

## Greater Glasgow NHS Board

### Board Meeting

Board Paper No. 2003/25

#### **DIRECTOR OF PLANNING AND COMMUNITY CARE**

#### **IMPLEMENT JOINT FUTURES: OUTCOME OF CONSULTATION ON INTEGRATION OF SERVICES – EAST DUNBARTONSHIRE**

**Recommendations:** the Board note to outcome of consultation and ratify the proposed way forward outlined in the attached paper and enclosed by the Joint Planning Forum.

#### **Responses to consultation and next steps**

##### **A) BACKGROUND AND PURPOSE**

The December Board Meeting approved for consultation proposals to move to integrated service delivery arrangements for Health and Social Care (attachment 1). The purpose of this paper is to enable the Health Board to note the responses to consultation and propose the Board ratify the four recommendations endorsed by the Joint Planning Forum. The recommendations are:-

1. the early establishment of a shadow Joint Health and Social Care Committee
2. the recruitment of a Head of Health and Community Care
3. the establishment of a project steering group charged with managing the initial change programme.
4. Immediate and ongoing communication with stakeholders

The detailed paper at attachment 2 was considered and approved by the Joint Planning Forum, with East Dunbartonshire Council, which brings together Board Members, Local Councillors, the Voluntary Sector and LHCC representatives:

The covering paper does not repeat all of the material in attachment 2, which fully describes the outcome of consultation and the proposed way forward. Its focus is on the key issues raised by NHS interests.

##### **B) ISSUES FOR THE NHS**

In considering these recommendations the Board may wish to reflect on the three key issues:-

- **has the consultation process been appropriate and engaging?**  
The proposals were developed by the senior officers group which brings together senior staff from health and social work, the Local Council of

Voluntary organisations and the chairs of LHCC's. Underpinning that group, and fully engaged in the development work, were care group planning structures, enabling a wider range of staff to bring their perspective to the shaping of the proposals. Section D of the attachment 2 describes in more detail the consultation process itself. In addition to this activity the proposals were distributed to and discussed by the Health Council, NHS advisory structures and the Area Partnership Forum.

- **whether the issues raised by the responses of NHS interests have been adequately addressed by the recommendations?**

Attachment 3 to this paper lists the responses received from NHS interests. They raised a number of significant issues:-

- a high degree of concern that the proposed locality structure would fracture whole system working in mental health.
- LHCCs supported the principle of integration but felt the proposals would lose the identity of their organisations and dilute the progress which has been made in achieving good local joint working and maximum delegation and devolution. In addition, there was concern that the key relationship with acute services was not addressed or enhanced by these proposals and that the drive to coterminosity would disrupt effective, existing working arrangements within the Anniesland, Bearsden and Milngavie LHCC.

- **a desire to see much more detailed proposals on governance and professional accountability arrangements for individual staff.**

The objective of the recommendations is to enable these and the other issues from consultation to be fully addressed but anchored to the principal that we need to integrate health and social care for East Dunbartonshire's population to deliver better services. Section E of the attachment two sets out the key points which the recommendations are intended to resolve. Significantly, in relation to the above concerns, these include:-

- Achieving local accountability for mental health within a system wide approach.
- Evolution paths for LHCC's including managing cross boundary issues.
- Maintaining and strengthening devolution and delegation.
- Achieving best standards of governance and professional accountability.

The proposed way forward and the points outlined above give an upfront commitment to reflect carefully on consultation responses in moving forward to implement an integrated structure. The essence of what is proposed is to create leadership and capacity to work through the detail of an integrated structure in a way which can address the issues and concerns people have raised. The full integration would be implemented at the end of this development phase, which would be steered by a project group bringing together the main constituencies of interest. Critically linked to that process will be a focus on communication and continuing engagement of key

stakeholders. The PCT – responding on the basis of a major internal consultation process – raised a range of staff concerns but supports the proposed way forward.

## **C) CONCLUSION**

The Board can be confident that the consultation process has fully engaged health staff and that the issues and concerns raised in consultation can be addressed by the recommendations in this paper – without mitigating our commitment to move to integrated service delivery which will improve the experience of patients and users.

# **Attachment one**

## **Joint Future Implementation Integrated Services: East Dunbartonshire Council and NHS Greater Glasgow**

### **Responses to Consultation and Proposed Next Steps**

#### **A INTRODUCTION**

The purpose of this report is to advise the Joint Planning Forum on the outcome of the recent consultation exercise on Joint Future Implementation and to make recommendations that will enable the Partnership to address issues raised during consultation and make a 'step change' to deliver a fully integrated health and social care structure for East Dunbartonshire.

This report details four main recommendations.

#### **Recommendations:-**

- 1. The early establishment of a Shadow Joint Health and Social Care Committee.**
- 2. The recruitment of a Head of Health and Community Care.**
- 3. The establishment of a Project Steering Group charged with managing the initial change programme.**
- 4. Immediate and ongoing communication with stakeholders.**

#### **B BACKGROUND**

The December 2002 Joint Planning Forum approved for consultation the attached paper 'Joint Future Implementation – Integrated Services: East Dunbartonshire Council and NHS Greater Glasgow' (Attachment 2). The Forum requested that a report back on the responses to consultation be submitted to the March Joint Planning Forum. This paper summarises the consultation paper, the responses received and outlines proposals for the next steps in the development of this work for approval by the Forum.

#### **C PROPOSAL SUMMARY**

The consultation paper 'Joint Future Implementation – Integrated Services: East Dunbartonshire Council and NHS Greater Glasgow' was distributed widely in December 2002. The paper set the context nationally and locally

including the recommendations of the Joint Futures Group that proposed specific local improvements to both service provision and integrated methods of service delivery. It also detailed the significant progress that had been made in implementing the Joint Future policy to date. The paper then proposed a number of significant developments aimed at consolidating previous work and developing a fully integrated health and social care model. The three key elements to move to integrated arrangements for service delivery were:-

1. Establishment of a Joint Health and Social Care Committee.
2. Establishment of a Head of Health and Community Care.
3. Developing a locality focused structure for the delivery of community based services.

## **D CONSULTATION PROCESS AND RESPONSES**

A range of consultation exercises were undertaken in an effort to include as many people as possible in the process. A standard presentation was developed and shared across staff groups. Agencies held seminars for staff, team meetings and joint planning structures were used as a vehicle to discuss and debate the proposals. A newsletter was developed in conjunction with the Staff Partnership Forum and distributed widely to health and social care staff. An internal consultation process was undertaken by the joint Trades Unions, and two seminars were held for elected members.

A total of 55 responses were received; 30 from individuals and 25 from agencies or groups. The responses can be grouped into three main categories:-

1. Broad support for a number of the proposals identifying the benefits of integration.
2. Significant and legitimate issues and concerns about the detail of the proposals.
3. A number of misunderstandings about the impact of the proposals on current operational arrangements.

The following section outlines further detail on each of these themes:-

### **1. Broad support for a number of the proposals identifying the benefits of integration.**

- Responses demonstrated commitment to improving the quality and availability of community health and social care services. The Joint Future agenda and further integration of services was seen as central to that commitment. The potential benefits to both service users and organisations from less duplication, a more efficient use of resources shared and better informed decision making, improved communication and improved service responses were emphasised.
- The establishment of a Joint Health and Social Care Committee was given widespread support. A Joint Committee is seen as necessary to fully

establish the partnership and provide the joint strategic vehicle to direct the evolution of the partnership.

