EMBARGOED UNTIL DATE OF MEETING.

Greater Glasgow NHS Board

Board Meeting
Tuesday, 16th December, 2003

Board Paper No. 03/74

Chief Executive, GGNHSB

OUTCOME OF CONSULTATION ON NHS WHITE PAPER: "PARTNERSHIP FOR CARE"

Recommendation: The Board is asked to:

i) receive and consider the comments submitted by consultees on "Partnership for Care";

ii) ask the Minister for Health and Community Care to dissolve the four existing NHS Trusts to be replaced by four Operating Divisions on 1st April, 2004;

iii) note that a separate consultation paper on the Development of Community Health Partnerships will be brought to the NHS Board for approval at its meeting in January, 2004;

iv) note that a fully detailed Scheme of Delegation will be brought to the Board in February, 2004, allowing a period of further discussion prior to its finalisation in April, 2004.

1. Introduction

1.1 The Minister for Health and Community Care launched the Health White Paper "Partnership for Care" on 27th February, 2003. Based on that White Paper and on subsequent Health Department guidance, the NHS Board approved at its August meeting Greater Glasgow's consultation paper and asked consultees to make their responses by 28th November, 2003. This paper brings back for the NHS Board's consideration the responses received.

2. The Responses Received to the Consultation Paper

2.1 Thirty-four responses to the consultation have been received. A summary of each response, which highlights the key points made in each case, is included in the paper attached at Annex 1 to this report. Full copies of the responses are available to members of the Board if they wish access to these. When the Board has considered this paper and agreed its next steps, an individual response will be sent to each consultee.

3. The Key Issues Arising from Consultees Responses

3.1 The Board's consultation paper was built around five key themes:

- The dissolution of the four existing NHS Trusts and their replacement with four Operating Divisions.
- The importance of enhancing leadership and the contribution of clinical leadership in Greater Glasgow.
- The move within NHS Greater Glasgow to a single employer and a single system.
- The development of Community Health Partnerships.
- The development of a clear Scheme of Delegation as part of the move to 'single system' working.

The next sections of this paper pick up consultees' responses on each of these key themes.

4. The Dissolution of the Four Existing NHS Trusts and Their Replacement with Four Operating Divisions

4.1 There were relatively few comments made by consultees on this issue. However, those consultees who did offer comment highlighted the importance (as indeed was described in the consultation paper itself) of ensuring that a move to 'single system' working did not see a return to previous models of 'command and control' management. Rather, it was emphasised that the opportunity should be taken to build on the strengths of operational management developed by the existing NHS Trusts.

4.2 Two consultees raised the question whether the Board should not consider a move away from a single Operating Division within North Glasgow. The Board had considered this issue specifically as part of the development of the consultation paper and had concluded that a migration from four NHS Trusts to four Operating Divisions represented the appropriate way forward at this point, recognising the potential impact on future structural arrangements which the development of Community Health Partnerships might involve.

4.3 A proposal also was made (as already raised in the discussion about the future strategy for Maternity Services within Greater Glasgow) that consideration be given to the creation of a new Maternal and Child Health Operating Division. Again, it is suggested that the migration of the four Operating Divisions in the same construct as the current NHS Trusts should ensue from 1st April, 2004, with any further change considered in the light of the development of Community Health Partnerships.

5. The Importance of Enhancing Leadership and the Contribution of Clinical Leadership in Greater Glasgow

5.1 Several consultees commented on this theme, largely welcoming the importance attached to it in the consultation paper. While a number of consultees were keen to hear more about the detail of this programme, several commented on the need to ensure that financial resource was made available to support the programme. The importance of linking this development also to service redesign and the role which Managed Clinical Networks will carry in support of that programme were emphasised, as was the need to ensure that Local Authority colleagues had the opportunity also to participate in these wider clinical development programmes.

5.2 A number of consultees also picked up the comments within the Board's paper which encouraged Advisory Committees to have a more proactive role. Several of the Advisory Committees have responded to this challenge, intimating that they are very keen to be able to operate more closely with the Board, not least in the areas of strategy development and service redesign.

6. The Move within NHS Greater Glasgow to a Single Employer and a Single System

6.1 There were several comments offered by consultees about this aspect of the consultation paper. Some emphasised that the proposed changes should be seen as an opportunity to built through a 'single system' pan-Glasgow approach on the trust, experience and success harnessed over recent years. There was also strong endorsement for the pan-Glasgow approach to workforce planning. Other consultees highlighted the need to be able to work across Operating Divisions in order to deliver Glasgow-wide modernisation of services.

6.2 Reflecting on the Human Resource's role and functions as employer of all staff from 1st April, 2004, one consultee argued strongly for the NHS Board to create a senior Human Resource post within the NHS Board to reflect the scale and complexity of the workforce challenges ahead, including harmonisation issues, workforce planning and organisational development. The responsibilities within this post must, however, be balanced by clear arrangements for operational control at Divisional Level. It should be noted that these issues form part of the development of the Scheme of Delegation whose preparation is covered in the penultimate section of this paper.

7. The Development of Community Health Partnerships

7.1 As the recommendations on the covering page of this paper explained, the development of Community Health Partnerships will be the subject of a separate consultation, with a paper brought to the NHS Board for discussion and approval at its meeting in January, 2004. Thereafter, a three month period of consultation will ensue with a final paper returning to the NHS Board in the Spring of 2004. It is expected that the effective date of operation for Community Health Partnerships will be 1st April, 2005.

7.2 Notwithstanding that there will be a separate consultation process which covers the development of Community Health Partnerships, there were more comments submitted by consultees about their development than about any other aspect of the consultation paper. Recognising that the development of these proposals is "work in progress" currently, this paper offers a brief summary of key points offered thus far by consultees.

7.3 There is strong support from a number of consultees on the development of Community Health Partnerships, building on many of the successful characteristics of Local Health Care Co-operatives (LHCCs). These have included the development of improved infrastructure for Chronic Disease, Services for Older People, and Services for People with Mental Health Problems. Many respondents stressed the importance of developing better interfaces between primary and secondary care, and highlighted the opportunities by which better multi-disciplinary team working would support this. Others stressed also that CHPs should have a strong influence in taking forward the redesign of clinical services, not least in the development of the services within the two Ambulatory Care Hospitals.

