

Greater Glasgow and Clyde NHS Board

Board Meeting

Tuesday 26th June 2007

Board Paper No. 2007/26

Director of Corporate Planning and Policy
Director of Acute Services Strategy Implementation and Planning
Director - Mental Health Partnership
Director - Renfrewshire Community Health Partnership
Director - Clyde Acute Services

CLYDE HEALTH AND SERVICE STRATEGIES: OUTCOME OF REVIEWS AND PROPOSALS FOR CONSULTATION

Recommendation:

The Board is asked to:

- **Approve the attached papers and proposals as:**
 - **the basis for formal public consultation and for external review.**

A. BACKGROUND AND PURPOSE

- 1.1 In April 2006, at the point of dissolution of Argyll and Clyde NHS Board and the migration of the Clyde area and services into Greater Glasgow, we established a series of service and strategy reviews. The purpose of this paper is to report to the Board on the outcomes of these reviews and to seek approval for a process of formal consultation where that is required within the terms of the extant national guidance on service change. The timing of that process will depend on the nature and timing of the requirement for external review, for which these papers also provide the necessary detailed information
- 1.2 The service and strategy reviews had a number of aims and drivers which are detailed in the attachments to this paper, and apply to all of the reviews. At headline level these are:
 - the need to modernise services in Clyde and ensure the right balance of local community and inpatient care and social and health care. This particularly applies to mental health and older people's services;
 - the requirement to ensure safe and sustainable services. This particularly applies to integrated care at the Vale of Leven;
 - the imperative to ensure economic provision of services and to identify action to address the £30 million deficit we inherited with our Clyde responsibilities - in line with our agreement with the Scottish Executive Health Department. This particularly applies to maternity services.

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B. STRUCTURE OF THIS PAPER

2.1 The attachments to this paper provide the basis for consultation and external review. They are structured as follows:

- Clyde-wide Overview

The first attachment (Annex 1) is a paper which:

- provides background and context;
- sets out the principles which underpin our proposals;
- describes how we will handle the issues for staff;
- describes the relationship of our proposals to national policy;
- sets out the drivers for change.

Finally, the Clyde-wide Overview clearly states the proposals for public consultation and the proposed consultation process.

- Detailed Proposals

For each of the programmes of review and planning we have attached a detailed paper. These will, with the Clyde-wide overview, be publicly available and form the basis of our consultation material:

- Modernising Mental Health Services (Annex 2);
- Maternity Services Review (Annex 3);
- Balance of Older People's Care: Johnstone Hospital (Annex 4);
- Integrated Care at the Vale of Leven (Annex 5).

- Health and Services for West Dunbartonshire and the Lochside

The final attachment (Annex 6) is a summary paper covering all of the programmes of planning and review in relation to West Dunbartonshire. This will be publicly available as a package with the material extracted from the Clyde-wide programmes which applies specifically to services in West Dunbartonshire.

C. CONSULTATION AND EXTERNAL REVIEW

3.1 The proposals in these papers have been subject to a wide range of public and community engagement in the process of their development. The proposals which now require formal consultation are:

- **the transfer of low secure learning disability services from Dykebar Hospital to Leverndale Hospital;**
- **the transfer of adult and elderly acute admission beds for mental health at the Vale of Leven to Gartnavel Royal Hospital;**
- **the transfer of adult acute admission beds for mental health from the RAH to Dykebar Hospital;**
- **the re-provision of continuing care beds for older people's mental health from Dykebar Hospital to partnership facilities;**

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- **the conclusion of the Integrated Care Pilot at the Vale of Leven Hospital and the reprovision of unscheduled care at the RAH;**
 - **the transfer of the continuing care service for older people at Johnstone Hospital to partnership facilities;**
 - **the closure of the delivery service provided in the Community Maternity Units at Inverclyde Royal Hospital and the Vale of Leven Hospital.**
- 3.2 The Cabinet Secretary has announced her intention to require external review of proposals for service change and prior to proceeding to formal public consultation we will require clarity on the timing and process for such a review and how that will relate to the normal process of public consultation.
- 3.3 The content of these papers is intended to serve both purposes - setting out at a high level of detail the reasons and processes which underpin our proposals - this enables the development of consultation material and full consideration by an external review process.
- 3.4 It is important to note the lengthy period of development of these proposals and the importance of being able to progress them without undue delay. Rapid progress is important because of pressing issues of safety and sustainability, services which require modernisation and at present are not fit for purpose or of best quality for patients and the need to provide services in an economic way and within the Board's financial allocation.

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CLYDE HEALTH AND SERVICE STRATEGIES OUTCOME OF REVIEW AND PROPOSALS FOR CONSULTATION OVERVIEW

1. INTRODUCTION AND BACKGROUND

1.1 Following the integration of the Clyde area with the Greater Glasgow NHS Board area, the new NHS Greater Glasgow and Clyde announced its commitment to set out options for the future of services in the Clyde area to give staff and patient certainty following several years of debate stemming from NHS Argyll and Clyde's planning and consultation processes.

1.2 This overview paper introduces the outcomes of our programmes of work, covering the areas outlined below, which are described in more detail in the later sections of this paper. These programmes of review and planning have covered:-

- Integrated Care at the Vale of Leven

In September 2006, when it became clear that the integrated care pilot at the Vale of Leven could not proceed to full implementation because of concerns about clinical safety, we established a substantial planning and community engagement process to consider the future of the pilot. We are now bringing the outcome of that work to consultation.

- West Dunbartonshire and Lochside Health Needs

We have undertaken a detailed review of health needs in the West Dunbartonshire CHP, also working with NHS Highland to cover their population. This work has been jointly led by the CHP and public health teams with a reference group and a series of wider community events.

- Clyde Mental Health Modernisation

A substantial review and planning process has developed proposals to modernise mental health across the Clyde area, strengthening community services and reviewing the provision of hospital care.

- Balance of Older People's Care and Services at Johnstone Hospital

The requirement for this review came from the extensive joint work between the new Renfrewshire CHP and Renfrewshire Council, building on the previous Argyll and Clyde older people's strategy work. We are now making specific proposals for change.

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Review of Maternity Services - Linking the Consideration of Clyde Maternity Services into the Established Greater Glasgow-wide Maternity Planning Process

This work has enabled us to consider the impact on Clyde services of planned changes in Glasgow hospitals and also to review the issues in relation to the utilisation of the IRH and Vale Community Midwifery Units, where substantially less births are occurring than was projected. It's conclusions are brought forward for consultation.

1.3 The purpose of this overview paper is to:

- set the context within which each of the review programmes and planning process have been undertaken;
- articulate the overarching drivers for change which have informed our proposals;
- describe the principles which have underpinned each programme of work;
- summarise the proposals we are making which require formal consultation
- set out our proposed consultation process.

2. CONTEXT

2.1 This section briefly sets the Clyde-wide context in which our proposals for each service have been framed.

2.2 **Mental Health and Older People Services**

We inherited incomplete strategies for older people and mental health services from the former Argyll and Clyde, which had variable levels of Local Authority engagement and commitment, particularly in relation to arbitrarily imposed financial savings which were not supported by detailed plans. The services across Clyde were characterised by under developed community services and an over reliance on beds, providing services to patients of variable quality and accessibility.

2.3 **Acute Services**

Argyll and Clyde had submitted proposals for acute services following an extensive planning, development and consultation process. These proposals had not been endorsed by the Health Minister and, therefore, had not been implemented, leaving a range of services in unstable and unsustainable arrangements. In relation to this consultation the pilot of the Integrated Care model had not been fully implemented.

2.4 **Maternity Services**

A relatively new pattern of maternity services was in place with Community Maternity units having replaced the previous Consultant led delivery services at the Vale of Leven and Inverclyde Hospitals.

2.5 Financial Position

Argyll and Clyde had levels of recurrent spending on services substantially above their share of the Scottish Health Services funding. At the point of dissolution we inherited a deficit of £30 million with our new Clyde responsibilities. Following extensive discussions with the SEHD a three year brokerage arrangement was agreed to enable a strategic approach to the re shaping of services to deliver financial balance. In each financial year we are required to make substantial progress to reduce the deficit and that can only be achieved by redesigning services and staffing to reduce costs.

3. PRINCIPLES

3.1 This section describes the principles which have been consistently applied in developing our proposals.

3.2 Safe and Sustainable

Safe and sustainable services should be provided as close to communities as possible.

3.3 Shifting the Balance of Care

Wherever possible services should be provided outside hospitals in primary care.

3.4 Accessible

Ensuring accessibility for patients and their visitors is a critical responsibility and each of our proposals describes the challenges and our approach to address them.

3.5 Economic

Services need to be delivered in an economic way which represents a proper utilisation of public finances.

3.6 Engagement

The process of developing all of our proposals has included a substantial programme of public and community engagement, from the stage of informing people who may be affected by changes, to community engagement groups participating in each stage of the review and planning process and a series of open public events to communicate more widely with the emerging issues and options and hear public views.

3.7 Staff

It is clear that our proposed changes will impact on significant numbers of staff across a number of locations, both those who directly provide the affected services and support staff.

Throughout the implementation of the changes proposed, work will continue with staff and their representatives to manage the impact of change. This will be done within the context of the national and local organisational change policies, which are based on the principle of “no detriment”.

Once staff directly affected by the changes proposed are identified, in addition to meetings with the trade unions, one to one meetings/individual redeployment interviews will be held. NHS Greater Glasgow and Clyde has a successful track record in redeploying staff taking into account individual’s skills and personal circumstances. Redeployment will be the first consideration with the aim of securing alternative employment for displaced staff as a result of service change. Based on this detailed redeployment principles will be agreed and a process of vacancy management will be put in place to secure alternative employment in alternative departments and locations.

Deployment may be to a post at a lower grade and in these circumstances protection of earnings will apply. Redeployment will also be supported by a training and development plan, which will include induction and orientation programmes, and retraining/skills updating where necessary.

Regular briefing sessions will be held with staff throughout the period of implementation.

3.8 National Policy

Our proposals have also been developed within the frameworks of National policy including:

- Delivering for Health and related policies on:
 - mental health;
 - rehabilitation;
 - long-term care;
 - acute care;
- Joint Futures for Community Care;
- Maternity Services.

4. DRIVERS FOR CHANGE

- 4.1 There have been a range of drivers for the different programmes of review and planning, the conclusions of which are outlined in the further detailed sections in this paper.

4.2 Acute Hospitals

- Changing clinical practice:
 - there are many more opportunities for treatment and care to be given in people's homes or local communities rather than being admitted to a hospital;
 - fewer hospital doctors are now trained to deal with a wide range of problems. Instead, they specialise in treating a similar number of conditions. Such specialisation produces more skilled and experienced staff with improved results for patients. However, this often requires services to be brought together in one place to enable essential skills to be shared and maintained.
- Changing workforce:
 - "Shaping the Future" described that in 2004 Scotland, along with the rest of the UK, faced overall shortages of clinical staff and serious shortages in some areas including radiology and pathology. It highlighted how unfilled posts disrupt services and increase waiting times. Changes in medical training and practice can lead to difficulties in attracting and keeping staff to provide certain services.
- The impact of employment legislation
 - the European Working Times Directive places an obligation on employers to reduce the number of hours staff are allowed to work. Historically, the NHS has relied on doctors working very long hours - sometimes as much as 100 hour per week. This is no longer allowed and therefore services need to be redesigned.

4.3 Shifting the Balance of Care

We are shifting the balance of the way care is provided to expand community services to better meet need.

4.4 Modern Facilities

We want to provide services in improved accommodation which is of a modern standard.

4.5 Financial Issues

We need to make changes to services in the West Dunbartonshire and Lochside area to ensure that across Clyde services are provided in an economic way which properly utilised public money and enables the inherited deficit to be reduced.

5. PROPOSALS FOR CONSULTATION

5.1 This overview paper provides a brief introduction to the programmes of review and planning which are covered in detail in the further sections of this paper. Many of our proposals are about strengthening and developing services but given this is a formal consultation process it is important to be explicit on the changes which require that formal process and would subsequently require Ministerial submission and approval. The proposals for change which require that process are:

- **the transfer of low secure learning disability services from Dykebar Hospital to Leverdale Hospital;**
- **the transfer of adult and elderly acute admission beds for mental health at the Vale of Leven to Gartnavel Royal Hospital;**
- **the transfer of adult acute admission beds for mental health from the RAH to Dykebar Hospital;**
- **the reprovion of continuing care beds for older people's mental health from Dykebar Hospital to partnership facilities;**
- **the conclusion of the Integrated Care Pilot at the Vale of Leven Hospital and the reprovion of unscheduled care at the RAH;**
- **the transfer of the continuing care service for older people at Johnstone Hospital to partnership facilities;**
- **the closure of the delivery service provided in the Community Maternity Units at Inverclyde Royal Hospital and the Vale of Leven Hospital.**

6. CONSULTATION PROCESS

6.1 This section describes our proposed approach to formal consultation - building on the extensive programmes of public and community engagement which have already been at the heart of our review and planning processes. The detail of each of those programmes is included within the sections on each element of our review and planning work.

It is important to emphasise that throughout these processes the Scottish Health Council has provided us with oversight and advice to ensure that we meet the requirements of national policy with regard to informing and engaging. The Scottish Health Council have been heavily involved in our preconsultation engagement and have given us their feedback. We have been able to address all of the points raised. We have been asked to address specific further points by providing detailed information during the consultation process and will do so.

6.2 Consultation Documents

Full consultation documents are attached to this overview covering:

- Health and services in West Dunbartonshire and Lochside;
- maternity services;
- mental health;
- older people's services in Renfrewshire.

6.3 Consultation Summary

A community newsletter-style document will be produced which will take full advantage of design format and language to ensure it is accessible and as clear as possible. This will cover all service proposals (but ensuring each is treated in its own right) and will be widely distributed via the Involving People and CH(C)P databases, GP surgeries, waiting areas, primary care providers and Local Authority facilities. Any material relating to mental health will also be shared with communities surrounding Rowanbank Clinic and Leverdale Hospital.

6.4 Alternative Languages and Formats

The above documents will carry references in other languages and in large print to the availability of translated, Braille and audio disc format materials.

6.5 Events

Events will be structured around presentations and workshops. Additional meetings can be organised on request:

- three public events will be staged specific to proposals affecting West Dunbartonshire and the Lochside;
- mental health - meetings in Inverclyde, Renfrewshire and East Renfrewshire;
- maternity - meetings in Inverclyde and coverage in the events for West Dunbartonshire;
- a single event staged in Renfrewshire in connection with older people's services

6.6 Advertising

Adverts providing summarised headline proposals and contact points for additional information will be used to launch the consultation period and draw attention to public meeting dates. These will appear in the local newspapers - Greenock Telegraph, Paisley Daily Express, Dumbarton and Vale of Leven Reporter Helensburgh Advertiser and Lennox Herald.

6.7 Website

All material will be made available on the NHSGGC website and specific consultation response pages will be created.

6.8 Media Releases

Tailored to suit local media requirements and interests.

6.9 One-to-one Meetings and Briefings for Individual Stakeholders

As required and will include key groups and elected representatives.

MODERNISING MENTAL HEALTH SERVICES

ADULT AND OLDER PEOPLES MENTAL HEALTH SERVICES FOR INVERCLYDE, RENFREWSHIRE,
WEST DUNBARTONSHIRE AND EAST RENFREWSHIRE

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APPENDICES:

More detailed appendices will be available during the consultation process. These will cover in greater detail the:

- local context;
- pre-engagement feedback;
- current services and proposed developments and changes.

1. SUMMARY AND OVERVIEW

- 1.1 NHS Greater Glasgow & Clyde took responsibility for delivering health services across Clyde in April 2006. Since then, local joint health and local authority planning groups, involving service user representatives, have been working with frontline staff to review the way existing services are organised with a view to developing plans that will achieve service improvement and modernisation.
- 1.2 In particular, this work has looked at how best we can redesign current services to shift the balance of care more towards enhanced community services, which better meet individuals needs.
- 1.3 The strategy provides the outcome of that joint work and sets out:
- what a modern mental health service looks like;
 - where we are now compared to such a service;
 - how we would put in place the core elements of a modern mental health service through redesign of services and reinvestment of savings to fund service developments.
- 1.4 The strategy has six core building blocks:
1. Development of community services
 2. Closure and reprovision of continuing care beds
 3. Reconfiguration of inpatient services
 4. Specialist services development
 5. Investment of resources released from the redesign of acute and continuing care inpatient services to fund:
 - service developments;
 - achieving £2m savings as mental health's contribution to the GG&C NHS Board's corporate savings targets to contribute to addressing the inherited NHS Argyll and Clyde financial deficits.
 6. Bridging funding to support the transition and service redesign to enable:
 - development of robust community services in advance of inpatient bed reductions;
 - bridging funding to support service redesign pending full release of site based savings.
- 1.5 A further summary of proposals in relation to each of these areas is provided overleaf:

Development of comprehensive community services

- 1.6 To ensure consistent access to core service elements of comprehensive services for all geographic areas of North and South Clyde through £3.5m investment to develop:
- primary care mental health supports;
 - community crisis resolution responses accessible on extended day and weekend basis;
 - expansion of community mental health teams.

Closure and reprovion of continuing care beds

- 1.7 Continuing care beds in N&S Clyde are currently provided at about 2.2 times the level of Greater Glasgow and other UK provision. This high level of provision reflects the use of continuing care beds as a default residential provision in the absence of a wider range of services not yet in place. Significant numbers of people currently cared for in continuing care beds would benefit from having their care safely provided in a community setting, from a range of care home or supported accommodation placements. For these individuals discharge from inpatient care would significantly enhance their quality of life and functioning.
- 1.8 The remaining continuing care provision would then be more appropriately focused on those with more complex medical care needs, and would require a lower overall number of beds. The current inpatient environment of continuing care is of variable and often low quality. Our proposal builds on the experience of Greater Glasgow arrangements, by reprovioning older peoples mental health continuing care beds in community settings based on Partnership models of provision which secure new provision with higher quality environments of care, including single room accommodation.
- 1.9 The strategy proposes investment of £3.4m to develop a range of accommodation with supports for those who would benefit from discharge from inpatient care including:
- supported accommodation places;
 - intensive community care support packages;
 - group homes;
 - care home places.
- 1.10 Additionally the strategy proposes reducing the overall number of continuing care beds and reprovioning older peoples continuing care beds in higher quality community based Partnership provision, normally located in each local authority area.

Reconfiguration of inpatient beds

- 1.11 99% of people with mental health needs receive their care from community based supports in primary or secondary care.
- 1.12 Less than 1% of people with mental health needs require admission to inpatient beds.
- 1.13 Current provision of acute admission beds in Clyde is about 1.4 times higher than that in Greater Glasgow. With comprehensive community services in place the bed numbers in N&S Clyde can then be reduced to levels comparable to those in Greater Glasgow.

1.14 In terms of location of beds the strategy has sought to retain local access to beds where this is consistent with principles of clinical safety, cost effective service delivery, and feasibility and capacity to deliver good quality inpatient services on particular hospital sites:

1.15 The strategy proposes:

Inverclyde

- Retention of Inverclyde adult and older people's acute admission services on the IRH site.
- Closure of older peoples continuing care beds currently on the Ravenscraig site, and reprovion of 33 older peoples mental health continuing care beds in a community based Partnership arrangement within Inverclyde.
- Closure of adult continuing care beds currently on the Ravenscraig site, and reprovion of 9 adult mental health continuing care beds within Inverclyde.

Renfrewshire

- retention of 40 older peoples mental health acute admission beds on the RAH site as now.
- closure of older peoples mental health continuing care beds on the Dykebar site and reprovion of 59 continuing care beds in a community based Partnership arrangement within Renfrewshire.
- consolidating all adult acute admission mental health beds in the good quality accommodation on the Dykebar site (currently split between the Dykebar and RAH sites) within Renfrewshire.
- reducing the overall number of adult continuing care beds and reprovion of 12 beds within the Dykebar site

East Renfrewshire: Levern Valley

- consolidate provision of adult mental health beds for all of East Renfrewshire from the Leverndale site already used by the majority population of East Renfrewshire covered by the former GG NHS Board (implemented during 2007)
- explore proposals to consolidate the small number of Older peoples mental health acute admission beds for all of East Renfrewshire on a single hospital site - either at the Leverndale Hospital or at the RAH
- closure of older peoples mental health continuing care beds on the Dykebar site and reprovion of continuing care beds in a community based Partnership arrangement – East Renfrewshire to access either Renfrewshire provision or Greater Glasgow provision based on whichever arrangement achieves the best fit between user need, local access and service availability

West Dunbartonshire: Dumbarton and Alexandria

The West Dunbartonshire population currently receives its acute admission inpatient services from 3 hospital sites:

- Vale of Leven for the Dumbarton and Alexandria catchment
- Gartnavel Royal for the Clydebank catchment
- Lochgilphead for Intensive Psychiatric Care beds

Our proposals are to:

- consolidate provision of all acute admission beds for WDC on the Gartnavel site and transfer the adult and elderly acute admission beds currently located on the Vale of Leven hospital site to the Gartnavel Royal
 - Transfer 24 acute admission beds (12 adult and 12 older peoples beds) for Dumbarton and Alexandria catchment to Gartnavel, in addition to the 24 beds (10 adult and 14 older people) already provided at Gartnavel for the Clydebank catchment population
- relocate IPCU beds from Lochgilphead Hospital to an additional 2 beds in Gartnavel Royal
- reprovide 12 Continuing care older peoples bed within WDC area using Partnership model (to serve the population of West Dunbartonshire and Helensburgh/Lochside)

The rationale for the consolidation of all West Dunbartonshire inpatient services (i.e. acute admission, IPCU and intensive rehabilitation beds) on the Gartnavel site includes:

- achieving preferred resident junior psychiatric medical cover arrangements
- achieving the benefits of consolidation on a site with enhanced hospital infrastructure of specialist management of inpatient service, practice development resources and bed management resources
- retaining the planned high quality inpatient single room accommodation benefits of the new Gartnavel hospital accommodation for the Clydebank catchment
- providing ground floor accommodation and safe access to garden space for inpatient ward accommodation
- achieving continuity of care between users of both acute admission and specialist mental health services on the same hospital site

Helensburgh/Lochside

Services to this population are funded and commissioned by the Highland NHS Board and provided through a service agreement with the GG&C NHS Board. The Highland NHS Board has indicated it recognises the desirability of the Helensburgh /Lochside population continuing to access the same inpatient services as available to the Dumbarton and Alexandria population, notwithstanding the proposed transfer of inpatient services from the Vale of Leven hospital to the Gartnavel hospital.

Specialist services for the South Clyde catchment (Inverclyde/Renfrewshire/East Renfrewshire Lavern Valley)

1.16 The following specialist inpatient services are already provided to a South Clyde catchment:

- specialist addictions beds
 - ICU Beds
- 1.17 Specialist addictions beds for South Clyde are currently provided from the 11 bedded Gryffe Unit at the Ravenscraig Hospital. It is proposed that specialist addictions beds for South Clyde are reprovided as part of a consolidated South Clyde and South & West Greater Glasgow service to be developed at the Southern General Hospital. The consolidation of 7 South Clyde beds with the 8 South & West Glasgow beds enables the service quality benefits of critical mass to be achieved in a small highly specialist service. The Ravenscraig site closure, by 2010, will occur in advance of the developments on the Southern General Hospital (SGH) site timetabled for 2012 to 2015. Pending the SGH developments a temporary interim location will be developed.
- 1.18 The ICU is currently located at Dykebar and it is proposed this retains its South Clyde catchment, but is relocated to the IRH.
- 1.19 Intensive rehabilitation beds are not currently provided in Clyde services, but their development would enable specialist management of a challenging behaviour group of patients generally requiring such support for 1-4 years, best provided in separate accommodation from the acute admission environment of care. It is proposed to develop 8 such beds for South Clyde on the Dykebar site.
- 1.20 Early onset psychosis services are currently provided from a specialist service for the South Glasgow population. The funding of this service will be increased to enable an expansion of the catchment to include the South Clyde population.
- 1.21 East Renfrewshire currently uses specialist services in both South Clyde and in Greater Glasgow. It is proposed to consolidate the specialist services patient flows for the whole East Renfrewshire population (ICU and Intensive Rehabilitation beds) with the services already used by the Eastwood population, which are located on the Leverdale site.

Specialist services for the North Clyde catchment (Dumbarton and Alexandria)

- 1.22 Historically the Dumbarton and Alexandria population has had limited access to specialist services, which have been provided either from Lochgilphead or from services South of the Clyde.
- 1.23 It is proposed to improve local access to such services by extending the access already available to the Clydebank population to the whole of the West Dunbartonshire (WDC) population, including the Dumbarton and Alexandria population:
- transferring ICU beds from Lochgilphead to an additional 2 beds for WDC in the Gartnavel Royal ICU
 - access to the intensive rehabilitation beds at Gartnavel Royal
 - WDC wide access to specialist co-morbidity beds currently provided only to the Clydebank population, at the Stobhill site
- 1.24 Early onset psychosis services are currently provided from a specialist service for the North Glasgow population. The funding of this service will be increased to enable an expansion of the catchment to include the Dumbarton and Alexandria population.

Development of Highly Specialist services: GG&C or Regional services

- 1.25 Prior to the establishment of NHS Greater Glasgow and Clyde Health Board, plans for Regional Medium secure specialist forensic services were based on separate development of specialist services on the Dykebar site for the West of Scotland catchment, and on the Stobhill site for the Greater Glasgow catchment.
- 1.26 It is proposed to consolidate medium secure services formerly planned (but not yet provided) on the Dykebar site, within the new 74 bed Rowanbank Unit (opening in July 2007) at the Stobhill Hospital in North Glasgow. This will include provision of 7 new medium secure beds for Clyde services.
- 1.27 The retention of low secure beds on the Leverndale site enables the absorption of additional medium secure activity at the Stobhill Rowanbank unit within existing bed capacity at the Rowanbank unit, without compromising previously agreed bed provision for the Greater Glasgow population.
- 1.28 Low secure adult mental health services for both Clyde (previously no planned provision) and Greater Glasgow will be consolidated as a single service based on the Leverndale site, providing 8 new beds for North and South Clyde.
- 1.29 Low secure services for learning disabilities are currently provided in separate services in the Dykebar 8 bed unit for the West of Scotland catchment (5 beds for Clyde, 3 beds for NHS Lanarkshire, NHS Ayrshire & Arran and NHS Fife), and Leverndale for the Greater Glasgow catchment. The proposal is to consolidate both services on the Leverndale site.
- 1.30 In general terms the consolidation of small highly specialist services, typically provided on a regional basis, achieves significant service quality and financial benefits since:
- larger specialist services can sustain dedicated access to scarce specialist multi disciplinary supports
 - larger services prove more attractive in terms of recruitment and retention of scarce and highly specialist staff who see larger services as offering enhanced opportunities for professional and career development
 - larger specialist services provide significant economies of scale and prove more cost effective to provide
- 1.31 To secure provision of these additional 15 medium and low secure specialist forensic beds to the Clyde population is a prerequisite legal obligation under the Mental Health Act, and requires new investment of £1.7m.

Reinvestment of funding to support the planned service developments

- 1.32 The planned service developments summarized above would cost £9.5m. However it is recognised by NHS GG&C that a specific allocation of £1.7m funds is required to meet the costs of the forensic services, leaving £7.8m to be released from service redesign for reinvestment.
- 1.33 Additionally mental health services in Clyde are required to deliver £2m savings to the GG&C Board as part of addressing the inherited Clyde deficit.
- 1.34 Therefore a total of £9.8m needs to be released from service redesign.

This will be achieved by:

- releasing the site infrastructure costs of Ravenscraig through the previously agreed closure and disposal of the site
 - maximising the use of good quality accommodation on the Dykebar hospital site, vacation of all other accommodation and disposing of a large part of the site
 - taken together the reduced expenditure on site infrastructure releases £3.0m
- 1.35 Reducing expenditure on continuing care and acute admission beds, following development of comprehensive community services and reduced provision of beds at equivalent levels to Greater Glasgow, releases £6.8m
- 1.36 Together these changes generate the £9.8m required to fund the rebalancing of services including the development of comprehensive community services; reprovision of Partnership continuing care beds in higher quality accommodation, and contribute £2m to the overall NHS GG&C Clyde Financial Recovery Plan.