**2. Significant and legitimate issues and concerns about the detail of the proposals.**

- A number of responses raised concerns that the locality model proposed may dilute or fragment the effectiveness of services. Authority wide solutions were also advocated in terms of specific care group services and also as a principle to maintain the integrity of the local authority area as a single locality of planning and service delivery. However, a two-locality model was favoured by others for reasons of critical mass, links with wider service networks and the view that East Dunbartonshire has two natural communities.
- Concern was expressed about the specialist role of mental health services being lost in a generic locality model. The mental health strategy group favoured a systems approach whereby specialist management of all acute and community mental health services was retained within a single management structure.
- A number of responses commented on the absence of detail beneath the higher management and executive functions highlighted in the proposals. As a consequence the structure was not clear on the split between planning, commissioning and operational responsibilities.
- Concern was expressed at our joint capacity to manage a significant change programme and the ongoing effective communication with stakeholders. A number of responses highlighted existing pressures on both budgets and management capacity and that the partnership would require additional investment to deliver this ambitious change programme.
- Greater clarity required regarding the relationship between the Joint Health and Social Care Committee, Greater Glasgow NHS Board and East Dunbartonshire Council particularly in relation to accountability and governance in an integrated system.
- It was widely recognised that the Joint Future agenda will raise the issue of harmonisation of staff's terms and conditions. This issue was stressed within the joint trade union response.
- Concern was expressed that the proposals do not reflect the identity or the achievement of LHCCs in East Dunbartonshire. Further clarity is required on the development of primary care organisations within an integrated community health partnership and the recently published White Paper 'Partnership for Care' will assist this process.
- Clarity on the relationship with acute services as a constant issue throughout the consultation responses emphasising the need for the partnership to ensure full engagement in wider service networks.

**3. A number of misunderstandings about the impact of the proposals on current operational arrangements.**

It is important that certain concerns raised within the Consultation process which do not reflect the actual Integration Proposals are quickly challenged and laid to rest.

- The views and experiences of particular key partners and stakeholders, notably the LHCCs are not reflected in the integration proposal.*

There has been extensive involvement of stakeholders, including LHCC chairs, in developing the proposals. Throughout that process we have always been clear that integration should be driven by benefits for patients and clients. This will require all parties to accept change, which is always unsettling and also to yield some of their authority to move to shared accountability. It is quite legitimate for primary care colleagues to seek assurance that positive aspects of LHCC development will not be damaged.
- Some respondents expected to see a detailed organisational structure in the proposal.*

At this stage of the development it was never intended to present a detailed organisational structure. Significant further work is required to allow us to move to that stage in the process.
- Anxiety was reflected in a number of responses around the blurring of professional roles and boundaries with a view that a wholesale move to generic workers was proposed.*

There is no suggestion that the professional identity or integrity of any group of staff within any of the partner agencies will be compromised or undermined.
- Concern was raised by both LHCCs, and by the LHCC Professional Advisory Committee in regard to the attachment of Community Nursing staff to GP practices.*

The integration proposal does not propose a change to community nursing attachments.
- Concern was expressed that pooling of budgets would result in a loss of financial clarity and control.*

The integration proposal needs to be underpinned by detailed financial arrangements with transparency and clarity on decision making - the joint committee is the critical body of joint authority for the use of resources. Nothing in the proposal will diminish or dilute the Council and / or NHS Greater Glasgow from responsibility in respect of their own financial management requirements.
- A number of care group services consulted expressed anxiety that a 'one-size-fits-all' locality management and service delivery structure will be imposed.*

We recognise that significant further work is required to establish the most appropriate detailed arrangements for each service.

## **E RECOMMENDATIONS**

From the responses to consultation it is clear that there is broad support for the further integration of services but a recognition that a significant amount of

work remains to be done on the detail. The recommendations to the Joint Planning Forum will address our need for capacity and leadership to direct the next stage of development.

Our objective is that these recommendations will enable us to address in final proposals the key issues from consultation, including:-

- achieving local accountability for mental health within a system wide approach
- the relationship to of this structure to children's services
- the balance of locality and East Dunbartonshire wide arrangements
- whether planning and commissioning is included in the Joint Head's remit as well as operational management.
- evolution paths for LHCC's including cross boundary issues
- maintaining and strengthening devolution and delegation
- achieving best standards of governance and professional accountability

We make 4 recommendations:-

1. The proposal for the establishment of a Joint Health and Social Care Committee received widespread support. It is proposed therefore that a Shadow Joint Committee be established in line with the recommendations in the proposal. The Shadow Committee should be constituted as early as possible to oversee the change programme.
2. The recruitment of the Head of Health and Community Care should be progressed. Without the capacity such a post would create we cannot address the agenda of detailed work, which the consultation process, quite rightly, highlights as required and which must be completed to deliver the integrated services which most people support. The postholder's initial focus, estimated over the first twelve months, will be to develop and refine the integration proposal in light of the feedback from the consultation, working with the project group described below. The operational management of services will remain within the current configuration during that development phase. Thereafter the Head will assume management responsibility and accountability, for the agreed range of services and the structure established in the development phase, reporting to the Joint Executive Group and through that to the Joint Committee. The final service and structure will be subject to East Dunbartonshire Council and Greater Glasgow NHS Board approval before the transfer of management responsibilities.
3. A small project steering group with senior colleagues to represent East Dunbartonshire Council (Social Work and Corporate Services), the Primary Care Trust, the LHCCs and GGNHSB should be convened to manage the initial change programme. Immediate priorities will include:-
  - the establishment of the Joint Committee
  - the process of finalising the remit and recruitment to the post of Head of Health and Community Care

- development of the concept and functionality of a joint executive group
  - consideration and establishment of a joint integration support function (including existing and additional capacity) to address issues from the consultation around:
    - human resources
    - information sharing and information technology
    - finance
    - performance and clinical governance.
4. To ensure immediate and ongoing communication with stakeholders. Initially this will involve the next edition of the joint newsletter and a Joint Future Update Seminar planned for 15<sup>th</sup> April 2003.

## **F NEXT STEPS**

If these recommendations are approved by the Joint Planning Forum we would seek the formal approval of the Council's Social Work committee and the NHS Board to establish the arrangements this paper proposes.

**JOINT FUTURE IMPLEMENTATION - INTEGRATED SERVICES  
EAST DUNBARTONSHIRE COUNCIL  
NHS GLASGOW**

**1. PURPOSE OF REPORT**

- 1.1. The purpose of this report is to advise the Joint Planning Forum of progress on the implementation of the Joint Future agenda, and to propose a model for the local integration of community health and social care services.
- 1.2. This report has been the product of considerable work involving the 4 principle Strategy Groups, under the executive direction of the Senior Officers Group. The report comprises four papers:
- ◆ A covering report outlining the background, context and proposed consultation process;
  - ◆ A draft paper that describes a structural and service related proposal for the integration of community care services in East Dunbartonshire ([appendix 1](#));
  - ◆ A draft paper that outlines the role and remit for the proposed establishment of a Joint Committee ([appendix 2](#));
  - ◆ A summary of the recommendations of the Joint Future Group, that define the agenda for integration ([appendix 3](#)).