7.4 There was strong support also from a number of Local Authorities for the positive and enabling approach which has been developed with Local Authorities as full partners: Local Authority partners envisage CHPs as substantive partnerships between health, Local Authorities and other key interests. Recognising the increasing breadth of responsibility envisaged for CHPs, one Authority suggested that a preferable name might be "Health and Care Partnerships".

7.5 Others highlighted further significant opportunities which the development of CHPs might present, including improved local access to services, better service integration and strengthening local regeneration and Social Inclusion Partnership working. The opportunity to develop a local role in health promotion and health improvement also was highlighted, allied to a clearer role for CHPs in taking forward Community Planning at the locality level.

7.6 A concern was raised by one consultee about the future arrangements for Mental Health Services, expressing a fear that there was a lack of recognition of the complex Mental Health network. There is ongoing discussion about the future arrangements for Mental Health and, indeed, of several other services, including Older People's Mental Health, Child Health and Child Adolescent Psychiatry, and Sexual Health and Family Planning. Further work is being developed within the relevant, existing planning structures responsible for each of these areas.

7.7 The point was also made, in relation to Dental Services, that CHPs offer dentistry opportunities and some potential difficulties. Specifically in relation to the Community Dental Service, the concern expressed about any disaggregation of the present arrangements is accepted though it will be part of the role of CHPs, in taking forward their health improvement responsibilities, to work with the Community Dental Service in shaping the priorities within their localities. The importance also of ensuring that the work of the Oral Health Action Teams is not disrupted as a consequence of organisational change is acknowledged.

7.8 Many of the key issues raised by consultees in relation to the development of Community Health Partnerships are under active consideration currently. Board Members received, as part of the December Seminar briefing, a copy of a draft discussion paper entitled "Community Health Partnerships: Organisation and Resources" which sets out how the key roles of CHPs can be realised. This paper and the key components which it comprises will continue to be developed during the next month such that a formal consultation paper on the development of CHPs can be brought to the Board for consideration in January, 2004.

8. The development of a clear Scheme of Delegation as part of the move to 'single system' working

8.1 A first draft is almost complete of the Scheme of Delegation which must accompany the move to 'single system' working. The Board's consultation papers set out the key elements which this Scheme should comprise. That work has been developed during the consultation period to a point where a draft Scheme will be available early in the New Year. The intention is that there should be an opportunity for further discussion about that draft before a paper is brought to the NHS Board in February. Thereafter, following the Board's consideration of the draft Scheme, there will be an opportunity for further discussion such that a finalised Scheme of Delegation can be concluded in April, 2004.

9. Next Steps

9.1 Following consideration of this paper by the Board, it is recommended that, in relation to the dissolution of the four NHS Trusts in Greater Glasgow, the Minister for Health and Community Care is asked to dissolve these Trust organisations and to replace them with four Operating Divisions on 1st April, 2004. The two other key strands of work described in this paper, on the development of Community Health Partnerships and on the preparation of a Scheme of Delegation, will return to the Board for consideration in January and February, 2004.

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NHS GREATER GLASGOW

WHITE PAPER – PARTNERSHIP FOR CARE
CONSULTATION : SUMMARY OF COMMENTS RECEIVED

PROFESSIONAL ADVISORY COMMITTEES	
Area Medical Committee	▪ Good characteristics of Glasgow's LHCCs should be built upon and it is possible that CHPs might be the natural progression from LHCCs – suggested that current LHCC set-up should not be lost as decision making needs to devolve down. Large CHPs might not be perceived as local enough. ▪ Concern that if an LHCC did not have significant influence on the proposed shape of the CHP, engagement of local patient and professional groups might be lost. Local involving nature of LHCCs is beneficial as the acute sector, social work and primary care should come together at such a forum and be engaged from a local perspective. ▪ Maximising co-terminosity is not a main objective in itself. Concern that due to the pressure of local authority budgets and services there may be a transfer of resources from health to social work which will be to the detriment of health service provision. Cross-boundary issue for resource and services need to be addressed. ▪ NHS Board's aim to have key principles to establish CHPs by December 2003 is, according to general practitioners, ambitious. ▪ On clinical leadership development – PCT have developed a good leadership programme but, as yet, it appears secondary care has not. ▪ CHPs may provide the best opportunity to engage secondary care through either the commissioning of services or control of budgets; CHPs should have a strong influence on the development of service provision in ACADs.
Area Nursing and Midwifery Committee	▪ Operating Divisions – existing arrangements maintained but unclear on grass roots interface between primary and secondary care ▪ Strong leadership needed throughout and across services within Divisions ▪ Devolving Responsibility to Staff – sensitively supported; appropriate training and education and clinical staff must be involved in shaping future services ▪ Clinical Leadership – will the NHS Board ensure that financial support is available to resource clinical leadership, as many staff will be excited and challenged by their future involvement?

Area Nursing and Midwifery Committee (cont'd)	▪ Clinical Advisory Structure – welcome encouragement for Advisory Committees to become more proactive – will build on nurses' reputations as strong and active leaders in shaping services. ▪ Single Employer – huge challenge in moving towards a single way of working – Committee happy to support Human Resources with this challenge. ▪ Audit – clear role for the Advisory structure to influence and support. ▪ Community Health Partnerships (CHPs) – important to get right the interface between primary and secondary care, particularly with ACADs being developed. ▪ Development of CHPs – geography, demographic size – support minimum population size of service. Issues of clinical governance to be considered. - Staffing – linking all professions to the Tiered Model of Promoting Health, Supporting Inclusion gives guidance as to who could be included. - CHPs Leaders – must have operational links to NHS Board, with clear links of delegated authority and support structures. - Boundaries – coterminous with Social Work? ▪ Health Education Establishments – role in delivering education to health care staff must support the shape of strategic direction. How will this be achieved? Learning and leadership programme would be beneficial.
Area Dental Committee	▪ CHPs – offers dentistry opportunities and some difficulties. CHP boundaries need to be clearly defined and hope co-terminous with NHSGG and local authority boundaries. ▪ Sub-division of general dental practice administration between CHPs could be problematic – large catchment areas for patients. Possible changes to contract should be borne in mind. ▪ Community Dental Service (CDS) – best retained as an area-wide directorate; service re-design is moving to a structure based on population groups rather than geographic areas. Implications for CDS in possible re-alignment of NHS Board boundaries. ▪ Moving to CHPs – ensure that Oral Health Action Team's work is not disrupted.
Area Allied Health Professions Committee	▪ Welcome attempt to put White Paper into a local context and would welcome a clear change management programme developing out of the consultation.