Access Issues

- 1.37 The strategy proposes substantial development of locally based community services thereby improving access to services for the 99% of people whose mental health needs are met in community settings. The proposals for the closure and reprovision of continuing care beds also see reprovision within local areas.
- 1.38 The strategy proposes significant geographic changes to a small number of inpatient services for about 15% of current admission and specialist beds used by about 560 people per year as follows:
- 24 beds transferred from the Vale of Leven to Gartnavel Royal used by c230 people per year
 - 8 IPCU beds for Inverclyde and Renfrewshire transferred from Dykebar to the IRH used by c46 people per year
 - 11 addictions beds transferred from Ravenscraig hospital to the Southern General used by c280 people per year
 - 8 learning disabilities low secure beds from Dykebar hospital to the nearby Leverdale used by c8 people per year

Bridging funding to support the transition and service redesign

- 1.39 It is widely accepted that the process of rebalancing services requires robust community services to be in place in advance of changes to inpatient services.
- 1.40 In order to cover the double running costs of development of community services and wider service redesign in advance of releasing the full ward and site based costs, the GG&C Board will provide non recurrent transitional funding of up to £3m per year for the period until March 2010.

Workforce issues

- 1.41 The strategy has proposed a substantial shift in the balance of care between inpatient and community services. Whilst this will create significant opportunities for the broadening and development of the skills of staff, the proposals may require a range of

individuals to work in different service, or in a limited number of cases different geographic settings.

- 1.42 NHS Greater Glasgow and Clyde has a significant track record in redeploying staff taking account of individuals' skills and personal circumstances. Redeployment will be the first consideration with the aim of securing alternative employment for displaced staff. The detailed principles for the operation of these policies are set out in Section 17 of the Strategy.

Developing Clyde Services with no detriment to Greater Glasgow services

- 1.43 The GG&C NHS Board has previously committed itself to the principle that the development of Clyde services should be achieved without detriment to existing planned and agreed levels of provision for the Greater Glasgow population. The service and financial framework for the Clyde strategy has therefore ensured this principle is reflected in the detailed arrangements for service development and reconfiguration.

2. INTRODUCTION

- 2.1 In April 2006 the Greater Glasgow and Clyde NHS Health Board was created following the dissolution of the Argyll and Clyde Health Board.

- 2.2 The Greater Glasgow and Clyde Health Board committed to build on the strengths of the previous NHS Argyll and Clyde plans, whilst reviewing them in the context of experience of developing comprehensive mental health services, both within the Greater Glasgow and Clyde area, and also throughout the UK.

- 2.3 This Strategy summarises the outcome of that joint work with our partner agencies and services users, and in particular sets out:

- what a modern comprehensive mental health service “looks like”
- “where we are now” within Inverclyde, Renfrewshire, East Renfrewshire, and West Dumbarton
- proposals to develop services to achieve the functions required of modern comprehensive services.

- 2.4 The scope of the Strategy includes:

- adult mental health services
- older peoples mental health services
- addictions inpatient services
- forensic services

- 2.5 A Clyde Mental Health Strategy Group was commissioned to progress the overall development of the strategy.

- 2.6 The group works on a partnership basis with membership drawn from the NHS GG&C Mental Health Partnership, NHS staff side representation, Acumen representing user interests, the four local authorities of Inverclyde, Renfrewshire, East Renfrewshire and

West Dunbartonshire, and local Community Health Partnerships covering the same areas.

- 2.7 The strategy is based on a framework and principles applicable across the whole of the Greater Glasgow and Clyde area.
- 2.8 However the approach has deliberately ensured that local planning groups are responsible for the application of those principles, in ways which are rooted in the local context and reflect the varied stage of service development for each of the four local authority areas.
- 2.9 In this way the service specification is the same for each area, but the detailed service models have been designed and adapted to the varying contexts and needs of each of the four local authority geographies.
- 2.10 This approach is reflected in this strategy document which sets out the overarching framework applicable to North and South Clyde, and then subsequent appendices set out the application of those principles for each of the four local areas.

3. VISION

3.1 Our vision is that service users should:

- receive supports which anticipate and prevent the development of illness
- receive the care and treatment supports they require
- receive care in local community settings where possible
- receive care which maximises recovery and minimises the disabling impact of their illness
- receive care on a timely basis in good quality services which are acceptable to service users and their carers
- be supported to live well in the presence or absence of illness

3.2 Beyond care and treatment supports our vision is that social attitudes evolve to become more socially inclusive, tolerant and supportive by:

- reducing stigma
- improving the recovery and “life chances” of people with mental distress through access to:
 - somewhere to live
 - income
 - work or meaningful occupation
 - things to do/leisure activities
 - support networks

- 3.3 Whilst the vision for service and treatment supports is primarily addressed to providers of specialist mental health services, the vision for wider social inclusion is one which can only be influenced through specialist mental health services working with the wider range of public, voluntary sector and private agencies.

4. MODERN COMPREHENSIVE MENTAL HEALTH SERVICES

4.1 Modern comprehensive Community Mental Health services need to be organised to deliver the following service functions which were set out in The Scottish Framework for Mental Health (1999):

- access and information
- needs for individual planning
- meeting needs in crisis
- needs for treatment and support with mental distress
- needs for ordinary living and long term support
- services to promote personal growth and development

4.2 There is now widespread consensus within the UK, informed by international experience, that comprehensive services should comprise a range of core service building blocks as summarised overleaf (albeit the detailed organisation and service models may vary between areas):

5. WHAT A MODERN MENTAL HEALTH SERVICE LOOKS LIKE

<p>Services provided in local community settings or in peoples own homes</p> <ul style="list-style-type: none"> • Primary care supports for people with more common and less complex mental health needs used by c25% of the general population • Secondary care supports for people with complex and enduring needs and used by c5% of the general population 	
Primary care supports	Identification and access to effective treatments for common mental health problems
Integrated Community Mental Health Team	Community teams based in local Resource Centres providing treatment and care for those with more complex and enduring needs
Crisis resolution and access to treatment out of hours (extended day or 24/7)	Rapid and urgent community response providing intensive treatment support to people experiencing a mental health crisis who might otherwise require inpatient admission
Assertive outreach supports	Structured assertive support to maintain contact with a small group of service users whose chaotic life styles might otherwise lead to disengagement from services and relapse
Personal growth and recovery supports for ordinary living	<p>Range of supports including:</p> <ul style="list-style-type: none"> • accommodation with supports • meaningful daytime activities • support to get and keep a job • access to a range of social care supports for practical daily living • access to support networks to reduce isolation • advocacy supports
Early Intervention first onset psychosis	<p>Rapid assessment and age related treatment at an early stage of someone’s first development of psychosis</p> <ul style="list-style-type: none"> • 14-30 age group • early intervention is crucial to support users and carers coping capacity at the early stage of illness
Continuing care beds	<p>For people with complex medical needs who require long term or life long support in an inpatient setting.</p> <p>Older peoples continuing care services may best be provided in community settings whereas adult continuing care services may best be provided on hospital sites.</p>

<p>Services provided in hospitals</p> <ul style="list-style-type: none"> Inpatient services used by less than 1% of the population 	
Acute admission beds	Assessment and Treatment of acute mental illness
Intensive psychiatric care beds	Assessment and Treatment of acute mental illness in a more secure setting to manage high risks of self harm or risk to others during the acute episode of illness

<p>Specialist services provided on a North or South Clyde/GG&C or regional basis</p> <ul style="list-style-type: none"> Highly specialist community services managing very complex needs and providing liaison consultation support to general services Highly specialist inpatient services provided on a North or South Clyde/GG&C or West of Scotland basis Services used by 0.02% of the population 	
Intensive rehabilitation beds	For a small number of people who need a sustained period of inpatient care for up to 5 years to ensure rehabilitation to a level of functioning consistent with discharge to community supports. Often a small inpatient group with high levels of challenging behaviours requiring a highly structured inpatient environment
Inpatient specialist addictions beds	<p>The majority of detoxification is managed in residential or community settings. Where inpatient admission is required for people who have a primary mental health problem coupled with a secondary addiction problem this is normally managed in psychiatric beds (c40% of inpatient admissions). However a very small number of people with major addictions problems and other secondary physical health or mental health needs require care in more specialist settings with staff groups skilled in addictions problems which may coexist with secondary physical health or mental health problems</p> <p>Community addiction services are normally provided to local authority populations as part of local services, albeit where these are small populations they may be provided to a larger population base</p>
Community eating disorders service and access to specialist beds	Specialist community services assess and treat the most complex presentations of eating disorders and assist generic community mental health teams in the care and treatment of less complex presentations. The specialist community eating disorders service is actively involved in pre-admission and post-discharge care for people accessing specialist inpatient provision.

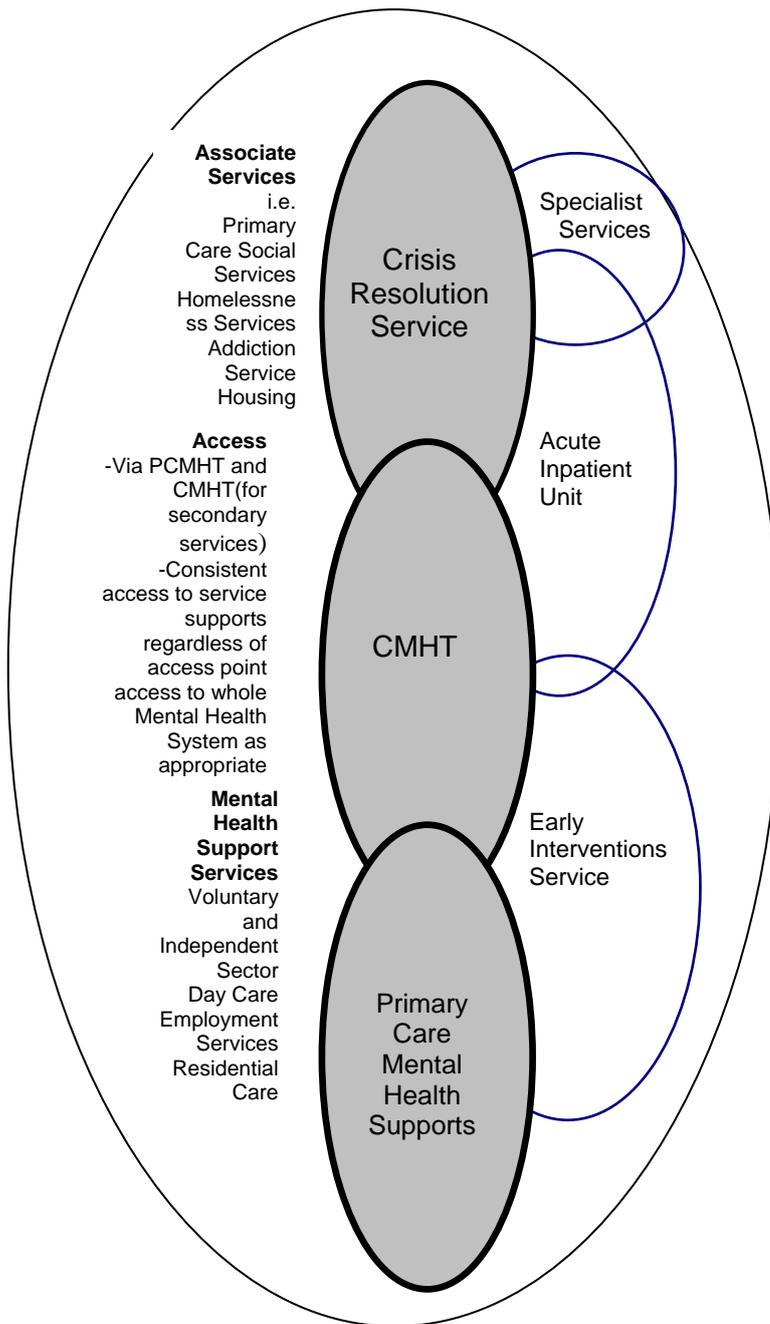
Specialist services provided on a North or South Clyde/GG&C or regional basis Cont.

Perinatal community service and inpatient beds for mothers and babies	Perinatal inpatient provision enables a safe and specialist environment for a baby to remain with its mother during her inpatient assessment and treatment episode. Care in mainstream inpatient beds is an unacceptable and unsafe environment for mothers and babies. Specialist community services assess and treat mothers with complex mental health needs in their home setting. For some people, this support will mean that admission to inpatient beds can be avoided. For people who require admission, the community service provides pre-admission and post-discharge support.
Forensic community service and inpatient services at varying levels of security	A very small proportion of people with a mental health problem may be at significant risk of committing a criminal offence whilst their judgment is impaired due to their illness. Care of these individuals takes place in environments of additional security by virtue of both physical security of the inpatient environment and specialist staff skilled in the management of forensic patients. Inpatient services are provided at varying levels of security from the state hospital providing a national high secure service, to regional medium secure inpatient services, and local services providing low secure inpatient services and specialist community services for those presenting lower degrees of risk.

- 5.1 In a modern service such as that summarised above each CHP/local authority area would have:
- A range of primary care supports and psychological interventions available through GP practices for people with the more common mental health problems
 - Resource Centres from which community mental health teams co-ordinate and provide a range of care and treatment supports including:
 - ordinary living and long term supports
 - management of complex care needs
 - assertive outreach supports
 - access to extended hours crisis resolution
- 5.2 About 95% of all care, treatment and support services are provided through the primary care supports and the community based Mental Health Resource Centres.
- 5.3 The community services are the core of the local mental health network and provide support for as short or as long is required, including long term ongoing support lasting months or years.
- 5.4 Such community services are underpinned by access to inpatient services for the small proportion of service users whose care is best provided in an inpatient environment.

- 5.5 Typically only c5% of mental health needs are cared for by secondary care services (including inpatient services); and less than 1% of mental health needs require service users to be admitted to inpatient beds, usually for a time limited period normally lasting no longer than 4-6 weeks.
- 5.6 This modern service is summarised in the diagram overleaf:

A CHP VIEW OF A MODERN MENTAL HEALTH SERVICE



 Services directly provided within a CHP

 Services generally provided to larger populations on a South Clyde basis, GG&C or WoS basis (albeit exceptionally acute inpatient units may be provided for CHP populations)

Broadly for CHP shaded service bubbles the ordering of the service bubbles reflects complexity of need with most complex needs at top of diagram,

Primary Care Mental Health Supports

- Identification/management of common MH problems
- Community bridge building/social supports
- Develop knowledge and facilitate access to full range of local resources
- Counselling and Brief therapeutic interventions
- Shared care of more complex needs with CMHT
- Health improvement and health promotion

Community Mental Health Teams

- CMHTs are the core of the Mental Health System, acts as gateway to full range of Specialist Mental Health System Services
- Providing treatment and care:
- specialist interventions with discharge back to Primary Care
- Substantial minority, ongoing treatment and care for people with complex and enduring needs
- Assessment and case/care management and access to specialist treatment
- 'Care Management' function re purchase of care packages
- Advice, guidance and direct support to primary care
- Develop knowledge and facilitate access of a full range of local resources
- Provide assertive outreach function

Crisis Resolution Supports

- Extended day or 24/7 service, access via CHP teams or specialist crisis service providing intensive care at home
- To help prevent admissions to hospital and speed discharge
- Expert support to CMHT's re management of acute relapse in hospital or community settings
- Short term case management during period of acute relapse
- Remain involved until crisis resolved and user linked to ongoing care of CMHT

Acute Inpatient Care

- Assessment and Treatment of acute mental illness
- Focused admissions with emphasis on planning appropriate discharge
- Emphasis on active use of time, maximising access to talking therapies
- Active engagement with meaningful day time activity
- Dedicated beds for each CMHT

Early Interventions First Onset of Psychosis

- Early diagnosis and treatment for severe mental illness
- 14 to 30 age group
- Early detection through links with youth services etc
- Rapid assessment and responsive age related treatment
- Bridge into Primary Care and Child and Adolescent services

Specialist Services inc.

- Forensic Services
- Eating Disorder Services
- Perinatal Services
- Liaison Psychiatry Service

6. NATIONAL POLICY CONTEXT

6.1 Any local strategy needs to ensure it takes account of the National legislative and policy framework.

6.2 The two main areas of significance are:

“The Scottish Mental Health Care and Treatment Act (2003)” which:

- requires services to be provided at the least level of restriction consistent with meeting service user needs
- requires provision of age appropriate services
- requires Health Boards to ensure access to specialist/tertiary services
- requires the NHS and local authorities to provide trained Mental Health Officers and Approved Medical Practitioners to implement the act, and in particular powers of compulsory treatment
- provides a balance of rights and responsibilities for service users, including the right to appeal to a mental health tribunal against care in excessive levels of security

“The Scottish Mental Health Delivery Plan” whose focus is:

- improving patient and carer experience of mental health services
- responding better to depression, anxiety and stress
- improving the physical health of people with mental illness
- better management of long-term mental health conditions
- early detection and intervention in self-harm and suicide prevention
- manage better admission to, and discharge from, hospital
- child and adolescent mental health services
- enhancing specialist services

The Mental Health Delivery Plan has three immediate performance targets to:

1. Reduce the annual rate of increase of defined daily dose per capita of antidepressants to zero by 2009/10.
 - relates to appropriate prescribing of anti depressant drugs
2. Reduce Suicides in Scotland by 20% by 2013
3. Reduce the number of readmissions (within one year) for those that have had a hospital admission of over 7 days by 10% by the end of December 2009
 - relates to ensuring effective post discharge community support reduces vulnerability to rapid relapse and inpatient readmission

7. LOCAL CONTEXT

7.1 NHS GG&C became responsible for Clyde Mental Health services in April 2006.

Challenges

7.2 THE GG&C NHS Board faces the following challenges:

- achieving recurrent financial balance by April 2010 – effectively requiring savings of £2m from mental health services
- limited access to capital expenditure
- developing a *service driven* strategy which delivers:
 - a shift in the balance of care from hospital based care to community based care supported by access to inpatient admission when necessary
 - substantial development of comprehensive community services to support and sustain such a rebalanced service
 - a closure and re-provision programme which provides high quality community settings for those people who have traditionally received care in inpatient NHS continuing care wards, but whose quality of life would be improved by discharge to community settings
 - improvement of the therapeutic environment of inpatient care
 - ensuring the ongoing sustainability of medical cover arrangements in the more challenging context of the National introduction of the Modernising Medical Careers arrangements for medical training and medical cover arrangements
 - local delivery of the high priority targets of the Mental Health Delivery plan
 - achieving sustainable financial balance, whilst minimising overall reductions to effective spending on direct services.

Opportunities

7.3 Notwithstanding the challenges summarised above the GG&C Board also has a number of opportunities and in particular:

- high degree of shared vision and values between the Partner NHS and Social Care agencies, and flexibility of joint approaches to enable practical and tangible progress
- substantial experience of delivering rebalanced mental health services to achieve the radical service rebalancing required
- substantial experience of operating such rebalanced services on a sustainable basis providing confidence in the practical sustainability, as well as the logic, of such service redesign
- experience that comprehensive community services can ensure sound care whilst requiring bed use at c60% of inherited Argyll and Clyde provision

- access to a range of financial and service benchmarking tools to enable the design and costing of such a rebalanced service
- opportunities for shared use of Greater Glasgow service capacity to support the Clyde developments both locally, and for GG&C wide developments
- access to transitional funding to provide the necessary time limited investment to underpin the service redesign during the transitional period to 2010.

8. WHERE ARE WE NOW?

8.1 The table below repeats the earlier table summarising the service building blocks of comprehensive community centred mental health services, and compares this to the current position in N&S Clyde

<p>Services provided in local community settings or in peoples own homes</p> <ul style="list-style-type: none"> • Primary care supports to c25% of the general population • Secondary care supports for people with complex and enduring needs and c5% of the general population 	
Primary care supports	Some areas have no specialist support/some areas have limited access; requires rolling out across N&S Clyde
Integrated Community Mental Health Team	Some areas have minimal or no CMHT staffing; no area has full geographic coverage at sufficient staffing capacity
Crisis resolution and access to treatment out of hours (extended day or 24/7)	No service provision for extended day/24/7 access to treatment support for mental health crisis in community settings; some areas have access to social care supports for those in life crisis and with a mental health problem
Assertive outreach supports	No service provision consistent with full implementation of assertive outreach programme responses
Personal growth and recovery supports for ordinary living	Wide range of practical supports, including creative partnerships with voluntary providers. Further work is required to assess the balance and degree of comprehensiveness of such supports
Continuing care beds	<p>Substantial numbers of patients who would benefit from community placements currently cared for in lower quality environment of life long NHS continuing care beds</p> <p>Continuing Care bed use at about 220% of Greater Glasgow level</p>

Services provided in hospitals	
<ul style="list-style-type: none"> Inpatient services used by less than 1% of the population 	
Acute admission beds	Overall acute bed provision at c140% of Greater Glasgow levels; varying ward sizes with a number of wards operating at greater than good practice norm of 20 bed ward size
Intensive psychiatric care beds	In place though throughput appears low suggesting sub optimal use of such beds

Specialist services provided on a North or South Clyde/GG&C or regional basis	
<ul style="list-style-type: none"> Highly specialist community services managing very complex needs and providing liaison consultation support to general services Highly specialist inpatient services provided on a West of Scotland basis Used by less than c0.02% of the population 	
Intensive rehabilitation beds	No specialist provision, sub group managed in general inpatient settings with consequential disruption to general inpatient therapeutic environment; small numbers mean specialist provision is only viable on a South Clyde basis.
Early Intervention first onset psychosis	No access to such services in North or South Clyde
Specialist co-morbidity addictions beds	Currently provided in Ravenscraig and requires relocation. Community addictions services underdeveloped
Community eating disorders service and access to specialist beds	No access to community eating disorder services and historic high use of inpatient extra contractual referrals
Perinatal community service and inpatient beds for mothers and babies	No access to community service; access to beds as part of WoS agreement
Forensic inpatient services at varying levels of security	Low secure learning disability services provided separately at both Dykebar (for West of Scotland) and Leverndale for Greater Glasgow services Planned development of Dykebar secure unit but no current provision for medium and low secure services; interim provision of Stobhill secure unit providing medium secure beds for West of Scotland including Greater Glasgow and Clyde; Leverndale providing low secure services to GG&C

8.2 When compared with the service building blocks of a comprehensive mental health service the table above suggests a picture of an incomplete and unbalanced service characterised by:

- under developed community services
 - postcode variations in access and response
 - comparatively low spend per head on community services
 - under developed primary care services
 - under developed community services
 - very limited urgent access to community treatment supports out of hours and weekends
- disproportionate reliance on hospital based responses
 - comparatively high levels of bed provision and use
 - variable quality of environment of hospital estate
 - high spend on hospital estate
- poor quality long stay care in inpatient settings
 - high numbers of patients inappropriately cared for in inpatient rather than community settings
 - variable quality of inpatient environment
- limited access to specialist services

9. THEMES FROM PRE ENGAGEMENT FEEDBACK

- 9.1 Pre-engagement events were held during the strategy development process to enable early sharing of the emerging direction of travel and provide an opportunity to shape the subsequent development of the strategy. The main themes from the pre-engagement events included:
- importance of retaining local service provision
 - need to focus on recovery and rehabilitation
 - welcomed investment in primary and community services (though concerned the deficit position doesn't deflect this)
 - concerned to ensure quality of care standards for continuing care and concerns as to how this is achieved in the proposed Partnership bed models
 - the need to develop and formalise the networks of collaborative partnership between not for profit organisations and NHS and social care
 - need to strengthen primary care supports beyond postcode variation
 - need for a focus on good quality admission and discharge arrangements
 - the need to take transport links into account to ensure good access to inpatient care locations
 - concerns over potential relocation of some services from their current locality and in particular that consolidation of adult acute services for Renfrewshire, at RAH, would reduce the standard of accommodation compared with the Dykebar admission wards
 - the need to bring a stronger service user focus to the formal consultation process, with a suggestion of targeted events for specific client groups.
- 9.2 The first round of community engagement events gave a strong indication of the general support for the rebalancing of services in favour of more developed community services. This was therefore consistent with the Clyde Mental Health Strategy Group's thinking, as set out in the significant community service development proposals in this consultation document.
- 9.3 The priority that local service users and community groups placed on good local access to inpatient services was also a key theme. The Clyde strategy group therefore applied a guiding principle to support local inpatient provision, except where this compromised the quality, cost effectiveness or clinical robustness of inpatient services.
- 9.4 This principle was reflected in the follow-up engagement events that focused on emerging options for inpatient provision, which advocated the retention of local acute admission services for older people and adults in each of the localities (except West Dunbartonshire where the challenges of retaining more local provision were outweighed by the advantages of consolidation of all WDC activity on the Gartnavel Royal site), as well as suggesting NHS commissioned 'partnership' beds may offer the best way of securing good, modern and local accommodation for older people's continuing care services.

- 9.5 As with current practice, there are smaller specialist inpatient services (for Addictions, Intensive Psychiatric Care, and Forensics) where critical mass and sustainability suggest they should continue to offer a service across locality boundaries.
- 9.6 The feedback received at the follow-up events, in the main reaffirmed the Clyde Strategy Group's thinking around its work on options for the future location of inpatient services.
- 9.7 However, the option to consolidate Renfrewshire adult acute admission beds at RAH saw opinion divided. Some saw the logic and clinical benefits of collocation and consolidation on the RAH site as a high priority; whilst other stakeholder feedback expressed concern that location at the RAH was unlikely to achieve the high standard of current purpose built accommodation at the Dykebar site, which had been hard fought to secure and was now highly valued.
- 9.8 Concurrently further work has explored the capital costs of providing single-room accommodation at refurbished RAH wards for this client group, to try and attain a standard of internal accommodation similar to that offered at Dykebar. Having further explored these issues it is clear that the costs of bringing the RAH wards to a similar environment and standard to those at Dykebar appear to be substantial, and difficult to justify at this point in time, given the good quality accommodation available at Dykebar.
- 9.9 We have therefore revised the original proposal to locate adult beds at the RAH, to a proposal to consolidate all adult mental health admission beds for Renfrewshire in the existing good quality Acute Assessment Unit accommodation at the Dykebar Hospital.
- 9.10 The proposals to consolidate all WDC admission activity at the Gartnavel site saw opinion more divided with concern at the potential loss of this local service to the Dumbarton and Alexandria population. The strategy proposes that the challenges of retaining the service at the Vale of Leven are outweighed by the benefits of consolidation of all WDC inpatient activity at the Gartnavel Royal site. The detail of this rationale is further considered in para 14.22 onwards.

**10. ACHIEVING A MODERN COMPREHENSIVE MENTAL HEALTH SERVICE:
HOW WILL WE GET THERE?**

10.1 The strategy has 6 main components:

1. Substantial development of comprehensive community services to support a rebalanced comprehensive community based mental health service
2. Closure and reprovision of continuing care beds in higher quality environments in community settings (older people) or hospital settings (adults)
3. Reconfiguration and development of inpatient services to lower benchmark levels of provision consistent with a sustainable rebalanced service
4. Development of access to specialist services for the Clyde population
5. Investment of resources released from the redesign of inpatient and continuing care services to:
 - Fund the service developments set out above
 - Achieve financial balance whilst minimising impact on direct service delivery
6. Bridging funding to support the transition and service redesign to enable
 - Development of robust community services in advance of inpatient bed reductions
 - Bridging funding to support service redesign pending full release of site based savings

10.2 A brief explanation of the rationale informing each of these components is summarised in the following sections 12-16.

10.3 A summary of the service and financial changes associated with these 6 components is provided in the following sections 12 – 16.

11. BENCHMARKING THE REQUIRED LEVELS OF COMMUNITY AND INPATIENT SERVICES

Benchmarking the levels of community services

11.2 The Sainsbury Centre for Mental Health/Department of Health (England) has produced guidance on the scale of staffing for the main adult community service teams:

- Community Mental Health Teams (CMHT's)
- Crisis Resolution and assertive outreach supports
- Early Intervention first onset psychosis services

11.3 This guidance has been applied into the context of the varying deprivation levels of GG&C areas, to model the outstanding required scale of additional staffing net of existing community staffing resources.

11.4 There is no similar clarity of required levels of primary care mental health supports, and the benchmark has therefore extrapolated from existing Greater Glasgow levels of provision.

11.5 No similarly developed benchmarking tools are available for use to model the required scale of older people's community mental health services, and the approach has therefore been more reliant on local judgement.

Benchmarking the levels of inpatient services

11.6 The Greater Glasgow Modernising Mental Health Strategy (1999) planned the levels of Greater Glasgow bed provision using a variety of approaches including:

- Epidemiological research indicating service norms
- Benchmarking against a range of UK inner city mental health services
- Local judgement on how to position Glasgow within the ranges of bed levels suggested by the approaches above.

11.7 Greater Glasgow services have, for some years, operated a rebalanced service with enhanced community services and reduced levels of inpatient beds. In the light of that experience Greater Glasgow has subsequently further revised downwards its assessment of required inpatient bed levels subject to comprehensive community services being in place.

11.8 Crisis resolution services have been developed throughout the UK. This experience has demonstrated Crisis resolution services can be expected to have a significant impact on the balance of care, achieving a 20% shift from inpatient to community care for adult admission beds. The Greater Glasgow beds have already achieved a 10% reduction in acute admission beds, and can be expected to achieve the remaining 10% following the further development of crisis and assertive outreach services in Greater Glasgow.