**2. CONTEXT**

- 2.1. The Joint Future Group was set up by Susan Deacon in late 1999, under the chairmanship of Iain Gray, then deputy Minister for Community Care, to improve partnership working between agencies and to secure better outcomes for people who use services and their carers by:
- (a) Agreeing a list of joint measures which agencies need to have in place to deliver effective services, and to set deadlines for that;
  - (b) Advising on the balance between residential and home-based care;
  - (c) Advising on the options for charging for care at home, and;
  - (d) Advising on how to identify and share good practice.
- 2.2. In total the Group made 20 recommendations, some of which proposed action by the Scottish Executive, but most proposed specific local improvements to both service provision and integrated methods of service delivery. The recommendations fall into 5 main groups:
- ◆ To rebalance care for older people;
  - ◆ To improve joint working;
  - ◆ To support joint working and rebalancing of care through new planning, financial and service management arrangements, locally and nationally;
  - ◆ To reduce inconsistencies in charging for home care and to provide free home care in certain circumstances, and;

- ◆ To improve the sharing of good practice.
- 2.3. A summary of the recommendations of the Joint Future Group is contained at [appendix 3](#).
- 2.4. In January 2001, the Scottish Executive responded to the Joint Future Group report and broadly endorsed its recommendations. In addition, the Scottish Executive indicated that it would introduce legislation during 2001 to allow Health and Social Work agencies to pool budgets and to directly provide services on behalf of one another. The Scottish Executive expects local partnerships to deliver integrated services in line with the Joint Future recommendations by April 2003.

### **3. DEVELOPING A MODEL FOR INTEGRATION**

- 3.1. The implementation of Joint Future policy in East Dunbartonshire has been marked by significant investment of time and effort by staff at all levels and across all stakeholder agencies over the past 12-18 months. The process has been driven by a number of key pieces of development work:
- ◆ The re-configuration of the Community Care Joint Planning Structures to facilitate priority consideration of the Joint Future agenda
  - ◆ The creation of a Trade Union Partnership Forum to reflect the joint commitment to transparency and staff-side involvement
  - ◆ The creation of 4 newly configured joint Strategy Groups, involving practitioners and managers in each of the principle care groups
  - ◆ Comprehensive scoping work to identify the potential for integration across the full range of community-based health and social care services delivered to service users in the East Dunbartonshire area.
  - ◆ The drafting of an initial Local Partnership Agreement, which lays out our joint commitment to integration and outlines the way forward.
  - ◆ The organisation of two seminars for elected members which sought successfully to engage Councillors in the Joint Future agenda, and explore possible models for partnership working.
  - ◆ The organisation of multiple briefing sessions, workshops and information sessions to involve and advise staff on the policy, practice and structural implications associated with integrated services.
  - ◆ The production of a Joint Staff Newsletter, providing staff with an accessible vehicle for information and feedback.
  - ◆ The full engagement of senior management across service and corporate settings within the council and throughout the health service.
  - ◆ The full involvement of the voluntary sector, through participation of the Council for Voluntary Services at the principle forums and groups engaged in the integration debate.
- 3.2. The intended outcome from all of these initiatives is a proposal for integration that makes sense, is workable and represents something better than exists at present for service users and staff. The paper attached at appendix 1 constitutes a proposed way forward that draws on the work done over the past 18 months. The paper is not a fixed position, but it provides an opportunity for stakeholders to consider an explicit and reasonably detailed proposal that attempts to reflect the outcomes from the work of the Strategy Groups, considerations of senior management across the partnership, staff contributions and the views of elected members. The paper also highlights a number of issues which need to be resolved.

Consultation is felt to be the most appropriate way in which these issues can be taken forward.

- 3.3. It is essential that this proposal has the opportunity to be considered properly by all parties before any aspect of it is taken forward. It would in any event have to be ratified formally by East Dunbartonshire Council and NHS Glasgow ahead of any adoption. The initial task is for this proposal to undergo a period of consultation, the outcomes of which will inform further considerations, with a view to a final proposal being developed early in 2003.

#### **4. THE CONSULTATION PROCESS**

- 4.1. It is essential that consultation on the proposals contained in this Paper be conducted through a structured process that will allow all stakeholders ample opportunity and time to make an appropriate contribution to the debate.
- 4.2. It is also important to highlight that public consultation has been undertaken through a variety of means by the partners, perhaps most notably in June 2001, with a report being produced on public perceptions of both the negative and positive aspects of current service delivery, and clear public expectations about the way forward for services.
- 4.3. It is intended that the consultation process should run for 6-8 weeks (January/February) with a report detailing the findings of the process to be submitted to the Senior Officers Group in March 2003.
- 4.4. It is important to emphasise the joint nature of this consultation which should be adopted across all partner agencies - this should be reflected in the process through, for example, joint presentations. It will remain the responsibility of each individual agency to ensure adequate consultation with their staff is achieved and that feedback is produced in a consistent manner.
- 4.5. To facilitate this, it is proposed that a standard pro forma should be produced and circulated with the covering report in order to ensure that consultation responses can be systematically collated and reviewed.
- 4.6. To ensure that the consultation process does not generate undue concern, and is as comprehensive and co-ordinated as possible, it should be structured as follows:
  - ◆ December - distribution of paper, briefing for all staff on the content of the proposals contained in the consultation paper and the process to be followed.
  - ◆ January/February - engagement with key partner organisations (including members and senior managers), the trades unions, the voluntary sector, users and cares groups and other relevant stakeholders.
- 4.7. It is anticipated that a number of mechanisms will be used to facilitate the process, including Strategy Groups, the Joint Futures Trade Union Partnership Forum, the partners' intranet and e-mail systems, a special staff newsletter and seminars with elected members, senior managers and other stakeholders. It is also important that, to reduce the organisational requirements of the process, scheduled meetings of existing stakeholder groups are utilised for consultation.
- 4.8. This process will only succeed and deliver valid information if all partners are fully committed to this process. Partners must recognise that they will have to dedicate time and resources to ensure the delivery of the agreed timetable.

## **5. THE WAY FORWARD**

- 5.1. The first stage in the consultation process is for this paper to be issued to the Joint Planning Forum for consideration. Thereafter, a final draft version of the paper reflecting that discussion will be issued for consultation, with a report to East Dunbartonshire Council Committee and Greater Glasgow NHS Board. A progress report would also be prepared for the Scottish Executive Joint Future Unit, as requested by them following the submission of the initial Local Partnership Agreement in April 2002.
- 5.2. It is hoped that the process described above will set the context for constructive consideration of these proposals for integration, and that the outcomes from this process will contribute positively to the development of a substantive model that will find favour amongst staff, management, elected members and most importantly, service users and their carers.

