

Greater Glasgow NHS Board

**Board Meeting
Tuesday, 19th August, 2003.**

Board Paper No. 03/51

Chief Executive, GGNHSB

WHITE PAPER: PARTNERSHIP FOR CARE – CONSULTATION PROPOSALS

Recommendation:

The Board is asked to:

- i) approve the attached consultation paper which seeks comment by 28th November, 2003 on the Dissolution of NHS Trusts within Greater Glasgow;**
- ii) note that a further consultation paper on the Creation of Community Health Partnerships will be brought to the Board for consideration in December, 2003, allowing consultation on both proposals to proceed between January and March, 2004.**

1. BACKGROUND

1.1 The Health White Paper “Partnership for Care” and the accompanying Health Department letter of guidance (HDL (2003) 11) require NHS Boards to consult publicly on two issues: the dissolution of NHS Trusts and the move within “single system” working to Operating Divisions; and the creation of Community Health Partnerships.

2. THE DRAFT CONSULTATION PAPER

2.1 The attached, draft consultation paper has three purposes. First, it seeks comments, by 28th November, 2003 on the dissolution of the four NHS Trusts within Greater Glasgow and their replacement with four Operating Divisions. The aim is to move to these new arrangements with effect from 1st April, 2004.

2.2 The paper’s second purpose is to set out the process by which the proposals for developing Community Health Partnerships will be taken forward over the coming months, such that formal consultation on these proposals can proceed in the period from January to March, 2004. Given the significant developmental challenge involved in the move to Community Health Partnerships, an implementation date for this change of 1st April, 2005 is proposed.

2.3 The third purpose of the consultation paper is to set out how the NHS Board proposes to deliver the key priorities within the White Paper. The consultation paper describes how some key organisational development challenges will be taken forward and how the Board will work to develop detailed schemes of delegation over the coming months such that the White Paper's imperative to devolve decision making responsibilities to Operating Divisions and, within those Divisions to frontline staff, is secured.

3. NEXT STEPS

3.1 The Board is asked to consider the consultation paper and to agree that the paper, amended if necessary in the light of the Board's discussion, is issued to consultees.

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NHS Greater Glasgow

Consultation Paper on Implementing “Partnership for Care”: Scotland’s Health White Paper

1. INTRODUCTION

1.1 Scotland’s Health White Paper, *Partnership for Care*, was published in February 2003. The focus of the White Paper is the promotion of health in the broadest possible sense and the creation of a modernised, patient-focused health service that is fit for the 21st century. Significant investment to bring about a step change in health improvement is now being matched by reform of the way health services are managed.

2. THE KEY THEMES WITHIN “PARTNERSHIP FOR CARE”

2.1 Five key interlinked themes presented in *Partnership for Care* drive this vision:

- a) Improving health – A new approach, including a statutory duty for NHS Boards, to improve health in Scotland and to reduce health inequalities. There will be a sustained effort to tackle the life circumstances and lifestyles that damage health, and Community Planning is seen as a prime vehicle for this. As the subsequent policy paper “Health Improvement: The Challenge” sets out, the focus will be on four areas: early years, teenage transition, the workplace and in communities.
- b) Listening to patients – Creating a patient-centred National Health Service, with a new statement of patient’s rights and responsibilities. The emphasis is on patient participation, empowerment and full partnership in their health care. There is to be better complaint handling, and better health information through services such as NHS 24.
- c) Higher standards of health care – Tackling waiting times through a new system of treatment guarantees and targets. Patients will be involved in developing standards for service delivery, and there will be a stronger role for inspecting performance against standards. There will be action to ensure clean hospitals, and a stronger role for intervention when health care standards are not met.
- d) Partnership, integration and redesign – Whole system redesign to deliver integrated services and enhanced partnership working to enable higher standards of health care to be delivered. New Community Health Partnerships will enable better integration of primary care health services with both social work and hospital services. Major redesign initiatives will involve patients and take integrated services across traditional boundaries.