Area Allied Health Professions Committee (cont'd)	▪ Key themes – welcomed; important to develop minimum standards around some of the themes, especially listening to patients and empowering and equipping staff. ▪ Staff will welcome opportunity to contribute to service modernisation and to professional development – hope it's for all grades of staff irrespective of full time or part time working. ▪ Broadly agrees with the re-focusing of leadership and the streamlining of clinical and operational lines of responsibility; keen to know the detailed clinical leadership programme and how this would complement the work currently being carried out locally. Area clinical leadership or linked to CHPs. ▪ Managed clinical networks must take everyone along. ▪ Clarity required around the process of developing allied health professional consultant posts; must be equitably distributed across the professions and the city. ▪ Existing advisory structure for AHPs should be enhanced; existing committees at Trust and NHS Board level should change from a consultative role to a more proactive planning role. ▪ Support for the move to a Glasgow-wide workforce planning. Learning organisation – does this include NHS university and experiential learning? ▪ CHPs – welcome principles underlying their development. ▪ Better service provision should include rehabilitation? specialist practitioners and would require additional resource to the ▪ Alignment with the joint future agenda is a significant challenge with regard to structures and boundaries.
PCT – AHP Advisory Committee	▪ Redesign would benefit from the involvement of good clinical leaders (capacity issue needs to be considered). ▪ Minimum standards should be developed around listening to patients and empowering and equipping staff. ▪ Seek detail of clinical leadership programme and how it will complement local work. Area clinical leadership or linked to CHPs. ▪ Clarity needed on developing AHP consultants. ▪ AHP Committee – enhance role – more proactive, planning role. ▪ Welcomes pan-Glasgow workforce planning.

PCT – AHP Advisory Committee (cont'd)	▪ Supports principles of development of CHPs. ▪ Alignment with Joint Future agenda – challenge with regard to structures and boundaries.
Area Optometric Committee	▪ Welcomes encouragement of patient involvement in their own health care. ▪ Welcomes central role given to the primary care team in the new Community Health Partnerships; wish to contribute at an early stage in the establishment and development of CHPs. ▪ Looking forward to multi-disciplinary team working to bridge the gulf between primary and secondary care and thereby improving the service for the patient. ▪ Information flow to and from the Optometrist practices to Ophthalmology Departments is poor, variable and, on occasions, non-existent. ▪ Welcomes the formation of NHS Quality Improvement Scotland as a single quality body for health with the power of rigorous and independent monitoring and inspection and the ability to tackle service failure. ▪ Capacity available within optometric practice to assist both Ophthalmologists and general medical practice in the diagnosis, treatment and management of patients both with acute and chronic eye conditions. ▪ Glasgow integrated eye service – an example of a newly developed clinical care network which has helped reduce waiting times in South Glasgow. ▪ Looking forward to contributing to the integrated care record; hope to increase role in glaucoma and age-related macular degeneration monitoring, cataract assessment and screening of diabetic patients. Plans to increase prescribing rights will enable Optometrists to diagnose, care and treat some patients in primary care. ▪ Hope that information of children's visual screening and eye examinations is saved in the children's services record.
Area Pharmaceutical Committee	▪ Trust Chief Pharmacist should move into corresponding lead roles in the four operating divisions as clinical directors to reflect their need for influence and access to decision makers in the new organisational structure. ▪ Pharmacy should be integral to the CHPs and should be included in the CHP organisational framework. ▪ The potential for partnership between community pharmacy and the voluntary sector should be developed at CHP level.

Area Pharmaceutical Committee (cont'd)	▪ CHP should be utilised as a framework for the development of the community pharmacy role in health improvement in line with the recommendations in the SEHD publications "The Right Medicine" and "Pharmacy for Health". ▪ Integration of primary and secondary care services should include consideration of medicines management and pharmaceutical care.
Dr J Summers, Secretary, Primary Care Trust Psychiatric Advisory Committee	▪ Support for Partnership For Care and agreed with principles underlying the paper – especially focus on improving patient involvement, increasing standards of care, enhancing integration of services and empowering clinical staff. ▪ Concerned that mental health will be subsumed within the development of Community Health Partnerships – similar concern expressed about development of the joint future agenda. Lack of recognition of its specialist secondary care nature with its main aim being the treatment and care of patients with severe enduring mental illness. Lack of recognition of the complex mental health network. ▪ Particular concerns about the possible fragmentation of the network especially the splitting of hospital services from the community and the potential dilution of specialist skills – could lead to marginalisation of both patients and services and hence a move backwards towards asylum-type hospital care. ▪ Strong support for the retention of a city-wide mental health operating division; if linked to primary care, recommend that it be named the Division of Primary Care and Related Community Specialties. ▪ A city-wide division of mental health would assist in maintaining professional standards; implementation of the new mental health legislation; implementation of national clinical guidelines and standards in general. ▪ Full support for moves towards maximising co-terminosity of services, but balanced against potential disruption to patient care. Consistency and continuity are essential elements of care provided to patients with severe enduring mental illness. ▪ The connection between secondary mental health care services and primary care is the relationship which most underpins service delivery; good example – South Psychiatric Sector of Glasgow – how the services try to address the co-terminosity issue. ▪ Full support for idea of clinical leaders having a higher profile and for a programme of developing such clinical leaders as long as it was fully resourced.