**CONSULTATION DRAFT  
JOINT FUTURE IMPLEMENTATION – INTEGRATED SERVICES  
EAST DUNBARTONSHIRE COUNCIL  
GREATER GLASGOW NHS**

**1. BACKGROUND**

1.1. There have been well developed and effective joint planning arrangements between the NHS Greater Glasgow and East Dunbartonshire Council (EDC) for a number of years. The report of the Joint Futures Group in 2000 gave new impetus to those arrangements with its requirement to deliver:

- ◆ Single shared assessment
- ◆ Aligned financial arrangements
- ◆ Single management arrangements for older people
- ◆ More integrated and devolved services and decision making

1.2. During Spring 2002, 2 seminars were held for East Dunbartonshire Councillors. The outcome of these seminars was a proposal, endorsed by Social Services Committee, in June 2002, to move to develop proposals for:

- (a) The development of a Joint Committee with devolved powers, to oversee the delivery of integrated community health and social services in East Dunbartonshire. The development of a pooled budget, based upon the evaluation of models elsewhere, with an undertaking to align budgets as an achievable ‘first step’.
- (b) The recruitment of a jointly funded, high level, single manager to lead on the implementation of the Joint Future agenda within the East Dunbartonshire locality, and the associated resource requirements to support the work of this post.
- (c) The purpose of this paper is to set out, for discussion, proposals about how services could be managed in an integrated way under the leadership of a single joint head. The paper does not propose detailed structures, but sets out key principles and an outline management structure. It is a starter to promote debate and discussion – not a definitive conclusion. Change will always cause anxiety, but the focus of the proposals is to improve services for people in East Dunbartonshire. There are particular challenges for staff – although we are not proposing changes to employment arrangements or terms and conditions – for the vast majority of employees. The proposals, have been developed through the work of the Senior Officers’ Group (membership at attachment 1), which brings together staff from the Primary Care NHS Trust, East Dunbartonshire Council, the voluntary sector and local Co-ops. A seminar at the end of August 2002 with a cross section of staff and the partnership forum informed this paper.

1.3. The paper is presented in 7 further sections and it is intended to enable for a wide ranging discussion so that final proposals can be put to the Senior Officers Group and Joint Planning Forum.

- ◆ **What are we trying to achieve by integrating management?**
- ◆ **Current structures and staffing**
- ◆ **Strategy Group Conclusions**
- ◆ **Proposed structure and key responsibilities.**
- ◆ **Accountability arrangements**
- ◆ **Issues**
- ◆ **Next steps**

- 1.4. In addition, the attached paper (appendix 2) sets out for discussion a draft agreement to underpin the establishment of a joint committee to ensure clear, joint accountability.

## **2. WHAT ARE WE TRYING TO ACHIEVE BY INTEGRATING MANAGEMENT?**

- 2.1. Our aim in proposing these integrated management arrangements is that they are the first step to move towards and facilitate the implementation of fully integrated health and social care services for people in East Dunbartonshire Council. The focus is on services to a population, not just community care and specialist services. This model also delivers a potentially very powerful vehicle for health improvement planning. The proposals include a strong locality focus, building on the progress made by LHCCs and social care staff working together. We want to ensure that local people and practitioners can be closely involved in the way services are delivered. However, this locality approach coupled with very clear East Dunbartonshire wide accountability arrangements, through a Joint Committee. The proposals also include EDC wide strategic planning arrangements for each care group to ensure there is a balance between locally sensitive decisions and consistent services across the Authority.
- 2.2. Our proposal is that putting in place an integrated management structure is a necessity to create the organisational capacity and focus to develop and deliver more detailed proposals for fully integrated services. The outline of how these services would work has been developed by Strategy Groups working to a template agreed by the Senior Officers' Group. We believe that at a macro level integrated services will offer:
- (a) Clear public accountability for local service provision – through a single structure with inescapable responsibilities for local services.
  - (b) Potential for greater innovation, for example, new staffing types and arrangements.
  - (c) Increased connection of local services with local interests including users, carers and the voluntary sector.
  - (d) More effective and efficient provision for organisations and for individual users by delivering:
    - ◆ A single care plan
    - ◆ A single key worker
    - ◆ A single assessment process
  - (e) Enabling better organised services for the individual and more services within pooled, collective budgets, strengthened locality management and leadership as well as stronger clinical/service team leadership.
  - (f) Full resources available for local deployment and priorities – within broad policy frameworks
  - (g) A properly resourced locality infrastructure developed and equipped to focus on it's population including their experience in acute services.
- 2.3. In addition to these macro benefits the strategy groups identified a number of benefits of change for their care groups:

(a) *Older People*

- ◆ Single point access
- ◆ Improved co-ordination
- ◆ Potential to plug service gaps
- ◆ Speedier access to appropriate services and clarity on care management
- ◆ Potential to improve services at home
- ◆ Service responses can match need more closely
- ◆ Shared information improving decision making

(b) *Mental Health*

- ◆ Shared assessment
- ◆ Consistent care
- ◆ Improved joint work with the voluntary sector
- ◆ More locality based decision-making including budgets
- ◆ Better access to services
- ◆ A single key worker with a holistic approach and overall responsibility
- ◆ Potential to improve Out of Hours services

(c) *Physical Disability*

- ◆ Single named worker
- ◆ Shared information avoiding repeated assessment
- ◆ Barriers to access reduced
- ◆ Simpler processes and more effective communication
- ◆ More appropriate and rapid response to care needs
- ◆ A culture of collective responsibility to meet clients needs
- ◆ Better knowledge of available services and skills
- ◆ Linking rehabilitation to care packages
- ◆ Reduced disruption freeing clinical time

### **3. CURRENT STRUCTURES AND STAFFING**

3.1. This section describes the current management and staffing arrangements for services in East Dunbartonshire Council, provided by the Social Work and Joint Ventures Directorate and the Primary Care NHS Trust. At headline level:

3.2. For Social Work services, the Head of Social Work is supported by 2 key posts: a Service Delivery Co-ordinator and Joint Ventures Co-ordinator heading more extensive structures. The former post is largely responsible for the management of community care and the latter for planning, commissioning and policy development, but with responsibility for some operational services, including home care, residential services and occupational therapy.

3.3. For the NHS, mental health services within East Dunbartonshire are managed by 2 Locality Managers, one of whom has significant responsibilities outside the EDC patch. These managers relate into the Trust's sector structures which, bring together the management of community and in-patient services. For primary care, the 2 LHCCs which cover the EDC area manage community services and have LHCC management groups with a high degree of delegated authority and resources and full clinical autonomy. For both functions, Divisional and Corporate management teams provide a range of inputs. Currently there is a National contract with individual GPs for the services they provide. New arrangements to put in place local contracts with GP practices are being implemented. Given the criticality of primary

care services to this integrated structure we have assumed new contracts would be locally managed as part of this structure, in collaboration with LHCCs.

- 3.4. In planning and policy terms, GGNHSB input is provided as part of the role of an Assistant Director of Planning and a Planning Manager – both with responsibilities for other Local Authorities. Similarly a Principle Health Promotion Officer leads health improvement work with EDC. For specialist services, the Mental Health and Addiction Teams cover planning, service development and performance management for EDC services as a component of their Greater Glasgow wide responsibilities. In the case of mental health, the team is combined with social care capacity responsible for planning, policy development and commissioning for Glasgow City Council.

## 4. STRATEGY GROUP CONCLUSIONS

- 4.1. This section briefly outlines the conclusions of the work each Strategy Group was set to advise on the most appropriate, integrated management arrangements for their services.

- 4.2. Strategy Groups covering older people, mental health, learning disabilities and physical disability were asked to develop detailed work defining:

- ◆ What services should come together into integrated provision?
- ◆ What generic services need to be accessed by the client group and how should these services be organised and accessed?
- ◆ What other services require to be accessed?
- ◆ Proposed organisation structure to manage integrated service delivery.
- ◆ Integrated service delivery processes for access and referral, allocations, key workers, single shared assessment, information sharing and commissioning and integrated service reviews.
- ◆ Budget requirements.
- ◆ Performance management arrangements.
- ◆ Benefits for clients.
- ◆ Setting service priorities.