11.9 The benchmarking for inpatient beds has therefore extrapolated from Greater Glasgow levels to determine the required bed levels for the North and South Clyde areas.

11.10 There is clear evidence that higher levels of service provision are associated with more deprived areas, and the bed benchmarking has incorporated a deprivation weighting to

reflect this. The deprivation weighting tools have been applied and used by Greater Glasgow services for 8 years with a broad consensus on the validity of the approach.

11.11 This benchmarking has then been refined by exception, based on local judgement, and final bed levels adjusted to reflect the modest adjustments required to take account of actual ward sizes.

11.12 The subsequent sections have provided tables which have used the benchmarking methodology to compare:

- current levels of provision in North and South Clyde
- Benchmarked required levels of provision
- Comparative levels of provision between Clyde services and Glasgow services
- Proposed levels of provision

11.13 This approach has been applied to:

- Continuing care beds
- Acute admission beds
- N&S Clyde Specialist beds
- Highly specialist beds provided on a GG&C or Regional basis

12. DEVELOPMENT OF COMMUNITY SERVICES

- 12.1 We have used service benchmarking tools to assess the scale of the services required to provide comprehensive CMHT's, Crisis and assertive outreach supports, and primary care supports. This has then enabled us to assess the deficit levels and funding required to respond to such deficits.
- 12.2 Provision of robust community services is a prerequisite of service rebalancing in which higher levels of more intensive community services sees a lowering of the required levels of inpatient services required. This has been the experience of services within both Greater Glasgow and throughout the UK. Services within Greater Glasgow have been operating on this basis for some years and demonstrated the practical sustainability of such a rebalanced service.
- 12.3 The proposed expansion of community services will provide consistent access to community services supports throughout the North and South Clyde area as set out in the GG&C service specification for community services
- 12.4 The strategy has proposed investments of £3.5m to:
- develop primary care services to ensure all GP practices have ready access to staff skilled in the care and treatment of patients with mild to moderate mental health needs
 - enhance community based mental health teams to increase their capacity to support people with more severe and enduring mental illness in the community
 - develop crisis services to provide community responses to people in an acute mental health crisis and to provide more intensive input to patients who may otherwise be admitted to hospital, and support the discharge of patients
 - provide assertive outreach supports to sustain contact and maintain the functioning of a small group of chaotic service users prone to relapse following disengagement from services

13. CLOSURE AND REPROVISION OF CONTINUING CARE BEDS

- 13.1 The NHS Management executive letter MEL 1996(22) sets out that NHS Continuing In Patient Care should be provided where someone requires ongoing and regular specialist clinical supervision on account of :
- the complexity of their medical, nursing or other clinical needs taken together *or*
 - the need for frequent not easily predictable clinical interventions *or*
 - the need for, or routine use of, specialist healthcare or treatments requiring specialist NHS staff supervision
 - a rapid degenerating or unstable condition which requires support from specialist medical or nursing supervision
- 13.2 It is clear that the current use of continuing care beds is far wider than the more focussed use summarised above and has often defaulted to become the long stay residence for a wide range of needs for which more appropriate services are not yet in place.
- 13.3 It is also clear that current arrangements for provision of continuing care take place in hospital environments of:
- variable and often poor quality
 - few wards with single room accommodation
 - an absence of space for visitors
 - limited space for therapeutic activities
- 13.4 The provision of continuing care within the Clyde area is about 2.2 times higher than provision within Glasgow, reflecting an unmodernised service used as default long stay accommodation, for a wide range of needs which do not require long term care in an inpatient setting.
- 13.5 This means that a number of people are currently cared for in continuing care beds, whose quality of life would be substantially enhanced by placement in community based accommodation with a range of supports. This has been our experience in Greater Glasgow where we have already implemented substantial closure and reprovision programmes, reprovided alternative care in community rather than inpatient continuing care settings, and experienced marked improvements in the quality of life and functioning of individuals.
- 13.6 With continuing care inpatient beds used for more focussed requirements the level of continuing care beds required will reduce substantially. Based on experience of such closure and reprovision programmes within Greater Glasgow, and elsewhere in the UK, we have benchmarked the requirements for continuing care within N&S Clyde.
- 13.7 Current levels of continuing care provision in Clyde services are about 220% higher than provision in Greater Glasgow and other areas of the UK.

Current and proposed bed levels showing comparison of Clyde bed levels to Greater Glasgow bed levels

Continuing Care beds

	Inverclyde	Renfrewshire	ERC (Clyde pop)	Total South Clyde	WDC (Clyde pop)	Total N&S Clyde	Helensburgh/Lochside (provided from GG&C hospital sites)
Current bed levels N&S Clyde							
<u>Continuing care</u>							
Adult	31	108	15	154	3	157	1
Elderly	80	59	7	146	8	154	4
total	111	167	22	300	11	311	5
Benchmark extrapolated from Greater Glasgow							
<u>Continuing care</u>							
Adult	9	15	2	26	5	31	1
Elderly	33	52	7	92	16	108	5
total	42	67	9	118	21	139	6
Comparative % current N&S Clyde to Greater Glasgow levels							
	%	%	%	%	%	%	%
<u>Continuing care</u>							
Adult	344	720	750	592	60	506	100
Elderly	242	113	100	159	50	143	80
total	264	249	244	254	100	224	83
Proposed bed levels							
(benchmark adjusted to reflect local judgement and best fit to ward sizes)							
<u>Continuing care</u>							
Adult	9	12	2	23	3	26	1
Elderly	33	52	7	92	8	100	4
total	42	64	9	115	11	126	5

13.8 There are currently 300 continuing care beds in South Clyde with 261 people using these beds. We propose to reprovide 115 beds for South Clyde supplemented by a range of community placements in:

- supported accommodation
- group homes
- extra care housing
- registered care homes

13.9 In Dumbarton and Alexandria there are 12 older peoples' beds providing a service to the Dumbarton and Alexandria and Helensburgh/Lochside populations. It is proposed to reprovide these beds within WDC through Partnership arrangements. Four adult continuing care beds are provided at Lochgilphead hospital and as the current cohort of users changes, we would transfer these beds to more local provision in Gartnavel Royal.

Arrangements for provision of continuing care beds

13.10 Within the Greater Glasgow area we have had substantial experience in reproviding continuing care beds into higher quality settings using a Partnership model of care, in which the levels of NHS medical and nursing staff are higher for complex needs and lower for less complex needs. This approach has enabled the provision of high quality living environments, in community rather than hospital locations, whilst enabling good control of medical and nursing standards, and overall quality of provision for a vulnerable patient group.

Adult continuing care

13.11 It is proposed that adult continuing care is provided from either an NHS facility based on an existing psychiatric hospital site or a Partnership model of care, located in a community setting.

13.12 The detailed arrangements will depend on the combination of needs in the current long stay cohort. Where the balance of needs is associated with very high levels of intractable and significant challenging behaviours it is likely such provision would be provided in specialist beds located on an NHS hospital site, as this can provide access to wider back up and support. Where the balance of needs is less complex, albeit still requiring inpatient care, our experience is that such needs can be met in Partnership bed arrangements located outwith acute hospital sites.

13.13 The detailed service model arrangements will be further developed based on the detailed outcomes of individual needs assessments. Pending that detail the strategy has proposed provision of adult continuing care beds in NHS provision on the Dykebar Hospital site.

Older peoples continuing care

13.14 For older peoples mental health continuing care it is proposed that:

- provision should enable separate spaces for functional and organic patients
- single room accommodation is generally preferable, albeit a mix of accommodation should be provided to allow reflection of individual choice of accommodation, as a small number of people may prefer shared accommodation
- location in community settings outwith inpatient sites, with access to the range of community networks and facilities
- provision based on Partnership models of care

14. RECONFIGURATION AND DEVELOPMENT OF INPATIENT BEDS

The number of inpatient beds

- 14.1 Throughout the UK Mental Health services have strengthened their community services and found this has enabled a rebalancing of services from an inpatient dominated service, to a community based service supported by access to briefer periods of inpatient care when required.
- 14.2 In considering issues of number and location of inpatient beds there is a tendency to emphasise the significance of local access to the provision of inpatient services, whilst underplaying the need for local access to comprehensive community services delivered in local areas. In terms of care and support for people with mental health problems:
- 95% of mental health problems are managed in primary care
 - 5% of mental health problems are managed in secondary care community and inpatient services
 - less than 1% of mental health problems are managed in inpatient settings where a hospital admission is required
- 14.3 In the above context the overwhelming priority is the development of locally accessible community resources, for the 99% of mental health problems managed in primary and community settings.
- 14.4 The current provision of acute admission beds for the Clyde area is about 1.4 times per head higher than that of the Greater Glasgow levels.
- 14.5 Greater Glasgow's experience has demonstrated the long term sustainability of operating at lower levels of inpatient bed use where this is underpinned by provision of comprehensive community services.
- 14.6 Our proposal is therefore to provide inpatient bed levels consistent with those of Greater Glasgow. The tables below summarise the current and future bed proposals for acute admission and specialist beds based on:
- the application of the benchmarking methodology
 - further refinements to reflect local judgements
 - achieving a "best fit" between benchmarking requirements and individual ward capacity.

Current and proposed bed levels showing comparison of Clyde bed levels to Greater Glasgow bed levels

Acute admission beds

	Inverclyde	Renfrewshire	ERC (Clyde pop)	Total South Clyde	WDC (Clyde pop)	Total N&S Clyde	Helensburgh/Lochside (provided from GG&C hospital sites)
Current bed levels N&S Clyde							
<u>Acute admission</u>							
Acute Adult	45	66	9	120	18	138	6
Acute Elderly	20	35	5	60	8	68	4
sub total	65	101	14	180	26	206	10
Benchmark extrapolated from Greater Glasgow							
<u>Acute admission</u>							
Acute Adult	25	42	6	73	14	87	4
Acute Elderly	17	26	3	46	8	54	2
total	42	68	9	119	22	141	6
Comparative % current N&S Clyde to Greater Glasgow levels							
	%	%	%	%	%	%	%
<u>Acute admission</u>							
Acute Adult	180	157	150	164	129	159	150
Acute Elderly	118	135	167	130	100	126	200
total	155	149	156	151	108	146	167
Proposed bed levels							
(benchmark adjusted to reflect local judgement and best fit to ward sizes)							
<u>Acute admission</u>							
Acute Adult	20	42	6	68	12	80	4
Acute Elderly	20	35	5	60	12	72	6
total	40	77	11	128	24	152	10

Notes to the table:

1. The figures for ERC and WDC relate to the catchment populations served by the previous Argyll and Clyde Health Board and don't include the full local authority catchments

2. The provision of beds for older peoples mental health acute admission beds in Renfrewshire is being led by the Renfrewshire Older Peoples Planning, Performance and Implementation Group. The application of the standard benchmarking methodology would see proposed bed provision at 26 beds. The Renfrewshire Older Peoples Planning, Performance and Implementation Group will further review the proposed level of provision at between 26 beds per the benchmark and 40 beds (the current level of provision) to determine the balance of care between inpatient and community services.

3. Helensburgh and Lochside services are commissioned by the Highland Health Board. The table above reflects the services to that population provided from the Vale of Leven site, which would be affected by the proposals in this report. The figures for Helensburgh/Lochside in the proposed bed requirements are based on the standard Benchmarking for services with developed community services, supplemented by local judgement. The Highland Health Board has indicated it would wish to ensure the Helensburgh/Lochside population continued to access the services also accessed by the Dumbarton and Alexandria population.

Guiding principles on the location and configuration of beds: service and clinical robustness issues

14.7 The following *service and clinical robustness principles* have informed proposals on the location of acute admission and related specialist beds:

- provision of inpatient mental health services can be provided on either a stand alone psychiatric hospital site or collocated with physical health beds on an acute medical admissions hospital site (a District General Hospital). Both forms of provision currently exist within the GG&C area and throughout the UK.
- the preferred location for inpatient mental health beds is collocation on an acute admission site as this has the benefits of:
 - access to physical and diagnostic investigations
 - opportunity to integrate both physical and mental health care, particularly for older people
 - proximity and support to Accident and Emergency units where significant numbers of people with mental health problems may present, particularly out of hours
- acute admission beds should be located on a site with medical cover arrangements which ensure acceptable levels of clinical safety (see further detail below)
- specialist addictions beds to be collocated :
 - at a minimum with a site with acute mental health admissions to ensure access to similar expertise and back up from medical and nursing support
 - preferably on a site with both acute mental health and physical health admissions – i.e. a DGH with Mental Health beds on site
- ICU to be collocated with:
 - adult acute mental health admissions to ensure access to psychiatric medical expertise and nursing support
- forensic medium and low secure beds should be:
 - located on a site with acute adult admission beds to ensure access to wider specialist medical and nursing expertise and support
- ward spaces should enable:
 - beds for patients with organic and functional needs to be located in discrete areas to enable separate management of these distinct patient groups
 - provision of age appropriate services

Medical cover issues

- 14.8 The national process of Modernising Medical Careers will see changes to the arrangements for training and provision of medical cover, particularly by junior doctors. The cumulative impact of these changes is likely to see:
- c20% reduction in allocation of junior doctor training posts between now and 2013 full implementation date, albeit local variations linked to nationally determined junior doctor training allocations
 - reduced direct patient contact time as part of junior doctor training
- 14.9 The cumulative effect of these changes is likely to make the long term sustainability of current models of medical cover significantly more challenging, particularly for sites covering smaller catchment populations.
- 14.10 In terms of medical cover arrangements for acute admission units the following principles are applicable to ensure clinically safe levels of medical cover:
- 14.11 Preferred arrangements:
- resident junior psychiatric medical cover on site supported by access to on call Consultant Psychiatrist support
- 14.12 Where this preferred arrangement is not feasible the minimum acceptable arrangement would be:
- integration of arrangements for Mental Health junior doctor cover with resident site based general medical cover arrangements for the hospital site
 - resident junior medical cover on site, involving both non psychiatric and psychiatric junior medical cover, with access to on call Consultant Psychiatrist support

Guiding principles on the location and configuration of beds: cost effectiveness and feasibility issues

- 14.13 In addition to the *service and clinical robustness* principles summarised above a number of further principles were considered to inform the detail of proposed location of beds. These *cost effectiveness and feasibility* principles are summarised below:
- the need to maximise site infrastructure savings to fund community service developments
 - the need to ensure the feasibility of specific site options in terms of :
 - ward and space capacity available for mental health use
 - achievement of acceptable quality therapeutic environments for inpatient and continuing care
 - compliance with the service and clinical robustness principles summarised above
 - capacity to provide sustainable provision of medical cover consistent with the preferred or minimum cover principles

- capacity to provide economic medical cover
 - capacity to provide cost effective provision taking account of size/critical mass issues (i.e. local/South Clyde/GG&C or Regional provision varies with bed numbers and degree of specialism)
 - capacity to achieve the site configuration within the capital allocations available
- 14.14 In general terms c85% of all mental health hospital site infrastructure costs are associated with the Dykebar and Ravenscraig psychiatric hospital sites. The site infrastructure costs of mental health provision on the RAH, IRH and Vale of Leven sites amount to only c15% of total infrastructure costs as the majority of such site costs relate to acute DGH use of these sites.
- 14.15 Maximising release of site costs on the Dykebar and Ravenscraig sites is therefore critical to funding the range of service developments set out in this strategy.
- 14.16 Location on DGH/ACAD sites rather than “stand alone” psychiatric sites is normally the clinically preferred option.
- 14.17 Broadly speaking this sees a congruence between the clinically preferred service location imperatives and the maximisation of financial savings. In general terms the approach has therefore been to:
- release the site infrastructure costs of the Ravenscraig hospital closure and disposal of the site
 - maximise the use of good quality accommodation on the Dykebar hospital site, vacation of all other accommodation and disposing of a large part of the site
 - maximise the use of DGH sites where this is consistent with cost effectiveness, service quality, clinical robustness and feasibility
 - use of Partnership models of provision for older peoples mental health continuing care to achieve both environmental improvements and maximise release of hospital site infrastructure savings
- 14.18 Finally we have sought to reflect the strong local desire for local provision of inpatient services wherever this can be achieved without compromising:
- the service and clinical robustness principles
 - the cost effectiveness and feasibility principles
- 14.19 Applying the above service, clinical safety, economic, and feasibility principles, and the benchmarked capacity requirements referenced earlier in the paper, the proposed provision of beds would see:
- acute admission and continuing care beds provided at a more local level
 - specialist beds provided on a South or North Clyde basis
 - highly specialist beds provided on a GG&C wide or Regional basis

14.20 Based on the application of these principles the detailed proposals and rationale is summarised in below:

Inverclyde

- retention of Inverclyde adult and older peoples acute admission services on the IRH site :
 - 20 adult and 20 older people's beds
- closure of older peoples continuing care beds currently on the Ravenscraig site, and reprovion of 33 older peoples mental health continuing care beds in a community based Partnership arrangement
- closure of adult continuing care beds currently on the Ravenscraig site, and reprovion of 9 adult continuing care beds with local flexibility about the detailed arrangements to reflect the need to balance the advantages between access to specialist provision located for a South Clyde catchment at Dykebar and more local location of less specialist provision

Renfrewshire

- retention of 40 older peoples mental health admission beds on the RAH site as now
- closure of older peoples mental health continuing care beds on the Dykebar site and reprovion of 59 continuing care beds in a community based Partnership arrangement
- consolidation of 42 adult acute admission beds in the good quality accommodation on the Dykebar site (currently split between the Dykebar and RAH sites)
- reprovion of 12 adult continuing care beds in higher quality accommodation on the Dykebar site

14.21 Our preferred proposal would have seen adult mental health beds located on the RAH site, however this would involve substantial capital and revenue costs which could not be prioritised given the alternative option of location of adult acute admission beds within the existing high quality accommodation on the Dykebar site.

East Renfrewshire: Levern Valley

- consolidate provision of adult mental health beds for all of East Renfrewshire on the Leverndale site already used by the majority population of ERC covered by the former GG NHS Board (6 beds already transferred during 2007)
- consider consolidation of the small number of Older peoples mental health acute admission beds for all of ERC on a single hospital site - either at the Leverndale Hospital or at the RAH
 - 5 Clyde beds currently at RAH
 - 12 beds currently provided at Leverndale Hospital

- closure of older peoples mental health continuing care beds on the Dykebar site and reprovision of continuing care beds in a community based Partnership arrangement
 - ERC to access either Renfrewshire provision or Greater Glasgow provision based on whichever arrangement achieves the best fit between user need, local access and service availability

West Dunbartonshire: Dumbarton and Alexandria

- consolidate provision of all acute admission beds for WDC on the Gartnavel Royal site and transfer the adult and elderly acute admission beds currently located on the Vale of Leven hospital site to the Gartnavel Royal
 - transfers 24 acute admission beds (12 adult and 12 older peoples beds) for Dumbarton and Alexandria catchment to Gartnavel, in addition to the 24 beds (10 adult and 14 older people) already provided at Gartnavel for the Clydebank catchment population
- IPCU beds relocated from Lochgilphead to 2 beds in Gartnavel Royal
- 12 Continuing care older peoples beds redeveloped within WDC area using Partnership model

14.22 The rationale for the proposed transfer of acute and older people's mental health admissions beds to the Gartnavel site is based on the following factors which are not achieved by continuation of the current arrangements on the Vale of Leven site:

- WDC is currently supported by 3 hospital sites (The Vale of Leven, Gartnavel Royal and Lochgilphead) – consolidating all WDC beds on a single site has significant advantages for the integration of inpatient and community services
- whilst a single WDC inpatient site could be achieved by placing all WDC activity on the Vale site it would not achieve the benefits summarised below

14.23 Consolidation of acute admission beds on the Gartnavel Royal site:

- supports integration of all WDC inpatient activity on a single site with continuity of care advantages for service users transferred between these beds:
 - acute admission beds
 - IPCU beds provided to West Glasgow and WDC
 - Intensive rehabilitation beds provided to West Glasgow and WDC
- retains the benefits of high quality of inpatient accommodation planned for the Clydebank population as part of the new Gartnavel hospital development
- provides ground floor accommodation and safe garden access
- achieves preferred medical cover arrangements with advantage of resident junior psychiatric medical cover on site
- reflects already established pattern of patient flows for Clydebank population which has already achieved good integration between inpatient and community services,

whilst extending the catchment population to include the Dumbarton & Alexandria population. Whilst this does mean greater distance in terms of access there are nevertheless good public transport links to Gartnavel

- the larger Gartnavel Royal mental health inpatient service has the benefits of more developed hospital infrastructure able to provide dedicated:
 - specialist management of inpatient service
 - practice development supports
 - bed management supports
 - collocation on a DGH site

-

14.24

Helensburgh/Lochside

14.25 Services to this population are funded and commissioned by the Highland NHS Board and provided through a service agreement with the GG&C NHS Board.

14.26 The Highland NHS Board has indicated its recognition of the desirability of the Helensburgh /Lochside population continuing to access the same inpatient services as available to the Dumbarton and Alexandria population, notwithstanding the proposed transfer of inpatient services from the Vale of Leven hospital to the Gartnavel hospital.

15. SPECIALIST SERVICE DEVELOPMENT

- 15.1 For a range of more specialist services the numbers of beds are so low that it is only feasible to provide such services to either a South Clyde, GG&C wide or Regional population. The table below sets out the current and proposed bed levels for Specialist Services.

Current and proposed bed levels showing comparison of Clyde bed levels to Greater Glasgow bed levels

<u>Specialist beds N&S Clyde</u>	Total South Clyde	WDC (Clyde pop)	Total N&S Clyde
Current bed levels N&S Clyde			
<u>Specialist beds N&S Clyde</u>			
Intensive Rehab	0	0	0
IPCU	8	3	11
Addictions	11		11
ARBD	0		0
total	19	3	22
Benchmark extrapolated from Greater Glasgow			
<u>Specialist beds N&S Clyde</u>			
Intensive Rehab	8	2	10
IPCU	10	2	12
Addictions	7	1	8
ARBD	2	0	2
total	27	5	32
Comparative % current N&S Clyde to Greater Glasgow levels			
	%		%
<u>Specialist beds N&S Clyde</u>			
Intensive Rehab	0		0
IPCU	80		92
Addictions	157		138
ARBD	0		0
total	70		229
Proposed bed levels			
(benchmark adjusted to reflect local judgement and best fit to ward sizes)			
<u>Specialist beds N&S Clyde</u>			
Intensive Rehab	9	2	11
IPCU	11	2	13
Addictions	7	1	8
ARBD			1
total	38		33

Specialist services covering a South Clyde catchment (Renfrewshire and Inverclyde)

- 15.2 The following specialist inpatient services are already provided to a South Clyde catchment:
- IPCU beds
 - specialist addictions beds

IPCU

- 15.3 Eight IPCU beds are currently provided on a South Clyde basis and the proposal is that this continues albeit with a change of location from Dykebar to a 10 bedded unit at the IRH.
- 15.4 The rationale for the change of location of beds is to optimise the use of inpatient capacity between the Dykebar and IRH sites whilst ensuring compliance with the service clinical robustness principles set out in para 14.7.

IPCU services are generally provided to catchment populations of 200,000 to 300,000 and therefore will always entail access issues beyond purely local service provision. It is recognised however that whereas the current location at Dykebar provided better access to the Renfrewshire population and more problematic access to the Inverclyde population, the strategy proposals would reverse this in favour of the smaller Inverclyde population.

Addictions

- 15.5 Eleven specialist addictions beds are currently provided at the Gryffe unit on the Ravenscraig site serving the South Clyde catchment population. No provision has historically been available for the North Clyde population. The specialist addiction beds provide an inpatient service for people whose primary problem is a complex addiction problem – albeit individuals who may also have other secondary physical or mental health problems in addition to their addiction needs.
- 15.6 Within the Greater Glasgow area one unit at Stobhill provides 15 beds to the population of the North and East Greater Glasgow catchment, and a second unit is planned to provide 8 beds to the South and West of the Greater Glasgow catchment. The beds are provided to meet the needs of people with a major addiction whose management is particularly complex by virtue of coexisting mental health or physical health needs.
- 15.7 In addition people whose primary problem is an acute mental health problem, and additionally have an addiction problem, are cared for within general psychiatry beds and may typically constitute c40% of the inpatient population
- 15.8 The specialist addiction beds in the Gryffe Unit will need to be relocated to facilitate the closure of the Ravenscraig site. Therefore these beds require relocation to another inpatient site. In considering the re-provision of these beds we considered either re-providing them as a smaller 7 -11 bedded South Clyde service, or as a larger unit providing a service to the South Clyde and South Glasgow area.

- 15.9 Our proposal is to consolidate the provision of 7 South Clyde and 8 South and West Glasgow beds as part of a larger 15 bed unit serving the South Clyde and South and West Glasgow population. Additionally the planned Greater Glasgow 8 ARBD beds may benefit from collocation with the additions beds and our proposal is to provide an additional ARBD bed for the Clyde area. This would increase the size of the unit to 24 beds. The rationale for this consolidation proposal is:
- quality services require access to a range of specialist disciplines to provide multi disciplinary supports required for the delivery of tier 4 services to the most complex range of addictions problems
 - units of less than 15 beds cannot sustain dedicated or economic access to such specialist supports (e.g. OT and psychology)
 - a larger 24 bed unit is likely to prove more attractive in terms of recruitment and retention of specialist staff who would see a larger unit as providing greater opportunity for their professional development, supervision and support
 - a larger 24 bed unit is likely to provide more cost effective provision at lower unit costs
- 15.10 The proposed location for a consolidated specialist addictions inpatient service is on the Southern General site as part of the site redevelopment. This location enables full compliance with both the minimum and preferred clinical location principles set out in para 13.7, whilst providing reasonable centrality to enable access for the South and West Glasgow and South Clyde catchment. We considered the option of location of the beds at a range of other sites including Leverndale/RAH/or Dykebar. However at this stage either no capacity to accommodate the beds has been identified on these sites, or in the case of Leverndale and Dykebar the sites would meet the minimum rather than the preferred collocation criteria of location on a DGH site.
- 15.11 The timing of the closure and disposal of the Ravenscraig site will require relocation of specialist addictions beds by 2010. However the broader SGH site developments are likely to mean the specialist addictions beds would become operational between 2012 and 2015. There will therefore need to be a transitional location for these beds between the closure of the Ravenscraig site and the development of the beds on the SGH site.
- 15.12 At this stage it is acknowledged that the Clyde Mental Health Strategy has necessarily dealt with the development of the addictions beds in the absence of a clear community and inpatient service addictions services strategy, or funding sources with which to generate the development of community services.
- 15.13 In particular the movement of the addictions inpatient beds will have implications for the viability of existing community and day services collocated with the Gryffe unit. The issues of broader service strategy and the implications for the community and day services will need to be more fully developed in advance of any move of the inpatient services – given the pace of redevelopment of the Ravenscraig site it is likely this move will occur over the next 2-3 years.
- 15.14 We will therefore establish a Clyde wide addictions planning process to resolve these outstanding issues and also to confirm the transitional location of the specialist addictions beds, in advance of the final location on the Southern General site.

15.15 The proposed reduction from an 11 bed to a 7 bed provision for South Clyde reflects:

- comparable levels of provision to Greater Glasgow
- the bed provision of 9 beds comprising of 7 beds for South Clyde, 1 bed for North Clyde and 1 ARBD bed

Intensive rehabilitation

15.16 Intensive rehabilitation beds are not currently provided in Clyde services, but their development would enable specialist management of a challenging behaviour group of patients generally requiring such support for 1-4 years beyond their acute admission, best provided in separate accommodation from the acute admission environment of care. It is proposed to develop 8 such beds for South Clyde on the Dykebar site.

Early onset psychosis

15.17 Early onset psychosis services are currently provided from a specialist service for the South Glasgow population. The funding of this service will be increased to enable an expansion of the catchment to include the South Clyde population.

Specialist services for the North Clyde catchment (Dumbarton and Alexandria)

15.18 Historically the Dumbarton and Alexandria population has had limited access to specialist services, provided either from Lochgilphead or from services South of the Clyde.

15.19 It is proposed to improve local access to such services by extending the access already available to the Clydebank population to the whole of the WDC population including the Dumbarton and Alexandria population:

- transferring IPCU beds from Lochgilphead to an additional 2 beds for WDC in the Gartnavel Royal IPCU
- access to intensive rehabilitation beds at Gartnavel Royal
- WDC wide access to specialist co-morbidity beds currently provided only to the Clydebank population at the Stobhill site

15.20 Early onset psychosis services are currently provided from a specialist service for the North Glasgow population. The funding of this service will be increased to enable an expansion of the catchment to include the Dumbarton and Alexandria population.