- e) Empowering and equipping staff – Strengthening the partnership of NHS Scotland and staff, who are the drivers for this change. There will be greater investment in staff to provide them with what they need to do their best for patients, with new support for professional development and training. Better reward systems for staff at all levels will progress alongside support for local leadership in service redesign and more resources will be devoted to workforce planning and development.

3. THE CONTEXT WITHIN NHS GREATER GLASGOW

- 3.1 These visionary drivers present significant opportunities for Glasgow, but also significant challenges, given the unique health and social care needs we face. 70% of Glasgow City's population lives in highly deprived areas, compared to 50% in the NHS Greater Glasgow area and less than 20% in Scotland overall. Illness caused by cancer, heart disease, addictions and poor dental health has a significantly greater impact on the health of the citizens of Glasgow. The challenge is therefore immense.
- 3.2 What is required therefore is a better way to meet this challenge. However, the change we are consulting on now is not about major structural reconfiguration, but rather how to work more effectively in partnership to deliver integrated services.
- 3.3 The purpose of this Paper, therefore, is to consult on dissolving NHS Trusts in Greater Glasgow and establishing an NHS system based on Operating Divisions and Community Health Partnerships (CHPs). This proposal for consultation is presented in the following section, and we then develop the White Paper's themes in a number of areas that relate specifically to NHS Greater Glasgow's circumstances.

4. PROPOSAL FOR CONSULTATION

- 4.1 The agenda which NHS Greater Glasgow is taking forward is formidable. It is vital that the Board's energies are directed towards delivering the priorities within the White Paper, through developing new ways of working and not least by strengthening the relationship between managers and clinical leaders.
- 4.2 The dissolution of NHS Trusts is not a return to the NHS prior to their establishment, but rather an opportunity to build on their experience and success over the past decade while adding value through a single system pan-Glasgow approach.

The aim is therefore to establish effective partnerships among all providers of health services in Greater Glasgow. It is crucially important not to lose the momentum needed to deliver the Board's key responsibilities and objectives. This is not to rule out further structural change in the future – which will be required to set up Community Health Partnerships and push forward the Joint Future agenda with Local Authorities - but this change will evolve to deliver the objectives of NHS Greater Glasgow and our service partners. This will demand a strengthening of leadership across the new integrated approach to health care and health improvement.

- 4.3 NHS Greater Glasgow's proposals for establishing Operating Divisions must be submitted to the Scottish Executive Health Department (SEHD) in December, 2003 so that the move to single system working can take place in April 2004. The Divisions will form part of a single statutory NHS organisation for Greater Glasgow and thereby further enhance single system decision making and working. The touchstone of the success of Operating Divisions will be the extent to which they are delivering through evolutionary change our vision for NHS Greater Glasgow.
- 4.4 The Divisions will be large, complex bodies requiring strong leadership and direction. Some of the Divisions in NHS Greater Glasgow will be larger than many of the NHS Boards in the rest of Scotland. The table below presents a picture of this size.

Operating Division	Expenditure £m	Staff
North Glasgow	481	13,000
South Glasgow	229	5,500
Yorkhill	96	2,200
Primary Care	516	12,300

This migration gives the Board the right structure to ensure that it moves forward its key priorities for action.

- 4.5 The purpose and functions of the Operating Divisions will include:
- Implement the strategic plans of the NHS Greater Glasgow system.
 - Organise and provide health services that are appropriate to the needs of Greater Glasgow.
 - Take operational decisions and manage the delivery of health services within the governance framework of the Greater Glasgow NHS Board.
 - Devolve real management authority to the local level by empowering frontline staff.
 - Integrate primary and secondary care services, namely GP/community and hospital services.
 - Facilitate the establishment of CHPs, engaging with Community Planning partners and maximising population alignment with Local Authorities.