LOCAL AUTHORITIES	
Glasgow City Council	▪ The establishment of Community Health Partnerships is broadly welcomed and the Council is keen to play its part in their development. ▪ Some reservations about the detail contained in the consultation paper on CHPs. ▪ Recognition of the complexity attached to delivering co-terminosity, CHPs will provide the opportunity to address this in local joint planning and service delivery processes and to establish effective links with the evolving community planning processes. ▪ Great opportunity for local services to engage with the public and ensure this is coherent with the development of public engagement in community planning. ▪ Undoubted benefits attached to the development of CHPs in providing local responses to local health plan issues – CHPs should work in partnership with existing city-wide health initiatives, particularly in relation to health promotion. ▪ The Council envisages the development of CHPs as the next logical step in implementing the joint future and integrated children's services agenda at a local level and providing the opportunity for further refinement of local planning structures and systems. ▪ Substantial progress has been made on the issue of co-terminosity – agreement has been reached in principle that CHP boundaries will match at least one and possibly two of the Council's Area Team boundaries – this in itself is a significant step forward. ▪ Locality level planning within children's services is currently being developed – opportunity for CHPs to provide a platform to deliver this. CHPs are being seen by the joint planning partners as a unique opportunity to harness the enthusiasm of stakeholders towards a shared goal. ▪ Within Social Work services briefing papers on the White Paper have been developed with emphasis on CHPs to a large number of community care and children's services. Staff enthusiasm for the establishment of CHPs is evident across the service as a whole. ▪ The Council wish to continue to discuss development of CHPs internally and with NHS colleagues and to date the Council has held an internal seminar for 60 managers to consider detailed thinking on CHPs and on 19 January 2004 will hold a joint event for Social Work Services and NHS managers which is hoped will provide a useful contribution to the Board's formal consultation process on CHPs.

West Dunbartonshire Council	▪ The paper offers a positive and enabling approach to the development of Community Health Partnerships – supported by the proposed divisional structure which the Councils believes will enable a smooth transition from the current Trusts to Operating Divisions by promoting stability during this time of change. ▪ Pleased to note that the proposals identified within the paper for CHPs reflect the Council's views; the report marks a positive progression for the Council's discussions with NHS Greater Glasgow and NHS Argyll and Clyde. ▪ Some concerns about the structure being used to take the proposal forward, in particular the NHS Steering Group – they are a large group entirely made up of NHS personnel. Involvement in planning by local authorities is separate from this and there is a danger that this may be seen as a subsidiary activity to that of the NHS Steering Group. Suggests that the Local Health Plan Steering Group should be used to share progress on CHP development and implementation.
North Lanarkshire Council	▪ Endorses the list of advantages detailed in paragraphs 4.6 and 4.7 of the consultation document, it does appear that the operating divisions are to be established much along the lines of existing NHS Trusts. Might have been helpful to incorporate the reason for retaining existing organisational divisions alongside any other options that may have been feasible. ▪ Welcomes the express need to enhance clinical leadership capacity; for reference to strong links with local authority partners the document is not entirely clear how the "care" aspect will fit with local clinical leadership capacity building. ▪ Recognises the challenge in moving to a single employer and welcomes the detail provided which reflects the considerable level of work that requires to be undertaken in this area. Noted that no mention is made of financial governance framework and the scheme of financial delegation to the powers of delegation which can now be implemented through the new joint working powers of Community Care and Health (Scotland) Act 2001. The intended impact for the service users/patients in future is expected to be considerable. ▪ Welcomes emphasis is given to joint planning/working with local authority partners. Councillors work in close partnership at local level with LHCCs to take forward the joint future agenda through local care partnerships which are co-terminous with LHCCs – with the Cumbernauld Local Care Partnership being attended by appropriate staff from Eastern LHCC in respect of Millerston – Chryston Corridor.

North Lanarkshire Council (cont'd)	▪ Supports notion of Community Health Partnerships functioning as substantive partnerships with local authorities. Population share of North Lanarkshire served by NHS Greater Glasgow is too small to sustain its own community health partnership. Present position whereby NHS staff play into local arrangements is an expedient solution to a structural problem that will remain until such times as NHS boundaries are co-terminous with those of local authorities. ▪ In response to national draft guidance on CHPs, Council replied that it would prefer to name them Health and Care Partnerships – signalling a fundamentally different approach, agenda and endorsing their joint remit.
LOCAL HEALTH COUNCIL	
Local Health Council	▪ Previous concern had been expressed regarding the formation of one Trust in the north of the city – hope new management operational divisions will not result in a repeat of the type of crisis experienced at the Beatson Oncology. ▪ Welcomes recognition that the proposed changes are an opportunity to build on the trust, experience and success through a single system pan-Glasgow approach; notes emphasis that the implementation of the key drivers within the White Paper will enable more services to be delivered in local communities and safe and high quality care in modernised hospitals. ▪ Welcomes wholeheartedly the recognition of a need to improve the involvement of the public in the planning of services and that patients should be in partnership with clinicians in decision making regarding their care. ▪ The over-centralised structure with command and control management had existed between 1974 and 1993 and led to the Health Board being looked on with suspicion by community groups and community leaders. Present proposed change to operational divisions could be perceived as a backward step with loss of local focus. Hope that operational divisions will be able to maintain and strengthen local lines of communications for patients and communities as well as developing local services. ▪ Provided the NHS Board with its response to the SEHD on the national consultation document on establishing Community Health Partnerships.
COMMUNITY COUNCILS	
Chryston Community Council	▪ No objection to the proposals providing they are going to improve the service, particularly the after care service.
NHS TRUSTS	
Yorkhill NHS Trust	▪ Supports the intention to minimise organisational disruption and promote the evolution of attitudes and behaviours.