- 5.3. This section briefly describes each group's conclusions on management arrangements

(a) ***Older People's Services:***

The Group identified 2 options. The first with an Older People's Service Manager across EDC supported by operational locality team co-ordinators, or secondly, an Older People's Co-ordinator in each locality, but reporting to a higher level locality manager with responsibility for all community care services.

(b) ***Mental Health Services:***

The group proposed 2 distinct mental health teams – one for each locality, managed by a single, EDC wide mental health manager. For primary care mental health, the group presented 2 potential options – either a manager within the mental health structure or, their alternative, within the LHCC structure. The group concluded that specialist management of mental health was the right model.

**(c) Learning Disability Services:**

The group has not completed its work and its initial submission suggested continuation of separate health and social care team leaders reporting to a field work manger – difficult to differentiate from the current arrangements and not offering an integrated team.

**(d) Physical Disability Services:**

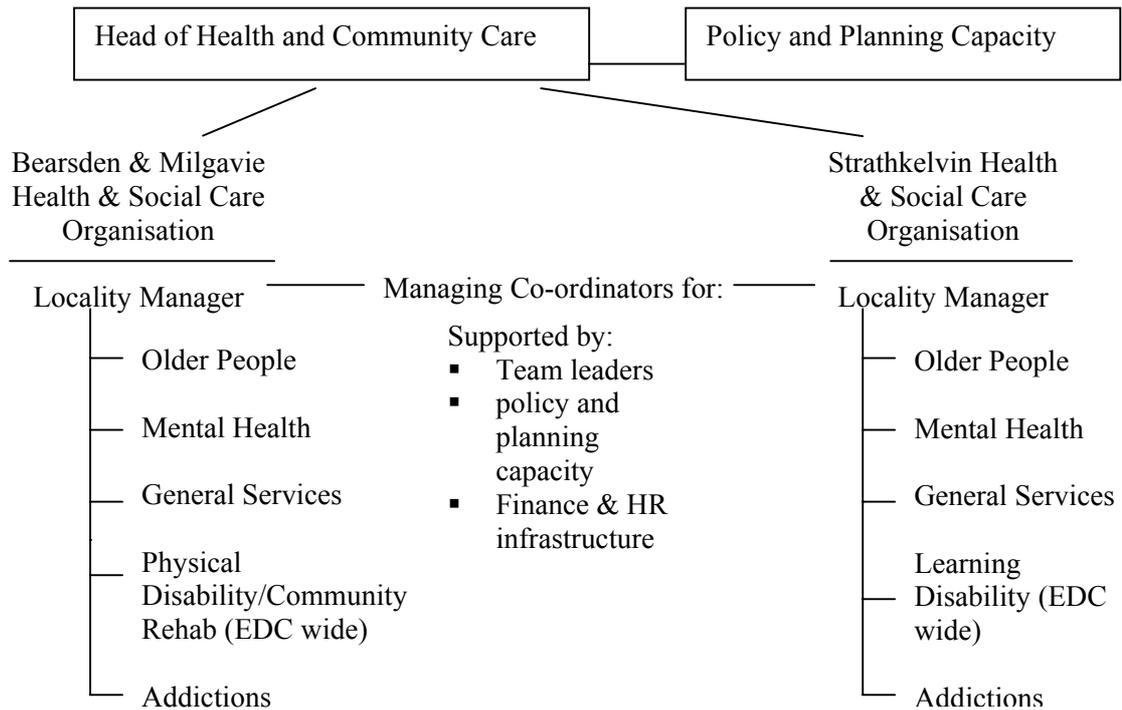
The group proposed an integrated service with a single, senior team leader managing the 3 current team leaders. There are particular issues for this service, because of the small size of the team and the fact that a number of its members work outside EDC. Discussion at the SOG began to develop a wider construct of a physical disability and community rehabilitation team, although this would require additional resources a significant service gap would be addressed.

## **6. PROPOSED STRUCTURE AND KEY RESPONSIBILITIES**

6.3. Taking stock of the work of the strategy groups and debate on their work a number of themes emerge which have informed the proposals in this section the key elements are:

- ◆ A strong locality based model with local accountability but with clear lines of EDC wide accountability, through a single senior manager, to a joint executive group and a formally constituted Joint Committee.
- ◆ Achieving maximum delegation of resources and decision making enabling fast and responsive services
- ◆ Building on the positive contribution the development of LHCC's has made particularly ensuring frontline, professional, staff can directly make as well as influence decisions.
- ◆ Enabling community and client influence on a visible and effective local management team
- ◆ A key role of the locality health and social care team is to exert positive influence on inpatient and other specialist services provided for its population. For acute services this will mean a strong relationship between locality team and the local hospital and for mental health with the sector based staff and services.
- ◆ Trying to achieve horizontal and vertical integration, ie bringing together operational staff into single teams as well as achieving a single management structure.

6.4. It is proposed that the following structure is developed further and implemented:



6.5. Set out below is a short summary of the responsibilities of each post based on the assumption that the overall Head is responsible for all community based health and social care services within EDC, developing contracts for primary care, managing the interface with specialist and in-patient health services and commissioning services from the private and voluntary sectors. This paper does not attempt to set out very detailed structures that should follow from debate on and agreement to principles, but we would expect the Head of Health and Community Care to be supported by strong policy, planning and performance management capacity, currently embedded in EDC structures.

**Locality Managers:** Responsible for the totality of health and community care service provision within their area, including directly managing staff providing:

- Specialist Services
  - Mental Health
  - Older People
  - Addictions
- Resources
  - Home care budget
  - Addictions
- General Services
  - Homecare?
  - Receiving services?
  - Primary care
    - Community services staff
    - Monitoring contracts for primary care
    - Contracts for purchased services

<p><b>Service Co-ordinators:</b></p> <p><b><u>Specialist Services</u></b></p> <p><b>Older People</b></p> <p><b>Mental Health</b></p>	<p>–</p> <p>–</p> <p>–</p> <p>–</p>	<p>Manage full range of local service provision.</p> <p>Contract for purchased services</p> <p>Lead on prevention and health promoting plus tackling social exclusion.</p> <p>Manage interface with non EDC specialist services and acute services.</p>
<p><b><u>General services</u></b></p>	<p>–</p> <p>–</p> <p>–</p> <p>–</p>	<p>Manage generic staff and services, including directly managing generic PCNHST and social care staff.</p> <p>Lead service development, innovation and performance management for generic services.</p> <p>Lead on developing local responsive acute care.</p> <p>Delegated management of GP practice contracts.</p>

6.6. There are questions about a wider role – for example around health improvement and social inclusion which are currently part of separate structures. These are probably second order issues – but could be a natural development of these arrangements. Some other issues:

- ◆ Due to the small size of the specialist physical disability/community rehabilitation and learning disability teams, single EDC wide teams are proposed.
- ◆ Home care shown as a query - need to discuss further, likewise assessment and receiving services – arguably this latter could usefully be designed as a single service entry point in a locality and, therefore, important to be managed there.
- ◆ For mental health this proposal does not fully reflect the Strategy Group’s views – there needs to be a wider debate about the locality/specialist balance as part of this consultation.
- ◆ For addiction services, thinking is less well developed, but likely to be analogous to physical and learning disability.