Examples of this integration of services are already developing within the Cancer Clinical Networks where clinicians are driving forward new approaches to care.

4.6 This proposal for Operating Divisions builds on the progress made in Greater Glasgow since the establishment in October, 2001 of a single NHS Board, which takes a corporate, inclusive approach to decision making. It is the next logical step in establishing a single system across NHS Greater Glasgow. The implementation of the key drivers within the White Paper will enable delivery of a number of advantages for patients in Greater Glasgow:

- More local services delivered in local communities.
- Safe and high quality health care in modernised hospitals.
- Shorter waiting times through redesigned services.
- Better health information and advice, and better support mechanisms for people to be healthy.
- Better public involvement in planning services.
- Partnership of patients in decision making.

4.7 There are also advantages for NHS staff in these proposals:

- A new opportunity to contribute to service modernisation.
- New reward systems and skill development.
- Enhanced partnership working.
- Support for professional development.
- Support for local leadership.
- New approach on workforce development and planning.

4.8 If health improvement is our ultimate aim, there are also a number of key areas where change will enable us to deliver our vision. These areas of change include:

- Enhancing operational leadership and the contribution of clinical leaders.
- Shaping NHS Greater Glasgow as a single employer and a single system.
- Establishing Community Health Partnerships

Our proposals in each of these key change areas are discussed in the following sections.

5. ENHANCING LEADERSHIP AND THE CONTRIBUTION OF CLINICAL LEADERSHIP IN NHS GREATER GLASGOW

5.1 The contribution of leaders throughout NHS Greater Glasgow will play a vital part in ensuring that the NHS Board fulfils the challenges set out in "Partnership for Care". The NHS Board wants to encourage an environment in which new ideas are brought forward and supported and where the development of managers and clinical leaders together strengthens their ability to make choices and take decisions.

5.2 The White Paper also emphasises the need to devolve responsibility to frontline staff. The Greater Glasgow NHS Board is committed to strengthening the role of clinical leaders at all levels across our health care system: at Board, Divisional, directorate and ward, team and departmental levels. We recognise that the initiation and implementation of service improvement will come faster if clinical staff are fully involved in developing and shaping this change. We recognise also that the development of this leadership capacity requires a commitment of time and resources.

- 5.3 There are a number of strands in our approach to enhancing the role of clinical leadership. First is the role of clinical leadership in the pan-Glasgow context to redesign services. The major investment in acute hospitals means that changes in how and where we deliver services to patients will impact significantly on the design of clinical services. We have been developing strong links with our local authority partners, particularly in taking forward the recommendations of the “Joint Future” report for modernising community care. We will involve further our academic partners in the workforce development plan and, as appropriate, in the design of clinical facilities to support service delivery.
- 5.4 A second strand is the role that clinical leaders will play at the operational level in driving change in key service areas, such as improving access and waiting times, streamlining diagnostic pathways and improving clinical outcomes. These areas are key to improving care in Greater Glasgow, and our support for local clinical leadership in service redesign will enable our pan-Glasgow objectives to be met.
- 5.5 There is, therefore, a need to enhance clinical leadership capacity in NHS Greater Glasgow. We will build on the strengths we currently have to:
- Ensure clinical leaders are at all levels across the health care system.
 - Strengthen relationships with our academic partners.
 - Develop our clinical advisory functions.
 - Expand our managed clinical networks.
- 5.6 We will work to ensure success by developing new opportunities by:
- Introducing a Glasgow-wide Clinical Leadership Development Programme for all clinical professional groups to develop the clinical leaders of tomorrow.
 - Investing in succession planning.
 - Introducing where appropriate new roles such as Nurse Consultants and Allied Health Professional Consultants.
 - Developing whole system clinical leadership roles.
 - Creating multi-disciplinary clinical redesign teams that operate across Greater Glasgow.
 - Exploring new and more flexible ways of working.
 - Enhancing the role of management to work in partnership with clinical leaders.
 - Enhancing clinical appraisal systems.
- 5.7 We are keen to work with the Clinical Advisory Structure to create stronger links with the NHS Board’s key objectives. In that way, the Advisory Structure also would support clinical leaders at the operational level in their efforts to take forward service redesign, and to facilitate change pan-Glasgow to deliver our service strategies.

