

Greater Glasgow NHS Board

Board Meeting

Tuesday 22nd February 2005

Board Paper No. 2005/17

Chair - Service Redesign Committee
Director of Planning and Community Care

Future Arrangements for Service Redesign and Improvement

Recommendation:

- **the Board approve the attached paper as a basis for wider discussion about future arrangements for service redesign and improvement.**

A. PURPOSE

1.1 The Board's Service Redesign Committee has been in place for the last year. The Committee decided that its first anniversary, coupled with impending changes to wider NHS organisational arrangements, meant it should review progress. The purpose of this paper is to set out the conclusions of that review for consideration by the Board. In considering this paper it is important to state upfront the key conclusions of the Committee that:

- NHSGG must be organised for improvement. That means that:
 - we ensure frontline staff have the skills, tools and authority to be able to drive improvement in the services they deliver;
 - the drive for improvement is explicit in corporate and individual objectives and in performance management;
 - we should consider a particular programme of organisational development to try and create a culture where staff at all levels "own" the drive for service improvement;
- information on service improvement needs to be collated and readily accessible;
- the work of the Patient Focused Public Involvement Committee should be properly linked to management processes which can drive service change.;
- we should have an efficient and accessible electronic means for staff to share thinking and experience of service redesign;
- service improvement should be a visible outcome of planning and review processes;
- we need to give visibility and profile to service redesign work perhaps through the establishment of an initial forum which could also run an annual or twice yearly event.

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It is a duty of the NHS Board to be assured that service improvement is happening. This requirement needs to be reflected in the design of corporate governance and performance management arrangements which will underpin single system working;

1.2 The Committee has concluded that delivery of these essential corporate views could be achieved and identified through the Board's embedded programmes of service improvement. Based on the appraisal in this paper, the Committee would make two key points:

- the Board should consider alternatives to a separate Service Redesign Committee as a means of delivering the Board's commitments and priorities;
- critical to any future organisational and governance arrangements will be the requirement through the planning and performance management processes to ensure the Board is satisfied that service change is being driven, in the interests of patients.

Whatever the Board's conclusion, as based on wider discussion, there will need to be clear arrangements in place to ensure delivery of service redesign as a way of achieving effective high quality services in the interests of patients.

B. BACKGROUND

2.1 Service Redesign Committees were required to be created by the "Partnership for Care" White Paper. The Greater Glasgow Service Redesign Committee was established at the end of 2003 - the NHS Board carefully considered, prior to finalising the role and remit of the Committee, the context in Greater Glasgow. Key points included:

- the Local Health Plan (LHP) as our primary coordinating vehicle for service modernisation and change. Bringing together the core strategies covering our main areas of responsibility, including primary care, community care, health improvement and tackling inequalities, acute services and mental health. These strategies all included substantial programme of service change and development;
- the LHP driving the allocation of resources through integration with the five year financial strategy;
- the LHP underpinned by a strong network of planning groups covering main priorities including Managed Clinical Networks;
- the LHP and associated plans formed the basis of our first Change and Innovation Plan - required by the SEHD to secure our full allocation;
- existing service change and redesign groupings, including the Glasgow Patient Access Team, the Clinical Fora (bringing together primary and secondary care practitioners), extensive programmes of work under the umbrella of modernising mental health services and the network of clinical redesign activity driven by the Acute Services review implementation process;
- the scale of activity in the NHS in Greater Glasgow with a culture of devolution to Divisions and LHCCs;
- strong partnerships with each Local Authority to drive forward service change and integration in community care and children's services.

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- 2.2 These important points of context created a debate about the function of the proposed Committee. The organisational arrangements outlined above would not enable the creation of a Service Redesign Committee which could drive a significant programme of work and decide on the allocation of substantial resources.

In trying to map out a coherent, meaningful programme of activity for a Committee this highlighted a number of dilemmas:

- the challenge of linking to other, extant processes without excessive complexity and duplication. Examples would include Quality Scotland Reviews, Clinical Governance and Effectiveness Committees and Division redesign structures;
- should the Committee lead on a limited number of redesign initiatives which are not being addressed elsewhere, if so, how should these be identified?
- should the Committee have a particular role in testing our system of leadership and support for innovation and redesign?
- how could the Committee coordinate and resource its activities when staff time and funding are in short supply?

