of Planning and Community Care’s paper “Community Health Partnerships: Progress Report and Model Scheme of Establishment” forms a substantive item on the agenda for the December Board Meeting.

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- 1.3 The Board has consulted already also on the establishment of a Mental Health Partnership as part of its new organisational arrangements. At its meeting in October, 2004, the Board approved the outcome of a year-long process, facilitated by the Sainsbury Centre, which concluded with a period of formal consultation, that a Mental Health Partnership should be created which would carry responsibility for mental health specialist and in-patient services across Greater Glasgow. A summary of the role and responsibilities of the Mental Health Partnership forms section four of this paper.
- 1.4 The main focus of this paper is to consult on the remaining aspects of the proposed organisational changes on which consultation has not yet taken place. In particular, these include a move away from the current Operating Divisions to a new structure proposed for the planning and delivery of Adult Acute, Maternity and Specialist Children's Services.

2. The context of the new organisational arrangements proposed

- 2.1 The health reform White Paper "Partnership for Care" issued in February, 2003 was built on 5 key inter-linked themes. It stressed at the outset the priority which the Executive attached to improving health and to narrowing the inequalities gap: this theme was amplified in a further policy paper "Health Improvement: The Challenge" which was launched in March, 2003. The second key theme within "Partnership for Care", that of listening to patients, put a strong emphasis on patient participation and empowerment. The Board's patient focus/public involvement arrangements have developed substantially in response to this challenge over the past two years.
- 2.2 "Partnership for Care" set out also a number of measures designed to secure higher standards of care. These included a new system of treatment guarantees, of which the most significant was the requirement to ensure that, by December, 2003, no-one would wait more than a maximum of 9 months for in-patient or day case treatment. That guarantee was delivered across NHS Greater Glasgow by the due date and further waiting times capacity plans are now addressing the new 26 week targets set for December, 2005 respectively for out-patient assessment and in-patient or day case treatment. In addition, "Partnership for Care" laid down a stronger role for inspection and for monitoring performance against standards. NHS Quality Improvement Scotland (NHS QIS) was created to bring these responsibilities together into a single organisation.
- 2.3 In order to ensure that patient-centred care sat at the heart of the reforms, the importance of partnership, integration and re-design was reflected in two ways within "Partnership for Care". First, it called for whole system re-design to deliver integrated services, and pointed, as its major innovation, to the creation of Community Health Partnerships: their role and contribution is set out in full in the accompanying paper from the Director of Planning and Community Care.

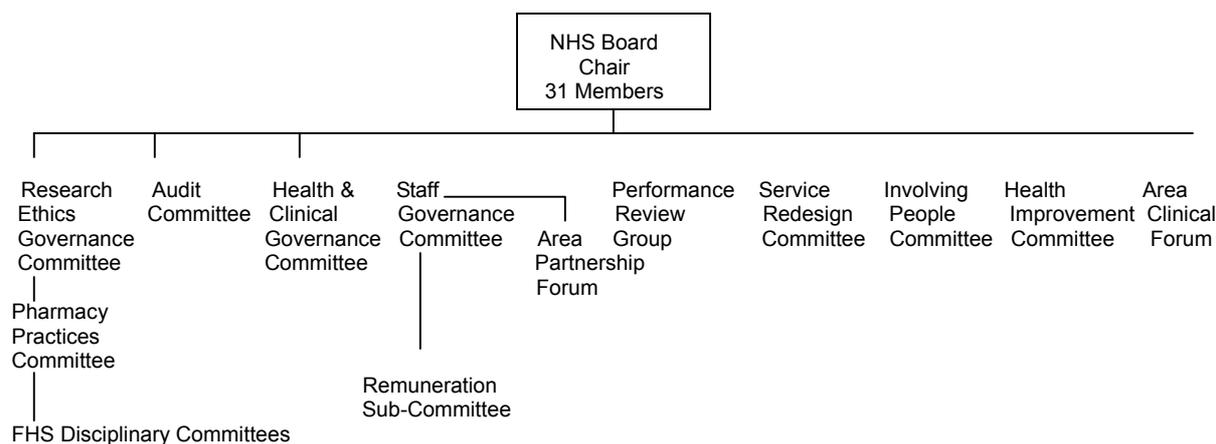
As part of the work in "whole system" development, the Board is committed to strengthen the interface between the Primary and Secondary Care sectors. This is already a key priority within the extant Primary Care Strategy: the organisational arrangements for the creation of CHPs and the proposed Acute Operating Division will specifically address this issue, both in the design of the respective structures, with appropriate cross-representation, and in the development of shared objectives for Senior Managers working within the respective structures.