5.8 We believe we have already made significant progress towards enhancing clinical leadership, but we recognise that much is still to be done. The Board's newly created Medical and Nurse Directors with their clinical colleagues from the Divisions and the Board's clinical advisory structure will take forward the implementation of this clinical leadership agenda. This work will connect to the work of the Service Redesign Committee which is charged with the responsibility for approving subsequent years' Change and Innovation Plans.

6. NHS GREATER GLASGOW AS A SINGLE EMPLOYER AND A SINGLE SYSTEM

6.1 The previous section of this paper emphasised the importance of developing leaders as a key responsibility of the NHS Board. In this section of the paper, we consider the transition to NHS Greater Glasgow as a single employer and reflect on the need to address some key policy issues on a pan-Glasgow basis while recognising that the bulk of HR responsibility will continue to be discharged within the Operating Divisions.

6.2 We employ over 33,000 staff, making NHS Greater Glasgow one of the largest employers in Scotland. If we are to improve health and health care, we must support, value and empower the staff who deliver care. Key to this is effective team working. This means giving staff the opportunity and incentive to design and deliver integrated services. This will require investment in staff, freeing them to do things better. Staff will initiate and lead service improvement if they are fully involved and understand the context of change. Where staff will have to work differently, they must be involved in driving the change process. Getting the size, shape and skills of the workforce right will be critical against a major change agenda over the next decade in Glasgow. Promoting flexibility and team working, encouraging new ways of working, providing training and development and working in partnership with staff will all be vital if NHS Greater Glasgow is to renew the provision of acute and further develop primary care services.

6.3 Moving from five employing authorities to one overall poses some major challenges. First is the range of issues that the new single employer will need to address on a pan-Glasgow basis, including:

- Workforce Planning – working with our service partners, both academic institutions and local authorities, to ensure that our long term requirements for the type and size of workforce needed for 21st century care is planned today.
- Pay Modernisation – implementing the Agenda for Change programme and the new GMS Contract. There remains also the potential for agreement of a new Consultant Contract.
- Learning Organisation – developing learning plans for staff, in partnership with trade unions, that take into account service redesign and clinical changes.
- Health and Safety – taking a new approach as a single employer to health and safety and occupational health issues, as we move towards developing a safer, healthier workplace.

6.4 A basic tenet of the White Paper and of the national Human Resources Strategy is that these issues will in future need to be addressed on an equitable basis across Glasgow. NHS Trusts' human resource policies often reflected local priorities: single system working will be designed to ensure fairness and consistency of people management policy and practice on a pan-Glasgow basis. This will involve considerable discussion and planning, and staff and trade union representatives will be involved in the decision making process on a partnership basis.

6.5 The implications of this for human resource management in NHS Greater Glasgow as a single employer are significant. We must both set policy at NHS Board level, and devolve decision making to operational levels so that decisions are taken as far as possible by frontline staff. During this consultation period, we will work on a scheme of delegation to make this happen, and will engage our staff in this process to ensure that the best result is achieved.

6.6 Single System Working – Finance and Information and Communications Technology (ICT)

The Board will continue to strengthen its 'single system working' across finance and ICT. The existing arrangements have attempted to anticipate the essential direction of the White Paper which thereby provides a key opportunity to further strengthen the approach. The fundamental driver is the need urgently to modernise services to reflect the advancements in clinical care, to improve patients' experience through the use of technology and to delivery cost effective services. Key priorities for the further development of this approach are summarised in the following paragraphs.