Highly Specialist services for a GG&C or Regional Catchment

15.21 The table below summarises the current and proposed provision for highly specialist services provided to a GG&C or Regional catchment.

Current and proposed bed levels showing comparison of Clyde bed levels to Greater Glasgow bed levels

Highly Specialist beds GG&C/Regional Services	Total N&S Clyde
Current bed levels N&S Clyde	
<u>GG&C /Regional provision for Clyde popn</u>	
Low secure adult mental health	0
Low secure adult learning disabilities	5
Medium secure adult mental health	0
Total	5

Benchmark extrapolated from Greater Glasgow	
<u>GG&C /Regional provision for Clyde popn</u>	
Low secure adult mental health	8
Low secure adult learning disabilities	3
Medium secure adult mental health	7
Total	18

Comparative % current N&S Clyde to Greater Glasgow levels	
	%
<u>GG&C /Regional provision</u>	
Low secure adult mental health	0
Low secure adult learning disabilities	167
Medium secure adult mental health	0
Total	28

Proposed bed levels	
(benchmark adjusted to reflect local judgement and best fit to ward sizes)	
<u>GG&C /Regional provision</u>	
Low secure adult mental health	8
Low secure adult learning disabilities	5
Medium secure adult mental health	7
Total	20

Forensic medium and low secure services

15.22 The Argyll and Clyde plans had proposed development of a 30 bed medium secure unit to be located on the Dykebar site to service a West of Scotland catchment excluding Greater Glasgow. Greater Glasgow has developed a 74 place medium and low secure unit on the Stobhill site in North Glasgow originally developed to serve a Greater Glasgow catchment population. The Stobhill site is a new purpose built unit which opened in July 2007.

Consolidation of medium secure services

15.23 It is clear that consolidation of medium secure services on a single site has a number of advantages compared to a 2 site option in terms of:

- lower capital and associated revenue costs
- reduced duplication of provision of infrastructure supports (e.g. recreational and other communal facilities)
- improved access to specialist dedicated multi disciplinary supports which are difficult to sustain in smaller 30 place units
- increased ability to recruit and retain specialist staff as larger units provide more opportunity for professional and career development
- lower revenue costs associated with reduced duplication of infrastructure supports and economies of scale
- higher quality of service provision linked to opportunity to recruit and retain dedicated specialist multi disciplinary supports
- improved flexibility in the matching of clinical space use to changing needs and changing patient populations through a pooled use of a higher number of ward spaces not available to the previously planned 2 ward 30 bed Dykebar unit

15.24 Pending the development of the Dykebar forensic unit the Stobhill unit is already the interim provider of medium secure beds to the West of Scotland, including the GG&C catchment.

15.25 It is therefore proposed to make this interim proposal permanent by consolidating medium secure services on the Stobhill site for GG&C and the West of Scotland and withdrawing the previous proposal to develop medium secure beds on the Dykebar site.

15.26 This proposal would provide 7 new medium secure beds requiring investment of £900k

Consolidation of adult low secure services

15.27 The Argyll and Clyde Board had made no provision for adult low secure services for its catchment. However the Mental Health Act requires that service users are cared for in the least restrictive environment consistent with their needs. It is therefore proposed to invest £800k to develop 8 low secure beds for the N&S Clyde catchment to be located on the Leverndale site.

Consolidation of low secure learning disability services

- 15.28 Additionally 8 specialist low secure beds for people with learning disabilities are located at the Dykebar site serving a West of Scotland catchment, and 8 similar beds for the Greater Glasgow catchment are provided on the Leverndale hospital site.
- 15.29 The logic of consolidation of small highly specialist services into a larger single service applies to the consolidation of the two separate low secure learning disability services into a single service on the Leverndale site. Broadly the rationale would echo that summarised above for the medium secure service.

Perinatal and Eating Disorder Services

- 15.30 The North and South Clyde catchments already have access to the 2 Regional perinatal beds located at the Southern General Hospital and this will continue.
- 15.31 Specialist Eating Disorder beds are currently provided through the Priory hospital located on the Southside of Glasgow and there are no current plans for GG&C to change these arrangements, as they already provide local access to a highly specialist regional service.
- 15.32 Within Greater Glasgow specialist community teams have been developed for both eating disorder services and for perinatal services. These specialist community teams provide a liaison and consultation service to support mainstream services to develop their capacity in the management of such specialist needs.
- 15.33 The specialist teams also provide direct case management of the most complex patient needs including pre and post admission arrangements.
- 15.34 In the long term an extension of the geographic coverage of the Greater Glasgow specialist community teams to cover the N&S Clyde catchment is required to provide appropriate service responses and ensure a community oriented service rather than an inpatient dominated service. However this catchment extension can only be achieved when the Clyde services can fund such developments which are beyond the scope of the current financial constraints.
- 15.35 In the interim the role of the teams will be more modestly extended to provide a liaison and consultation advice resource to mainstream services in the N&S Clyde area.

16. ACCESS

- 16.1 The strategy proposes the substantial development of community services thereby improving access to these supports for the 99% of mental health service users whose needs are managed in community settings. Additionally the closure and reprovision of continuing care beds has also sought to enable the retention of NHS continuing care services in each of the Clyde localities.
- 16.2 The strategy also proposes a range of changes to the location of inpatient services used by 1% of mental health service users whose needs are managed in inpatient settings. These more significant geographic changes affect c15% of current admission and specialist beds used by about 560 people per year. The access implications of the inpatient service changes are summarised below.

Acute admission

- 16.3 Wherever practical and feasible, we have sought to retain non-specialist inpatient services within each of the Clyde localities. This has been achieved in respect of the proposals for adult and older peoples' acute admission services for Inverclyde and Renfrewshire.
- 16.4 The proposed transfer of adult and older people's acute admission services from Vale of Leven Hospital to Gartnavel Royal Hospital will mean some residents of West Dunbartonshire travelling longer to receive inpatient care, or for those visiting. About 230 people per year use the Vale acute admission beds. For the reasons outlined in the strategy, it is considered that the benefits of consolidating these services for all of West Dunbartonshire on a single site at Gartnavel outweigh additional travelling issues.
- 16.5 Nevertheless, we will work with local bus operators to explore whether the existing transport provision is adequate and if not, explore the scope to improve the frequency or availability of buses. For those able to travel by train, a regular service currently operates between both areas. By car, the 16 mile one-way journey between Vale of Leven and Gartnavel is estimated to take in the region of 20 minutes.

Addictions

- 16.6 Inpatient specialist provision for addictions is currently provided on a pan-locality basis. In the case of addictions, the Gryffe unit at Ravenscraig Hospital currently offers a service to the Clyde localities of Inverclyde, Renfrewshire, and East Renfrewshire and no current service provision to West Dunbartonshire. The consolidation of addictions services across Greater Glasgow & Clyde offers significant benefits, in terms of access to a wider pool of multi-disciplinary supports for patients (South Glasgow & Clyde inpatient services proposed for Southern General Hospital and North Glasgow & Clyde inpatient services proposed for Stobhill Hospital).
- 16.7 About 280 people each year use the addictions beds. In overall terms the proposals will improve access to such services for the various populations within the North and South Clyde area. However it is acknowledged that access issues impact differently for the different sub geographies. For Renfrewshire, East Renfrewshire and West Dunbartonshire localities the proposals will improve accessibility to addictions inpatient care. For Inverclyde, the proposals have a detrimental impact on accessibility. Again, we will work with local bus operators to explore whether the existing transport provision is adequate and if not, explore the scope to improve the frequency or availability of buses. By car, the distance between Ravenscraig Hospital and Southern General is approximately 23 miles, one way, with an estimated travelling time of 30 minutes.

- 16.8 Inpatient specialist provision for Intensive Psychiatric Inpatient Care (IPCU) is currently provided from Lochgilphead for West Dunbartonshire residents and at Dykebar Hospital for Renfrewshire, East Renfrewshire and Inverclyde. The proposed transfer of IPCU services from Lochgilphead to Gartnavel Royal will significantly improve local access. The close proximity of Dykebar and Leverndale Hospital (under 3 miles) is not anticipated to offer difficulties in the transfer of East Renfrewshire's Levern Valley IPCU provision to Leverndale.

IPCU

- 16.9 The proposed transfer of the 10 bed remaining South Clyde IPCU provision from Dykebar to Inverclyde Royal Hospital will have positive access implications for Inverclyde and negative access implications for Renfrewshire. Currently about 46 people per year use the service. Any patient requiring to travel to an IPCU for admission will do so under the supervision and responsibility of the NHS. The period of time that a patient is expected to be cared for within IPCU should be relatively short and therefore any inconvenience for visitors should only be for a relatively short period of time. In terms of transport links, IRH is well served by a train connection that can be accessed from the Paisley Gilmour Street station. By car, the journey time is approximately 20 miles one-way, with an estimated travel time of 30 minutes.

Forensic services

- 16.10 Again, the close proximity of Dykebar and Leverndale Hospital is not anticipated to cause any notable difficulties for the proposal to transfer low secure learning disability beds from Dykebar to Leverndale. About 8 people per year use this service.

Intensive Rehabilitation

- 16.11 The proposal to develop specialist adult intensive rehabilitation beds, adult low secure forensic beds and forensic medium secure beds are effectively all new services. From that perspective, they neither have a positive or negative impact for existing patients. Escorting patients for admission to these services will be under the supervision and responsibility of the NHS

17. WORKFORCE ISSUES

- 17.1 Throughout the implementation of the changes proposed, work will continue with staff and their representatives to manage the impact of change. This will be done within the context of the national and local organisational change policies, which are based on the principle of “no detriment”.
- 17.2 Once staff directly affected by the changes proposed are identified, in addition to meetings with the trade unions, one to one meetings/individual redeployment interviews will be held. NHS Greater Glasgow and Clyde has a successful track record in redeploying staff taking into account individual’s skills and personal circumstances. Redeployment will be the first consideration with the aim of securing alternative employment for displaced staff as a result of service change. Based on this detailed redeployment principles will be agreed and a process of vacancy management will be put in place to secure alternative employment in alternative departments and locations.
- 17.3 Deployment may be to a post at a lower grade and in these circumstances protection of earnings will apply. Redeployment will also be supported by a training and development plan, which will include induction and orientation programmes, and retraining/skills updating where necessary.
- 17.4 Regular briefing sessions will be held with staff throughout the period of implementation.
- 17.5 About 145 staff are directly affected by the proposed geographic changes to inpatient locations which would move staff outwith their current local authority/CHP area:
- IPCU 30
 - Addictions beds 25
 - Vale of Leven 60
 - Learning disabilities 30
- 17.6 Beyond the services specifically summarised above the wider service redesign proposals and rebalancing of inpatient and community services would see a reduction in overall bed provision and an increase in community service provision.
- 17.7 For all of these staff groups the principles set out in paragraphs 17.1 to 17.4 above would be applied.

18. FINANCING THE CLYDE STRATEGY

18.1 Contrary to popular belief there does not appear to be a major inequity of spend per head on mental health services between the Greater Glasgow area and the Clyde area.

18.2 Rather the pattern and outputs of such expenditure are differently balanced with Clyde services spending:

- 1.5 times as much per head on inpatient services compared to Greater Glasgow
- half the spend per head on community services compared to Greater Glasgow
- high levels of spend on site infrastructure costs of services located on multiple hospital sites deflecting from spend on direct services

18.3 This pattern of expenditure is a function of:

- comparatively high levels of inpatient provision
- comparatively high levels of expenditure on inpatient hospital estate and the revenue costs of sustaining such a multiple site infrastructure
- comparatively low levels of expenditure on underdeveloped community services

18.4 The Clyde strategy is required to:

- bring existing deficit budgets into recurrent balance = £0.2m
- fund the development of comprehensive community services = £3.5m
- fund the retraction and reprovision programme = £3.4m
- fund the development of specialist services = £1.7m
- contribute to the GGC&C corporate recovery plan to contribute to the overall deficit reduction inherited from the Argyll and Clyde Health Board = £2.0m

18.5 Achieving the expenditure requirements summarised above requires achieving savings through:

- releasing site infrastructure costs by rationalisation of the number of hospital sites from which services are provided by:
 - releasing the site infrastructure costs of the Ravenscraig site through closure of the hospital and disposal of the site
 - maximising the use of good quality accommodation on the Dykebar hospital site, vacation of all other accommodation and disposing of a large part of the site
- reducing expenditure on inpatient services resultant from providing fewer beds, consistent with the reduced requirements associated with more comprehensively developed community services

- unit cost savings from provision of a range of community based accommodation with supports in place of more expensive continuing care bed provision

18.6 The table overleaf summarises these major financial changes to underpin the implementation of the Clyde Strategy.

Table of service change and financial investment

SERVICE CHANGE	FINANCIAL COMMITMENT
Expenditure commitments on service developments	£'m
<p><i>Development of community services</i></p> <p>a. Primary care supports/psychological interventions 0.7</p> <p>b. Community mental health team expansion adults / Crisis services development/ Early intervention first onset psychosis 2.3</p> <p>c. Community mental health team expansion older people 0.5</p> <p><i>Total development of community services</i> £3.5m</p>	
<p><i>Closure and reprovision of continuing care beds and development of range of community placements</i></p> <p>Develop a range of community placements</p> <ul style="list-style-type: none"> • supported accommodation placements • residential and nursing home placements • Enhanced community care packages <p><i>Total retraction and reprovision of continuing care beds</i></p>	£3.4m
<p><i>Specialist services development</i></p> <ul style="list-style-type: none"> • 8 forensic medium secure places and 7 low secure places • access to specialist liaison consultation advice <p><i>Total specialist service developments</i></p>	£1.7m
<i>Contribution to GG&C Corporate recovery plan</i>	£2.0m
<i>Revenue consequences of capital commitments</i>	£0.7m
<i>Sustainable baseline budget adjustments</i>	£0.2m
TOTAL ALL SERVICE DEVELOPMENTS	£11.5m
<p>SERVICE CHANGE</p> <p>Funds released to underpin expenditure commitments</p>	FINANCIAL COMMITMENT £'m
<p><i>Reduction in acute and continuing care beds to benchmark levels</i></p> <ul style="list-style-type: none"> • reduction of 54 acute admission beds and 185 continuing care beds 	£6.8m
<i>Reduction in site infrastructure costs</i>	£3.0m
<i>Investment in forensic service developments</i>	£1.7m
TOTAL ALL SOURCES OF FUNDS TO INVEST IN SERVICE DEVELOPMENTS	£11.5m

Bridging funding to support the transition and service redesign

- 18.7 It is widely accepted that the process of rebalancing services requires robust community services to be in place in advance of inpatient bed closures.
- 18.8 In order to cover the double running costs of development of community services and wider service redesign, in advance of releasing the full ward and site based costs, the GG&C Board will provide non recurrent transitional funding of up to £3m per year for the period until March 2010.

Developing Clyde Services with no detriment to Greater Glasgow services

- 18.9 The GG&C NHS Board has previously committed itself to the principle that the development of Clyde services should be achieved without detriment to existing planned and agreed levels of provision for the Greater Glasgow population. The service and financial framework for the Clyde strategy has therefore ensured this principle is reflected in the detailed arrangements for service development and reconfiguration.

19. SUMMARY OF BENEFITS AND LIMITATIONS OF THE CLYDE STRATEGY

Reflection of pre-engagement feedback within the Strategy

- 19.1 The pre-engagement and local planning groups have signalled a range of issues. The summary below has both reflected these issues and also the way in which the strategy has responded to such issues.
- the need to develop primary and community services and end geographic variations in access to support
 - *reflected in strategy proposals for development of comprehensive community services on extended day/24/7 basis*
 - the need to strengthen service responses to people in a mental health crisis
 - *reflected in strategy proposals to develop crisis services*
 - the desire to keep non specialist inpatient and continuing care beds locally provided
 - *reflected in proposals to retain local inpatient and continuing care beds for Inverclyde and Renfrewshire, whilst acknowledging the wider benefits of consolidating West Dunbartonshire adult and older peoples' acute admission beds on one hospital campus at Gartnavel Royal Hospital.*
 - the need to improve the quality of the inpatient environment and ensure the changes have no adverse effect on this
 - *reflected in proposals to develop continuing care beds through Partnership bed arrangements to achieve substantial improvements to quality of care environment*
 - *reflected in retention of use of adult acute admission beds at Dykebar given higher quality of inpatient environment.*
 - the need to develop more formalised partnership networks of collaboration and care between the not for profit providers and the NHS and social care services
 - *The development of more formalised collaborative networks between partner agencies will be given increased emphasis and mainstreamed as part of the ongoing implementation of the strategy.*
 - the need to improve the management of admission and discharge to inpatient care
 - *Expansion of Integrated CMHT's, and the development of crisis resolution services will enhance the capacity to more proactively manage the process of admissions and discharges. Community health and social work staff will work closely through joint assessment and care planning processes to identify the needs of the individual and to ensure the appropriate services are in place to support the person's discharge at the earliest opportunity.*
 - the need to ensure any Partnership models of care have robust quality assurance arrangements to maintain standards of care
 - *The detailed implementation of Partnership models of care will be based on the development of service specifications and contractual arrangements which*

ensure robust arrangements are reflected in the detailed models and contractual arrangements for Partnership beds

- the need to ensure financial deficits don't deflect from expenditure on community services
 - *The financial framework for the strategy has retained planned levels of investment in community services*

Benefits and limits of the Strategy

19.2 The Strategy has addressed the most pressing needs to:

- rebalance services and establish sustainable comprehensive community services with the major service building blocks in place
- provide a sustainable financial framework to underpin service development
- deliver £2m net savings to meet the mental health contribution of £2m to the GG&C Clyde financial recovery plan,

19.3 However the strategy has identified other areas of shortfall which we have not been able to address at this stage given the financial constraints, including:

- achievement of full benchmark staffing levels for community services albeit current proposals achieve the majority of this ambition
- development of specialist community services for eating disorders, perinatal services – pending such developments we will nevertheless provide some support to local services by providing access to liaison advice and support functions (but not case management or treatment) from the equivalent Greater Glasgow services
- more radical development and improvements to the quality of the inpatient environments of care
- further developments of the range of personal growth and recovery supports for ordinary living
- release of funds to support the development of community addictions services

19.4 In this context the strategy should be seen as a major and ambitious further phase of service development, rather than a complete response to all service deficits identified through the strategy process.

19.5 It should also be recognised that the experience of mental health services as they go through this development cycle, is that once they have operated such a rebalanced service there will doubtless be further flexing and refinements of views about bed numbers and models of care – all the more so as services become more flexible in working with new cohorts of service users and less dominated by the needs of the historic long stay cohorts.

19.6 In this sense the strategy should be seen as a 3-5 year “route map” rather than an inflexible and unchangeable pattern of provision for a period beyond 3-5 years.

20. CONSULTATION

- 20.1 Pre-consultation community engagement events were held in March and May for each of the Clyde localities. These events were organised to help shape the strategy development and to gauge stakeholder's views on emerging options around service configuration. Discussion at these events covered the breadth of services within the strategy. In addition, the Scottish Health Council has been liaising with NHS Greater Glasgow & Clyde to offer advice and validate our engagement process.
- 20.2 NHS Greater Glasgow & Clyde will conduct a public consultation around the significant service change proposals set out within this mental health strategy document.
- 20.3 In addition, a summary of these proposals will be included in a community newsletter-style document which will take full advantage of design format and language to ensure it is accessible and as clear as possible. This summary will cover all current Clyde service proposals (i.e. beyond mental health) and will be widely distributed via the Involving People and CH(C)P databases, GP surgeries, waiting areas, primary care providers and Local Authority facilities. In addition to Clyde community interest groups and stakeholders, mental health forensic service proposals will also be shared with communities surrounding Rowanbank Clinic and Leverndale Hospital.
- 20.4 The consultation document and summary will carry references in other languages and in large print to the availability of translated, Braille and audio disc format materials.
- 20.5 Consultation events will be structured around presentations and workshops
- three public events will be staged covering all proposals (including mental health) specifically affecting West Dunbartonshire and the Lochside
 - mental health specific events will be held in Inverclyde and Renfrewshire/East Renfrewshire
- 20.6 Adverts providing summarised headline proposals and contact points for additional information will be used to launch the consultation period and draw attention to public meeting dates. These will appear in the local newspapers - Greenock Telegraph, Paisley Daily Express, Dumbarton and Vale of Leven Reporter Helensburgh Advertiser and Lennox Herald.
- 20.7 All material will be made available on the NHSGGC website and specific consultation response pages will be created.

MATERNITY SERVICES REVIEW

1. INTRODUCTION AND SUMMARY

- 1.1 NHS Greater Glasgow and Clyde has initiated a number of service reviews since taking responsibility for the health of the population of the Clyde area, as the successor to Argyll and Clyde Health Board.

As part of these service reviews it undertook to review maternity services in the Clyde area. The review has focussed on two main issues:

- the impact of changes which are planned to maternity services in Greater Glasgow on services in Clyde;
- the utilisation of the community maternity units in Clyde.

Within the former Greater Glasgow, maternity services are provided across three main patient sites, Princess Royal Maternity, Queen Mothers Hospital and Southern General Hospital. Princess Royal Maternity and Queen Mothers Hospital both provide tertiary services. In 2005/06 there were 12,000 births across Glasgow.

NHS Greater Glasgow undertook a detailed maternity review and has developed a strategy for service provision. Future service will be provided from two sites, Southern General Hospital (5,200 births) and Princess Royal Maternity (6,800 births) both supporting tertiary referrals. Each site will provide low risk birthing rooms and Early Pregnancy Assessment Units. All appropriate antenatal services will be provided locally with only the highest risk pregnancies having to be seen in the centre.

1.2 **Background**

NHS Argyll and Clyde undertook a major review of maternity services in 2003, which resulted in a redevelopment and reconfiguration of services across the Board area. This redesign of services resulted in the current configuration of consultant and midwifery led units at the Royal Alexandra Hospital (RAH) and Community Maternity Units (CMUs) at Inverclyde Royal Hospital (IRH) and the Vale of Leven Hospital (VoL). Women from the Inverclyde and West Dunbartonshire areas retained the choice to access delivery services in Greater Glasgow hospitals.

The reconfigured service was underpinned by the principles of individualised care, promoting women's choice and locally accessible midwifery care. Predictions of activity levels were estimated and were considered to be sufficient to support sustainable and affordable service delivery.

1.3 **Activity**

The CMUs within Clyde offer a valuable comprehensive maternity service to their local population. While recognising that the CMUs are busy in their delivery of antenatal and post natal services, it is clear that they are significantly under utilised within their birthing suites. Within Inverclyde and Vale of Leven around 30% (27% at VoL, 32% IRH) of pregnant women are choosing to book with their local CMU. Of the 30% of women who choose the CMU, around 30% (36% VoL, 25% IRH) actually

deliver within the unit. This equates to 9% of the total caseload, therefore 91% of women from Inverclyde and the Vale of Leven catchment areas are currently delivering in maternity units distant from their local CMU.

In 2006 IRH and VoL had 73 and 74 deliveries respectively, averaging 1.4 births/week. As the birthing suite element of the service is staffed 24 hours/7 days a week by two midwives at each site, there is a disproportionate amount of resource attached to this service. 40% of staffing resource is associated with the birthing suite for 12% of women who labour (recognising only 9% deliver) within the VoL and IRH units. The cost per birth at IRH and VoL is £5,696 and £5,753 respectively. The comparable cost for the midwife led service at the RAH is £1,836 per birth.

A number of women are transferred from midwifery led care in the antenatal stages of their pregnancy due to health related reasons that move them from a low risk category to higher risk, whilst around 30% (29% from VoL and 32% from IRH) are transferred during labour, most of which incur an ambulance journey of 25-30 minutes. The Audit of Care Provided and Outcomes Achieved by Community Maternity Units in Scotland 2005. Scottish Programme for Clinical Effectiveness in Reproductive Health demonstrated that the Scottish average (%) of transfers to a consultant led unit in labour or within one hour of labour was 17% (2005). The transfer rate from the Vale of Leven and the IRH are significantly above that average.

1.4 Demographics

The CMUs have been developed to provide midwife led maternity care to low risk, healthy women. Eligibility criteria are used to assess risk and clearly identify women suitable for low intervention midwifery led care. Of the 73 parliamentary constituencies for which the Scottish Index for Mortality and Deprivation captured information in 2006, Dumbarton and Greenock are both in the 25 most deprived constituencies (by share of the 20% most deprived zones figures). This impacts significantly on the number of women who are eligible to deliver within a CMU. However the converse of this, is while women are insufficiently healthy to be eligible to deliver within the CMUs, their health needs are such that local provision of the full range of antenatal and post natal services including Special Needs in Pregnancy (SNIPS) and Early Pregnancy Assessment Unit (EPAU) is essential. The provision of high quality antenatal and postnatal care is of particular importance to women living in deprived communities.

1.5 Options for Service Delivery

A “working group” consisting of staff members, staff side representatives, finance and management representatives, was tasked to look at alternative models of care for the CMUs, within the principles of providing a value for money service across Clyde, whilst maintaining local access to maternity care.

The group began by establishing requirements for essential local service provision, a comprehensive suite of antenatal and postnatal services deemed necessary to meet the health needs of the local population. The working group progressed a long list of options to a short-list of four.

The four short listed options were:

Option 1: Status Quo

Option 2: Retain local births at all units through on-call shift pattern at VoL and IRH

Option 3: Retain local births at all units through Caseload Management at VoL and IRH

Option 4; Single midwife-led delivery service for Clyde, sited at RAH

All four options retained current levels of local antenatal and postnatal services and the choice for women to access delivery services in Glasgow hospitals.

1.6 Selection of Preferred Option

The four options were evaluated in terms of their relative benefits and associated risks by a working group including staff and users.

Option 4, a single CMU birthing unit for Clyde, located at the RAH was appraised and scored as the preferred option for service delivery. This option:

1. Retains all essential local services at the IRH and VoL:
 - Antenatal Care by Midwives- Antenatal Care in the community, GP surgeries, CMU and women's homes;
 - High risk antenatal care by consultant obstetrician in the CMU;
 - Full programme of parent education;
 - Ultrasonography service x 5 days with midwife scanners for routine booking scans;
 - Ultrasound service supported by high-risk sessions and anomaly scans undertaken by medical and specialist midwifery ultrasonographers;
 - Community based post natal care;
 - Triage drop-in service;
 - Special Needs in Pregnancy (SNIPS);
 - Special Needs Liaison;
 - Complimentary Therapy;
 - Smoking Cessation;
 - Home Births.
2. Retains the choice of low intervention births for women in Clyde, either at the RAH, Paisley or within Glasgow.
3. Delivers substantial savings towards reducing the financial deficit.

Our proposal for consultation is therefore the closure of the delivery elements of the Community Maternity Units at Inverclyde Royal and the Vale of Leven hospitals with women from those areas retaining the choice to access consultant or midwife led services at the RAH or the maternity units in Glasgow.

1.7 Impact of the Proposal

The impact on local services at IRH and VoL is only on delivery services. The tables below illustrate the proposed change.

Impact - VoL	2006	Proposed Service
Routine antenatal visit	5818	5818
Antenatal day care	571	571
Scans (midwife and Consultant)	1599	1599
Early Pregnancy Assessment	1039	1039
Parent Education	1579	1579
Community postnatal checks	3677	3677
Births	74	0

Impact - IRH	2006	Proposed Service
Routine antenatal visit	6849	6849
Antenatal day care	948	948
Scans (midwife and Consultant)	4531	4531
Early Pregnancy Assessment	881	881
Parent Education	2051	2051
Community postnatal checks	5081	5081
Births	73	0

1.8 Access

Access to high quality antenatal and postnatal services are critical for women living in deprived communities. These proposals preserve the status quo in respect of the full range of antenatal and postnatal care. The only change in terms of access is that around 150 women will make a single additional journey to the centre of their choice in either the RAH or in Glasgow, to give birth to their babies.

1.9 Consultation

This section describes our proposed approach to formal consultation. This builds on the extensive programme of public and community engagement which has shaped this review.

1.9.1

Consultation Summary

A community newsletter-style document will be produced which will take full advantage of design format and language to ensure it is accessible and as clear as possible. Information about the review of the CMUs will be contained in this newsletter which will be widely distributed via the Involving People and CH(C)P databases, GP surgeries, waiting areas, primary care providers and Local Authority facilities.

1.9.2 Alternative Languages and Formats

The above documents will carry references in other languages and in large print to the availability of translated, Braille and audio disc format materials.

1.9.3 Events

Events will be structured around presentations and workshops. And will be held in Inverclyde and West Dunbartonshire

1.9.4 Advertising

Adverts providing summarised headline proposals and contact points for additional information will be used to launch the consultation period and draw attention to public meeting dates. These will appear in the local newspapers - Greenock Telegraph, Paisley Daily Express, Dumbarton and Vale of Leven Reporter, Helensburgh Advertiser and Lennox Herald.