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- 2.4 In its penultimate chapter, “Partnership for Care” recognised the importance of empowering and equipping staff to deliver the priorities which it set out: in particular, it gave a commitment to support professional development and training. It promised also that more resources would be devoted to workforce planning and development: this commitment is being enacted through the major strands of workforce planning now being developed nationally, regionally and locally.
- 2.5 The final chapter of the paper, “Organising for Reform” enjoined NHS Boards to concentrate on strategic leadership and performance management, and placed a formal duty on Boards to put in place devolved systems of decision making. It also signalled the abolition of NHS Trusts by April, 2004.
- 2.6 This sets the context, therefore for the next steps in moving fully into ‘single-system’ working in Greater Glasgow. In the subsequent sections of this paper, in which the new organisational arrangements are detailed, they will be placed firmly in the context of Partnership for Care and of the key outcomes which each part of the system will be expected to deliver.

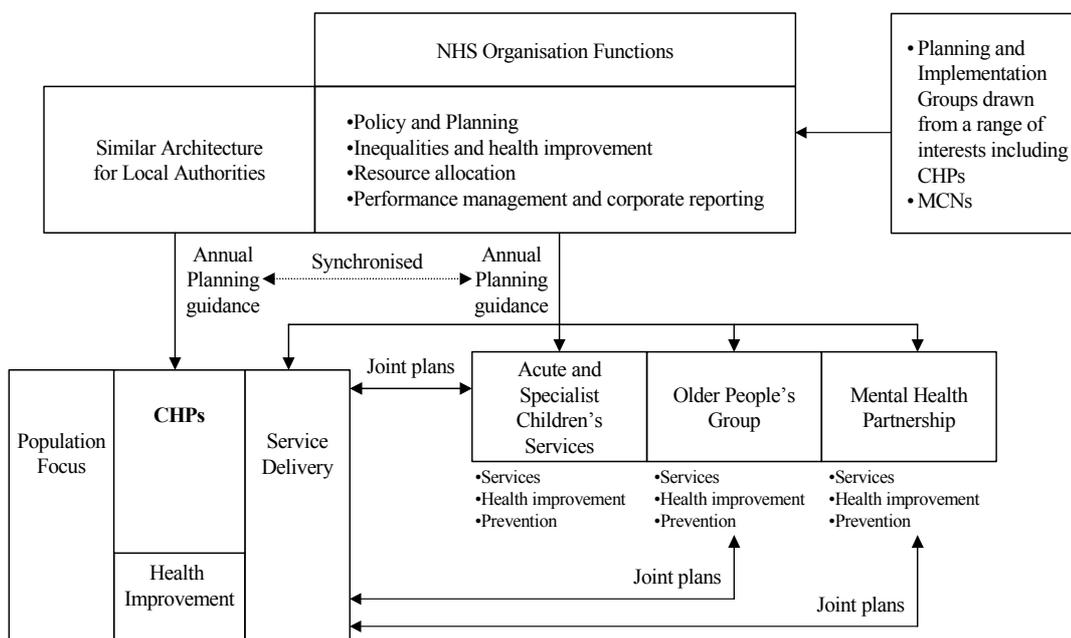
3. Hearing what patients say

- 3.1 The Board’s new organisational arrangements re-affirm its role as a Board of governance. The formal sub-committee structure proposed reflects the 3 key planks of governance stipulated in Partnership for Care – corporate (audit\risk management), health\clinical and staff governance; all 3 elements are now enshrined in law, as indeed is the requirement to ensure appropriate arrangements for patient focus and public involvement.
- 3.2 Board Members have debated, in a series of seminar discussions, the range of governance functions which should be embodied in these new organisational arrangements. In addition to the statutory governance functions described above, the Board has confirmed the importance of the role of the Performance Review Group and has also reflected its statutory responsibility for PFPI by designating that function the status of a Board Sub-Committee.
- 3.3 Beyond these responsibilities, Members of the Board have again reflected, alongside their consideration of the initial paper debated in August, 2003, on the need to ensure that the national priority now being accorded to tackling inequalities in health is reflected in the Board’s revised internal arrangements. To that end, the Board is proposing the establishment of a further sub-committee, responsible for overseeing its role in working with Community Planning partners to deliver the step change in health improvement which the Executive’s policy seeks. The schematic which depicts this whole range of responsibilities is shown below.



- 3.4 Beyond these governance functions, the Board’s Corporate Management Team has worked to define those functions which should be delivered across the ‘single system’. That work identified 4 key functions: a capacity for policy and planning; a coherent approach to tackling inequalities and delivering health improvement; a robust system of resource allocation; and the development of enhanced arrangements for performance management and for corporate reporting.