6.7 The Financial Governance Framework

A workshop to discuss **audit arrangements** has already been held, involving members of the Board and Trust Audit Committees, together with internal and external audit. Initial discussion indicated:

- continued need for Trust based focus on the wider "risk management" agenda bringing together:
 - clinical governance;
 - staff governance;
 - financial governance.
- Board-wide Audit Committee to set strategy in terms of:
 - Pan-Glasgow financial governance framework.
 - Related harmonisation of relevant policies and procedures.
 - Sign off of Internal and External Audit Plans.
 - Sign off of NHS Greater Glasgow Consolidated Accounts.

More detailed proposals will be developed and finalised through further discussion.

6.8 Financial Governance Framework

A commitment was made at the same workshop to review existing documentation that comprises the "Financial Governance Framework" in each Trust, with a view to harmonising all existing policies into a Board-wide Financial Governance Framework. Next steps will include discussion with Internal and External Auditors on how to proceed, initially by pulling together existing documentation to establish the extent of differences.

6.9 Scheme of Financial Delegation

Informed by the follow-up action described in 6.7 and 6.8 above, work can then begin on drafting a “scheme of financial delegation” in order to support Board-wide operations after March, 2004.

6.10 Ways of Working within Finance and ICT

The emerging ways of working across the finance function have anticipated many of the messages in the White Paper: an open book approach has been successful in ensuring financial break-even at the end of the previous two years. The core pivot to this process is the regular series of meetings (held at least monthly) between the four Trusts’ and Board’s Directors of Finance. Proposals will be developed to strengthen and consolidate on this approach, not least to support the work of the Board’s Performance and Resources Monitoring Group.

6.11 A Matrix approach to working is already well established across IT and reflects the priority projects as set out in the pan-Glasgow ICT Strategy. That Strategy in turn was developed and driven by Clinicians and their aspirations and hopes for improving the delivery of services to patients by the sensible use of technology. A range of further proposals is being developed to ensure continuing success in the delivery of the Glasgow-wide ICT Strategy. These proposals also will be developed through discussion in the coming weeks and months.

7. DEVELOPING COMMUNITY HEALTH PARTNERSHIPS

7.1 Background

One of the most fundamental proposals within the White Paper is the evolution from Local Health Care Co-operatives (LHCCs) to Community Health Partnerships (CHPs).

The White Paper acknowledges the progress made by LHCCs in developing into responsive and inclusive organisations. It proposes their evolution into Community Health Partnerships, with an enhanced role in service planning and delivery. CHPs will have important roles both in working with Local Authority partners and services and in working with the Operating Divisions within NHS Greater Glasgow to strengthen the primary care\secondary care relationship which is a major priority within the second phase of the Primary Care Strategy.

The proposal is that the CHPs will:

- Ensure patients and a broad range of health care professionals are fully involved in service delivery, design and decisions.
- Establish a substantive partnership with Local Authority services.
- Have a greater responsibility and influence in NHS resource deployment.
- Play a central role in service redesign.
- Act as a focus for integrating primary care, Local Authority and specialist health services.
- Play a pivotal role in delivering health improvement.

7.2 NHS Boards are required to review the organisation and operation of their existing LHCCs by early 2004, with these objectives in mind. Within the same timescale we are required to produce – with Local Authority partners – plans to ensure more effective working with social care in locality arrangements. A further requirement is that NHS Boards must also work with Local Authorities to review how service planning and delivery can be better designed to meet community needs. A particular challenge for us in NHS Greater Glasgow will be to support our Local Authority partners in designing CHPs tailored to meet local requirements, yet also ensuring a degree of uniformity across the CHP structures.

The results of this planning process with Local Authorities will show how we will:

- Maximise co-terminosity of service provision and organisational boundaries.
- Target funding at integrated services.
- Empower NHS and Local Authority staff who provide care with clear schemes of delegation.
- Extend joint resourcing and management to mental health services from April 2004.