1.9.5 Website

All material will be made available on the NHSGGC website and specific consultation response pages will be created.

1.9.6 Media Releases

Tailored to suit local media requirements and interests.

1.9.7 One-to-one Meetings and Briefings for Individual Stakeholders

These will be held as required and will include key groups and elected representatives.

2. DETAILED INFORMATION

2.1 Review Process

The purpose of this review was to:

- examine the maternity service configuration within Glasgow and take account of any implications for services within Clyde;

- provide a detailed review of the current service and associated resources, understand the reasons why the service is under utilised and provide alternative options for service provision.

To undertake the review a structure of operational and planning teams was put in place, responsible for ensuring engagement and involvement of key stakeholders in the review and development of detailed options for the service. This included:

- a reference group;
- community engagement and staff meetings;
- an option appraisal event.

2.2 Facilities

The CMUs developed within Clyde provide local antenatal and postnatal care for all women within their catchment area, including high-risk women through a model of shared care with Obstetricians and General Practitioners. Women who have been assessed as low risk can choose to give birth within their local CMU.

The Community Maternity Unit at the VoL is a purpose built unit within the Vale of Leven Hospital. It comprises accommodation for out-patient antenatal obstetric and midwife clinics, a day care unit and a parent education facility, which is also used as a drop-in service for women. There is a separate access to facilities for women experiencing early pregnancy problems (EPAU) and together with the antenatal care service there is access to a dedicated obstetric ultrasound department.

Accommodation for the birthing suite comprises four birthing/postnatal rooms one of which incorporates a birthing pool.

The Community Maternity Unit at Inverclyde Hospital is situated on level F of the acute hospital. The CMU was adapted from existing in-patient facilities and now comprises accommodation for antenatal clinics, two dedicated ultrasound rooms, a Special Needs in Pregnancy (SNIPs) room and a parent-education facility.

Accommodation for the birthing suite comprises two adapted birthing/postnatal rooms with a temporary birthing pool facility in one.

Resources were invested in each unit based on anticipated activity rates relating to caseload size and number of births. Each CMU is open and staffed 24 hours a day/ 7 days a week.

2.3 Staffing Resource 2006/07

Midwifery	VoL CMU:	IRH CMU:	RAH CMU:
WTE Trained	23.14 trained	27.87 trained	41.19 trained
WTE Untrained	4.51 untrained	3.99 untrained	4.42 untrained

2.4 Rollover Budget 2006/07

	Pays	Non-pays
VoL CMU	£1,026,300	£62,000
IRH CMU	£1,185,400	£56,000

2.5 Analysis of caseload and births

Vale of Leven Hospital-

It was anticipated that Vale of Leven CMU would have between **179 and 210** births based on a caseload of **844**, i.e 21-25% of caseload would result in CMU birth.

Actual Activity				
Year	Bookings	Births	Caseload	%Births:caseload
2004	140	61	758	8%
2005	162	64	735	9%
2006	204	74	744	10%

Based on 2006 information, Vale of Leven CMU is delivering between 35% and 41% of predicted births or 8-10% of caseload.

Inverclyde Royal Hospital-

It was anticipated that Inverclyde CMU would have between **204 and 240** births based on a caseload of **960**, i.e 21-25% of caseload would result in CMU birth.

Actual Activity				
Year	Bookings	Births	Caseload	%Births:caseload
2004	180	91	911	10%
2005	316	115	841	14%
2006	287	73	892	8%

Based on 2006 information, Inverclyde CMU is delivering between 30% and 36% of predicted births or 8-13% of caseload.

2.6 Transfers in Labour

Each of the CMUs have eligibility criteria, based on risk factors for a CMU birth. These are based on the national criteria published in the Overview Report of the Expert Group on Acute Maternity Services (EGAMS) 2002. An important issue in relation to delivery services is the extent to which women need to be transferred when already in labour.

Intrapartum Transfers to a Consultant Led Unit

Vale of Leven	Women admitted in labour	Transfers to a consultant-led unit in labour or within one hour of delivery		Transfers to a consultant-led unit in the 2 nd stage of labour	
	No	No	%	No	%
2004	77	17	22	0	0
2005	78	26	33	4	5
2006	102	30	29	2	2

Inverclyde Royal	Women admitted in labour	Transfers to a consultant-led unit in labour or within one hour of delivery		Transfers to a consultant-led unit in the 2 nd stage of labour	
	No	No	%	No	%
2004	101	18	18	0	0
2005	154	45	29	3	2
2006	107	34	32	0	0

The Audit of Care Provided and Outcomes Achieved by Community Maternity Units in Scotland 2005. Scottish Programme for Clinical Effectiveness in Reproductive Health demonstrated that the Scottish average (%) of transfers to a consultant led unit in labour or within one hour of labour was 17%. Clearly the IRH and VoL centres are substantially above that level. It is not a desirable model of service to ambulance transfer women in labour - where that can be avoided.

3. OPTIONS FOR SERVICE DELIVERY

3.1 A 'working group' consisting of staff members, staff side representatives, finance and management were tasked to look at alternative models of care for the CMUs, adhering to the principles of providing a value for money service across Clyde, whilst maintaining local access to maternity care.

3.2 The group began by establishing and defining those services which are regarded as essential to the provision of a local service. They termed this 'Essential Local Service Provision' (ELSP). They then 'brainstormed' a long list of potential options, which would deliver these requirements. This information was shared with operational staff and following this no further options or changes to essential service provision were added.

3.3 **Essential Local Service Provision**

- Antenatal Care by Midwives- Antenatal Care in the community, GP surgeries, CMU and women's homes
- High risk antenatal care by consultant obstetrician in the CMU
- Full programme of parent education.
- Ultrasonography service x 5 days with midwife scanners for routine booking scans
- Ultrasound service supported by high risk sessions and anomaly scans undertaken by medical and specialist midwifery ultrasonographers.

- Community based post natal care
- Triage drop-in service
- Special Needs in Pregnancy (SNIPS)
- Special Needs Liaison
- Complimentary Therapy
- Smoking Cessation
- Home Births

3.4 The working group progressed from the long list of options to a short-list of four. The four short listed options were

1. Status Quo
2. Retain local births at all units through on-call shift pattern at VoL and IRH
3. Retain local births at all units through Caseload Management at VoL and IRH
4. Single midwifery-led unit in Clyde, sited at RAH

All four options retain all essential local service provision. The detail of the option appraisal is Appendix 1 of this paper.

The preferred option was concluded as a single midwifery led delivery service at the RAH with women from Inverclyde and West Dunbartonshire retaining the choice to access the three midwifery-led delivery services in Glasgow. This model:

- retains all essential local services;
- continues to offer a range of delivery choices;
- offers an economic service contributing an estimated £500K in savings to the reduction of the Clyde financial deficit.

4. STAFF

4.1 It is clear that a number of our proposed changes will impact on staff. Our commitment is to ensure that all affected staff have redeployment opportunities which can meet their aspirations and best utilise their skills.

4.2 Throughout the implementation of the changes proposed, work will continue with staff and their representatives to manage the impact of change. This will be done within the context of the national and local organisational change policies, which are based on the principle of “no detriment”.

4.3 Once staff directly affected by the changes proposed are identified, in addition to meetings with the trade unions, one to one meetings/individual redeployment interviews will be held. NHS Greater Glasgow and Clyde has a successful track record in redeploying staff taking into account individual's skills and personal circumstances. Redeployment will be the first consideration with the aim of securing alternative employment for displaced staff as a result of service change. Based on this detailed redeployment principles will be agreed and a process of vacancy management will be put in place to secure alternative employment in alternative departments and locations.

4.4 Deployment may be to a post at a lower grade and in these circumstances protection of earnings will apply. Redeployment will also be supported by a training and

development plan, which will include induction and orientation programmes, and retraining/skills updating where necessary.

- 4.5 Regular briefing sessions will be held with staff throughout the period of implementation

5. PUBLIC ENGAGEMENT

- 5.1 Four public events were held in order to facilitate the inclusion of the user perspective in the review. The first event was a public meeting, held at the David Lloyd Centre in Paisley. It agreed a strategy for community engagement that would focus on meeting with current and recent users of maternity services in Clyde, meeting in venues and at times that would be convenient for women with young children and that would aim to provide an opportunity for women to discuss the review with key health professionals.

- 5.2 Following this strategy a further three community engagement events were held.

- 5.3 All the women who came to the meetings were recent and/or current users of maternity services in Clyde. Some were accompanied by friends or partners and some by family members. The events were supported by members of the Maternity Services Review Reference Group and Midwives from the local services.

- 5.4 There was extensive publicity for the meetings. They had been promoted by the CMUs and all were well publicised with the help of Inverclyde Community Care Forum, West Dunbartonshire Community Health Partnership, GP practices, chemists, baby shops, post offices and local community venues. In addition a school bag drop to nursery and primary school pupils was undertaken in Inverclyde.

- 5.5 The purpose of the meetings was to try to build an explanatory account of women's decision-making in maternity care, particularly the reasons why they chose or did not choose to use the CMUs. The discussions are summarised below.

- 5.6 What do women like about care at the CMU?

- a wide range of services used and valued at the CMU including phone line for advice, day care/drop in support on demand, alternative therapies, early pregnancy service, pre-conception advice, breast feeding classes and support, physiotherapy;
- having continuity of a small midwifery team and the subsequent personalised attention was important to women;
- the model of care in the CMU was valued and women felt empowered as a result;
- the CMU approach builds trust and good relationships with midwives;
- the local CMU facilitates the involvement of partners and the extended family
- local services are less stressful as don't have to worry about travel – either to appointments or when go into labour;
- the intensive one to one experience of care in the CMU was valued;
- women welcomed the opportunity for a natural birth;

- the knowledge and skills of the midwifery staff were acknowledged and women felt safe in their care and know that if transfer to a CLU was required this would be undertaken.

5.7 Why do they not use the CMU?

- lack of knowledge of what was available at the CMU;
- a feeling that GPs inappropriately steered women to the CLU, especially for a first baby;
- women's lack of information on their options and the perception that they don't have a choice;
- fear of the unknown and presumptions of pain;
- fears of risks so want a doctor present —"just in case";
- impression of 'strict' criteria for the CMUs;
- lack of knowledge of direct access to midwife;
- pressure from others – family, friends, colleagues – to use the CLU;
- the local perception of the VoL hospital as 'troubled'.

5.8 A number of other issues were raised that appeared relevant to the review. These were:

- geography and lack of public transport make access to Paisley and Glasgow difficult;
- women wanted consistent information on services from health care professionals;
- lack of information available to the public about low intervention birth;
- decision on where to deliver can't be made quickly – need time to learn about options before making a choice;
- need to educate local women and health professionals on the benefits of, services available and good outcomes at the CMUs;
- it was expressed by some women that there might be too much emphasis on what could not be done at the CMU and more emphasis should be made of what is possible. A fine balance needs to be achieved to ensure informed choice is made.

6. CONCLUSION

6.1 An inclusive process involving staff, staff side representatives, service users and managers has been carried out to review the CMUs in Clyde, cumulating in a proposal of an alternative model of care which retains choice for women in Clyde, and provides local access to antenatal and post natal care, whilst maximising the use of resources and delivery of financial savings. The proposal of a single midwifery led delivery service at the RAH, also aligns service configuration to the strategic direction of Glasgow's maternity services, whereby low intervention, low risk deliveries will be provided alongside consultant led services at the Southern General Hospital and Princess Royal Maternity, Royal Infirmary.

6.2 The CMUs within Clyde will continue to offer a valuable comprehensive outpatient maternity service to their local population.

- 6.3 As the birthing suite element of the CMU services is staffed 24 hours/ 7 days a week by two midwives there is a disproportionate amount of resource attached to this service for the population benefits. In essence this means that resource is disproportionately targeted at the healthiest women who meet the criteria for local delivery, rather than at those with the greatest health need.
- 6.4 The CMUs have been developed to provide midwife led maternity care to low risk, healthy women. Eligibility criteria are used to assess risk and clearly identify women suitable for low intervention midwifery led care. Of the 73 parliamentary constituencies for which the Scottish Index for Mortality and Deprivation captured information in 2006, Dumbarton and Greenock are both in the 25 most deprived constituencies by share of the 20% most deprived zones figures. This impacts significantly on the number of women who are eligible to deliver within a CMU. However the converse of this is that while women are insufficiently healthy to be eligible for local delivery, their health needs are such that local provision of the full range of antenatal (including the Special Needs in Pregnancy Service and Early Pregnancy Assessment Service) is essential.
- 6.5 Maternity services across Clyde will be subject to further review following the implementation of these changes and as part of the continuing process to achieve financial balance.

OPTION APPRAISAL

An option appraisal process was carried out on 23rd May 2007, with 24 members of the steering group and working group, including staff, service users, staff side representatives, finance and managers.

BENEFIT CRITERIA

The four options were evaluated in terms of their relative benefits. Each benefit criterion was scored by the group giving it a weighting, then each option was scored against how well it met the criterion. The benefit criteria were as follows:

1.	Maximises acceptability to staff (e.g. in relation to working patterns and health and safety)
2.	Maximises acceptability to women (e.g. minimises need to wait for midwife to open CMU unit or requirement to go home within 6 hours after birth)
3.	Maximises accessibility for women (e.g. maximises local access, including for special needs services, and minimises travel time and cost for families)
4.	Meets service standards (e.g. relating to choice, one-to-one care in labour and continuity of care)
5.	Maximises choice in type of birth for women
6.	Maximises accessibility to members of the multi-disciplinary team in emergency situations
7.	Maximises the number of women eligible for and likely to take up the option of CMU birth
8.	Minimises the number of ambulance call-outs
9.	Maximises alignment to NHS Greater Glasgow and Clyde strategy
10.	Maximises perceived best use of resources

RISK CRITERIA

Each member of the group allocated each risk factor a score in terms of its likely impact, then scored these against each of the options.

1.	Inability to recruit and retain staff
2.	Inability to meet working time directives
3.	Inability to comply with family friendly and work-life balance policies

4.	Reduces health and safety for staff (e.g. due to lone working or increased stress)
5.	Reduces health and safety for women and babies (e.g. due to discharge within 6 hours following birth)

OPTION APPRAISAL SCORING

The results of the benefits and risk scoring was calculated by a Health Economist in the planning department. The cost of each option, ranked from highest to lowest in cost saving terms were incorporated into the overall result.

	Option 1 Status Quo	Option 2 On-call	Option 3 Caseload	Option 4 RAH Midwifery- led Delivery Service
Risk Score Lowest score=lowest risk	5.96	16.95	17.71	6.92
Weighted Benefit Score	527	412	388	508
Cost	£4,106,800	£3,568,175	£3,634,934	£3,550,763
Cost Benefit Weighted benefit score divided by cost	129	115	107	143
Ranking	2	3	4	1

Option 1: Status Quo

Service Description

This option retains the current service of:

- Dedicated on-duty midwifery staff Monday - Friday for early pregnancy, day-care, Special Needs In Pregnancy service, parent education at RAH, VoL and IRH.
- Antenatal high risk obstetric clinics and ultrasound sessions at RAH, VoL and IRH.
- Two dedicated midwives available on-duty 24/7 for birthing suite and telephone advice/drop-in at RAH, VoL and IRH.
- Seven day daytime community midwifery service for antenatal and postnatal care.

Benefits

- Women have access to local birthing unit.
- No change to staff working practice and rotas.

Risks

- Retains three units working under capacity in Clyde.
- This option does not address maximising use of NHS resource to deliver a 'value for money' service.
- This option does not release financial benefits that would support reduction of Clyde's deficit.

Option 2: Retain Local Births at All Units through On-call System at IRH and VoLService Description

- RAH services remain as described in option 1.
- All essential local service provision remains at VoL and IRH.
- Dedicated on-duty midwifery staff Monday-Friday to cover early pregnancy, Special Needs In Pregnancy service and ultrasound sessions at VoL and IRH.
- Midwifery staff on-duty to cover day-care, clinics and community will also provide cover for the birthing suite Monday-Friday 9-5pm as required, VoL and IRH.
- Out of hours cover for birthing suite provided by two on call midwives from Monday-Friday from 5pm -9am, VoL and IRH.
- At weekends birthing suite covered by one of two midwives on-duty for community midwifery service 9-5pm supported by one on-call midwife from 9am-5pm, VoL and IRH.
- Out of hours cover for birthing suite at weekends provided by two on-call midwives from 5pm-9am.
- Total of ten on-call periods from 5pm to 9am, Monday-Friday (five nights with two midwives per night).
- Total of six on-call periods at weekend - one each day to support community midwife and four to provide two on-call staff per night.

Benefits

- Women have access to local birthing unit.
- Flexible workforce, enabling financial savings to be made.
- Remaining staff continue to work at their local site.
- Midwives able to practice using full range of midwifery skills.

Risks

- Requires **all** staff at both VoL and IRH to participate in on call rota.
- Lead in time for Midwives to arrive to open birthing suite out of hours (u to 1 hour).

- Health and Safety - staff required to open up birthing suite out of hours, both units isolated. VoL isolated building, IRH isolated floor within main building.
- Health and Safety - women arrive at unopened unit prior to midwife. No A&E service at VoL.
- Potential disruption on daytime services following on-call.
- Pressure on women to be discharged home soon after birth for community based postnatal care, as unit not staffed. Potential impact on breast feeding support.
- Potential to breach EWTD in times of high activity and staff absence.
- Occupational stress associated with on-call commitments.
- Financial savings will be released incrementally in line with staff turnover and organisational change policy process.

Option 3: Retain Local Births at all Units through Caseload Management at IRH and VoL

Service Description

- Based on 'Albany practice model' (London). Provision of a dedicated midwife throughout pregnancy and birth for a caseload of low risk women.
- Two hundred low-risk women at VoL and IRH would receive total maternity care episode from a team of 5 midwives on each site including the provision of intra-partum care at home or at CMU of choice in Clyde.
- Each midwife has a total primary caseload of 40 women and is named secondary midwife with commitment to provide care for an additional 40 women.
- Midwives provide on-calls as necessary and do not receive enhanced or on-call payments but receive 3 months leave each year.
- Remaining women receive high-risk care as per status quo.
- All other local services remain same as status quo.
- Birthing suite at RAH remains staffed 24/7.

Benefits

- Women have access to local birthing unit and have continuity of care for women from a named midwife.
- Flexible workforce, enabling financial savings to be made.
- Remaining staff continue to work at their local site.
- WTE staff who carry a caseload are able to practice using their full range of midwifery skills.

Risks

- Impact on work/life balance for midwifery staff.
- Sustainability - very high burnout rate reported at other centres which have introduced caseload management.
- Lead in time for Midwives to arrive to open birthing suite out of hours (up to 1 hour).

- Health and Safety - staff required to open up birthing suite out of hours, both units isolated. VoL isolated building, IRH isolated floor within main building.
- Health and Safety - women may arrive at unopened unit prior to midwife. No A&E service at VoL.
- Staff not carrying a caseload are unable practice using their full range of midwifery skills.
- Financial savings will be released incrementally in line with staff turnover and organisational change policy process.

Option 4 Single Midwifery-led Delivery Service for Clyde, sited at RAH

Service Description

- All essential local service provision remain at VoL and IRH.
- Additional one midwife per shift at birthing suite would be required at RAH, rotated from VoL and IRH to enable midwives to practice full range of skills.
- 1.94 WTE additional auxiliary support at RAH.
- Women can access RAH or Glasgow services.

Benefits

- Maximises use of available capacity and resource.
- Flexible workforce, enabling financial savings to be made.
- Negates need for intrapartum transfers from IRH and VoL CMUs.
- Extended criteria used at RAH, expands eligibility for more women to have CMU birth.

Risks

- No local access to birthing suite at IRH and VoL.
- Potential impact on CLU and Glasgow services if women chose non CMU birthing option.
- Potential increase in ambulance requests from home to birthing unit of choice.
- Financial savings will be released incrementally in line with staff turnover and organisational change policy process.

BALANCE OF OLDER PEOPLE'S CARE: JOHNSTONE HOSPITAL

1. PURPOSE

1.1 The purpose of this paper is to:

- set out a proposal to consult on changes to the NHS continuing care provision for frail older people in Renfrewshire including the closure of the present service at Johnstone Hospital;
- outline the background, context and key drivers to this change.

2. BACKGROUND

2.1 In November 2006, NHS Greater Glasgow and Clyde confirmed that the next step in the ongoing review of the balance of care for older people's services across Renfrewshire would be to review the provision of frail elderly continuing care services located at Johnstone Hospital.

2.2 This review would be set in the context of a wider balance of care programme of work being led by the Joint Planning, Performance and Implementation Group for Older People (OPJPPIG) within Renfrewshire. This is a joint group between Renfrewshire CHP (RCHP), Clyde Acute Services, Mental Health Services, Voluntary sector and Renfrewshire Council and has responsibility for the development of the joint strategy for older peoples services and its implementation. This group sits within a wider arrangement of joint planning of services across Renfrewshire.

2.3 These joint planning arrangements for older peoples services have made substantial progress towards delivering a number of important outcomes including:

- additional services for patients to improve health and wellbeing;
- transparency over resources;
- joint plans, priorities and decision making;
- strengthening clinical involvement in these arrangements;
- joint ownership of service pressures and challenges.

2.4 In February 2007, an engagement event was held with key stakeholders, family members and carers, following which a short life working group was established to take forward the review of frail elderly continuing care bed provision. This short life working group has reported directly to the Joint Planning, Performance and Implementation Group described in 2.2 above. A subsequent engagement event was held in May 2007.

2.5 The focus of this event was to update key stakeholders, family members and carers on:

- the review process;
- key issues arising from the review;
- proposals for change.

- 2.6 The two engagement events were attended by 74 individuals / groups. Written feedback was shared with all attendees and other interested parties. The Scottish Health Council have been active participants in the process.
- 2.7 The engagement process has also included a number of meetings with staff at Johnstone Hospital to ensure that they were fully briefed on:
- the engagement process;
 - how the review and potential outcomes may affect them.
- 2.8 Members of the Staff Partnership Forum have been actively involved in the work to date.
- 2.9 A key link with this review is the work programme relating to service provision for older people with mental illness. The proposals for these services are addressed in a separate paper; Clyde Mental Health Strategy: Adult and Older Peoples Mental Health services for Inverclyde, Renfrewshire, West Dunbartonshire and East Renfrewshire.

3. POLICY CONTEXT AND DRIVERS

- 3.1 There are a number of key policy influences that have shaped the ongoing and wider review of the balance of care of older peoples services across Renfrewshire.
- 3.2 These include *All Our Futures: Planning for a Scotland with an Ageing Population (Scottish Executive 2007)*, *Better Outcomes for Older People: Framework for Joint Services (Scottish Executive 2005)* and *Delivering for Health (Scottish Executive 2005)*.
- 3.3 A key element of NHS guidance on which we have based our proposals relates to the provision of continuing care. This states that:
- 3.4 Continuing care is where the complexity, nature or intensity of their health needs (ie, medical, nursing and other clinical needs) or the need for frequent, not easily predictable clinical interventions, requires the regular specialist clinical supervision of a consultant, specialist nurse or other NHS member of the multi-disciplinary team (SEHD 1996), the NHS should provide continuing care.
- 3.5 Through these policy documents, there are a number of principles, which have shaped our work. These include:
- providing services as close to peoples homes as possible;
 - supporting more people at home via an improved range of community based services as an alternative to institutional care, where appropriate;
 - ensuring specialist service provisions focused on those with most complex needs;
 - delivering better use of existing older peoples bed capacity;
 - delivering a better network of linked services between Health and Local Authority;

- reducing inappropriate admissions to hospital where possible and enabling supported discharge through step down and effective rehabilitation services;
- ensuring older people receive an improved quality of care and faster access to a wider range of services;
- more effectively involving and supporting service users and carers.
- providing NHS continuing care with ready access to specialist clinical input when required.

3.6 A range of new developments are being progressed jointly by RCHP, Acute Services and Renfrewshire Council as part of our joint approach, aimed at developing community based person centred integrated systems of inter-disciplinary and multi agency care, designed to promote disease management and maximising independence. Through doing so, the aim is to reduce hospital admission and length of stay. Examples of these developments include:

- a joint District Nursing and Social Work Care Management project focused on patients with chronic disease who are at risk of multiple hospital admission. This is aimed at enabling more proactive disease/disability management in partnership with the service user, thereby preventing avoidable hospitalization;
- further enhancement of the Community Alarms Service will provide 24-hour support for vulnerable people at risk, of emergency or multiple hospital admissions, through planned and emergency interventions at home and by use of more sophisticated assistive technology;
- introduction of two Gerontology Nurse Specialists providing specialist advice and clinical support to Care Homes and staff is a key function of these roles thereby preventing inappropriate hospital admission from care home settings;
- introduction of Interface Pharmacist Roles to provide specialist pharmaceutical knowledge, advise and clinical interventions and promote medication compliance in elderly patients, ultimately achieving more effective treatment and reduction in adverse drug reactions and reducing emergency and multiple hospital admission;
- introduction of Extra Care Housing facilities:
 - three Extra Care Housing units will be introduced in 2007/2008 in Renfrewshire. These units will provide a 24 hour care and meals service, whilst replicating the advantages of remaining at home, such as having own front door; security of tenure; access to social networks and housing support. This model of accommodation and intensive support is designed as an alternative to care home admission;
 - the first unit, of 25 flats is expected to be available for tenancy in summer 2007 with the second development scheduled for availability in autumn 2007;
 - access to the service is through a comprehensive needs assessment. Eligibility is restricted to people who are primarily elderly and have complex health and social care needs including dementia;
- social work currently provides around 800 day care places a week for frail older people and those with dementia. The service model has remained unchanged for over ten years although a programme of refurbishment and upgrading of day centres is almost complete. Day care continues to be a popular choice for older people and their carers as a means of maintaining independence and social supports. A strategic review of Social Work day care

services is at an early stage and will now be progressed on a joint basis with health. The review is examining current and future needs for both frail and dementia day care and will present proposals on the role and scale of local day care services over the next 5 - 10 years. The timing and scope of this review presents an opportunity to dovetail with the review of NHS continuing care services for older people and, in particular, the review of day hospitals.

- 3.7 All of the above initiatives are inter-related in terms of providing best value and care outcomes. They are aimed at enabling older people to remain at home for as long as possible and prevent avoidable hospital admission, reduce length of stay and offer a real alternative to care home admission.
- 3.8 Access to these services is underpinned by comprehensive and shared assessments of :
 - patient/client needs; other mainstream social care services;
 - medical and nursing services provided by local GPs and District Nursing Services.

3.9 Delayed Discharges

- 3.9.1 In recent years delayed discharges have been tackled effectively by the partnership working across Renfrewshire and we have recorded significant and sustained reductions. In 2006/07 we met and exceeded Scottish Executive target for patients delayed over six weeks. The target for 2007 was 17.

Table 1 - Summary of Number of Delayed Discharges in Renfrewshire

Year ending March	2001	2002	2003	2004	2005	2006	2007
DD over 6 weeks	181	166	72	46	20	10	11

- 3.9.2 Our performance in relation to short stay patients, in the same period, was slightly short of the target. While we are confident we can continue to improve performance on delayed discharges, the new target of zero by April 2008 is an extremely challenging one to achieve, particularly in the context of a growing elderly population and higher levels of bed activity and throughput of patients. Further improvements will be achieved by continuing to implement our joint strategy for older people as well as streamline joint operational processes and systems for recording, referral and care planning. This work is underway.
- 3.9.3 A joint protocol on patient choice has been endorsed by the Council, the CHP and the Acute Division and was launched in May 2007. It is intended that this will be rigorously applied by hospital-based staff working closely with colleagues in Renfrewshire Council, and will positively impact on the numbers of people delayed awaiting a care home of their choice in future.
- 3.9.4 As these improvements continue, and are sustained, it is clear that we must review how resources previously tied up by delays in discharge can be redirected.

3.10 Day Hospital Review

3.10.1 There are two day hospitals on the RAH site - one for frail elderly and one for older adults with mental illness. Under the auspices of the Older Peoples JPPIG, a review of the frail elderly day hospital commenced in April 2007 with the review of the day hospital for older adults with mental illness due to commence in June 2007. These reviews will consider patient pathways, referral patterns, interventions and outcomes, staffing levels and location. In addition rapid access clinics and integration with Multi-Agency Team for Care at Home (MATCH), Stroke Outreach Team and other aspects of intermediate care will be included.

3.11 Assessment and Rehabilitation

3.11.1 In recent months, work has been undertaken to improve the assessment and rehabilitation pathway for those patients admitted to the RAH. This has seen the average length of stay reduced by 6 days. Due to the reconfiguration of medical beds, it is also anticipated that older people within these wards will commence rehabilitation at an earlier stage with a significant number being discharged directly home or to an alternative setting.