The schematic below illustrates the key dynamics and inter-actions which are designed to secure delivery both of these corporate functions and of involvement therein of colleagues from other parts of the new structure.



- 3.5 In abolishing NHS Trusts, “Partnership for Care” sought a streamlining of bureaucracy within single-system working. There is an important balance to be struck between concentrating the key planks of governance at NHS Board level and ensuring that there are adequate streamlined processes in place within the new operating units to assure the NHS Board that its clinical governance and risk management processes are adequately embedded there.
- 3.6 The detailed design of those arrangements will be taken forward during this consultation period; the Board’s Medical and Nursing Directors are working with their counterparts across NHS Greater Glasgow on the design of a clinical governance and risk management structure which fits with ‘single-system’ working. The Chair of the Audit Committee will review, with the Board’s Chief Executive, Director of Finance and the External Auditor, how best the Divisional governance structures established during 2004 can be re-defined to meet the objectives of the new organisation.

4. Creating the Mental Health Partnership

- 4.1 At its October, 2004 meeting, the Board approved the outcome of the detailed process, facilitated by the Sainsbury Centre for Mental Health, which devised the arrangements by which the respective responsibilities for local, and more specialist, mental health services should be delivered.

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- 4.2 There were 4 key components of the proposal:
- The first involves the creation of a Partnership Board, including Councillors, NHS Non-Executives and CHP representatives. To deliver that Board's policy, a Director will be appointed to take forward implementation of the approach which the Board has approved. The NHS Board approved in October the appointment of the Director to this effect.
 - The second involves the creation of an Executive Team, led by a Director to ensure a whole system approach to the planning and delivery of services.
 - The third involves the Mental Health Managers in each CHP to be accountable for delivery of all local mental health services but working also as integral part of Partnership Management Team to ensure there is a cohesive mental health system across full range of services.
 - The fourth involves three of the CHP Mental Health Managers carrying wider responsibility for area services, including in-patient beds.
- 4.3 That paper also flagged the need to consider whether the Partnership could be developed to take responsibility for other integrated specialist services including addictions, homelessness and learning disabilities. Proposals on such arrangements will be brought to a future Board meeting.