7.3 These arrangements are to be reflected in the Local Partnership Agreements, which are our key joint documents with Local Authorities, to include:

- Reduced bureaucracy and duplication.
- Modern and integrated community services focused on natural localities.
- Integrated community and specialist health care through clinical and care networks.
- Organisations which support achievement of service delivery.

7.4 Moving on from LHCCs

Greater Glasgow has 16 LHCCs – covering populations ranging from 23,000 to 115,000. Our LHCCs have made good progress in delivering the key objectives set for them:

- Modernising and developing primary care services.
- Improving access for patients.
- Improving staffing and ways of working.
- Working with other agencies and secondary care.
- Improving infrastructure in primary care and developing as organisations.
- Contributing to the Local Health Plan.

7.5 Our Primary Care Strategy reflects strong service improvement and change agendas – for chronic diseases, older people and mental health – that have been driven by LHCCs to remove health inequalities. In moving to CHPs, we want to accelerate progress in a number of areas:

- Service integration with Local Authorities, including for children's services
- Networking services with secondary and specialist care, reflecting the ongoing investment in new hospitals and the redesign of services

- Developing comprehensive approaches to health improvement
- Achieving real community engagement and influence on planning and strategy
- Developing clinical networks and engagement between primary and secondary care

7.6 Three other opportunities emerge from the development of CHPs:

- Access – We would also like to explore the benefit that can result from combining the establishment of CHPs with service redesign to improve access to services. The development of services at a local level should both impact the demand for hospital services and enable patients to more readily return to their home or care in a community setting.
- Inclusion – A further opportunity will be to explore the potential for wider responsibilities for regeneration and social inclusion as we develop the CHPs. The migration to Community Health Partnerships must build on the strengths of LHCCs, but also recognise that CHPs will be significantly different entities, with much greater resources, autonomy and responsibilities, and stronger accountability, than current LHCC arrangements.
- Patients and public – Amongst the key roles of CHPs will be ensuring that they maintain an effective dialogue with their local communities through the development of the local Public Partnership Forum (PPF). The Health Department's guidance stresses that these Forums should be as representative as possible. While CHPs will be accountable to the NHS Board, they will be responsible through their PPF to the communities for which they are provide services.

A key aspect of an NHS Board's scheme for establishing CHPs will be the proposals for obtaining the widest possible representation on its Public Partnership Forum. The consultation guidance makes clear the Health Department's expectation that these proposals will have been developed with the active involvement of local stakeholders and will carry the explicit endorsement of the Local Advisory Council. In developing proposals for the creation of these local forums, the NHS Board will be able to build on the excellent work undertaken within a number of LHCCs in Greater Glasgow in developing arrangements for patient and public involvement.

7.7 Moving to CHPs: Scottish Executive Guidance

The White Paper was not detailed or prescriptive in its propositions about Community Health Partnerships. Further guidance issued for consultation in mid-July 2003 sets out more details of national thinking, and includes a number of points similar with our own initial thinking and discussions, including:

- Confirming the focus of CHPs as health improvement, better services and community involvement, and their role as a key influence on strategic planning and resource allocation.
- Confirming the emphasis on the implementation of the Joint Future agenda on service integration alongside the development of CHPs, and re-emphasising CHPs as the substantive partnership with Local Authorities.

- Proposing expanded roles in health improvement and promoting the role for CHPs in the health improvement component of community planning.
- Including the integration of children's services in thinking about CHPs.
- Establishing the substantial status of CHPs within NHS operational structures.
- Creating networks with hospital and specialist practitioners.

7.8 Establishing CHPs in Greater Glasgow

Our intention is to achieve an approach to the development of Community Health Partnerships in Greater Glasgow characterised by a highly inclusive process, recognising the wide range of stakeholders who should shape the Partnerships and have a role in them, and evolution of existing LHCC arrangements in a way which maintains primary care commitment and the existing momentum for change and development within Co-ops.