4. CURRENT CONTINUING CARE PROVISION FOR FRAIL OLDER PEOPLE IN THE POPULATION

4.1 Historically the number of residential care and inpatient beds for older people in Renfrewshire has been similar to the national averages. However, this has masked a higher than average level of NHS continuing care provision. Currently we have 60 NHS continuing care beds for frail older people at Johnstone Hospital.

4.2 There are 25 care homes for older people in Renfrewshire; 16 of which are privately owned, 4 are owned by the voluntary sector and 3 by the Local Authority. These 25 homes provide a total of 1354 beds of which Renfrewshire Council purchases 1039. The balance of 315 is accounted for by; residents placed by other Local Authorities, vacant rooms and double rooms with single occupancy. In addition the care home beds within Erskine Hospital are viewed as a national resource, but are used significantly by Renfrewshire.

4.3 Earlier balance of care studies for older peoples services were updated and approved on a joint basis between NHS Argyll and Clyde and Renfrewshire Council in 2002 and 2004. Since then, NHS continuing care provision in Renfrewshire has reduced. Through the ongoing work of the Older Peoples Joint Planning Performance and Implementation Group, it is accepted by partner organisations represented, that there remains an over provision and dependency on NHS continuing care beds. This view is based on the analysis of current patterns of need and dependency set against how these should be met in the future.

Table 2 - Summary of the beds 2002 - April 2007

Year	Rehabilitation and Assessment Beds RAH Site	Frail Elderly Number of NHS Continuing Care Beds Johnstone Hospital Site
Actual 2002	120	188
Balance of Care Target 2004	90 + 30 Stroke Beds	24
Actual 2007	90 + 30 Stroke Beds	60

- 4.4 The table above shows a move from 188 frail elderly continuing care beds at Johnstone in 2002 the current level of 60. In 2004, NHS Argyll and Clyde set a target to move this level down to 24. Sections 7 and 8 of this paper confirm that this target (24) no longer applies.
- 4.5 We know that from the data available, 60% of the patients identified as requiring continuing care and resident at Johnstone Hospital are categorised as high dependency (against the national average of 53%) and 45% clinically complex (against the national average of 46%). On the basis of the review work completed to date we believe that a higher number (ie, higher than 24) of NHS continuing care beds is required.
- 4.6 Therefore we have been able to revise the target number of beds based on the changing demographics of our population and the improved application of clinical assessment of continuing care patients.
- 4.7 Section 7 of this paper sets out the revised proposed bed provision and outlines wider service changes that will enable us to now move forward to deliver appropriate and informed change.

5. RENFREWSHIRE RESIDENT POPULATION AND ACCESS

5.1 Resident Population

- 5.1.1 Table 3 below sets out the population in Renfrewshire by age and sex. These data are as at June 2005.

Table 3 - Population by sex and age group: 30th June 2005

Age Group	Male	Female	Total
0-4	4,598	4,531	9,129
5-9	4,916	4,669	9,585
10-14	5,399	5,201	10,600
15-19	5,616	5,318	10,934
	20,529	19,719	40,248
20-29	9,857	9,753	19,610
30-39	11,200	12,788	23,988
40-49	13,056	14,081	27,137
50-59	10,868	11,634	22,502
	44,981	48,256	93,237
60-69	8,231	9,497	17,728
70-79	5,343	7,148	12,491
	13,574	16,645	30,219
80-89	1,896	3,486	5,382
90+	203	711	914
	2,099	4,197	6,296
Total	81,183	88,817	170,000

- 5.1.2 These data reflect an increase in the actual number and proportion in the population aged over 65 years. This is more marked in the over 75 age group. The average life expectancy in Renfrewshire is lower than the national average (71 years for men, 77 years for women). Using the current population projections, it is expected that the number of people aged over 75 will increase over the period to 2013 by 23%. From these analyses, it is clear that the care needs of the older population are set to increase over the next 5 to 10 years.
- 5.1.3 By 2013, it is anticipated that at least 230 additional older people (from 2005 level) will require the level of care that a care home provides. Based on the current profile of the present care home population, it is estimated that around 70% of these people will require support with mental health needs and 30% will have complex physical care needs.
- 5.1.4 It is against this population analysis that the joint planning processes have sought to focus on how we best target resources to enable needs to be met and for specialist services to be targeted at those with the most significant and complex needs.

5.2 Access

- 5.2.1 The Johnstone Hospital site is relatively isolated from the other centres of population of Renfrewshire in the context of long-term care provision. Currently we have 60 NHS continuing care beds at Johnstone Hospital of which 45 residents are categorised as requiring NHS continuing care. The profile of the addresses of origin of the current patients demonstrates that only 18% are Johnstone. A total of almost 65% lie within the combined greater Paisley and Renfrew areas and the remaining 17% are spread across the surrounding villages.

- 5.2.2 Section 8 of this paper confirms that the proposed re-provision of continuing care beds will locate services within Renfrewshire, ensuring local access for our population.

6. CURRENT SERVICE CHALLENGES

- 6.1 Analysis undertaken in Renfrewshire since 2001 (using NHS Scotland Information Services Division data) has shown that the dependency levels of care home residents and tenants of sheltered/very sheltered housing are lower than they should be for these types of specialist provision.
- 6.2 Work has now started to ensure that this service provision is better balanced with needs through: improved assessment arrangements; a more effective approach to managing discharge from hospital, and a commitment to improve commissioning arrangements for purchased care. It is evident from this that significant numbers of older people could, with appropriate community based health, social care and voluntary services, live independently in their own homes.
- 6.3 This will be further enabled by the sustained impact of actions being taken between Renfrewshire CHP, Clyde Acute Services, and Renfrewshire Council to reduce the levels of delayed discharges. A key outcome from these actions will be to improve capacity and utilisation of the existing bed provision across older people's services.
- 6.4 Work to address the delays in discharge has been ongoing since 2001 and there is now a target that by March 2008, we will see delivery of zero delayed discharges against the target set by the Scottish Executive.
- 6.5 Within Renfrewshire, we know from earlier analysis, now confirmed by this review, that we have significant numbers of delayed discharge patients temporarily residing in NHS continuing care beds at Johnstone. The agreed view (by partner organisations represented within the review process) is that this is a misuse of this specialist service provision. It is also agreed that in delivering and sustaining the delayed discharge target by March 2008, we must now plan for how the current service resource tied up with delayed discharge can be used in future.
- 6.6 A second key factor in providing a balanced and linked network of appropriate services for older people, are the concerns of families, carers and service professionals. Development of older people's services across Renfrewshire to date has used models informed by best practice, improved risk assessment and management and robust evidence. It is important that we continue to prioritise safe and high quality services, informed by best practice, to support people to live in their own homes where possible.
- 6.7 The current accommodation at Johnstone Hospital also presents some challenges. National Care Standards, driven by the principles of dignity, privacy and safety, require that modern care settings include individual rooms with ensuite facilities for residents. At Johnstone there are two 30 bed wards, each of which contains four six bed rooms plus 6 single rooms. In addition to the wards there is a day area, communal living area and recreation hall. Our ability to modernise the accommodation at Johnstone is significantly limited by challenge of decanting residents and the major cost of upgrading.

7. WHY CHANGE PROVISION OF CONTINUING CARE SERVICES?

- 7.1 Table 2 (section 4) confirms the current level of rehabilitation and assessment beds, and NHS continuing care beds within Renfrewshire.
- 7.2 There has been a change in the profile of the continuing care patients; there has been an increase in those who are physically frail with repeated and unpredictable needs requiring intervention at the end stage of their life. We know that from the data available, 60% of the patients identified as requiring continuing care and resident at Johnstone Hospital are categorised as high dependency (against the national average of 53%) and 45% clinically complex (against the national average of 46%).
- 7.3 We also know that there are a number of patients occupying continuing care beds at Johnstone Hospital who were placed there before the appropriate alternatives to continuing care were available. In the year just ended (2006/2007) the maximum length of stay at Johnstone Hospital was almost 9 years, however the length of stay is reducing. Over 50% of current patients resident at Johnstone Hospital have been there for less than 12 months.
- 7.4 It is expected that as the criteria for admission to NHS continuing care beds is applied to ensure this provision is used for those with the most appropriate needs, the average length of stay in continuing care beds will decrease.
- 7.5 The review process has therefore covered a range of analyses. These include:
- a review of the criteria for admission to continuing care services with the intention that this be consistently applied and that services are focused on those with the most complex needs;
 - average length of stay of current residents in continuing care beds and how this is expected to change over time;
 - a review of the number of admissions to continuing care beds (and length of stay) of people who are categorised as requiring other provision and are only temporarily resident at Johnstone Hospital;
 - a review of end of life stay in continuing care.
- 7.6 This analysis has involved senior clinicians, and service managers from both NHS and Local Authority.
- 7.7 We therefore know that there has been a change since 2004 relating to average length of stay across the 60 continuing care beds. We also know that there has been a continued use of these specialist care beds to temporarily accommodate patients who are categorised as being delayed in their discharge from hospital, often awaiting a move to a care home place.
- 7.8 Table 4 below sets out over the time periods 2005 and 2006 the average length of stay within the continuing care beds at Johnstone, and notes the numbers of beds occupied on average during these periods by delayed discharges.

Table 4 - Average Length of Stay in Continuing Care Beds - Johnstone Hospital

Time Period	Discharges	Deaths	Average Length of Stay (days)	Average Length of Stay Prior to Death (days)	Beds Occupied by Delayed Discharges
April - Dec 2005	27	47	222	104	14
April - Dec 2006	53	42	173	51	16

- 7.9 The average length of stay has reduced significantly within the above time period. Our conclusion from this analysis is that we can expect the average length of stay for new admissions to continuing care to reduce further, and with sustained delivery of the delayed discharge target, we will see a reduction in the numbers of patients occupying continuing care beds.

8. PROPOSED CHANGES TO FRAIL ELDERLY CONTINUING CARE

- 8.1 We remain committed to providing NHS continuing care services within Renfrewshire for local people. We are also committed to ensuring a high quality service that is accessible and focussed on those with greatest need. The review has concluded that we need fewer NHS continuing care beds, stronger relationship between the acute assessment and continuing care services, and that NHS continuing care must be provided within a modern accommodation setting. It has also concluded that we must invest in further community based service development.

- 8.2 We are therefore proposing the closure of Johnstone Hospital and to:

- reduce the number of Frail Elderly continuing care beds in Renfrewshire from 60 to a new target in the region of 35. The exact number will be determined through ongoing prospective audit of continuing care patients and by close monitoring of our work to shift the balance of care;
- re-provide these continuing care beds into modern accommodation using a partnership model. This model would be a partnership using accommodation available through the Local Authority, independent or voluntary sector. These beds would be located within Renfrewshire and in a central location such as Paisley or Renfrew to provide improved access to our population. This service would continue to be NHS Consultant-led and staffed by NHS nurses. While the alternative option of re-provision on the RAH site would meet a number of our criteria, there is no prospect of suitable accommodation in the short to medium term;
- subject to the outcome of the consultation, we will finalise the service specification for the required model. A process to finalise a location and provider for the future service will follow this. This process will be agreed through the OP JPPIG and will specifically involve approaches being made to the Local Authority, Private and Voluntary providers;

- ensure that NHS continuing care within a partnership model is focussed on the needs of those people assessed as requiring NHS continuing care services, consistent with the definition set out in 3.2 above.

8.3 We would aim to deliver the proposed model during 2008. To deliver this change, considerable planning for the implementation phase would be required. This process will be steered by the OP JPPIG with input from operational managers and relevant services. This would include close working with patients and their family members and carers. A detailed implementation plan would also address the changes as they impact on workforce, transport and access, communication, linkages between services and finance.

8.4 It is recognised that any proposed service change which seeks to balance the interests of current patients with the needs of our wider population of older people will result in concern and anxiety for patients, family members and carers. We will ensure that a sensitive approach is taken with long term continuing care patients and their relatives or carers. Individual meetings, involving clinicians, will be planned with family members or carers. Independent advocacy will be made available if required.

9. FINANCE

9.1 NHS Greater Glasgow and Clyde - through Renfrewshire Community Health Partnership and Acute Services and the Mental Health Partnership - has been developing a joint financial framework for Older Peoples Services (which include services for frail older people and for older people with a mental illness such as dementia) in partnership with Renfrewshire Council.

9.2 The financial issues related to NHS continuing care services for frail elderly are therefore linked to a wider pool of resources available between health and social care to provide a range of care for older people.

9.3 The cost of current NHS continuing care services at Johnstone Hospital is shown below in Table 5.

Table 5 - Cost of Current NHS Continuing Care Services at Johnstone Hospital

Continuing Care Beds	Total Cost £k	Cost/bed £k
60	2,589	43.1

9.4 The total cost of reprovding services from the Johnstone Hospital site will be £1.6m. Our proposal is that the balance of the current expenditure will contribute to delivering financial balance across Clyde and to the development of community services.

9.5 In delivering a smaller, focused NHS continuing care services within Renfrewshire, the financial challenge is threefold:

- to secure a service in modern accommodation that offers high quality and value for money;
- to release resource that contributes to NHS Greater Glasgow and Clyde delivering financial balance across Clyde-based Services;

- to invest resource in a joint plan with partners that delivers an improved balance and range of services for older people across Renfrewshire.

9.6 The exact and final details of the resource release and the balance of application from this proposed change are still being finalised. However, it is clear from work concluded to-date that we can secure a high quality NHS continuing care service whilst delivering on the two other challenges above.

10. WORKFORCE

10.1 Current Staffing Levels on the Johnstone Hospital Site for continuing care services are 62.24 whole time equivalent staff trained and untrained nursing staff. In addition other services and staff are located on this site.

10.2 Throughout the implementation of the changes proposed, work will continue with staff and their representatives to manage the impact of change. This will be done within the context of the national and local organisational change policies, which are based on the principle of 'no detriment'.

10.3 Once staff directly affected by the changes proposed are identified, in addition to meetings with the trade unions, one to one meetings/individual redeployment interviews will be held. NHS Greater Glasgow and Clyde has a successful track record in redeploying staff taking into account individual's skills and personal circumstances. Redeployment will be the first consideration with the aim of securing alternative employment for displaced staff as a result of service change. Based on this detailed redeployment principles will be agreed and a process of vacancy management will be put in place to secure alternative employment in alternative departments and locations.

10.4 Deployment may be to a post at a lower grade and in these circumstances protection of earnings will apply. Redeployment will also be supported by a training and development plan, which will include induction and orientation programmes, and retraining/skills updating where necessary.

10.5 Regular briefing sessions will be held with staff throughout the period of implementation.

11. CONSULTATION

11.1 This will build on the programme of engagement events that commenced in February 2007 (detailed in section 2.4 of this paper). It is important to note that throughout this process the Scottish Health Council has provided with oversight and advice to ensure that we meet the requirements of national policy with regard to informing and engaging. The Health Council has asked us to ensure that detailed information is available on the planning work underlying these proposals and we will ensure that is the case. We will also ensure that the process outlined in section 8 of this paper achieves full engagement with individual patients and their relatives.

- 11.2 A NHS Greater Glasgow and Clyde Consultation Summary will be produced in a design format and language that ensures clarity and accessibility. This will cover specifically the proposed changes to frail elderly continuing care provision in Renfrewshire within the context of the overall review of Clyde Health and Service Strategies. This summary will be widely distributed within Renfrewshire via our existing database of contacts, our Public Partnership Forum, GP practices, pharmacies/other primary care providers, community clinics/health centres and through Local Authority facilities.
- 11.3 The consultation summary will carry references in other languages and in large print to the availability of translated; Braille and audio disc format materials.
- 11.4 A consultation event, structured around presentations and workshops will be held in a central location, likely to be Paisley. If required additional meetings can be arranged.
- 11.5 Adverts providing summarised proposals and contact points for additional information will be placed in the Paisley Daily Express to launch the consultation period and draw attention to public meeting dates.
- 11.6 All material will be available on the NHS Greater Glasgow and Clyde Website; a specific consultation response page will be provided.
- 11.7 Meetings and Briefings for Individual Stakeholders will be arranged as required.

INTEGRATED CARE AT THE VALE OF LEVEN

1. INTRODUCTION AND SUMMARY

- 1.1 In April 2006, when NHS Greater Glasgow and Clyde (NHSGGC) was established, the Lomond Integrated Care pilot project was running at the Vale of Leven Hospital but it had not been fully implemented. NHSGGC committed to developing plans to fully implement the pilot, which was intended to enable emergency medical care to continue to be provided at the hospital. In September 2006 it became clear that the integrated care pilot could not proceed to full implementation because of concerns about clinical safety. NHSGGC therefore established a substantial planning and community engagement process to consider the future arrangements for the provision of unscheduled medical care at the Vale of Leven.
- 1.2 This paper outlines the outcome of that planning process, covering in detail the provision of anaesthetics, unscheduled medicine and rehabilitation services at the Vale of Leven Hospital. The paper also describes the service changes that have taken place at the Vale of Leven over recent years.
- 1.3 The paper describes the community engagement process that has been undertaken, the impact that the proposed changes will have on patient access to services, and their impact on the staff who work at the Vale of Leven Hospital.
- 1.4 **The proposal for consultation is that the Integrated Care Pilot cannot be safely fully implemented and should be concluded, requiring the transfer of unscheduled medical care to the RAH.**
- 1.5 In our view, following appropriate consultation, if Ministerial approval is given, this transfer should take place as soon as possible. The detailed work on the partial model of Integrated Care currently in place at the Vale highlights significant clinical issues in relation to the protocol, intended to ensure the most seriously ill patients bypass the Vale and are taken to Paisley, and the arrangements to ensure rapid assessment and transfer of patients who become seriously ill while in the Vale.
- 1.6 In making this proposal, which will affect 6,000 patients, it is important to set the context of the services and activity which will remain at the hospital. These are described in the table below.

Service	Patients per Annum
Minor Injuries Unit	8,000
Daycase and short stay planned procedures	8,000
Day Hospital for elderly patients	9,000
Planned Diagnostic Imaging Services	11,500
Outpatient Services	50,000
Renal Day Patient Services	5,000
Haematology Day Patient Services	5,500
Rehabilitation Inpatients	1,400
Total	98,400

1.7 The rest of this paper is presented in the following sections:

Section 2 : Overview of the Integrated Care Pilot, conclusions about its safety and the subsequent planning process.

Section 3 : Review of anaesthetic services.

Section 4 : Review of options for the provision of unscheduled medical care.

Section 5 : Review of rehabilitation services.

Section 6 : Preconsultation community engagement.

Section 7 : Access for patients and visitors.

Section 8 : Impact on staff

Section 9 : History of service change at the Vale of Leven

Section 10 : Proposed consultation process

2. OVERVIEW OF THE INTEGRATED CARE PILOT

2.1 Background and Purpose

2.1.1 NHS Greater Glasgow took responsibility for services in the Clyde part of the former NHS Argyll and Clyde at 1st April 2006. The services for which the Greater Glasgow and Clyde Board became responsible included the Integrated Care project at the Vale of Leven. In taking on that responsibility we made a clear commitment to support the pilot to enable definitive conclusions to be reached on the safety and sustainability of the proposed model of care.

2.1.2 The Vale of Leven Integrated Care model was developed as a response to the challenge of sustaining medical emergency admission services at the Vale of Leven from the point,

initially expected to be in late 2006, when it is not possible to continue to provide on site, out of hours anaesthetic and medical junior cover. The model was developed by the Lomond Integrated Care Steering Group (LICSG), which emerged as a group of primary and secondary care physicians, AHPs, nurses and members of the public in the autumn of 2004. The LICSG took responsibility for identifying new models of care which could:

- safely and sustainably maintain services at the Vale of Leven;
- bring together disparate core services and professionals into a new, integrated team approach across primary and secondary care;
- develop new ways of working, with staff moving out of their traditional areas to provide care more responsive to patients;
- use new skills and methods to identify the needs of patients and their conditions with the aim of directing patients straight to the hospital that is best equipped to deal with their condition.

2.1.3 The Integrated Care model which was then developed through two years of detailed work had four key elements:

- (a) An assessment and scoring system enabling patients likely to require intensive or anaesthetic care to be identified and bypass the Vale for admissions to the RAH or be rapidly referred on from the Vale assessment unit into the RAH.
- (b) Out of hours a nurse practitioner “hospital at night” team which could safely and effectively provide cover with medical input from a primary care physician.
- (c) A retrieval service to ensure that patients requiring a more acute level of care than can be provided at the Vale could be safely transferred to the RAH.
- (d) The early transfer back of patients living in the Vale catchment area after they had completed an acute episode of care in another hospital for ongoing care and rehabilitation.

2.1.4 The pilot was intended to test the safety and sustainability of this model. This section outlines the process through which we reviewed the potential development of the pilot and the conclusions of that process

2.2 Initial Appraisal of the Pilot

2.2.1 During the transition to the new NHS Board arrangements we established a dialogue with key clinicians and managers from Argyll and Clyde involved in the Integrated Care pilot. Our stock take of progress highlighted the fact that the pilot, as established at that point, did not fully reflect the Integrated Care model. The original intention was that the pilot was to be implemented on a phased basis with the early months focused on testing elements (a) and (c) with full pilot implementation by June 2006. The position on elements (b) and (d) was as follows:

- An SHO was present on the Vale site overnight working with the primary care physician;
- The majority of anaesthetists on-call cover was provided by locums resident on the Vale site providing rapid response support;
- The retrieval service was not in place; its critical element of intervention was covered by the on-call and on site anaesthetic cover, which was able to ensure anaesthetic intervention within the 45-minute target, which would be established for the retrieval service.

2.2.2 These arrangements meant that the model was not being fully piloted and, therefore, the pilot process would not enable a comprehensive evaluation of the safety and sustainability of the Integrated Care service. We therefore proposed further development of the pilot to fully test the four elements of the model of care including:

- fully implement the hospital at night model with on site medical support provided by general practitioners;
- mimic the effect of the off site retrieval team.

2.2.3 This was to be achieved by a two-step process:

- from August 2006 the hospital at night practitioners will be in place. At that point we propose to withdraw the SHO cover to fully pilot the GP medical support;
- from October 2006 to withdraw the on site anaesthetic cover to mimic the target response time of 45 minutes which the model envisaged for the retrieval team.

2.2.4 These changes were designed to enable evaluation of the full Integrated Care model to inform decisions on whether or not the definitive implementation of the model was safe and sustainable and to test the critical clinical elements of the pilot which we identified as:

- the effectiveness of the medical assessment materials in achieving appropriate ambulance bypass and early identification of patients at risk in the medical assessment unit;
- cardiac arrest and other urgent interventions being delivered effectively;
- the effectiveness of the extended skills training for medical and nursing staff;
- the delivery and quality of the clinical guidelines and protocols which underpinned the pilot;
- the effectiveness of management of patients who deteriorate at the Vale.

2.2.5 We also implemented revised project management arrangements.

2.3 Clinical Discussion

2.3.1 In order to discuss our appraisal of the pilot and proposals for its development we arranged an open meeting of clinical staff from the Vale and local GPs.

2.3.2 This meeting took place in June 2006. A range of views emerged among consultants on the safety of the withdrawal of the onsite anaesthetic cover, which was required to fully implement the pilot. It was clear from the discussion at the meeting that the critical issue, which would define whether or not the pilot could proceed, was the concern about clinical safety. The full pilot, with the withdrawal of on site anaesthetic cover, to reflect the proposed Integrated Care model, required explicit confirmation from the Vale Consultant Physicians and Clinical Directors that they were satisfied this would represent a safe system of work. While the GPs would provide the out of hours cover they could only do so with the on call consultant taking ultimate clinical responsibility for all patients. Without that cover an acute service could not be provided at the Vale. We concluded a more detailed discussion on the issue of safety was required with the responsible consultants.

2.4 The Issue of Clinical Safety

2.4.1 A further meeting with the Vale of Leven Consultant Physicians was held in July 2006. The meeting focused on the need to establish that the Consultant Physicians who would be providing clinical cover to the hospital, out of hours, with the GPs providing the immediate medical intervention, were satisfied the arrangement was a safe system of work. The context for the discussion was not an abstract evaluation of safety but rather the requirement to confirm that, from a clinical governance perspective, the Consultants providing clinical cover to the next phase of the pilot were confident it did not expose patients to avoidable and unnecessary risk, in the context of relatively proximate full acute general hospital facilities. The wide ranging discussion had a number of key conclusions which are outlined below:

- the experience of the pilot so far had raised concerns about the timing of medical interventions for a small number of patients;
- the bypassing expectations had not been fully met and while it was clear that this position could be improved it was agreed that this would not entirely exclude seriously unwell patients arriving at the Vale or those already inpatients becoming unpredictably seriously unwell;
- there was a clear expectation on the part of the Consultant Physicians at the Vale that after the pilot phase they would become part of a larger pool of Physicians with RAH colleagues providing cover to the Vale and ensuring their continuing exposure to the full range of acute care to maintain their skills and expertise;
- while there was an aspiration that the evolution of the primary care practitioner model would enable these clinicians to operate on their own account it was acknowledged this would not be for the foreseeable future;
- discussion touched on a number of arrangements elsewhere in the UK and the potential role of the Royal Colleges. However, it was agreed that these wider points of debate could not mitigate the need to reach a local judgment on the durability and safety of the pilot;
- it was clear there was a major challenge in terms of capacity and organisation if unscheduled care was not delivered at the Vale;
- there was clear and collective anaesthetic advice from the Clyde wide Directorate that, in the context of relatively proximal full acute hospitals, the pilot did not represent an acceptably safe model of care from an anaesthetic viewpoint.

2.4.2 In the light of this outcome it was clear that:

- there were significant issues about the clinical safety of moving to the next phase of the pilot, without on site anaesthetic cover;
- beyond the pilot phase the model was not sustainable without cover from the wider group of physicians at the RAH.

2.4.3 We agreed that a further discussion to include the RAH Consultants should be convened to enable conclusions to be reached on the future of the pilot. This further discussion was scheduled for August 2006. Vale and RAH Consultant Physicians and Geriatricians were invited.

2.4.4 The meeting focused on:

- enabling RAH Consultants to discuss and debate the model and proposed full pilot with Vale colleagues;
- testing the RAH Consultant views on the safety concerns which had been raised at the previous meeting and their views on their potential contribution to out of hours cover to the Vale site.

2.4.5 The discussion covered a similar range of issues as the session with the Vale Consultants. A range of significant concerns about the clinical quality and safety of the model were expressed. There were additional concerns raised:

- a model of two-site cover from a wider, joint pool of Physicians was possibly not tenable;
- there had not been detailed discussion about cover after the pilot;
- there was a shared recognition that the Vale Consultant posts are not tenable as a stand-alone group and there would be real challenges in recruiting to this model of Consultant working and cover.

2.4.6 The conclusion of the discussion was that there was a high, shared, level of concern across the extended group of Physicians and Anaesthetists who had the opportunity to consider the pilot so far and its extension. On the basis of that clear and consensus clinical opinion it was our conclusion that providing unscheduled care at the Vale without anaesthetic cover is not a safe system of work and could not proceed to the full pilot. This outcome inevitably meant that the model of Integrated Care could not proceed as conceived.

2.5 Conclusions

2.5.1 This section has mapped out in detail the process NHS Greater Glasgow and Clyde established to take forward and strengthen the Integrated Care pilot to full implementation in a structured and robust way and how we concluded that it was not possible to move to the full pilot and therefore that providing unscheduled care on the basis set out in the Integrated Care model was not possible.

- 2.5.2 Given that conclusion and the fragility of the current arrangements, with on site cover provided by short-term locum Anaesthetists, and a substantial element of the Consultant cover also provided by locums, we needed to plan to implement change as soon as possible.
- 2.5.3 We also concluded that we should establish a comprehensive local briefing process for staff, and local GP's and for wider community interests. This was launched in September 2006.
- 2.5.4 Although the 2004 conclusion that anaesthetics could not be sustained at the Vale had been accepted and was the basis on which the Integrated Care model had been developed there was pressure to revisit that conclusion, given the outcome of the Integrated Care pilot.
- 2.5.5 The planning process which was established in the autumn of 2006 was organized as shown below, including a strand of work to review anaesthetics.

Vale of Leven Integrated Care	Reference Group	Review groups: - Anaesthetics - Rehabilitation - Emergency Medicine
		Community Engagement Group: - Anaesthetics. - Rehabilitation. - Emergency Medicine.

- 2.5.6 These reviews in relation to anaesthetics, unscheduled medicine and rehabilitation have now been concluded. These conclusions and their impacts on the future provision of services at the Vale of Leven are outlined in the following sections.