5. Adult Acute Services, Maternal, Women's and Children's Services

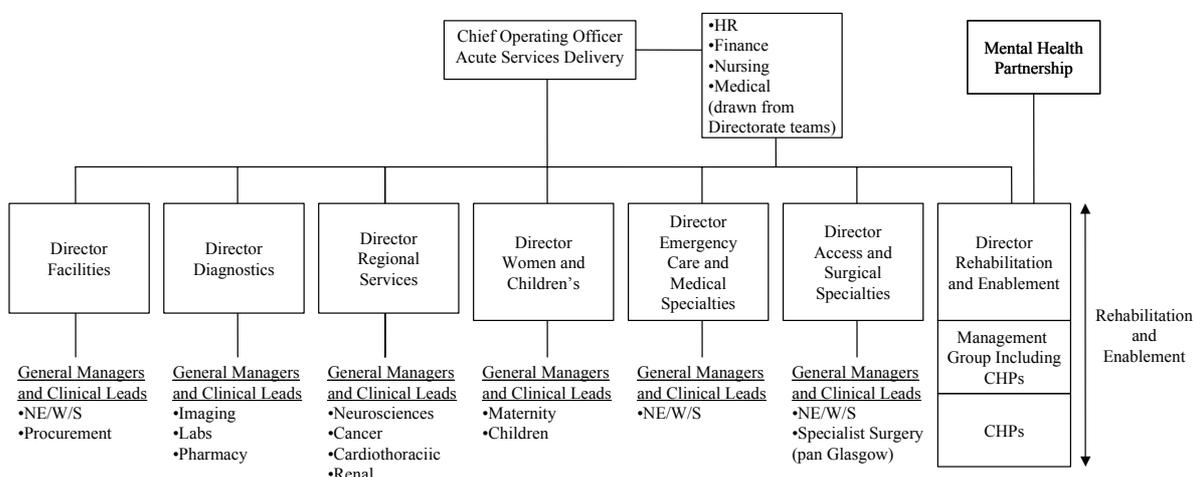
- 5.1 In looking at the options for a future structure for acute hospital services, the Board's Corporate Management Team first assessed the key challenges which this sector will face over the next decade. In implementing the Board's plan for modernising acute care within the city, for the next ten years, 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 to the Board a move to a single acute services structure, but with distinct operating and planning leadership.
- 5.2 In addition to the major challenge which implementation of the acute services plan involves, the Board needs to be satisfied that it 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 within 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: in order to support these processes of improvement, there are opportunities to consolidate a number of clinical support services into single, pan-Glasgow arrangements.
- 5.3 In considering the detail of this operational structure, the Corporate Management Team was concerned that change should not fracture the well established clinical and managerial relationships which have evolved in the North and South Divisions. It wanted also to ensure visible and decisive senior management in hospital sites. The essence of the 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 at least a half-time medical lead and Heads of Nursing and Finance.

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The creation of a single Director 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.

- 5.4 The major directorates of emergency care and access reflect the two most significant service priorities: to deliver high quality, effective and economic emergency care, and to continue to reduce waiting times. These largest clinical directorates are underpinned with sector based General Managers, manifesting the Board’s commitment to deliver “Partnership for Care’s” call to ensure that management responsibilities are devolved within our operating structures. 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.
- 5.5 We are not proposing a series of separate functional Directors but rather that there will be finance, medical, nursing and human resources leadership, working across the whole Division, supporting the Chief Operating Officer. These roles will have defined corporate responsibilities and will be populated from the senior staff within the Directorates. For example, the medical lead for the Access and Surgical Specialties Directorate could also be the Operating Division’s Medical Director, with appropriate additional support. Division-wide responsibilities could include clinical governance or health care acquired infection.
- 5.6 The core proposition is, therefore, that the Directorates manage all of the services and resources for which they are accountable, such that all service delivery staff are managed within each Directorate, and not through external professional hierarchies.

Potential Acute Services Structure



5.7 Acute Planning

In the light of the demands of the Acute Services Review, action has already been taken to create a single Acute Planning Team, bringing together resources from the previously separate Operating Division and NHS Board structures. The Acute Planning Team has four 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; and, within the pan-Glasgow planning framework, to lead the development of the acute services components of the overall NHS Plan related to acute

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services, ensuring that national and local priorities are fully reflected and followed through to detailed implementation plans.

- 5.8 In addition to these core responsibilities, the Acute Planning 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, Coronary Heart Disease and Stroke; and to take the lead on planning for chronic disease.
- 5.9 **Maternal, Women's and Children's Services**
- The proposed, single Acute Operating Division includes a discrete Directorate for Maternal, Women's and Children's Services. That Directorate would bring together the present three separately managed Maternity Services, two separate Gynaecology Services and hospital Children's Services, presently based at Yorkhill. Members of the Corporate Management Team saw a number of advantages of this model which are described below.
- 5.10 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 affect the creation of CHPs, are set out in the related paper from the Director of Planning and Community Care which forms part of the agenda at the Board's December meeting.
- 5.11 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 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.
- 5.12 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.
- 5.13 The proposal is, therefore, that a focused and cohesive Directorate arrangement within the Acute Operating Division can achieve a strong Maternal and Child Health focus. The distinct planning process for Children's Services, linked to the new focus and capacity in CHPs on Child Health, allied to the stronger inequalities policy approach should give the Board confidence that the focus on women and children will be stronger in the totality of the new organisational arrangements.