6.7. The core proposition of this arrangement is a strong focus on the 2 localities rather than EDC wide specialist management – that emphasis is open to debate and may need clearer articulation of pros and cons and how the strengths of specialism can be captured in a locality orientated structure.

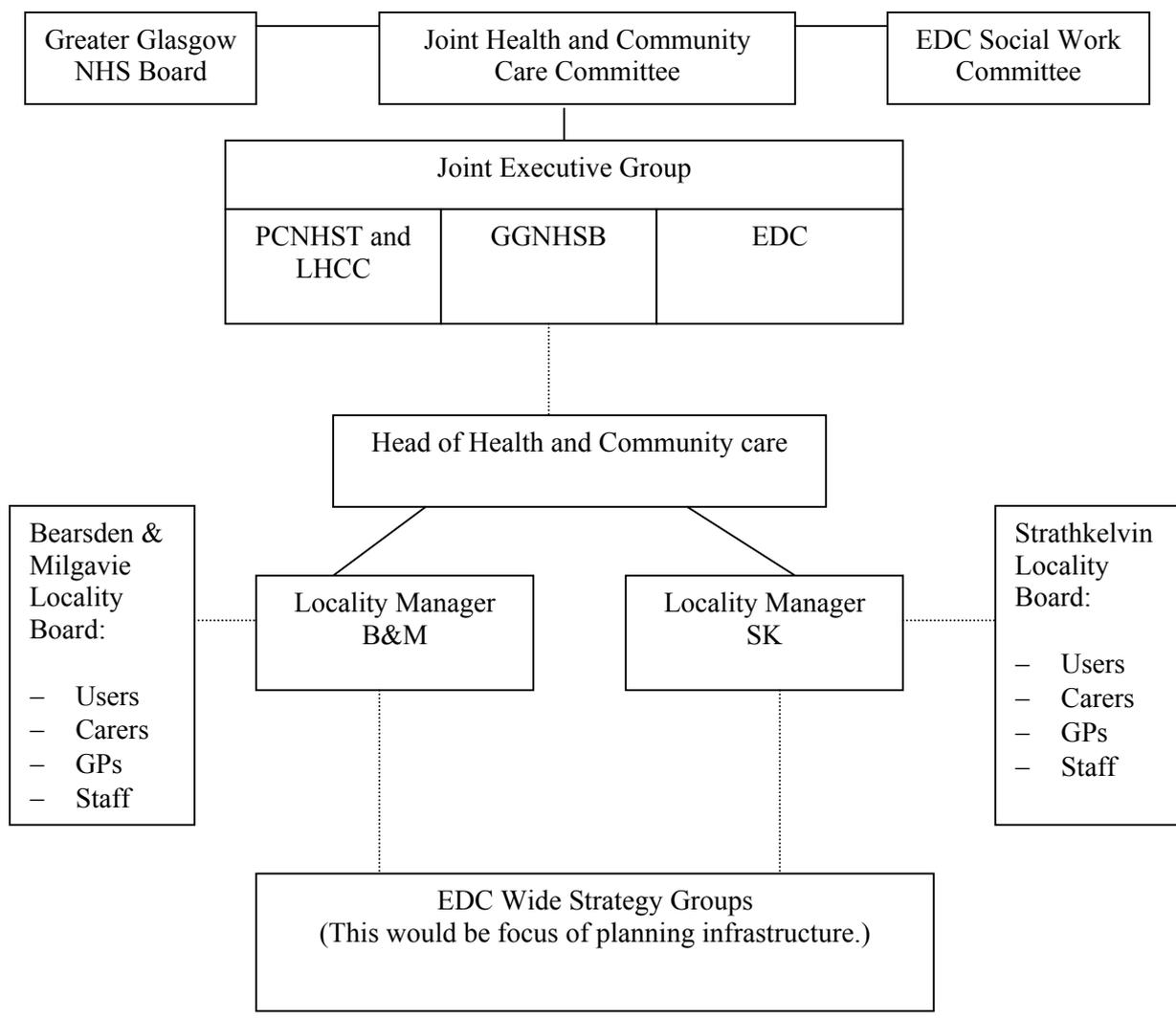
6.8. For mental health this cuts across the strategy group proposal of a single manager across East Dunbartonshire Council. An alternative is East Dunbartonshire wide co-coordinators for specialist services, including older people and mental health with 2 locality managers for community services – loses strong locality focus and accountability – increases specialist management.

6.9. These proposals have significant implications for Co-op structures, which need full debate with LHCCs.

6.10. A critical bit of work to finalise these proposals must be defining what powers and resources the partners will devolve to the joint Head and through that post to the locality managers. Our core objective, of strong locality structures assumes significant delegation of decisions and resources within EDC frameworks.

**7. ACCOUNTABILITY ARRANGEMENTS**

7.3. This section outlines proposals for accountability arrangements for the integrated structure. It is based on the current situation of 3 legal entities being party to the arrangements, which may be subject to change in the future. A core objective is to achieve strong Authority wide accountability as well as local ownership, accountability and influence.



- 7.4. The Locality Boards are a significant feature of these accountability arrangements with the aim of providing a direct link between frontline staff, users and carers and decision making and planning. We would expect their members to have time allocated to participate and their chairs to be members of the joint committee. The requirement for EDC wide accountability is met in a number of ways:-
- ◆ On a day to day basis the line management of locality managers by the Head of Health and Community care.
  - ◆ A joint executive group, enabling Directors of the three partner organisations to work closely with the joint Head.
  - ◆ The EDC wide strategy groups developing plans and policy frameworks, supported by EDC specific planning capacity
  - ◆ A clear financial system with appropriate financial support across the integrated structure.
  - ◆ At the apex of the integrated structure is a Joint Committee, the proposed remit of which is outlined in the attached paper (appendix 2).

## 8. ISSUES

- 8.3. This section outlines some of the issues which we believe are important to debate and resolve:
- (a) In developing more detailed implementation arrangements and structures we need to explore further the arrangements which be required to ensure that the statutory responsibilities of each organisation and individual staff are not compromised by these integration proposals.
  - (b) Staff will be anxious about these proposals, we need a clear and consistent process of engagement and reassurance. This is not about less people, but better use of our staff. Nor is it about wholesale change to employment and contractual arrangements which would remain unchanged for the vast majority of staff.
  - (c) The proposed structures section needs further detailed development work.
  - (d) This structure focuses on service delivery and further debate is needed about what structures are required for planning and policy development. We need EDC capacity with linkages to GGNHSB structures where those are appropriate and add value – for example in the planning of specialist services.
  - (e) We need to set out proposals for the infrastructure to support each of these posts and the overall structure. There are 2 dimensions to the infrastructure issue:
    - ◆ What is provided by the parent organisation mainstream capacity?
    - ◆ What is embedded within the joint health and community care structure?
  - (f) How does this proposed structure, essentially for community based services provided within EDC relate to current structures and what is the impact on voluntary LHCCs?
    - ◆ Primary care provision is not currently geographically defined. We need clarity on how patients registered with GP practice in EDC, but who live elsewhere will receive services.