Yorkhill NHS Trust (cont'd)	▪ Essential to retain robust financial and clinical governance arrangements at divisional level, recognising that Trust staff have felt energised by the operational independence enjoyed over the last 10 years and therefore the new arrangements should not constrain further progress. <u>Views of Staff</u> ▪ Support the health improvement objectives, recognising that the promotion of children's health and well-being has a positive health impact on adult life. Suggestion for the development of a Centre for Child Public Health with a strong link to the proposed Glasgow Centre for Population Health. ▪ Consultation paper appears to be grounded in the belief that the hospital-based NHS Trusts treat Glasgow residents only – about 40% of children treated at the RHSC come from the West of Scotland and beyond. ▪ Essential for NHSGG to consult with its partners regionally and nationally to provide holistic tertiary services in a networked way. Section 9 of the consultation document does not appear to take this point into account. ▪ Support for strengthening financial arrangements to reflect the costs of this caseload. ▪ Encouraged to see that the proposal is not to return to the centralised system of management which prevailed prior to the establishment of Trusts, but to build on the experience and success over the past decade. ▪ Support for the principle of enhancing clinical leadership but clarity sought on resource implications – both human and financial and how leadership programmes will be developed. ▪ Support for addressing human resources across NHSGG on an equitable basis but recognises the need to retain operational autonomy to deal with particular staffing issues in operating divisions. ▪ Recognition that there is no current capacity within NHSGG to assume the human resources role and functions as employer of all staff from 1st April 2004 for support for the creation of a senior human resource post within the NHS Board to reflect the scale and complexity of the workforce challenges, including harmonisation issues, workforce planning and organisational development. Must be balanced by clear local control at operational level. ▪ Enthusiasm from staff to get involved with partnership working and back-filling of key posts would be essential to achieve this.

Yorkhill NHS Trust (cont'd	▪ On finance information and communications technology there is a broad support for single system working providing there is flexibility to allow divisional variations. The White Paper requires the appointment of a clinical director of information management and NHSGG's intention is not clear in this respect. <u>Community Health Partnerships</u> ▪ Broad support for the introduction of CHPs as a natural evolution from the development of LHCCs. ▪ Size of CHPs in population terms is important and may well inform the range of services that will be included. ▪ Delaying the full implementation date for CHPs until April 2005 is extremely sensible and allows the opportunity to organise resource and staff. These new organisations, which will give the opportunity to organise, resource and staff them appropriately. Opportunities arising from these new organisations include: i) Strengthening community engagement; ii) Improving access to services on a local basis; iii) Maximising co-terminosity of service provision; iv) Improving integration of primary health care and community services with Social Work and Education; v) Strengthening management arrangements for existing joint services; vi) Offering comprehensive approach to health improvement; vii) Improving regeneration and social inclusion. ▪ Hope that the creation of CHPs will build on Yorkhill's experience in children's services by strengthening existing arrangements that are already working effectively in addition to supporting new service improvements to be achieved through this approach. ▪ The White Paper offers an opportunity to consider the creation of a new maternal and child health operating division – it would create a single integrated system in order to address issues of equitable provision and coherent management of care across maternal and child health services based on the effective links between enhanced community services and hospital services. Benefits would include:- i) Glasgow-wide model of care with robust supporting structure;

Yorkhill NHS Trust (cont'd)	ii) Improved links between primary, secondary and tertiary care; iii) Solid foundation for developing community midwifery and paediatric services within CHP structure; iv) Continuity for families by linking services for mothers, babies and children. v) Greater integration with local authorities and more effective regional planning of child and maternal health services.
<u>NHS BOARDS</u>	
Argyll & Clyde Health Board	▪ Note the proposal is to replace existing Trusts with Operating Divisions. ▪ Interested in seeing how the 4 Operating Divisions management structures will be re-organised to operate as a single system (Argyll & Clyde have established integrated operating divisions). ▪ Welcome opportunity to discuss developing networking arrangements between primary and secondary/specialist care to ensure a true single system working regardless of organisational boundaries for patients who access NHSGG services from Argyll & Clyde. ▪ NHSGG should review operating divisions management structures and the responsibilities of directorate managers and clinical leads both in primary care and secondary care to include acute and primary/ community service representation on the management teams. ▪ Jointly facing a number of cross-organisational issues including maternity – reflect wider catchment area and policy direction from SEHD. ▪ Wider community served by NHSGG should explicitly figure within proposals for single system working. Need to continue to explicitly demonstrate this by continuing cross-organisational managed clinical network developments and transparency via regional planning process. ▪ <u>Community Health Partnerships</u> i) Broad welcome of the goals and aspirations for developing CHPs. ii) Not enough emphasis given to the critical role of CHPs with regard to primary and secondary care integration from a re-design and modernisation model and its resultant NHS accountabilities. Encourages NHS Board to reflect on this and give it as high a profile within CHP arrangements.

Argyll & Clyde Health Board (cont'd)	iii) Critical that A&CHB and NHSGG work jointly to address the CHP boundaries issue. East Renfrewshire and West Dunbartonshire cross our respective boundaries. NHSGG should consider CHPs being formally represented within divisional management teams both in primary and acute and suggests serious consideration is given to this proposal. ▪ Acknowledges well-constructed consultation proposal which offers a significant and critical opportunity to ensure the successful reform of health services in NHSGG and its wider catchment area.
Dumfries & Galloway NHS Board	No comment
Forth Valley NHS Board	No comment
UNIVERSITIES	
Caledonian University – Schools of Nursing, Midwifery and Community Health and Health and Social Care	▪ Enormity of challenge in meeting a patient-focused health service fit for the 21st Century was recognised. ▪ The five key themes of the paper were thought to raise the profile of education for health professionals and the need for strong partnership working. ▪ Strong emphasis on liaison with academic institutions was welcomed – seen as an opportunity for further involvement of GCU in the provision of formal programmes of education as well as continued professional development, particularly in the area of leadership and clinical practice. ▪ How many CHPs would be formed in comparison to the current number of LHCCs – lack of clarity with co-terminosity with local authority boundaries and lack of clarity regarding who would actually form CHPs, how they would be managed and structured. ▪ How would reorganisation affect the role of present lead nurses and AHPs in Trusts. ▪ Concerns regarding budgeting issues – local authorities holding a budget or RHSC, Yorkhill competing with adult funding. However, integration of children's services being part of the re-design is welcomed. Hope that the opportunity is taken to establish seamless integrated service provision for the child population and their families. ▪ What involvement do HEIs have at this time? ▪ How will CHPs impact on student support and experience in the community and acute areas? ▪ Will there be increased opportunity for students to have an inter-disciplinary experience; will it be feasible for students to have 50% community and 50% institutional experience?