3. REVIEW OF ANAESTHETIC SERVICES

- 3.1 The anaesthetics review group included anaesthetists from across Greater Glasgow and Clyde (including the Clinical Directors from Glasgow and Clyde), Primary Care physicians, Acute Medicine physicians and acute services planning staff.
- 3.2 The terms of reference of the group were to:
 - review services across Greater Glasgow and Clyde to consider if the combined staffing of the services would allow different cover on the Vale site;
 - identify other models across the UK to see if other solutions could be transferred to the Vale.
- 3.3 A further key task was to answer issues raised by the Community Engagement Group in relation to anaesthetics.

3.4 A detailed report outlining the conclusions of the anaesthetics workstream has been completed. The key points from the workstream are outlined in the following sections.

3.5 Previous NHS Argyll and Clyde work on Anaesthetics

In 2004 NHS Argyll and Clyde had undertaken a detailed assessment of the sustainability of anaesthetics at the Vale of Leven site. Following the changes to Emergency Surgery, Maternity Services and Accident and Emergency services that had been introduced at the Vale between October 2003 and January 2004 the Clinical Director for Anaesthetics had written to the Minister outlining that anaesthetics could only be sustained at the Vale of Leven in the very short term. The reason for this was that there was simply not the volume of work that would allow anaesthetists to maintain their skills base or provide adequate training workload to sustain training accreditation. In 2004, the Board of NHS Argyll and Clyde had recognised that anaesthetics could not be sustained at the Vale of Leven site and had therefore approved the development of the Lomond Integrated Care pilot as described in Section 4.

3.6 Anaesthetic Review Process

In order to adequately review the 2004 findings of NHS Argyll and Clyde the review process established by NHSGGC in October 2006 identified several key questions that needed to be answered. These questions also summarise the issues raised by the community engagement group in the October meeting:

- Why are the current anaesthetics arrangements not sustainable?
- Can we develop the posts at the Vale to make them more attractive?
- Why can anaesthetists from elsewhere in Glasgow and Clyde not rotate to cover the Vale?
- Are there no other models of providing anaesthetics available?

To answer these questions a work programme was developed which involved:

- analysis of the activity at the Vale of Leven Hospital;
- analysis of the rota arrangements across Clyde;
- analysis of the rota arrangements across Greater Glasgow;
- discussions with a range of sites across Scotland and England to assess whether there are alternative models either for providing anaesthetic services or for providing unscheduled medical services without on-site anaesthetic provision.

The findings of each of these elements are outlined below.

3.7 Anaesthetics Activity at the Vale of Leven

In the 15 months from February 2006 to April 2007 anaesthetics staff were called to deal with, on average, approximately one patient per week out of hours (between 6pm and 8am) and just over one patient a week within normal hours (between 8am and 6pm).

The Regional Education Advisor has confirmed that this level of activity is not enough to meet training requirements for doctors in training or for consultants to maintain their specialist skills. This means that a stand-alone consultant anaesthetics rota is not sustainable at the Vale of Leven site due to the volume of activity being seen.

3.8 Analysis of Anaesthetics Rota Options across Greater Glasgow and Clyde

The type of anaesthetist required to support the provision of unscheduled medical services is one who has skills in airway management in emergency situations. This skillset is more aligned to the Intensivist Anaesthetist or the emergency care doctor and is not within the average competencies of a general anaesthetist. General anaesthetists specialise in maintaining the major part of anaesthetic services which is providing cover for theatres.

Bearing in mind the fact that what is required at the Vale of Leven to sustain unscheduled medical services is an Intensivist Anaesthetist, detailed analysis has been undertaken on the rota arrangements across NHS Greater Glasgow and Clyde.

One option which has been considered is providing consultant cover to the Vale of Leven by rotating anaesthetists who are predominantly based at other sites through the Vale for specific time periods. In theory spending only short times at the Vale (say a one week period every six months) would mean that the anaesthetist was able to maintain their skills when based at other, busier, sites. This option is one that has been widely regarded by community groups within the Vale catchment as being straightforward to implement. The practicalities of this model, however, mean that it is not one that is possible to deliver.

The reasons for this conclusion are outlined in the following points:

- The service required at the Vale of Leven is essentially critical care airway support for sick medical patients.
- The vast majority of anaesthetists across Glasgow and Clyde have not had recent training, or more importantly ongoing experience, in intensive care medicine, which is the type of care this group of patients requires.
- Consequently, the provision of the type of care required at the VoL involves a degree of responsibility which is potentially outwith the competence of the majority of anaesthetists.
- Most anaesthetists who are not trained in intensive care medicine are therefore unwilling to deliver this type of care.
- There are currently 33 consultant anaesthetists across Glasgow and Clyde who are trained in intensive care medicine. In addition, within Clyde there are several anaesthetists who provide care critical care coverage who were trained under the

older system and who have maintained their skills in order to sustain critical care services at the RAH and the IRH.

- This body of consultants provides cover to 7 intensive care units across Glasgow and Clyde.
- Within their total available hours this group must ensure a number of different objectives are fulfilled:
 - deliver a demanding on-call service;
 - undertake adequate ongoing experience in an ICU to ensure that their intensive care skills are maintained;
 - provide sufficient anaesthetic input into theatres to enable the theatre work to continue;
 - undertake sufficient work in theatres to maintain their competence as theatre anaesthetists.
- In order to balance these objectives and maintain their skills in both theatre anaesthetics and intensive care it is not appropriate for this group of staff to spend time undertaking duties which do not maintain or enhance their skills.
- Maintaining services at the Vale of Leven would require each of these consultants to deliver approximately 2 weeks of resident on-call cover at the Vale each year. Resident on call would represent a very significant departure from current work patterns for the overwhelming majority of consultants in Glasgow and Clyde, including intensive care specialists. We would expect very few intensive care consultants to be willing to take up such a radical change to their job plan.
- Maintaining the same level of rota frequency as currently provided (around 8 weeks per year) would mean this group of consultants being exposed to 6 weeks on-call intensive care workload in a busier acute site and 2 weeks resident each year at the Vale of Leven. Given the low levels of activity at the Vale of Leven any time spent in the Vale would result in this group having less exposure to patients who require the use of their specialist skills.
- These circumstances would potentially result in the de-skilling of this group of staff and in the interests of clinical standards this is not a situation that we are prepared to attempt to impose on these highly trained, senior doctors.
- More importantly, however, the requirement to have anaesthetic consultants providing resident on-call cover would have a profound impact on the ability of NHS Greater Glasgow and Clyde to sustain services across all sites. The reason for this is that providing resident cover for one night from 5pm to 9am is equivalent to providing 5 sessions of work. Providing one 24 hour period of resident cover on a Saturday or Sunday is equivalent to 8 sessions. A consultant providing resident cover at the Vale of Leven for one week would therefore be “working” for the equivalent of 41 sessions. This is 25 sessions for the weekday

overnight cover (5 sessions x 5 days) and 16 sessions for the weekend cover (8 sessions x 2 days). This is the equivalent to 6 weeks of direct clinical workload for an anaesthetic consultant and effectively means that providing one week of resident on call cover at the Vale would mean that the consultant was not able to work for the next six weeks.

- This would result in NHSGGC being unable to provide intensive care services at other sites. It would also result in the de-skilling of anaesthetists.
- We can not simply pay consultants extra to have them provide cover at the Vale over and above their normal working patterns. Even if anaesthetists were prepared to do this it would not be compliant with the EWTD requirements.
- Simply recruiting more consultants to this cohort of staff across Glasgow and Clyde and then rotating these staff to cover increased numbers of sites is not a practical solution because:
 - the contact time that the consultants have with the type of patients who maintain or enhance their skills would be considerably reduced when they were based at the VoL;
 - the requirement to provide resident cover at the Vale would mean each consultant requiring approximately six weeks away from patient care for every one week spent at the VoL. This would reduce their skillset and be cost prohibitive;
 - we are unlikely to be able to convince this cohort of staff to provide resident cover at the VoL.

3.9 Alternative Models

Having concluded that it is not possible to sustain anaesthetics at the Vale of Leven based on the current configuration of services either via a stand-alone rota or by rotating staff from other sites, the workstream has reviewed other models of care from across the country. The purpose of this was to assess whether there exists an alternative model either for providing anaesthetics to the Vale or for sustaining unscheduled medicine without on-site anaesthetic services.

A number of sites across the country were contacted to explore the feasibility of developing alternative models of care. These sites were selected on the basis that the services they provided might inform the search for a safe and sustainable future anaesthetic model on the VoL site. Sites included: Dr Gray's Hospital, Elgin; New Galloway Hospital, Dumfries; St John's, Livingstone; Falkirk Hospital; Kendal Hospital and Hexham Hospital.

In the appendix to the detailed paper on anaesthetics which will be available during the consultation there is a table which provides detailed information in relation to the sites contacted. These sites were selected as it was assumed that due to the similarity of their function they might inform the search for a safe and sustainable future anaesthetic model

on the VoL site. None of the sites, however, offered a viable alternative model or a direct comparison in terms of the population served, or the services delivered. Previous comparison had been made between the Vale of Leven Hospital and Kendal Hospital who had attempted to develop a model of care which provided unscheduled medical admissions without anaesthetic support out-of-hours. Kendal has, however, faced the same challenges as anticipated at the Vale of Leven and has subsequently required to have its services downgraded to a nurse led unit due to staff recruitment issues and clinical governance concerns. The inpatient beds at this site will become rehabilitation beds.

It was also anticipated that the interim report from the nationally established Remote and Rural Steering Group would inform the search for alternative models. The main aim of the steering group is to deliver a strategy for sustainable health care in remote and rural Scotland. The definition of remote and rural is informed by the clinical peripheral index. This takes into account population density, practice size and the time to reach secondary care. Given its proximity to hospitals which provide the full range of acute services the Remote and Rural Steering Group have not identified the Vale of Leven as being either a remote or a rural hospital. It was hoped, however, that the interim report would highlight new ways of working within smaller sites that could be adopted by the VoL. One of the issues being considered by the group was the anaesthetic support required on a remote and rural site. The interim report suggests there will be no change in the model of anaesthetics cover required in the rural general hospital in future and that the current "consultant protected model of anaesthesia" will apply. It would appear, therefore, that there are no new models of care available.

3.10 Anaesthetic Workstream Conclusions

For the reasons outlined in detail both in the above section and in Appendix 1 the anaesthetic workstream therefore conclude that:

- the workload at the Vale is not sufficient to meet the training needs of trainees or consultants, meaning a stand-alone rota cannot be developed at the hospital;
- there are no opportunities to rotate intensivists anaesthetists from other sites in Clyde to cover the Vale;
- there are no alternative models of care to allow unscheduled medicine to be sustained without anaesthetics.

These conclusions mean that, despite the additional work that has been undertaken, the position remains that anaesthetics cannot be sustained and, given the conclusion that the Integrated Care model cannot be safely implemented, this means that unscheduled medical admissions cannot be retained on the Vale of Leven site.

In addition to the powerful clinical arguments set out in this section it is also important to restate our obligation to provide economic and cost effective services for the small number of acute patients treated at the Vale of Leven Hospital - this test could not be met in providing an onsite anaesthetic service.

4. REVIEW OF OPTIONS FOR THE PROVISION OF UNSCHEDULED MEDICAL CARE

- 4.1 Following the conclusion that the Lomond Integrated Care pilot would not proceed, this group was established to review the future options for the transfer of unscheduled medical care from the Vale of Leven Hospital. Participants in the group included: physicians from the Vale, the Royal Alexandra and Glasgow hospitals; GPs from West Dunbartonshire and Argyll and Bute CHPs; and NHSGGC operational and planning managers.
- 4.2 The review examined four options for patients requiring access to unscheduled medical care:
1. All medical patients from the Vale catchment would flow to the Western Infirmary in Glasgow
 2. All medical patients would flow to the Royal Alexandra in Paisley
 3. There could be a split geographical catchment allowing some patients to go to Glasgow and others to Paisley
 4. The choice of destination hospital could be left to patients themselves or their GP
- 4.3 Discussion with the Community Engagement Group suggested that option 3, which would have involved splitting the Vale of Leven catchment, would not be practical and we concluded that option 4 would not allow robust planning for high quality services to be available when patients needed them. Both these options were therefore ruled out. This meant that the Western Infirmary and the Royal Alexandra Hospital were the options which were focused on.
- 4.4 In considering both of these options a number of advantages were identified for the RAH proposition. These were:
- The RAH clinical team already deal with the most acutely unwell patients from the Vale catchment area.
 - The SAS are clear that the RAH is more accessible for emergency ambulances and will enable them to get patients to hospital more rapidly than a Glasgow option.
 - The RAH option enables the integration of unscheduled medical and surgical care.
 - Analysis shows that appropriate physical capacity can be developed at the RAH to accommodate the additional MAU patients.
 - In the example of obstetric services, where patient choice already exists as to whether to access services in Glasgow or at the RAH the majority of patients choose to access services in Paisley.

- there is a well developed and very substantial network of clinical relationships between the two hospitals, There are five key points which are important about this
 - the most acutely unwell patients from the Vale catchment currently access services in the RAH hospital.
 - there are approximately 6000 A&E attendees from this area at the RAH, of whom around 3800 are admitted.
 - there are around 1700 admissions into the RAH mainly for planned operations from the Vale area.
 - there are strong clinical links to facilitate the transfer of patients between the RAH and the Vale;
 - doctors based at the RAH provide very substantial clinical input to services at the Vale as part of their regular working patterns. Over 70 consultant half-day sessions each week are delivered at the Vale of Leven Hospital by clinicians based at the RAH. This is the equivalent to having 10 consultants dedicated to the Vale of Leven Hospital and its communities. It allows, however, access to a much wider range of specialties than could be provided by 10 clinicians. These sessions include 12 surgical and orthopaedic theatre sessions, 5 endoscopy sessions, 2 fracture clinics, 2 A&E follow up clinics, 22 radiological sessions, 21 Obstetrics and Paediatrics sessions, 3 Ophthalmology clinics and 10 clinics for surgical and orthopaedic patients. Changes to the links between the RAH and the Vale would potentially threaten the ability to maintain these services.

4.5 In addition to the advantages of transferring the medical activity to the RAH, a number of reasons have identified why it is not practical to transfer the activity from the Vale catchment to the WIG.

1. **A&E Capacity.** The Western Infirmary currently struggles to meet the 4 hour waiting time target within Accident and Emergency. It would not be practical to transfer the 6000 medical patients who currently attend the MAU at the Vale of Leven to the Western Infirmary A&E department. This department does not currently have the physical space to cope with these additional patients and to increase the physical capacity would required significant capital investment.
2. **Critical Care capacity.** As service changes at the Vale of Leven have been introduced over the past decade and the most acutely unwell patients have transferred to the RAH appropriate critical care resources at the RAH have been developed to cope with the increased demand. This includes the provision of HDU and ITU care and emergency theatre provision. Expanding these services at the Western would require significant capital investment.
3. **Future of the Western Infirmary.** The NHS Greater Glasgow Acute Services Strategy is clear that the Accident and Emergency services currently provided at the Western will in future be provided from the New Southern General Hospital.

This will be developed by 2012. After this time the Western Infirmary will not provide hospital services. This means that upgrading the Western to temporarily accommodate the emergency activity from the Vale of Leven catchment would provide a solution for only four years. This would not be an effective use of public resources.

- 4.6 For these reasons it is recommended that unscheduled medical services should be transferred to the RAH and that patients from the Vale catchment requiring access to unscheduled medicine should follow the A&E, Surgery and Trauma and Orthopaedic emergency patients to the RAH.**

5. REVIEW OF REHABILITATION SERVICES

- 5.1 The rehabilitation review group included physicians from the Vale and Royal Alexandra, West Dunbartonshire Community Health Partnership staff, GPs, the Associate Medical Director, the Lead Director of Rehabilitation and operational and planning managers.
- 5.2 Terms of reference were to explore potential models for rehabilitation services at the Vale of Leven if unscheduled medicine was not on site.
- 5.3 The review identified a number of options based on different staffing requirements. These options were:
- the status quo – no changes other than from ongoing joint service planning;
 - patients transfer at an early stage in their admission - circa one week;
 - patients transfer at a later stage - circa two weeks;
 - patients transfer near the end of their admission.
- 5.4 These options were discussed with the community engagement group in January 2007.
- 5.5 Based on detailed analysis of the number of patients admitted and the average length of stay across a range of conditions, the review has concluded that, whilst there will be some changes in the patients accessing rehabilitation, approximately the current numbers of beds could be maintained at the Vale. This would involve early transfer of patients back to the Vale of Leven from the RAH, and is therefore similar to the second option outlined above.
- 5.6 Rehabilitation will be provided for
- people of all ages who have suffered a stroke;
 - people of all ages who need rehabilitation after a broken leg;
 - older people who need rehabilitation after an emergency admission or a planned operation.
- 5.7 Patients will still be under the care of a hospital Consultant and will receive specialist medical, nursing and Allied Health Professional care.

- 5.8 Rehabilitation services will also be subject to further review as the long-term model of care develops across NHS Greater Glasgow and Clyde.

6. PRECONSULTATION COMMUNITY ENGAGEMENT

- 6.1 In addition to the initial programme of community engagement group in relation to the Integrated Care Pilot, each of the reviews described in the earlier section established have interacted with the community engagement group established by West Dunbartonshire CHP, at the beginning of the review process and throughout their work. Specific feedback from the community engagement group to each of the reviews was used to inform the work undertaken. This specific input is outlined in the previous sections.
- 6.2 In addition to the ongoing group, two widely attended public sessions were held in February 2007 at the Beardmore Hotel. At these sessions detailed analysis undertaken as part of the health needs assessment for West Dunbartonshire was discussed. In addition, there were presentations and discussions on the progress being made and the models being considered in relation to anaesthetics, unscheduled medicine and rehabilitation.
- 6.3 The Scottish Health Council (SHC) have also met regularly with NHSGGC to ensure that the pre-consultation engagement requirements have been met. Both the SHC and NHSGGC have found these regular meeting helpful in ensuring that pre-consultation process has been appropriately undertaken and that NHSGGC are now ready to move to full consultation.
- 6.4 Two further meetings of the community engagement group were held in May 2007 to plan for a further event at the Beardmore hotel and to ensure that the community engagement group were aware of the recommendations in relation to each of the workstreams. **The members of the community engagement group have expressed their disappointment in the conclusions of the review work and the proposed for the provision of unscheduled medical care to patients currently served by the Vale of Leven Hospital and do not support it.**
- 6.5 We have followed an appropriate pre-consultation community engagement process and this process has made a significant contribution to identifying the key issues which needed to be addressed in each review process and in shaping the work of the review groups.

7. PATIENT AND VISITOR ACCESS

- 7.1 We are very aware of concerns about the capacity of the SAS to respond to these proposed changes to patient flows and the implications for visitors.

7.2 There are three elements which have been carefully considered in relation to the increased numbers of patients who will require to access services at the RAH. These are:

- the requirement for increased numbers of patients to access the RAH by ambulance;
- the requirement for increased numbers of patients to transfer back from the RAH to the Vale by ambulance;
- the requirement for patients and visitors to use public transport to access the RAH and travel home.

These three elements are covered in more detail in the rest of this section.

7.3 Detailed work has been undertaken by NHS Greater Glasgow and Clyde and the Scottish Ambulance Service (SAS) to identify the additional ambulance service resource that is required to make sure that all patients affected by the changes can be taken to the RAH.

7.4 This work has involved a number of steps:

- identifying the current number of patients from the West Dunbartonshire and Lochside communities who travel to the Vale and the RAH hospitals by ambulance;
- calculating the additional time it will take for the ambulance to travel from each of the points where patients are picked up to the RAH instead of to the Vale;
- factoring the time required for the return journey (taking account of the ambulance services ability to provide a “dynamic” service by repositioning ambulances);
- projecting how peoples reliance on ambulance services will change because they will access services at the RAH rather than at the Vale;
- factoring in the overall growth in demand for ambulance services that is projected across the Clyde area.

7.5 A detailed paper outlining how these stages have been worked through is being prepared jointly by the SAS and NHSGGC. The outcome will be that the SAS will require additional staff and ambulances available 24 hours a day to ensure that an appropriate service can be delivered to the West Dunbartonshire and Lochside communities. The SAS are still to finalise the exact costs of associated with implementing the required changes. Similarly, the location where ambulances are to be based is still to be determined. This additional ambulance capacity will obviously increase the ability of the SAS to deliver a “dynamic” service which will ensure that when an ambulance from one area is taking a patient to Paisley vehicles from another area will be able to cover if required.

7.6 The second area considered has been the requirement to transfer increased numbers of patients from the RAH to the Vale of Leven to undertake the rehabilitation stage of their treatment. We project that at most, approximately 1400 patients will require to be transferred each year. A process has been worked through by NHSGGC and the SAS to

identify the level of resource required to meet this demand and it is projected that one additional patient transport vehicle working on an extended day basis and on a Saturday will be enough to allow us to meet this demand.

- 7.7 The third area of consideration has been the provision of public transport between the Vale of Leven and the RAH. Since February 2006 a bus service connecting the Vale of Leven Hospital to the Royal Alexandra Hospital has been funded, initially by NHS Argyll and Clyde, and since April 2006 by NHS Greater Glasgow and Clyde. The service, 340, runs six times a day in both directions. Approximately 10,000 passenger trips were reported by the bus operator to have been made between 1st April 2006 and end March 2007, equating to approximately 4 passengers per bus trip. How many of these trips were made by people wishing to visit either hospital is unclear – it has been noted at the RAH that some passengers alighting the bus walk away from the hospital. It has also been noted by patient's groups, that the provision of a bus service from either hospital does not address the needs of those elderly patients who may have some distance to travel to get to the Vale in the first instance.
- 7.8 One option we will explore is to use the monies which currently fund the VoL/ RAH bus to fund a different type of service. Demand responsive transport (DRT) is a type of transport which collects people from their homes and brings them to their destinations at an agreed time. It may be possible to have a number of minibuses operating across the area bringing patients or visitors from their own home to hospital.
- 7.9 Another option may be to see if the route of the current bus service can be modified to provide a service to more people. Discussions have already begun with the major transport providers around the options for ensuring that services are available to the maximum possible number of people. These options will be discussed as part of the consultation process.

8. IMPACT ON STAFF

- 8.1 It is anticipated that approximately 150 staff currently based in the Medical Assessment Unit, The Coronary Care Unit, The High Dependency Unit and in wards 3 and 6, along with some staff who provide support services will be affected by the proposals.
- 8.2 Throughout the implementation of the changes proposed, work will continue with staff and their representatives to manage the impact of change. This will be done within the context of the national and local organisational change policies, which are based on the principle of “no detriment”.
- 8.3 Once staff directly affected by the changes proposed are identified, in addition to meetings with the trade unions, one to one meetings/individual redeployment interviews will be held. NHS Greater Glasgow and Clyde has a successful track record in redeploying staff taking into account individual's skills and personal circumstances. Redeployment will be the first consideration with the aim of securing alternative employment for displaced staff as a result of service change. Based on this detailed

redeployment principles will be agreed and a process of vacancy management will be put in place to secure alternative employment in alternative departments and locations.

8.4 Deployment may be to a post at a lower grade and in these circumstances protection of earnings will apply. Redeployment will also be supported by a training and development plan, which will include induction and orientation programmes, and retraining/skills updating where necessary.

8.5 Regular briefing sessions will be held with staff throughout the period of implementation.

9. THE HISTORY OF SERVICES CHANGE AT THE VALE OF LEVEN

9.1 **Service Changes Prior to mid-2004**

In the mid-1990s major trauma and orthopaedic services for the Vale of Leven catchment were provided from the WIG. Most patients requiring access to these services in an emergency situation were initially taken to the Vale of Leven for assessment at A&E before being transferred onwards. For a number of reasons there were concerns within the local community about the service. A tendering process for the provision of these services was therefore undertaken and the RAH hospital was the successful bidder. At this stage, therefore, trauma and orthopaedics and some paediatric services for the Vale of Leven catchment were provided from the RAH hospital.

Attempts have been made for a number of years to develop a sustainable strategy for the Vale of Leven. From 1999 to 2001 work was undertaken on the “Vale of Leven project” which considered how best to develop the Vale of Leven Hospital and its clinical services. The project identified the key issues in relation to each of the specialties provided at the hospital. It concluded that:

- an inpatient general surgical service at the Vale of Leven could not be maintained in its current form primarily due to medical manpower and clinical governance concerns;
- the obstetric and gynaecology services at the Vale of Leven were not viable in their current form because of medical manpower and clinical governance concerns arising from activity levels;
- the A&E service relied on the back up of surgical and anaesthetics teams. Obstetric and gynaecology services affect anaesthetics and therefore affect A&E. Changes to these services required a new service model in A&E.

Although outlining the need for change, the “Vale of Leven project” did not generate any agreed specific plan for the future of the hospital.

In December 2002 surgical services at the Vale of Leven came close to total collapse. This was because of surgeons leaving to take up positions elsewhere or retiring and there being an inability to recruit replacements. In December 2002 the two remaining surgeons both applied for positions elsewhere. These surgeons agreed not to take-up

the alternative posts and to stay on until service integration could be managed effectively between the RAH and the Vale. Therefore during 2003 plans were made and enacted to transfer surgery and urology services to the RAH.

Also in 2003 a major review of maternity services across NHS Argyll and Clyde was undertaken. The conclusions of this review dovetailed with the findings of the national Expert Group on Acute Maternity Services (EGAMS) and led to the development of community midwifery services at the Vale of Leven and Inverclyde Hospitals. Consultant led obstetric and gynaecology services for the Vale catchment were therefore transferred to the RAH. In January 2004 Accident and Emergency services also transferred to the RAH. During January 2004 short-term arrangements were established to sustain anaesthetics at the Vale to allow unscheduled medical admissions to be maintained. It was clear at that stage that these arrangements were absolutely short term and it was anticipated that “Shaping the Future”, the 2004 NHS Argyll and Clyde Clinical Strategy which was then being developed would result in a clear direction for the Vale of Leven hospital. “Shaping the Future” is described in more detail in later in this section.

Whilst the emergency and complex inpatient element of these services were transferred to the RAH arrangements were made to sustain planned care, day services, and rehabilitation at the Vale of Leven.

Since January 2004, the medical assessment unit at the Vale of Leven has treated 6000 each year admitting 3000, the most acutely unwell patients from the Vale of Leven catchment area have bypassed the Vale and been treated in the RAH. In addition, approximately 6000 patients from the West Dunbartonshire and Lochside area attend A&E in the RAH each year. The Scottish Ambulance Service indicate that it is quicker for patients from West Dunbartonshire and the Lochside to access emergency services at the RAH, Paisley than at the Western Infirmary Glasgow. Around 1700 patients are admitted into the RAH for planned care each year.

9.2 “Shaping the Future” 2004: NHS Argyll and Clyde Strategy

In summer 2004 NHS Argyll and Clyde undertook a consultation period on its strategy for the future of health services across the Argyll and Clyde area. Overwhelming service pressures faced at the Vale of Leven had already seen the reconfiguration of trauma and orthopaedic, surgery, urology, maternity, gynaecology and accident and emergency services.

“Shaping the Future” attempted to bring certainty about the future for the Vale of Leven Hospital. It described the reasons why services in Argyll and Clyde needed to change and proposed two options for the Vale of Leven Hospital. The drivers for change and the options proposed are summarised in the following sections.

“Shaping the Future” outlined that Hospital Services across Argyll and Clyde needed to change for a number of reasons.

Changes in the population in Argyll and Clyde:

- the strategy projected that there will be fewer children and young people;
- it also projected that there will be more older people;
- it stated that overall the population of Argyll and Clyde is reducing (by 5% over 15 years);
- it outlined that services need to develop to meet the specific requirements of the changing population.

Addressing health needs:

- the strategy described that whilst the health of the people of Argyll & Clyde is improving in many ways it is still poor compared to most other Western European countries. Within Scotland, Argyll and Clyde is one of the areas where people are likely to die younger and suffer poor health at a young age. The health services that we provide must meet the changing health needs of the people of Argyll and Clyde.

Changing clinical practice:

- clinical practice is how healthcare professionals treat patients. The consultation document described that what might have been best clinical practice in the past is unlikely to be best today. Improved understanding of illnesses, better ways of finding out what is wrong with a patient and a greater range of treatments allow for the provision of higher quality care today than ever before. The strategy explained that services must change to allow these advances to be capitalised upon;
- it identified that there are many more opportunities in Argyll and Clyde for treatment and care to be given in people's homes or in local communities rather than being admitted for long term care to an institutional setting like a hospital;
- the strategy explained that fewer hospital doctors are now trained to deal with a wide range of problems. Instead, they specialise in treating a smaller number of conditions. Such specialisation produces more skilled and experienced staff with improved results for patients. However, this often requires services to be brought together in one place to enable essential skills to be shared and maintained.