- ◆ The ABM Co-op has 2 practises within it who geographically sit outside EDC– what are the implications for this voluntary structure of these proposals, which are EDC focussed. How can we maintain cross boundary doctor collaboration for peer review and audit without wider implications – for example, what if staff are required for a particular joint programme?
  - ◆ Can chronic disease management cross boundaries as we move to horizontal integration and how desirable is it to promote EDC wide primary care collaboration rather the current construct?
  - ◆ Linked to these issues above, where bits of a post holder belong in EDC what management arrangements are required.
- (g) These proposals are, essentially, a first stage integration – recognising that statutory structures do not yet enable us to go further.

### 9. NEXT STEPS

- 9.3. The next important step is to use this paper, with approval by the partner organisations, as a way of widely consulting all of the interests – clients, carers and staff – to enable us to develop final proposals for approval.
- 9.4. If we proceed towards this fully integrated structure, the first step would be identifying the Head of Health and Community Care who would need to be in post to enable implementation of the rest of any final structure.

## EAST DUNBARTONSHIRE INTEGRATED HEALTH AND SOCIAL CARE SERVICES JOINT COMMITTEE – CONSULTATION DRAFT

### 1. INTRODUCTION

- 1.3. The Scottish Executive is committed to improving the quality and availability of community care services. The Joint Future agenda is central to that commitment. It offers the opportunity to develop innovative and holistic approaches to continuously improve the results for people with community care needs through better joint working by local authorities and NHS bodies. Part 2 of the Community Care and Health (Scotland) Act introduces new arrangements that remove legal barriers to joint working between local authorities and NHS bodies. They build on the principles of the Joint Future agenda and enable the full range of joint working arrangements for joint resourcing and joint management set out in Circular CCD 7/2001.
- 1.4. In order to secure and further the objectives of the national Joint Future policy requirements, it is proposed that a Partnership is established to jointly deliver a range of community based health and social services in the geographical area defined by East Dunbartonshire Council.
- 1.5. The broad purpose of this Partnership is to deliver fully integrated health and social care services that will service the local community of East Dunbartonshire by improving, maintaining and restoring health and independence.
- 1.6. In order to establish this Partnership, it is proposed that a Joint Committee is created with defined delegated authority by all partners. This agreement outlines the purpose of this Joint Committee, its role, the extent of its authority and its composition.
- 1.7. For the purposes of this agreement, the Partners to which the agreement refers includes the following organisations who would be represented on the joint Committee on the basis shown:
  - (a) Greater Glasgow National Health Service Board - 2 representatives (including one non-executive member from the Acute Trust)
  - (b) East Dunbartonshire Council - 6 representatives
  - (c) Greater Glasgow Primary Care NHS Trust - 2 representatives
  - (d) Anniesland, Bearsden and Milngavie Local Health Care Co-operative (LHCC) - 1 representative
  - (e) Strathkelvin Local Health Care Co-operative (LHCC) - 1 representative
  - (f) Such officers as are appropriate and required from any of the partner organisations shall be entitled to attend meetings of the joint committee in order to provide advice, support and information.
  - (g) The Joint Committee will develop and implement a joint management structure within 12 months of its operation, which will thereafter form a Schedule to this agreement.

### 2. CONSTITUTION

- 2.3. This agreement aims to set out clearly the undertakings given by the Partners and the intended basis of their relationship. It is the intention of the parties to operate the agreement in a spirit of mutual trust.
- 2.4. This Agreement shall not be regarded for any purposes as creating a partnership between the Partners in terms of the Partnership Act 1890.

### 3. JOINT COMMITTEE

- 3.3. In order to further the objectives of the Partners as set out in Schedule 2 each of the Partners has agreed to delegate to the High Level Single Manager, with direction and advice provided by the Joint Committee, responsibility for advising the Partners on the development of integrated health and social care services for adults in East Dunbartonshire. These services are described in Schedule 3 annexed\* hereto. The services may change over time as a consequence of service redesign or development.
- 3.4. The Joint Committee shall, insofar as it conforms to the approved strategic objectives and priorities of the Partners:-
- (a) regulate its proceedings and business according to the Joint Committee approved Standing Orders;
  - (b) agree the basis on which any joint facilities or services are to be procured and provided and the basis on which contracts for such services are to be entered into (taking into account that the Joint Committee is not a separate legal entity until such time as it is established as such by statute or otherwise, facilities and services will be procured by one of the Partners on behalf of the Joint Committee) in accordance with the terms of Clause 4 (Power to Contract) of this Agreement;
  - (c) agree the programme for, and the method of, providing an integrated health and social care service for adults in East Dunbartonshire;
  - (d) agree a strategy to achieve the objectives of the Partnership, as detailed in Schedule 2 annexed\* hereto, with a view to ensuring joint service delivery and that access to and information about the services detailed in Schedule 3 annexed\* hereto, are available to clients in a clear and user-friendly form.
  - (e) further the sharing of information, including client assessments, among the Partners with a view to enhancing the provision of service to clients, taking into account the Data Protection Act 1998 and the statutory and common law obligations of confidentiality;
  - (f) develop strategies to facilitate communication among the Partners and other agencies, with a view to securing the Partnership aims and objectives detailed in Schedule 2;
  - (g) develop strategies to address human resources issues that may arise, bearing in mind that each Partner will retain responsibility for its employees, who will continue to be employed under existing terms of service unless otherwise agreed by the Partners;
  - (h) develop the integration of information technology systems as required by the Partners;
  - (i) establish financial arrangements for the Partnership, that satisfy the requirements of all Partners, taking into account current statutory reporting and auditing requirements which apply to the Partners and the Partners' individual public accountability for expenditure;
  - (j) together with the Partners, consider the legal issues and arrangements required to further the Partnership;

- (k) review the performance of each Partner of its obligations under this Agreement;
- (l) report to the Partners on progress in furthering the objectives of the Partnership as and when required and in a form required by the Partners;
- (m) ensure that financial statements in respect of the income and expenditure within the aligned/pooled budgets, together with detailed annual reports, are prepared in accordance with the requirements of the Partners and Clause 5 (Financial Accountability) of this Agreement and shall ensure that reasonable access to financial information relevant to the Joint Committee is available to the Partners and their appointed internal and external auditors;
- (n) accept and comply with any other requirements imposed by the Partners and formally notified to the Joint Committee.

#### **4. POWER TO CONTRACT**

- 4.3. The Joint Committee is not a separate legal entity and this Agreement shall not be regarded for any purpose as giving rise to contractual rights or liabilities. Nor shall the Joint Committee be entitled to enter into any contract or agreement with a third party in its own name. Each of the Partners accordingly undertakes to retain existing contracts and enter into new contracts in its name insofar as these are appropriate in furthering the objectives of the Partnership.

#### **5. FINANCIAL ACCOUNTABILITY**

- 5.3. Within an aligned budget framework the Chief Executives and Directors of Finance of the partner organisations shall retain their financial accountability. The Partners will delegate responsibility for budgetary control to the High Level Single Manager.
- 5.4. With regard to the adoption of a pooled budget framework, such arrangements will be subject to full and formal agreement by all parties and will be supported by appropriate revision to this Agreement, subject to Clause 11 (Variation).