6. An integrated structure for Older People's Services

- 6.1 This section of the paper summarises a detailed piece of work which currently is in progress on the development of an integrated structure for Older People's Services. The development work has been initiated by the Older People's Service Development Group on an integrated, 'whole system' solution for older people's services. The primary focus and initial discussion was on the development of older people's services within the context of Community Health Partnerships. However, in the Group's early discussions, there was highlighted the need to consider the relationships between an integrated older people's service and arrangements for other community care groups.

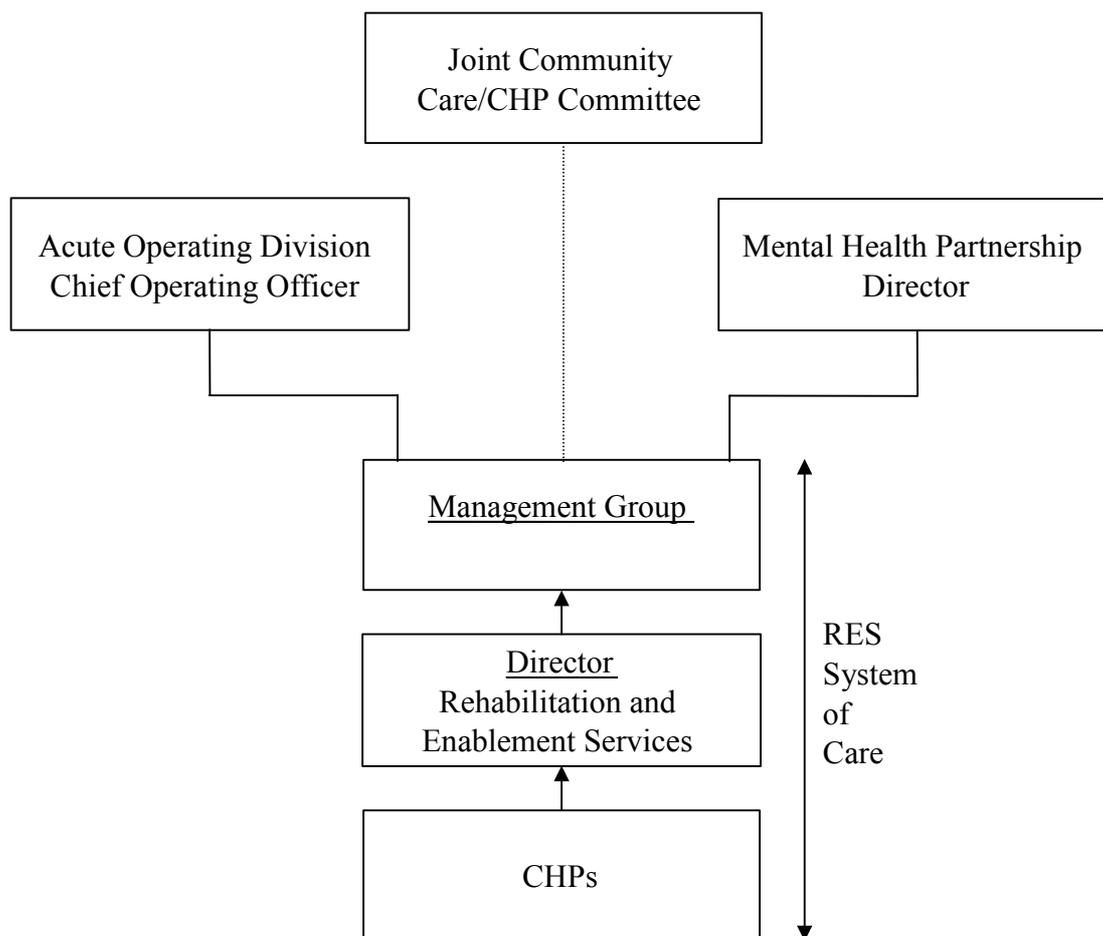
The further development of this thinking has now led to a general acceptance that the Group should consider service integration across three main care group areas of activity: physically frail older people's services; services for older people with a mental illness; and services for adults with a disability.