A changing workforce:

- "Shaping the Future" described that in 2004 Scotland, along with the rest of the UK, faced overall shortages of clinical staff and serious shortages in some areas including radiology, pathology and psychiatry. It highlighted how unfilled posts disrupt services and increase waiting times. Changes in medical training and practice can lead to difficulties in attracting and keeping staff to provide certain services. Retaining good local access to services and maintaining quality may involve local clinicians working more closely with specialists from other hospitals to continue to provide services, but in a different way.

The impact of employment legislation:

- the strategy explained that the European Working Time Directive places an obligation on employers to reduce the number of hours staff are allowed to work. Historically, the NHS has relied on doctors working very long hours – sometimes as much as 100 hours per week. This is no longer allowed and therefore services need to be redesigned.

Pay modernisation:

- in 2004, NHS Argyll and Clyde described the impact that pay modernisation would have. It explained that there are new, UK-wide, employment contracts for all staff. It suggested that these changes would improve patient care and make careers in health more attractive, thereby improving the recruitment and retention of staff. These contracts would require radical redesign of how NHS staff work and will, in turn, allow major improvements to services for patients.

Ongoing training and development:

- the strategy document described how the skills of NHS staff depend on on-going experience, professional training and development and having access to appropriate supervision. Services must be designed so that staff are able to maintain and develop their skills to provide the best possible standards of care and to meet accreditation requirements.

Resources:

- the strategy explained that NHS Argyll & Clyde spent about £40 million each year more than its allocated Scottish Executive funding. It stated that health services have to be managed within budget and that money needed to be released to develop the health services required for the future.

Geography:

- the strategy described that the geography of Argyll and Clyde is one of the most diverse in Scotland. Making sure that health services are safe and sustainable across Argyll and Clyde presented particular challenges. It emphasised that social deprivation and transport issues are important factors in accessing healthcare services.

9.3 NHS Argyll and Clyde Strategy Proposals

In response to these drivers NHS Argyll and Clyde had proposed that specialist inpatient care be concentrated on the RAH site. This meant two options for the Lomond area.

“In Lomond we are proposing, at the Vale of Leven site or an appropriate alternative local site:

- Option A - An ambulatory care hospital providing out-patient and minor injury services (which make up the majority of current services). Emergency and acute in-patient services will be provided in Greater Glasgow as a long term plan, with a commitment to explore the possibility of providing intermediate care locally.
- Option B - An intermediate hospital providing out-patient and minor injury services (which make up the majority of current services) together with intermediate in-patient beds. Emergency and acute in-patient services will be provided in Paisley.”

9.4 Strategy Outcomes

Whilst the 2004 NHS Argyll and Clyde strategy was published and consulted upon it was not taken to formal conclusion. This means that it did not receive a formal response from the Minister for Health before it was announced, on the 19th May 2005, that the process of dissolving NHS Argyll and Clyde was to begin.

Although no formal Ministerial response had been provided in relation to “Shaping the Future” the drivers for change outlined in the document still existed. It was clear in January 2004 when Accident and Emergency Services transferred to the RAH that the solutions in relation to anaesthetics and unscheduled medicine were short term. There was a need to develop sustainable solutions to the challenges faced at the Vale of Leven. In particular, during 2004, the Board of NHS Argyll and Clyde definitively concluded that 24/7 anaesthetic provision to support unscheduled medicine was not sustainable at the Vale of Leven Hospital.

In an attempt to avoid the requirement to transfer all unscheduled medical care to the Royal Alexandra Hospital it was proposed that a new model of care would be developed at the Vale of Leven Hospital. This new model of care was called the Lomond Integrated Care Pilot.

An earlier section of this paper describes the Lomond Integrated Care pilot project.

10. THE PROPOSED CONSULTATION PROCESS

- 10.1 This section describes our proposed approach to formal consultation - building on the extensive programmes of public and community engagement which have already been at the heart of our review and planning processes.
- 10.2 During the consultation process public events will be organised to discuss the proposals outlined in this document. These will be structured around presentations and workshops and avoid holiday dates.
- 10.3 Adverts providing summarised headline proposals and contact points for additional information will be used to launch the consultation period and draw attention to public

meeting dates. These will appear in the local newspapers - Dumbarton and Vale of Leven Reporter Helensburgh Advertiser and Lennox Herald.

- 10.4 All relevant material will be made available on the NHSGGC website on specific consultation pages.
- 10.5 Local media releases will be published tailored to suit local requirements and interests.
- 10.6 One to one meetings and briefings will be held for local stakeholders and groups as required.

11. CONCLUSION

- 11.1 The extensive programme of work over the last 18 months has established that:
 - the Integrated Care model cannot be fully implemented and therefore the Vale of Leven Hospital cannot continue to provide unscheduled medical care;
 - the RAH is the best option to provide this service to the Vale of Leven population.

HEALTH NEEDS AND SERVICES FOR WEST DUNBARTONSHIRE AND THE LOCHSIDE PROPOSALS FOR CONSULTATION

[The material from the Clyde-wide papers relating to this area will be attached to a final version of this paper]

1. INTRODUCTION AND BACKGROUND

- 1.1 Following the integration of the Clyde area with the Greater Glasgow NHS Board area, the new NHS Greater Glasgow and Clyde announced its commitment to set out options for the future of services in the Clyde area to give staff and patient certainty following several years of debate stemming from NHS Argyll and Clyde's planning and consultation processes.
- 1.2 This paper sets out the outcomes of the four strands of review and planning which relate to West Dunbartonshire and the Lochside:
- health needs assessment;
 - modernising mental health services;
 - review of maternity services;
 - review of integrated care.
- 1.3 The health needs assessment conclusions and recommendations are covered in section 5 of this paper.
- 1.4 The outcome of three of these strands of planning and review require formal public consultation and Ministerial approval because they propose service changes at the Vale of Leven Hospital. These changes are:
- **the conclusion of the Integrated Care Pilot at the Vale of Leven Hospital and the reprovision of unscheduled care at the RAH** affecting 6,000 patients each year, against a level of hospital activity of 77,000;
 - **the closure of the delivery service provided in the Community Maternity Units at Inverclyde Royal Hospital and the Vale of Leven Hospital** affecting 74 patients, against continuing activity of 15,000;
 - **the transfer of adult and elderly acute admission beds for mental health from the Vale of Leven and their reprovision at Gartnavel Royal Hospital** affecting around 500 patients.
- 1.5 The proposals are the outcomes of the series of programmes of review and planning outlined in summary below and described in more detail in the attachments to this paper.
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Integrated Care at the Vale of Leven

In September 2006, when it became clear that the integrated care pilot at the Vale of Leven could not proceed to full implementation because of concerns about clinical safety, we established a substantial planning and community engagement process to consider the future of the pilot.

- Clyde Mental Health Modernisation

A substantial review and planning process has developed proposals to modernise mental health across the Clyde area, strengthening community services and reviewing the provision of hospital care.

- Review of Maternity Services - Linking the Consideration of Clyde Maternity Services into the Established Greater Glasgow-wide Maternity Planning Process

This work has enabled us to consider the impact on Clyde services of planned changes in Glasgow hospitals and also to review the issues in relation to the utilisation of the IRH and Vale Community Midwifery Units, where substantially less births are occurring than was projected.

1.6 The purpose of this overview paper is also to:

- set the context within which each of the review programmes and planning process have been undertaken;
- articulate the overarching drivers for change which have informed our proposals;
- describe the principles which have underpinned each programme of work;
- set out our proposed consultation process.

2. CONTEXT

2.1 This section briefly sets the Clyde-wide context in which our proposals for each service have been framed.

2.2 Mental Health and Older People Services

We inherited incomplete strategies for older people and mental health services from the former Argyll and Clyde, which had variable levels of Local Authority engagement and commitment, particularly in relation to arbitrarily imposed financial savings which were not supported by detailed plans. The services across Clyde were characterised by under developed community services and an over reliance on beds, providing services to patients of variable quality and accessibility.

2.3 Acute Services

Argyll and Clyde had submitted proposals for acute services following an extensive planning, development and consultation process. These proposals had not been endorsed by the Health Minister and, therefore, had not been implemented, leaving a range of services in unstable and unsustainable arrangements. In relation to this consultation the pilot of the Integrated Care model had not been fully implemented.

2.4 Maternity Services

A relatively new pattern of maternity services was in place with Community Maternity units having replaced the previous Consultant led delivery services at the Vale of Leven and Inverclyde Hospitals.

2.5 Financial Position

Argyll and Clyde had levels of recurrent spending on services substantially above the share of the Scottish Health Services funding. At the point of dissolution we inherited a deficit of £30 million with our new Clyde responsibilities. Following extensive discussions with the SEHD a three year brokerage arrangement was agreed to enable a strategic approach to the re shaping of services to deliver financial balance. In each financial year we are required to make substantial progress to reduce the deficit and that can only be achieved by redesigning services and staffing.

3. PRINCIPLES

3.1 This section describes the principles which have been consistently applied in developing our proposals.

3.2 Safe and Sustainable

Safe and sustainable services should be provided as close to communities as possible.

3.3 Shifting the Balance of Care

Wherever possible services should be provided outside hospitals in primary and community care services.

3.4 Staff

It is clear that a number of our proposed changes will impact on staff at the Vale of Leven Hospital, both those directly providing these services and support staff. There will be a single, coordinated process to engage staff.

Throughout the implementation of the changes proposed, work will continue with staff and their representatives to manage the impact of change. This will be done within the context of the national and local organisational change policies, which are based on the principle of “no detriment”.

Once staff directly affected by the changes proposed are identified, in addition to meetings with the trade unions, one to one meetings/individual redeployment interviews will be held. NHS Greater Glasgow and Clyde has a successful track record in redeploying staff taking into account individual's skills and personal circumstances. Redeployment will be the first consideration with the aim of securing alternative employment for displaced staff as a result of service change. Based on this detailed redeployment principles will be agreed and a process of vacancy management will be put in place to secure alternative employment in alternative departments and locations.

Deployment may be to a post at a lower grade and in these circumstances protection of earnings will apply. Redeployment will also be supported by a training and development plan, which will include induction and orientation programmes, and retraining/skills updating where necessary.

Regular briefing sessions will be held with staff throughout the period of implementation.

3.5 Accessible

Ensuring accessibility for patients and their visitors is a critical issue and each of our proposals describes the challenges and our approach to address them. We recognise the particular issues for patients from West Dunbartonshire and the Lochside in accessing alternative facilities. That access challenge has been a particular driver to maintain as much activity as possible local while addressing the wider principles outlined in this section. Our proposals to address the access issues are outlined in each of the detailed sections.

3.6 Economic

Services need to be delivered in an economic way which represents a proper utilisation of public finances.

3.7 Engagement

The process of developing all of our proposals has included a substantial programme of public and community engagement, from the stage of informing people who may be affected by changes, to community engagement groups participating in each stage of the review and planning process and a series of open public events to communicate more widely with the emerging issues and options and hear public views.

3.8 National Policy

Our proposals have also been developed within the frameworks of National policy including:

- Delivering for Health and related policies on:
 - mental health;
 - rehabilitation;
 - long-term care;

- acute care;
- Joint Futures for Community Care;
- Maternity Services.

4. DRIVERS FOR CHANGE

4.1 There have been a range of drivers for the different programmes of review and planning, the conclusions of which are outlined in the further detailed sections in this paper.

4.2 **Acute Hospitals**

- Changing clinical practice:
 - there are many more opportunities for treatment and care to be given in people's homes or local communities rather than being admitted to a hospital;
 - fewer hospital doctors are now trained to deal with a wide range of problems. Instead, they specialise in treating a similar number of conditions. Such specialisation produces more skilled and experienced staff with improved results for patients. However, this often requires services to be brought together in one place to enable essential skills to be shared and maintained.
- Changing workforce:
 - "Shaping the Future" described that in 2004 Scotland, along with the rest of the UK, faced overall shortages of clinical staff and serious shortages in some areas including radiology and pathology. It highlighted how unfilled posts disrupt services and increase waiting times. Changes in medical training and practice can lead to difficulties in attracting and keeping staff to provide certain services.
- The impact of employment legislation
 - the European Working Times Directive places an obligation on employers to reduce the number of hours staff are allowed to work. Historically, the NHS has relied on doctors working very long hours - sometimes as much as 100 hour per week. This is no longer allowed and therefore services need to be redesigned.

We recognise that in the last ten years these issues have led to a series of service changes at the Vale of Leven. However we believe that the innovative ways of working and networking services and our proposals to retain the vast majority of services find the balance between local access and safe and sustainable acute services.

4.3 Shifting the Balance of Care

We are shifting the balance of the way care is provided to expand community services to better meet need.

4.4 Modern Facilities

We want to provide services in improved accommodation which is of a modern standard.

4.5 Financial Issues

We need to make changes to services in the West Dunbartonshire and Lochside area to ensure that across Clyde services are provided in an economic way which properly utilised public money and enables the inherited deficit to be reduced.

5. WEST DUNBARTONSHIRE AND THE LOCHSIDE HEALTH NEEDS ASSESSMENT

[Lochside material awaited for NHS Highland]

5.1 Summary of Key Findings

This assessment of the health needs of West Dunbartonshire residents emphasises the importance of poverty and disadvantage in the creation of poor health. The key findings of high levels of health damaging behaviour and chronic diseases emphasise the need for effective community and primary care health improvement services. They emphasise the priorities of addressing poverty, behaviour change, chronic disease management in primary care and effective clinical networks.

This section summarises the key findings of the needs assessment, conclusions and recommendations. The detailed information and data can be found in the full report.

5.2 Demography

Like many areas of the West of Scotland, West Dunbartonshire has a falling population, particularly in the younger age groups. At the same time, it is predicted that there will be more individual households, and therefore greater demand for housing, as more people will be living alone or in single parent families. Single parent households in West Dunbartonshire (14.3%) are significantly more common in West Dunbartonshire than in Scotland as a whole (10.5%). Single lone mother households, a vulnerable group at risk of poverty and domestic abuse and therefore posing greater demands on social services, are rising most rapidly as a subgroup of single parent families. Pensioner households now make up 23% of households in West Dunbartonshire (similar to the Scottish average); many of these elderly people will have multiple chronic diseases and some will be living in isolation and deprived conditions. All these demographic changes have implications for healthcare and social services, particularly community care and services for older people.

5.3 Socioeconomic Determinants of Health

West Dunbartonshire CHP is a socio-economically mixed area that has considerable pockets of severe under-privilege. According to SIMD, West Dunbartonshire has far less of its population living in the most deprived 1% of data zones than either Greater Glasgow and Glasgow City. Nevertheless, West Dunbartonshire has experienced an economic downturn over the past 10 years whereas Glasgow City is experiencing an economic boom. In 2004, 37% of the West Dunbartonshire population lived in the 20% most deprived datazones compared to 20% for the Scottish population. As a result, unemployment is high in these areas (second only to Glasgow in a national league table of 'employment deprived') and there is a heavy reliance on low wage, part-time jobs and state benefits. Almost one quarter of the West Dunbartonshire population have all their income from state benefits, a similar percentage for Glasgow City. Significantly, the average wage in West Dunbartonshire is 10% lower than that in Glasgow City, perhaps explaining why self-reported difficulty making ends meet was much higher in West Dunbartonshire than in Greater Glasgow in the 2005 Health and Wellbeing Survey. Quality of housing and educational achievement are similar for Glasgow City and West Dunbartonshire.

These issues will require considerable and concerted multi-agency efforts, involving both the public and private sector. Unless these socio-economic determinants are successfully addressed, the current difficulties faced by roughly 25% of the West Dunbartonshire population can be expected to continue. This will have important knock-on effects in terms of unhealthy lifestyle, increasing prevalence of risk factors and disease.

5.4 Unhealthy Lifestyles

The effects of unemployment and poverty have been exacerbated by the adoption of unhealthy lifestyles. A significant published literature links poverty with unhealthy lifestyle and premature death, complicated by a sense of loss of control and disempowerment. Unhealthy lifestyles are self-reported in the NHSGGC Health and Wellbeing Survey of 2005 and can be compared a wide range of statistics in Greater Glasgow. This demonstrated considerably higher prevalence of smoking, excessive alcohol intake, binge drinking, higher consumption of junk food and lower uptake of physical exercise amongst WDCHP residents compared to their Greater Glasgow equivalents.

Drug misuse is a problem in West Dunbartonshire although less common than in Glasgow City. These problems will need to be tackled with more assertive and more imaginative health improvement initiatives aimed at making it easier and more enjoyable to adopt healthier lifestyle habits.

5.5 High Prevalence of Risk Factors

It is also clear that unhealthy lifestyles have translated into higher prevalence rates of the risk factors for serious disease and premature death. These include high blood pressure, obesity/overweight, poor oral health and diabetes as reported by various sources including the primary care reporting systems and Health and Wellbeing Lifestyle survey. All these risk factors will need to be proactively identified in the community and treated using pharmacological and behavioural approaches before

they progress to frank disease. Primary and secondary coronary heart disease prevention schemes currently being considered for West Dunbartonshire by NHS GGC should help to bring these risk factors under control.

5.6 High Prevalence of Chronic Disease

Not surprisingly, the high prevalence of risk factors has translated into high rates of common chronic diseases that are also the main causes of death in Scotland and significant causes of hospitalisation, namely coronary heart disease, smoking-related cancer, stroke, chronic obstructive pulmonary disease, and diabetes. Alcoholic cirrhosis in West Dunbartonshire has been climbing since 1985 and more steeply than anywhere else in Scotland, which itself overtakes European rates.

5.7 High Incidence of Chronic Disease and High Death Rates

The overall outcome of this combination of socioeconomic deprivation and unhealthy lifestyles is a position at the top, or near the top, of the Scottish council league tables for all-cause mortality, coronary heart disease incidence, acute myocardial infarction incidence, lung cancer (assumed to be smoking-related), domestic violence, and alcoholic cirrhosis mortality.

Some evidence of under-utilisation of health services for some groups

There is limited evidence available that suggests that, despite concerted efforts in recent years to make health services more accessible to users, some West Dunbartonshire residents from socio-economically underprivileged areas in need do not access health services for coronary heart disease as quickly or effectively as they should. This Scottish-wide phenomenon is attributed to a tendency in males to deny symptoms of serious illness and/or the perception that there is nothing that can be done for them. Given that this apparent under-utilisation in West Dunbartonshire applies far more to males than females, it is believed that a behavioural component exists that needs to be addressed by improving mechanisms that permit diagnosis of risk factors and disease and bring patients in contact with the specialist services when they need it. A wide range of services provided by Managed Clinical Networks for chronic diseases in the Greater Glasgow area are being extended into the remainder of the Greater Glasgow and Clyde area. These include Local Enhanced Service contracts and related on-line tools, patient referral pathways and integration and improvement of the wide range of community services that exist to tackle unhealthy lifestyles and clinical risk factors.

5.8 Mental Health

Primary care data on mental health suggests that the prevalence of severe mental illness in West Dunbartonshire is near the Scottish average and that some Glasgow CHPs have a higher prevalence than does West Dunbartonshire.

However, other data suggests that milder forms of mental ill health may be more common in West Dunbartonshire on the basis of lower prevalence of self-reported perception of general mental or emotional wellbeing, prescription rates for psychoactive drugs and more objective quantification of mental health (including scores on the GHQ12).

Suicide rates in West Dunbartonshire males have climbed steeply since the early 1980s and now occupy a position near the top of the Scottish league table, exceeding rates for Glasgow City and only topped by the Highland and Island councils, which have historically had the highest rates in Scotland. There is no evidence to suggest that these high rates are due to the proximity of West Dunbartonshire populations to the Erskine bridge.

5.9 Child Health

High rates of smoking in pregnancy and low breastfeeding rates in West Dunbartonshire will have important implications for child health and future adult health. It is encouraging to note the high immunisation rates in West Dunbartonshire, which are high compared to Scotland and some other areas of NHS Greater Glasgow and Clyde.

5.10 Conclusions and Recommendations

Socioeconomic determinants of health play a major role in the quality of life, the quantity and spectrum of disease experienced and the life expectancy of the local population in West Dunbartonshire and therefore need to be addressed in West Dunbartonshire before any lasting change to health outcome can be expected.

Socio-economic disadvantage is strongly linked to unhealthy lifestyle, whether by association or causal linkage, and mediated by a sense of lack of control and disempowerment. This association is clearly visible in West Dunbartonshire. In addition, unhealthy lifestyle, independent of socioeconomic level, is a risk factor for future disease and premature death. Therefore, unhealthy behaviour, regardless of socioeconomic status of the individual, must be robustly and firmly targeted by tried and tested health improvement efforts, as well as novel or experimental approaches. These findings support the need for improved prevention and chronic disease management. These services are delivered in primary care and the community and promote the need for a shift in balance of care from hospitals to the community.

There is a tendency for the most socio-economically deprived residents throughout Scotland to undergo sophisticated investigation and treatment for coronary heart disease less often than expected given their incidence and mortality rates for CHD. This phenomenon is also seen in West Dunbartonshire males, and until recently West Dunbartonshire females, although this underutilisation is less than observed 10 years ago. Evidence suggests that this relates to differences in sickness response behaviour by gender and a historical tendency for women to be deemed poorer candidates to cardiac surgery. Efforts need to be made to ensure that both men and women with genuine disease are identified and referred to the appropriate specialist services in order to maximise their clinical outcome, regardless of socioeconomic status. There is, therefore, a pressing need to extend the various mechanisms of the Managed Care Networks for chronic disease, including CHD, already implemented in the Greater Glasgow area to the remaining Clyde areas, including West Dunbartonshire.

Chronic diseases are better managed in the community than in acute hospitals. For all disease conditions combined, use of health care by socioeconomically deprived

residents of West Dunbartonshire will tend to be reactive and reliant on more advanced forms of treatment whereas use of healthcare by more privileged residents will tend to be more proactive and reliant on preventative services. Therefore, important ways to reduce the need for more interventionist treatment in West Dunbartonshire is to monitor socioeconomic conditions, prevalence of lifestyle and clinical risk factors, disease incidence and death rates in response to:

- economic regeneration;
- targeted and global health improvement initiatives;
- primary and secondary prevention of common chronic diseases including CHD, stroke and diabetes;
- extension of fully functioning Managed Care Networks for common chronic diseases across NHSGGC to ensure that, once diagnosed with confirmed disease, residents of West Dunbartonshire have equal access to modern specialist services.

The recommendations we propose for discussion and debate based on this needs assessment are:

- substantial and sustainable regeneration (especially in relation to the local economy, the quality of local housing stock and transport infrastructure) that can be shown to have demonstrably positive impacts on the health status of local communities is essential. This would be helped by more consistent use of integrated impact assessment approaches (within which “health” is a strong element). There is also a need to reinforce current, and explore potential for further economic regeneration in West Dunbartonshire;
- there is a need to improve educational attainment, especially those in most disadvantaged communities and amongst looked after and accommodated children. The CHP and the Council should continue to develop the Health Promoting Schools programme locally. All stakeholders (especially local voluntary and community groups) have an important role to play in developing aspirations and resilience amongst children and young people;
- there is a need to tackle employability locally in a coherent manner through emerging Community Planning structures. In addition, local employers should seek opportunities to develop themselves as healthy workplaces; and welfare right programmes need to be developed further;
- all stakeholders should identify the contributions that they can make to reversing the “obesogenic” environment to improve diet and increase physical activity. The NHS should further develop exercise referral and weight management schemes. The Council should ensure that promoting walking and cycling feature strongly in local transport schemes; and increase the range and accessibility of opportunities for physical activity for children, young people and older people in particular. The Council and schools should take a lead in providing free, nutritionally balanced school meals, with free fruit schemes resourced in across all schools as a minimum (potentially in partnership with local voluntary organisations);
- local initiatives aimed at increasing uptake of physical exercise for the general population, including by promoting walking or cycling to school or work should be explored. This should be in conjunction with West Dunbartonshire council, local voluntary sector groups, Sustrans and the private sector;

- all stakeholders should identify the contributions that they can make to reducing incidence and prevalence of smoking locally, especially amongst pregnant women. The CHP should lead on the development of a comprehensive local tobacco control plan that emphasizes “de-normalising” smoking. The NHS (especially general practice) should increase provision of and access to different levels of effective smoking cessation support. The Council should strengthen its role in reducing the visibility of cigarette promotions and illicit sales;
- efforts aimed at curbing alcohol abuse are particularly critical in West Dunbartonshire given the many locally observed effects of high alcohol consumption and binge-drinking, including high blood pressure and stroke; domestic abuse; drunk driving and alcoholic cirrhosis. All stakeholders should identify the contributions that they can make to reducing incidence and prevalence of alcohol misuse, both in terms of binge-drinking amongst young people and chronic drinking amongst adults/older people. The NHS and Council should further develop addictions services locally, ensuring that mainstream services meet the needs of different groups. The Council should use existing licensing legislation to curb availability (eg, limiting sales at outdoor events) and cheap sales (eg, drinks promotions in pubs and shops). Local multi-agency forums should ensure that there is a strong emphasis on “denormalisation” and incidence reduction in their activities. Education programmes to increase awareness and knowledge should be clearly outcome-focused and evidence-based (eg, ensuring local campaigns underpinned by social marketing principles). Initiatives involving GPs querying their patient’s intake and encouraging and supporting efforts to reduce intake are required that are similar to existing efforts aimed at encouraging smoking cessation in primary care. There should be a review of the aims and objectives and the action plans of the existing Alcohol and Addictions Action Team, and strengthen its efforts in tackling alcohol misuse, with a view to enabling it to refocus more strongly on alcohol in addition to drugs in conjunction with the NHSGGC, West Dunbartonshire Council Licensing Authority, the WDCHP and relevant NGOs (Alcohol Concern and Alcohol Focus Scotland);
- all stakeholders should identify the contributions that they can make to increase the levels of breastfeeding amongst new mothers. This should include encouraging a positive breastfeeding culture (eg, the Breastfeeding Nursery Initiative) along with further investigation of local barriers to breastfeeding (particularly within most deprived communities);
- develop further screening for unhealthy lifestyles and clinical risk factors in high risk populations to underpin both primary prevention (ie, well people) and secondary prevention (ie, people with confirmed chronic diseases) interventions. This should be in line with relevant clinical guidelines, with a focus on coronary heart disease, stroke and diabetes;
- develop further, and extend into West Dunbartonshire (and the remainder of the Clyde area), existing Greater Glasgow Managed Care Networks, and their various component services (such as LES contracts and referral pathways) for common chronic diseases such as coronary heart disease, lower respiratory disease, stroke and diabetes. Monitor the uptake of services to ensure those in need access them appropriately;

- national funding for “Keep Well” should be utilised to implement a Locally Enhanced Service for CHD and increase capacity of Health Improvement Services in the community required to underpin the scheme;
- further work is required on palliative care to ensure equity of access and quality of care;
- Bear local statistics in mind when planning new services. Ensure that the demographic and epidemiological disease profile of West Dunbartonshire residents, and the nature of their existing unmet need, is fully understood and considered, when planning new health services in the Greater Glasgow and Clyde area;
- the Community Planning Partnership should be strengthened as a mechanism for setting strategic direction for and coordinating health improvement across local stakeholders. The Joint Health Improvement Plan should be outcome-focused, with priorities that reflect the key findings of this assessment.

6. CONSULTATION PROCESS

6.1 This section describes our proposed approach to formal consultation - building on the extensive programmes of public and community engagement which have already been at the heart of our review and planning processes.

6.2 Consultation Documents

Full consultation documents are attached to this overview covering the following services at the Vale of Leven **[These will be extracted from the Clyde-wide papers for the final version of this paper]:**

- Integrated care at the
- maternity services;
- mental health;

6.3 Consultation Summary

A community newsletter-style document will be produced which will take full advantage of design format and language to ensure it is accessible and as clear as possible. This will cover all service proposals (but ensuring each is treated in its own right) and will be widely distributed via the Involving People and CH(C)P databases, GP surgeries, waiting areas, primary care providers and Local Authority facilities.

6.4 Alternative Languages and Formats

The above documents will carry references in other languages and in large print to the availability of translated, Braille and audio disc format materials.

6.5 Events

Events will be structured around presentations and workshops. Additional meetings can be organised on request. Three public events will be staged specific to proposals affecting West Dunbartonshire and the Lochside;

6.6 Advertising

Adverts providing summarised headline proposals and contact points for additional information will be used to launch the consultation period and draw attention to public meeting dates. These will appear in the local newspapers - Dumbarton and Vale of Leven Reporter Helensburgh Advertiser and Lennox Herald.

6.7 Website

All material will be made available on the NHSGGC website and specific consultation response pages will be created.

6.8 Media Releases

Tailored to suit local media requirements and interests.

6.9 One-to-one Meetings and Briefings for Individual Stakeholders

As required and will include key groups and elected representatives.