- 7.9 Alignment with other critical policy imperatives – including implementing the Joint Future agenda, rising to the Health Improvement Challenge, and bridging the divide between primary and secondary care – is important, as is recognising the potential impact on a wide range of staff of these changes and ensuring a partnership approach.
- 7.10 We have already held an open event, attended by a wide range of NHS staff, to begin to discuss what we want CHPs to achieve. This reflects the importance of strengthening the linkages and interactions within the NHS, not least between the Primary and Secondary Care Sectors. An NHS Steering Group has been formed, representing LHCCs, Acute and Children's Trusts, Health Promotion and Public Health. The objective of this group is to contribute to the shaping of our proposals.
- 7.11 We regard Local Authorities as key partners in developing CHPs if we are to achieve their full potential. We have agreed a process with each Authority – running in parallel to the Steering Group, to ensure their direct influence on the CHP profile for their area.
- 7.12 Our aim is to conclude proposals on the key principles to establish CHPs by **December 2003**. These should include:
- Boundaries for CHPs
 - What services, budgets and staff are directly managed by CHPs
 - Scheme of delegation to CHPs and partners within these organisations
 - How accountability of CHPs will be organised
 - How key CHP interfaces will be managed
 - How CHPs will influence strategic planning and resource allocation
 - How CHPs will relate to other NHS and Local Authority operational structures

We have to be clear about how CHPs will operate and how they will make a difference.

7.13 These principles should be agreed with each Local Authority prior to consideration by the NHS Board, for full and inclusive consultation, enabling final decisions to be taken in **April 2004**. We believe that the potentially profound changes which we may wish to propose will require a further twelve month development period, leading to full implementation in **April 2005**.

7.14 We do not expect CHPs to affect the employment arrangements of the vast majority of staff, but there are likely to be changes to accountability arrangements and responsibilities of some staff, reflecting the final arrangements. A key objective of the development process outlined above will be to ensure staff are well informed about what is going on and are able to influence our thinking. We also recognise the clinical, professional and managerial leadership challenge we will need to meet to maximise the potential of CHPs. A key strand of our development work will be putting in place a leadership programme for potential CHP leaders to ensure we equip key staff for the challenge of change and leadership.

8. DELIVERING OUR VISION

8.1 The agenda which NHS Greater Glasgow is taking forward is formidable. It is vital that the Board's energies are directed towards delivering the priorities within the White Paper, through developing new ways of working and not least by strengthening the relationship between managers and clinical leaders.

8.2 Moving from NHS Trusts to Operating Divisions is just one part of delivering our vision in NHS Greater Glasgow to achieve the objectives in *Partnership for Care*. Our ideas outlined above for developing clinical leadership, operating as one employing authority and one system and establishing Community Health Partnerships all provide substance behind this Consultation Paper.

8.3 During the period of consultation, we will be developing a scheme of delegation to ensure the effective delivery of our strategy. We have stressed that this unitary structure is not one of centralisation, but rather enabling decisions to be reached and implemented at an operational level – not only in Divisions and CHPs, but also at directorate, ward, team and department levels. Throughout the emphasis has been on a patient focused NHS.

8.4 This scheme of delegation and supporting guidance will describe how NHS Greater Glasgow will work to ensure the vision of *Partnership for Care* is achieved. Improving health in the broadest sense is our aim, and we will maximise the best practices of governance – clinical, staff and corporate – to make this happen.

9. DEVELOPING OUR PROPOSALS

9.1 This consultation paper starts a process of involvement and discussion which will continue over the next three months. During that period, there will be a programme of discussions arranged with the Advisory Structure, Partnership Forums, the Health Council, and with staff in order to develop the detailed implementation arrangements. Individuals and Groups will have the facility to participate both through the arrangements described above or through submitting individual views in response to this consultation paper.

9.2 Formal responses to this paper should be sent to:

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Responses should be made by Friday, 28th November, 2003.

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