- 6.2 In developing the initial proposals for a CHP Older People's Service and in the subsequent discussions within the Group, a number of key issues have been identified which are shown below:
- arrangements need to be in place to ensure system wide planning and performance management arrangements;
 - resource decisions that impact on older people's services need to be focused on the needs of older people;
 - we need improved planning and service delivery across primary and secondary care settings;
 - a recognition of the need to bring closer together mental health and frail elderly services;
 - a need to ensure that there is appropriate specialist clinical input within CHP Service.
 - The relationship between generic services and older people's services (and indeed other community care client groups) needs to be developed. How do we ensure that generic services are responsive to the needs of older people.
- 6.3 In developing these proposals, the Group recognised that a rehabilitation service needed to deliver a number of prerequisites:
- a fully integrated service through a step change in the "joint future" agenda across community based health and social care services;
 - improve and integrate the planning and service delivery across primary and secondary care settings;
 - efficient management of patient/client flow across service boundaries;
 - a balanced solution recognising the need for system wide frameworks and locality based priorities and solutions;
 - both managerial and clinical leadership throughout the service framework; and arrangements that reflect the use of generic health and social care services and the 'overlap' with other care group services
- 6.4 The Group's work has now reached a point where it is considering proposals for rehabilitation and enablement services (RES) which will be responsible for the planning and delivery of an agreed range of rehabilitation and enablement services and for exerting influence across a wide range of other partnerships and service providers to secure the delivery of agreed strategic priorities.

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The RES will be responsible for the delivery of rehabilitation services for all adults and mental health services for older people. The further development of this model is being progressed within the Development Group and will return to the Board for detailed consideration when final proposals have been constructed. This work is particularly focussed on ensuring that the final detailed arrangements do not fracture key relationships between older people’s mental health and adult mental health and between frail older people’s services and other acute services. Illustrated below is a proposed Directorate of Rehabilitation and Enablement which would manage the non-local elements of services including beds, other specialist care, allied health professions, rehabilitation and day hospital facilities, and specialist physical disability facilities and resources.

Proposed Directorate of Rehabilitation and Enablement (RES)



7. Taking forward the detailed design of the new structures

7.1 The focus of the public consultation is on the move away from the current structure of four Operating Divisions to the new arrangements which are proposed in this paper. Alongside this consultation, the detailed work of designing the new structures will be taken forward, with full staff and staff partnership involvement. To that end, the NHS Board’s Director of Human Resources has drafted a paper on “Managing the Transition” which sets out the key principles by which the process will be managed.

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These reinforce the commitment to a partnership approach; the application of the policy of “no detriment”; an assurance that there will be no compulsory redundancies; a commitment to communicate with all directly affected staff as soon as possible when the details of structural arrangements become clear; and, wherever possible, to match any displaced individuals to new posts but, where competition is necessary, to endeavour to ensure that the number of interviews for any one individual is kept to a minimum.

8. Timetable for responses to consultation and for moving into implementation

- 8.1 Subject to comments and amendments made following discussion at the NHS Board meeting, the intention is to issue the consultation paper quickly following the NHS Board meeting. Comments from consultees on all aspects of the consultation paper are welcome. As the specific issues for consultation are relatively few, it is proposed that the consultation run for just over six weeks, with comments to be returned by Friday, 4th February, 2005. That would allow the NHS Board to consider the responses to consultation and make decisions about the new organisational arrangements at the February Board meeting.
- 8.2 The effective date for implementing the new arrangements is 1st April, 2005. That date will signal the move into the new arrangements: the expectation is that implementation will progress steadily through the 2005\06 year, as the new organisations develop their capacity to deliver the different roles which they will discharge. It will be important, however, in order to guard against a loss of momentum in continuing to take forward the Board’s key priorities for action to keep the period during which competition for posts is carried out as short as is possible so that uncertainty for staff is kept to a minimum.

T.A. Divers
16.12.04