Caledonian University – Schools of Nursing, Midwifery and Community Health and Health and Social Care (cont'd)	▪ Who will make up the community planning partners and what will his role be? ▪ What kind of responsibilities will be devolved in frontline staff – have staff intimated their support for this? ▪ Who will lead the clinical development programme – will it augment the existing leadership programme recently undertaken by health visitors and district nurses. ▪ How many CHPs are expected in Glasgow and how will they be led; will LHCCs be merged or will completely new groups and new boundaries be developed – who will decide? ▪ If local authorities are not part of the CHPs, how will services be integrated and how will this impact on delivery of nursing and social care. ▪ The development of existing occupational health services would be welcomed – will new services be multi-disciplinary?
<u>LHCCs/GPs</u>	
South West LHCC	▪ Welcomes the re-unification of the Board and development of a more coherent approach to the whole system of health care delivery in Glasgow. ▪ Some concerns on the implementation of Community Health Partnerships – potential for primary care to lose its voice as a collective view and primary care may become inhibited by the cost and complexity of the acute sector. ▪ Welcomes the view that CHPs will have an important role in working with local authority partners and working with the operating divisions within NHS Greater Glasgow. ▪ CHPs focus on integrating primary care, local authority and specialist health services requires clarity about the degree of development of such tasks – a clear understanding of the management structure and any joint futures agenda and sufficient resources to enable CHPs to support the clinical 'time out' to deliver change. ▪ Clarity sought on the position of CHPs in relation to other bodies – such as Social Inclusion Partnerships, Community Planning partners and Health Promotion. Views that Health Promotion and its budgets need to be devolved to CHPs. ▪ Welcomes co-terminosity with social work area service team boundaries but assumptions should not be made about the current area social work services boundaries and that these are reviewed along with the review of Local Health Care Co-operative constituencies.

South West LHCC (cont'd)	▪ Concern that the current plans for delivering and developing mental health services do not encourage local whole system approaches – community health services should be managed locally. ▪ LHCCs should contribute to the development of local partnership agreements. ▪ LHCCs would support the development of improved infrastructure for chronic disease, services for older people, services for people with mental health problems and services for people with alcohol and addiction problems and, looking to the future, services for children in devolved structures. ▪ CHPs should have a continuing role in service re-design and be viewed as partners in the development of ambulatory care and diagnostic services. ▪ Access is best done by local clinicians working together within a clinical governance framework although this may mean development at an unequal pace but this is an inevitable part of the innovation agenda. CHPs, together with the Board, can share their experiences for equitable improvement across the city. ▪ CHPs should take the place at the top table of community planning structures and these should be devolved to local patches within the city. Key frustration has been the inability to develop a local role in health promotion as the role has been centralised as a Board function. This is encouraging local communities to see their natural partner as being the Board and not their local community health structures. Will only improve if these functions are devolved to CHPs. ▪ Local public partnership fora welcomed. ▪ Potential for including children's services in CHPs is welcomed. ▪ CHPs must be robust enough to work with secondary care partners on an equal and mutually respectful basis – this could be a most powerful driver for reform and change. ▪ In establishing CHPs any development needs to be inclusive and needs to evidence the benefits of such change. The NHS Steering Group must be seen to be an effective mechanism for ensuring that the huge numbers of staff involved in primary care are truly represented. ▪ Key issues on the development of CHPs need to be communicated clearly and consulted upon in the second phase of the change process – other than LHCC work there has been little activity to ensure staff are well informed about what is going on and able to influence the thinking.

South West LHCC (cont'd)	▪ Change will only be achieved if staff believe it to be meaningful – already considerable anxiety about the nature of the changes. ▪ Unified Board and CHPs – a positive step which will lead to easier links, improved communication, shared agenda and sharing of skills with a fusion of ideas which enhance health and health care in Glasgow. Challenges – devolved responsibilities should attract devolved finance. CHPs can mobilise our resources and do this in partnership with local authorities as well as the acute sector. If poorly done, CHPs could narrow clinical focus, lead to increased boundaries, increased bureaucracy and become reactive to central priority setting rather than proactive organisations taking the lead on the ground.
Dr K O'Neil, South Glasgow Association	▪ Envisaged that CHPs will maintain an effective dialogue with the local communities through the development of local Public Partnership fora for each CHP. ▪ Under the themes and proposals in Partnership for Care:- (a) What should be central and what should be decentralised to a CHP and area management? (b) Should managerial, governance and administrative support be decentralised? (c) If so, how do we avoid a bureaucratic approach? (d) Are joint future partnership arrangements on hold, e.g. LPIGS? (e) How do we protect and empower the local connection? (f) What is the design and development process? ▪ Important to reflect on how we retain a locality focus in terms of population but also the engagement of primary care which has been one of the successes of the LHCC model. ▪ System dynamics, modelling and redesign can only work in a whole system approach. All the key players have a sense of ownership of the agenda and a commitment to improving patient care. ▪ A critical aspect will be public and patient involvement – supported by NHS Quality Improvement Scotland and the new arrangements for the Scottish Health Council. ▪ Direct and care services as service providers must have an accountability framework to CHP. The role of community development also needs to be clarified. ▪ The size and nature of CHPs will dictate the nature of the services that they are capable of providing. Primary care organisations need to develop coherent relationships either with single sector operating divisions or with acute specialties or a mixture of both.

