

Greater Glasgow NHS Board

Board Meeting

Tuesday, 16 September 2003

Board Paper No. 03/55



Director of Planning and Community Care

Service Redesign Committee - Proposals

Recommendation:-

The Board discuss the establishment of its Service Redesign and Innovation Committee and agree its: Chair, Membership & Remit.

1. INTRODUCTION & BACKGROUND

This Paper sets out progress in developing proposals to establish a Service Redesign Committee.

- 1.1 The Health White Paper included a very strong, crosscutting focus on service redesign.

There is a clear intention that:

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

NHS Boards are expected to co-ordinate redesign activity by putting in place service redesign programmes and developing a Change and Innovation Plan that is specific, prioritised and resourced.

Plans must:

- Demonstrate active participation by patients and leadership by clinicians;
- Challenge traditional boundaries of service delivery;
- Develop sustainable services;
- Ensure information systems support changing patterns of care.

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

These proposed local arrangements are to be underpinned by national support for service redesign through the work of the newly created Centre for Change and Innovation (CCI). The CCI will provide practical support and expertise to help the NHS in Scotland improve the way in which care is provided for patients. The CCI draft work programme is **Attachment 1**.

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

Significant examples include:

- The Primary Care Strategy – putting innovative services into local communities and new resources into primary care;
- Clinical planning groups leading service change for heart diseases and stroke;
- A radical Information Strategy, well into implementation;
- Modernising Mental Health – shifting the balance of care and implementing new clinical services;
- Managed clinical networks for cancer developing programmes of service change;
- Integrated and highly accessible sexual health services at the Sandyford Initiative;
- Integrated older peoples services with Local Authorities.

Attachment 2 to this paper is our initial Change of Innovation Plan, which describes a range of these activities. The Plan was required to demonstrate:-

- Active participation by patients and leadership by clinician;
- Challenge to traditional service boundaries;
- Sustainable services;
- Information systems supporting changing patterns of care.

And to reflect three key priorities:

- Developing community health services;
- Integration and managed clinical networks;
- Producing definitive membership proposals to reflect that final role and remit.

Our plan was approved and funding has been released for 2003/04.

We now need to make decisions on the establishment of the Service Redesign Committee.

2. PROCESS SO FAR

In order to scope out the remit and membership of the Committee we ran two short Workshops with a wide range of interests, including Clinical Staff, Managers and the Local Health Council.

The Centre for Change and Innovation also participated in our discussions. The purpose of the sessions was to consider the SEHD guidance on Service Redesign Committees and how we should establish an effective Committee for Greater Glasgow. We debated extensively issues around the remit, membership and connections the Committee needed. At it's extremes the discussion could be characterised as the choice between a highly active, visible Committee, driving a significant programme of work and with direct decision making on resources – to a coordinating and facilitating role but with limited direct decision making, rather linking to existing planning, decision making and resource allocation processes. Similarly, the debate about membership ranged from an assembly of the visual suspects from advisory structures, the management and the Health Council – to more radical approaches, for example inviting staff to nominate successful innovators or holding elections to the Committee.

The following section describes in more detail the themes emerging from the discussions and Section 4 suggests a number of conclusions for the Board to consider. The essence of the dilemma we have is to find a way of establishing this Committee, which adds value to the work of Trusts and their staff in driving service change and innovation across the massive range of services, and patient events, which we deliver.

3. ISSUES FROM DISCUSSION

A number of headline themes emerged from our two meetings. These have been clustered into the following headings:

- Resources
- Staff Capacity
- Membership
- Developing the Annual Plan
- Programme of activity

3.1 Resources

The potential construct of the Committee in terms of resources ranges from deployment of significant funding to a very limited role in funding decisions. The sense of the two meetings can be summarised as follows:-

- Major funding decisions should be made through the Local Health Plan process - there was not general support for a significant and separate bidding process under the auspices of the Committee for recurring funds.
- There is a need to be able to deploy some resources to support redesign activity, for example freeing up staff time and double running, while change is implemented.
- Support was also expressed for the Committee having resources possibly through endowment funding, to offer bursaries or grants to individuals or teams to carry out redesign or training for it.

3.2 Staff Capacity

We identified as a key challenge creating time and space for staff to be able to be more reflective about the services they provide and how they as practitioners can change and innovate. A theme we returned to was the extent to which operational pressures mitigate against delivering service changes which requires time, commitment and energy.

There was also some sense that we have created a culture of 'learned helplessness' in some parts of our services, in which staff do not take responsibility for addressing problems and making improvements. We also debated the lack of visibility of information about redesign techniques and considered how effective approaches to what often seem daunting challenges could be delivered. One suggestion was the learning set type approach but this may be better sponsored through Trusts.

There was a consensus that to encourage staff the Committee needed to deliver high visibility for innovation and change efforts, so communication, probably through a properly developed and resourced website, is a fundamental requirement, which could also link to the CCI's developing plans for communications.

3.3 Membership

As the previous section described, there was an extensive debate about membership in both sessions. Clearly form needs to follow function but it would be fair to say that there was an emerging consensus that traditional Committee membership is not appropriate. People felt that we do need to offer membership to innovators and enthusiasts, perhaps with a requirement to be nominated or apply setting out potential contribution the individual can make. The paradox in this approach is the need to also give the Committee corporate clout, traditionally achieved through weighty membership.

Inevitably, there is a need for much wider engagement and two routes emerged from the discussion - firstly, Trust approaches to engaging their own staff in this activity need to be retested and secondly, there was support for an annual major forum for redesign building on the successful experience of the PCT's Quality Conferences.

3.4 Developing The Annual Change And Innovation Plan

The introduction section confirms the SEHD's expectation that Boards should submit an annual Change and Innovation Plan to access their Arbutnott share of the centrally held resources.

We discussed the role the Committee should play in the development and of submission of the Plan. It would not be possible or appropriate for all redesign and innovation activity to take place under the direction of the Committee. Our initial 2003/04 Plan set out the wide range of these activities which are already embedded in our Local Health Plan and core activity within NHS Trusts and SE Guidance confirms the key link the Local Health Plan in developing programmes of change and innovation.

It is proposed that the Service Redesign and Innovation Committee draws out of the mass of activity associated within the Local Health Plan the content of the Change and Innovation Plan. In addition, consideration should be given to whether the Committee promotes and sponsors new redesign activity where it identifies significant issues or gaps. This point relates to the programme of activity section below:

3.5 Programme of Activity

In trying to map out a coherent meaningful programme of activity for a Committee we identified a number of dilemmas:-

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

4. CONCLUSION

It is suggested that the Board discuss the proposals set out below as the basis for a Membership and Committee remit which would enable us to move to early establishment. These proposals are drawn from the debates and dilemmas outlined above.

We could establish a Committee anchored on the following propositions, that the Committee is:-

- Has membership drawn together in an innovative way reflecting enthusiastic and committed redesigners rather than traditional nomination routes.
- The Committee pulls together the Change and Innovation Plan, mainly from the Local Health Plan.
- The Committee has access to limited, non-recurring resources to support initiatives and endowment funding to support and develop staff capability in redesign activity.
- Links to the CCI to influence national policy development.
- Sponsors a small number of priority initiatives reflecting Local Health Plan priorities but not emerging elsewhere.
- Promotes change and redesign activity through identifying issues and gaps and 'gingering up' existing processes and structures to address them.
- Develops a strong communication and good practice profile - accessible to all staff.
- Chaired by a Clinical Board non-executive, John Nugent is willing to take this role, which also offers a clinical dimension and a primary care focus.