#### **6. BUDGET AND RESOURCES**

- 6.3. Nothing in this agreement shall diminish or dilute the Council and NHS Glasgow from responsibility in respect of their own financial management requirements.
- 6.4. However it is accepted that by entering into the partnership, the parties agree that it would be the expectation that neither the Council nor the NHS parties will take unilateral action to withdraw funding from the partnership without consultation and discussion with the other parties with a view to reaching agreement.
- 6.5. It will be the responsibility of the High Level Single Manager to establish appropriate mechanisms for the functions devolved to the partnership to be considered within the primary budget setting procedures of both organisations. An agreed joint budget to cover all the agreed service and development obligations, must be agreed prior to 31 March each year.
- 6.6. The Joint Committee will develop and implement a joint resourcing framework within 12 months of its operation, which will thereafter form a schedule to this agreement.

**7. AUDIT**

- 7.3. The Chief Internal Auditors of the Partner organisations shall jointly prepare Strategic and Annual Plans on the basis of an agreed and common risk assessment methodology. These Plans shall be presented to the Joint Committee at the beginning of the financial year(s) to which they relate.
- 7.4. The Heads of Finance of the Partner organisations shall meet with their respective External Auditors and agree the External Audit requirements of the Partnership.

**8. LIABILITY, RISK MANAGEMENT AND INSURANCE**

- 8.3. Each Partner shall remain separately responsible for staff employed by and contracts entered into by that Partner. The High Level Single Manager shall be responsible for ensuring that, wherever possible, the relevant Partner is defined and the appropriate risk management arrangements applied for all activities and assets. The High Level Single Manager shall prepare a risk management strategy for those areas of risk (such as business risk) where responsibility cannot be assigned to a single Partner. The relevant Partner shall ensure that insurance arrangements exist where appropriate and allowable in accordance with the risk management programme.

**9. CONFIDENTIALITY**

- 9.3. Each Partner shall treat as strictly confidential information which may become available to it about any other Partner as a result of any Partner's involvement in the Joint Committee.

**10. WINDING UP**

- 10.3. Any of the Partners to this agreement may at any time give 6 months notice of an intention to terminate it. Should such notice be given all Partners will use their best endeavours to arrive at an alternative agreement or an agreed variation to this agreement.
- 10.4. Should the Partners conclude that such endeavours are not likely to be successful, this agreement will be dissolved from a date 6 months later than the receipt of the notification or such other date as may be agreed between the parties.
- 10.5. On dissolution of the Joint Committee, an account shall be prepared in accordance with the joint resourcing schedule referred to at 6.4 of this agreement.

**11. VARIATION**

- 11.3. This agreement may be varied at any time by agreement between the Partners.

**12. INTELLECTUAL PROPERTY**

- 12.3. Unless otherwise agreed, all data, information, audit plans, reports and any written document created or produced by the Joint Board pursuant to providing the Services detailed in Schedule 2 annexed\* hereto shall be the property of the Partners equally.
- 12.4. Unless otherwise agreed, all and any intellectual property rights in such data, information, audit plans, reports and any written material shall vest equally in the Partners.

**13. SCHEME OF DELEGATION**

13.3. This agreement is supported by the Scheme of Delegation annexed\* at Schedule 6.

***\*Please note that all annexes referred to in the text to are still to be developed.***

## REPORT OF THE JOINT FUTURE GROUP RECOMMENDATIONS FOR IMPLEMENTATION

### 1. REBALANCING CARE OF OLDER PEOPLE

#### Joint Hospital Discharge/Rapid Response Team

- ◆ Every local authority area should have in place a comprehensive, joint hospital discharge/rapid response team.

#### Intensive Home Support/Augmented Care Schemes

- ◆ Every local authority area should have in place a comprehensive, joint intensive home support team.

#### Short Breaks

- ◆ Each year, agencies should provide both more short breaks (to reduce the number of carers providing most care, without a break), and more breaks at home.

#### Practical Shopping/Domestic/Household Maintenance Service

- ◆ Every local authority should identify the need for a practical shopping/domestic/household service, and arrange it comprehensively.

#### A Service Development Centre for Older People

- ◆ The Executive should, in 2001, set up an older people's service development centre to champion the development of good and innovative community care services, promote training and assist implementation of the Group's proposals.

### 2. IMPROVING JOINT WORKING

#### Single Assessments

- ◆ Agencies locally should have in place single, shared assessment tools and supporting procedures initially for older people and for those with dementia, and thereafter for all client groups

#### Intensive Care Management

- ◆ The Scottish Executive should redefine care management as 'Intensive Care Management', which will be for people with complex or frequently changing needs.
- ◆ Care managers should be trained in 'Intensive Care Management' throughout 2001-2002. Only those who have undertaken such training should carry out 'Intensive Care Management'.

#### Information Sharing

- ◆ The Scottish Executive should, by 2002, offer a strategic lead on the development of community care information, information sharing and systems integration.

- ◆ Locally, the arrangements for single shared assessments should include specific proposals for the necessary sharing of information between agencies, by obtaining explicit client approval.

### Equipment and Adaptations

- ◆ To modernise and improve equipment and adaptation services, the Scottish Executive should establish a strategic overview, and set out a programme of change that will require agencies locally to integrate equipment and adaptation services with the rest of community care services, and put in place a number of specific measures that will result in a better-focused and more effective service for the user.

### Occupational Therapy Services

- ◆ To target occupational therapy services more effectively, agencies need to modernise equipment and adaptation services, and to remove duplication between hospital and community based occupational therapy services wherever practical. For community care services that reorganisation needs to begin as soon as possible, followed by the rest of health and social care within the context of the wider agenda for joined up health, housing and social care services.

## **3. PLANNING, FINANCIAL AND SERVICE MANAGEMENT FRAMEWORKS**

### National Planning and Financial Framework

- ◆ The Scottish Executive should set up a programme planning and financial framework, beginning with services for older people in 2001.

### Joint Resourcing and Joint Service Management Locally

- ◆ Local authorities (that is social work and housing), health boards, NHS trusts and Scottish Homes should draw up local partnership agreements, including a clear programme for local joint resourcing and joint management of community care services collectively or for each care user group individually.
- ◆ As a step towards that, and recognising current progress on the ground, every area should introduce joint resourcing and joint management of services for older people, and in preparation for that introduce shadow arrangements.

## **4. CHARGING**

- ◆ COSLA should develop guidance on charging policies to reduce the inconsistencies in home care charging.

## **5. GOOD PRACTICE**

- ◆ The Scottish Executive should identify measures to improve the collection and dissemination of good practice by linking together the bodies in the field in a more cohesive structure, using the benefits of networking and information technology.

**EAST DUNBARTONSHIRE JOINT FUTURE CONSULTATION  
RESPONSES FROM NHS INTERESTS**

1. Primary Care Trust including contributions from:-
  - LHCC Woodlands
  - North Division of Psychiatrists
  - LHCC ABM
    - District Nurses Response
    - Health Visitors
  - East Division of Psychiatrists
  - Mental health Partnership Forum
  - Community Physical Disability Team
  - Nursing Advisory Committee
  - The Alcohol and Drug Directorate
  - North East Sector AHP
  - Primary Care Division
  - Trust Psychiatric Advisory Committee
2. Area Partnership Forum
3. Advisory committees, nursing, medical and LHCC.
4. Greater Glasgow Local Health Council.
5. Strathkelvin and Anniesland/Bearsden/Milngavie LHCCS.
6. Mental health team
7. Older peoples team
8. Older peoples mental health team
9. Joint Commissioning Team; mental health
10. 15 individual mental health staff