Dr K O'Neil, South Glasgow Association (cont'd)	▪ CHPs may need to align themselves to provide the best partnership mechanism and economies of scale at this interface. ▪ Expectation is that Mental Health Services are an integral part of CHPs – patient focussed services and integration can only work if all the partners are engaged and working within the same accountability framework.
CHURCHES	
Archdiocese of Glasgow	▪ Proposals outlined – positive development. ▪ Welcome development of Community Health Partnerships and strengthening of relationship with Social Services. Maximising co-terminosity of service provision welcomed, together with plan to target funding at integrated services. ▪ Positive move to reduce bureaucracy and devolution of authority to frontline staff.
SIPs/COMMUNITY GROUPS	
North Glasgow Social Inclusion Partnership: Building People's Capacity Sub-Group	▪ Timescale of consultation – limited and restricts ability to engage with partner organisations in formulating a response. ▪ NHS Board should have contacted partners sooner in a different capacity to allow more meaningful discussion on proposals. ▪ Consultation document – more concerned with principles and statements of intent – all very worthwhile and difficult to fault. ▪ With no concrete proposals or options for implementation – difficult to provide a detailed response. ▪ Supports good work of LHCCs – reaffirms need that future partnership structures should build on strong foundations in place (not need to establish parallel structure). ▪ Welcome CHPs evolution to complement and integrate with Joint Futures, Children's Services Planning and Community Care. However, lack of clarity on how this will be achieved – await next set of proposals. CHPs – role on Community Planning agenda – important mechanism for delivering health improvement. However, lack of clarity on future community planning structure in Glasgow seems to work against this being an easy transition. ▪ Welcome commitment to genuine partnership with the public and establishment of public partnership seen as an important mechanism to do this. Caution on utilising representative approach only; use range of different methodologies in engaging the public. Adequate resourcing, clear lines of communication between professional organisations and the public – key to success of these partnerships.

North Glasgow Social Inclusion Partnership: Building People's Capacity Sub-Group (cont'd)	▪ CHPs: i) Co-terminous with LA boundaries, existing planning structures and geographic communities. ii) Scale of Partnerships – balance between delivering strategic objectives and ensuring meaningful public involvement. iii) devolution of powers and resources – carefully considered to allow meaningful decision making at CHP level, with clear lines of accountability between the centre and local levels – would allow access, inclusion and patient/public opportunities to be realised.
South East Health Service Forum	▪ Difficult to respond constructively without single proposal to work on – more a rehearsal of aspirations. ▪ Clinical leadership programme – should be in place already, along with a management approach which encourages staff to develop and use their skills. ▪ New operating divisions – encouraging that public, patients and staff can shape services but disappointing if implication is that they have been denied these opportunities for years. Process should have started before political decisions were made on re-organisation. ▪ NHS Greater Glasgow to recruit public and patient representatives – the NHS Board should have no role in this area. Direct representation to the NHS Board is regarded with deep suspicion, extremely unlikely to reflect the needs of the man in the street and diversity of services in different geographic areas should be reflected in the input to the NHS Board. ▪ On limiting staff changes – true management can involve telling as opposed to asking. Paper reads as though management may be going cap in hand to staff to plead for concessions – requirement to manage must not be compromised. New investment to encourage greater team working – but local management must have ownership of its implementation. Is it not part of the culture already? Human Resource Policies – fairness and consistency – they are not an option. ▪ Community Health Partnerships – More staff? Where from? What for? At what cost? ▪ Complex organisation: would appreciate an organisational chart to reflect who will be responsible to whom for what and where. Aspirations within document are generally beyond reproach but mean little if not accompanied by timetables for delivery and methods of verifying their effectiveness.

STAFF	
31 Consultant Orthopaedic Surgeons	▪ Strong support for an integrated approach with a co-ordinated evidence-based strategy for service redesign ▪ Most effective representation – by reformed Orthopaedic Subcommittee, to ensure strong clinical input to the development and delivery of Change and Innovation plan for establishing a modernised, patient-focused service
Dr C Morrison, Public Health Consultant	▪ Managed Clinical Networks (MCNs) – ideally placed to undertake clinical redesign
	▪ MCN link needed to Operating Divisions and CHPs. ▪ Avoid duplication and overlap if creating new vehicles of linking with local authorities, primary care and specialist health teams. ▪ Pan-Glasgow planning – neglected in document – without it the opportunities for duplication and time wasting are even greater than now.
Mr W O M Davis, Dept of Clinical Physics (by e-mail)	▪ Formidable agenda across NHS Greater Glasgow ▪ Integration of primary care health services with social work and secondary care – appealing; whole system re-design and integrated services vital. ▪ Concern at proposal to establish Operating Divisions; Hospital Divisions set up a decade ago – led to splits in long-established clinical teams serving clinical specialties. Divisions divide. ▪ All staff require to be team stakeholders – staff development, advancement and flexibility must be managed locally – not by remote Divisional Managers.
Mr W O M Davis, Dept of Clinical Physics (by e-mail) (cont'd)	▪ Balance between large complex Divisions requiring strong leadership and devolving real management authority to the local level by empowering frontline staff – the key to success or failure
Ms R Grant, Clinical Training Facilitator (by e-mail)	▪ Staff usually resistant to change – proposals start with little change and then subsequent change later (CHPs). ▪ Boundaries not being removed between primary and secondary care, therefore interface work more difficult. ▪ Key IT integration; if primary and secondary care continue to be in separate Divisions then barriers will remain. ▪ Redesign fundamental – if around local authorities and CHPs, then primary and secondary care should be included at the start. Geographical Divisions would mean a management/leadership structure through all parts of health care shaped around service users' needs and not present organisational structures.