- 2.3 In response to Partnership for Care, the Board concluded that the Committee should have a coordinating and facilitating role and should be established on the following propositions:

- has membership drawn together in an innovative way reflecting enthusiastic and committed redesigners rather than traditional nomination roles;
- the Committee pulls together the Change and Innovation Plan, mainly from the Local Health Plan;
- the Committee has access to limited, non-recurring resources, to support initiatives and endowment funding to support and develop staff capability in redesign activity;
- links to the Centre for Change and Innovation to influence national policy development;
- sponsors a small number of priority initiatives reflecting Local Health Plan priorities but not emerging elsewhere;
- promotes change and redesign activity through identifying issues and gaps and “gingering up” existing processes and structures to address them;
- develops a strong communication and good practice profile - accessible to all staff;
- chaired by a Clinical Board non-executive which also offers a clinical dimension and a primary care focus.

C. SERVICE REDESIGN COMMITTEE CONSIDERATION

- 3.1 The Committee agreed to use its December 2004 meeting to review progress and that meeting considered four key questions supported by a pack of background material. That material included:

- information on other Service Redesign Committees;
- the original Board papers debating and establishing the role of the Committee.

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- 3.2 In reviewing the information from other Board areas we highlighted a number of significant points to inform our discussion. Service Redesign Committees in other Board areas are characterised by:
- operation as more traditional Board subcommittees with membership essentially Board members;
 - public and patient involvement being dealt with through this structure;
 - major clinical strategies led by the Service Redesign Committee;
 - the Service Redesign subcommittee leading the development of the Local Health Plan;
- 3.3 It is clear that the Greater Glasgow arrangements are very different from other Board areas:
- we have a Local Health Plan Steering Group which oversees a complex set of planning arrangements which focus on Local Authorities, on Managed Clinical Networks and on major priority areas such as Coronary Heart Disease and Stroke;
 - we have a Public and Patient Information Subcommittee which leads our work in this area of responsibility chaired by a Board Non Executive;
 - our major clinical strategies for mental health, acute services, primary care, have been developed through processes established specifically for that purpose.
- 3.4 Having considered these points the Committee then focused on the questions below:
- **reflect on what the Service Redesign Committee was originally set up to do and take stock of what it has achieved one year on against the Service Redesign Committee original intentions. What are the pros and cons of Greater Glasgow NHS Board having a separate Service Redesign Committee?**
 - **what distinguishes the Service Redesign Committee at the NHS Board from service redesign work going on throughout the city in general?**
 - **how does the Committee contribute to the governance of service redesign?**
 - **what do members see as a future role for the Service Redesign Committee?**
- 3.5 Emerging from the discussion were a number of conclusions which the February Committee considered in concluding the advice it offers the NHS Board. These were:
- the Committee has provided a useful networking opportunity;
 - there is a clear tension between trying to codify a systematic service redesign into a formal and structured process rather than focusing on organising for service improvement;
 - inconsistencies in membership and attendance have hampered effective working;
 - the Committee tries to bring together too many disparate interests;
 - as an NHS structure the Committee creates issues when so much of our service improvement activity is focused on a multi-agency approach;
 - service redesign, which is actually a strand of service improvement, needs to be embedded throughout the organisation - not seen as the responsibility of a single Committee;

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- the superficial attraction of creating a service modernisation or redesign department as a corporate function cuts across trying to embed responsibility at all levels of the organisation and taking a devolved approach;
- many staff do not feel able to and responsible for driving improvement in the services in which they work.

D. CONCLUSIONS

- 4.1 The outcome of the December 2004 and February 2005 Service Redesign Committee discussions has led to the conclusion that, while the improvement of NHS services must remain a key priority for the Board - a separate sub committee with that focus may not be the best vehicle to deliver added value. The move to a different NHS organisation could create other opportunities to embed improvement throughout the organisation and within much more systemic performance arrangements.

Publication: The content of this Paper may be published following the meeting.

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