Ms R Grant, Clinical Training Facilitator (by e-mail)(cont'd)	▪ Staff will accept change if they see real improvement in the delivery of service and it is not a vision of constant small change.
Mr DG Paul	▪ Proposed intentions and sentiments for patients – along the current lines, but reservations about whether they will ever be achieved ▪ How will existing NHS Trusts work together in harmony in the future and at what cost? ▪ Who is going to ensure that the public, patients and staff can influence future services, when it is not currently being done on a regular basis? ▪ How are the NHS Board going to recruit staff, public and patient representatives – will it be "those and such as those" who will be invited to participate? ▪ Community Health Partnerships – recruitment? – or have participants already been selected? ▪ Where is the new investment coming from for this change? Existing projects are not being completed due to lack of funds. ▪ No mention how clinical standards, aims and targets will be improved. ▪ No mention of increased training and education for staff and participating patients. ▪ Proposals – a minimum basis of a plan for change, but lacking detail, costing, procedures and timescales.
Mr R Duncan (by e-mail)	▪ Why has North Trust been left as a single unit? Better to have 3 units of roughly equal size.
P Duffy (by e-mail)	▪ External review of diagnostic services highlighted that cross city "divisions" have led to a fragmented, unco-ordinated service. ▪ Fundamental challenge – the need to modernise on a pan-Glasgow basis. ▪ A lot of sense for departments doing the same function to be linked; particularly as we move to a more flexible, ambulatory model/structure. ▪ Constructive dialogue needed to enable pan-Glasgow co-ordination rather than "operating divisions".

M Crichton, Superintendent Radiographer, Victoria Infirmary (by e-mail)	▪ In recent years, many operational changes. Victoria has suffered yet strives to reduce waiting lists and have figures which are envied – will this be recognised or finance put towards others to bring them up to the Victoria's level? ▪ Support Consultant AHPs and professional development. ▪ With CHP will there be a reversal of the movement of staff from primary care to the acute sector with respect to radiographers?
Dr RDH Monie, Clinical Director, Medical Directorate, Southern General Hospital	▪ Eighth major administrative change related to delivery of healthcare in last 20 years: staff must feel they have been visited by the "Curse of Petronius" ▪ Document full of rhetoric and short on specifics ▪ Trust to Operating Division – no change other than in name. ▪ No mention of emergency medical care and the difficulties faced in maintaining – difficult to deliver waiting time targets, far less improved especially with the demands of out of hours emergency care. ▪ Appears that the North Trust has a disproportionate share of resources.
Mr David Leese, Assistant Director of Planning & Community Care	▪ Move to single system working should include a clear and explicit statement about what we expect from the single system dividend to be and outcomes is expected to deliver. ▪ The natural advantages of separating out the strategic planning/purchasing/performance management and operational management/service delivery roles should not be lost in the move to a unified system. A clear statement on ways of working, integrated working and how they fit together and how they will be reviewed and adapted over time should be included. ▪ Clear statement required on the roles and responsibilities of the NHS Board and each operating division (possibly through the Scheme of Delegation). All staff in NHSGG should receive a copy and be fully briefed on the changes to the ways of working, responsibilities, governance and accountability and the differences and outcomes that these proposals are expected to deliver. ▪ Single system working proposals should be explicit about how service planning and change and performance management will be delivered. ▪ Investment will be required in supporting change to ways of working and thinking. Key elements include:- i) Developing ways of working;

Mr David Leese, Assistant Director of Planning & Community Care (cont'd)	ii) Development of cultural drivers – developing people's mindsets/behaviours/attitudes/ways of thinking and doing and how performance is measured; iii) Development of an investment in management and clinical leadership. ▪ With the development of CHPs there should be a significant and highly visible approach to organisational development at the outset – many of the comments relating to operating divisions would also apply to CHPs around investment in OD, high calibre management and clinical leadership. ▪ Need to develop a whole system approach to OD and systems/process transformation within the implementation of the proposed changes. Important we do not miss the opportunity of creating CHPs for developing the way in which other parts of the system look and operate and for re-shaping what they do and what they are accountable for (and how). ▪ CHPs should build clear and robust bridges to other parts of the NHS system in Glasgow (operating divisions, managed clinical networks, universities). ▪ We should invest in arrangements to monitor, evaluate and learn from how we move forward and implement the proposals in the White Paper – ties back to previous comments made about the high profile and resourced investment in an organisational development approach. We need to be aware how others have moved forward and changed and explore how other organisations can work with us as we evaluate, learn and adapt to these changes over the next one to three years.
NHS Greater Glasgow Librarians	▪ The NHS Library Service aim to integrate across NHS Greater Glasgow creating a single system service supporting all staff, including contractors within the primary care sector, partnership working with local government, voluntary sector, higher and further education and the public. Therefore, NHS Librarians committed to the principles contained in the consultation document. ▪ Greater Glasgow NHS Library Services known for their innovative developments but this has been based on short term project based funding – long term future of many developments are jeopardised by the lack of reliable, consistent funding. Disproportionate amount of staff time is devoted to identifying negotiating sources and short term contracts make it difficult to attract and retain staff.

NHS Greater Glasgow Librarians (cont'd)	▪ Dissolution of Trusts will create a structure that provides consistency in strategy and policy while allowing flexibility at a local level – greater flexibility is welcomed but it should not obstruct the integration of operational matters. A library strategy will ensure all staff encounter the same standard of service and user entitlements with equity of access in any one of the Libraries – opens up the library service across NHS Greater Glasgow. ▪ CHPs – their development will emphasise the need for equity of access to library and information services; all participants have the same level of access to resources, information and knowledge. The library service has a strong background in working in partnership and the strategy consolidates the many existing links with local authority, higher education and voluntary sector. ▪ Effective patient and public involvement will be supported by an empowerment through access to knowledge and evidence – library service should be central to the provision of health information to patients and the public. The development of Access Glasgow Health and partnership with the voluntary sector and local authorities will provide on line access to health promotion. Access to electronic sources will be vital, however, extending this service to patients and public will require investment in ICT and adequate technical support. ▪ Interface between primary and secondary care – requires equitable access to resources information and knowledge – library strategy supports this by making the improvement of library services to primary care as a central plank in the creation of a seamless service with no distinctions between the sectors. This shift in the provision of care from the hospital setting to the patient's home reinforces the need for access to information and evidence within those settings. ▪ The proposal for greater investment in staff to provide them with what they need should include proper investment in library services. The emphasis on the role of frontline primary care staff and the development of new services and ways of working highlights that many of these staff currently do not have access to the full range of library services and the library strategy pays particular attention to this. Enhancing and strengthening leadership and encouraging new ideas at local levels requires access to the evidence and knowledge provided by the library services.

J C Hamilton
Head of Board Administration
11.12.03