

Greater Glasgow and Clyde NHS Board

Board Meeting

Tuesday 18th December 2007

Board Paper No. 2007/56

Director of Corporate Planning and Policy

CLYDE SERVICE CHANGES: REPORT OF THE INDEPENDENT SCRUTINY PANEL

Recommendation:

The Board:

- welcomes the Panel's report and advice;
- notes the detailed responses to points raised by the Panel with regard to:
 - mental health;
 - maternity services;
 - unscheduled medical admissions;
 - older people's continuing care;
 - value for money and best value and option appraisal;
 - consultation and public engagement.

1. BACKGROUND AND PURPOSE

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 which had a number of aims and drivers which apply to all of the reviews. At headline level these were:

- the need to modernise services in Clyde and ensure the right balance of local community and inpatient care and social and health care;
- the requirement to ensure safe and sustainable services;
- 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.

Our service and strategy reviews were conducted on the basis of the extant planning and public engagement guidance of the Scottish Executive. Following the May election, and the establishment of the Scottish Government, the new Cabinet Secretary for Health and Wellbeing announced a new process of external scrutiny for proposals for service change. It is important to note that the final process for external

scrutiny is presently subject to wide consultation but the principles articulated has been applied to our situation.

The outcomes of our Clyde reviews were submitted to the Board meeting in June 2007 which approved them as the basis for formal public consultation and for the external review process. The purpose of this report is to bring the report of the Independent Scrutiny Panel (Attachment 1) to the Board and to offer our observations on the Panel's conclusions. Later papers on each service area set out how we propose to respond to those conclusions in taking forward each of our reviews and proposals for change. In considering the Panel's report, it is important to restate the context, principles, national policy and change drivers which informed our reviews.

2. CONTEXT

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. The rest of this section sets the service and financial context.

Integrated Care at the Vale of Leven

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. The pilot of the Integrated Care model was one element of those services. 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

We inherited incomplete strategies for 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. A substantial review and planning process developed our 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

As with mental health, we inherited a partial strategy for older people's services from Argyll and Clyde which did not have Local Authority support. The requirement for this review came from the extensive joint work between the new Renfrewshire CHP and

EMBARGOED UNTIL DATE OF MEETING

Renfrewshire Council, building on the previous Argyll and Clyde older people's strategy work.

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

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

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

This section describes the principles which were consistently applied in developing our proposals.

Safe and Sustainable

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

Shifting the Balance of Care

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

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.

Economic

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

Engagement

The process of developing all of our proposals 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.

National Policy

Our proposals were also 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

There have been a range of drivers for the different programmes of review and planning.

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.

EMBARGOED UNTIL DATE OF MEETING

- 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.

Shifting the Balance of Care

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

Modern Facilities

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

Financial Issues

We need to make changes to services 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

The proposals for change which we concluded in June 2007 and have been subject to the scrutiny process are:

- **Mental Health:**
 - 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 reprovion of continuing care beds for older people's mental health from Dykebar Hospital to partnership facilities.
- **Integrated Care at the Vale of Leven:**
 - the conclusion of the Integrated Care Pilot at the Vale of Leven Hospital and the reprovion of unscheduled care at the RAH.
- **Older People's Services:**
 - the transfer of the continuing care service for older people at Johnstone Hospital to partnership facilities.

- **Maternity Services:**
 - **the closure of the delivery service provided in the Community Maternity Units at Inverclyde Royal Hospital and the Vale of Leven Hospital.**

6. OUTCOME OF INDEPENDENT SCRUTINY

The report of the Independent Scrutiny Panel provides us with a wealth of useful material and advice to consider in moving forward our service strategies and reviews to conclusion.

We also welcome the fact that the process of independent scrutiny was intended to improve public confidence in the decision-making by NHS Boards. The Panel's endorsement of the principles of all but one of our main proposals, its conclusions about the quality of a number of the elements of our work and detailed advice on the further work and material which should be available for formal consultation, should create greater public confidence in the process of making decisions. This is particularly the case in relation to our proposals on the future of integrated care at the Vale of Leven, which have generated a high level of local community concern.

It is important to state we accept many of the Panel's conclusions and guidance, however, it is also important to highlight areas which require clarification, debate or represent points of some divergence.

The further sections of this report provide commentaries on the key elements of the report covering:

- **mental health;**
- **maternity services;**
- **unscheduled medical admissions;**
- **older people's continuing care;**
- **value for money and best value and option appraisal;**
- **consultation and public engagement.**

In our overall consideration of the Panel's report we have particular concerns about the proposed approach to consultation and about the very detailed critique of our technical approach to service and financial planning, which we have found difficult to relate back to the Panel's more positive conclusions about our actual service change proposals.

We have sought in this paper, and those which follow it, to respond rapidly but comprehensively to the Independent Scrutiny Panel report. This reflects our position in our June consideration that:

"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."

Finally, it is important to be clear on the next steps across our proposals. In essence, where we propose formal public consultation we will submit the outcome of that consultation to the Cabinet Secretary for approval. Part of her consideration of our recommendations will be their review against both the Independent Scrutiny Panel report and the final report of the Scottish Health Council on the public engagement and consultation process.

7. MENTAL HEALTH

The Panel report endorses a number of our proposals and raises issues of concern. The areas of support are:

- The proposals for relocation of beds in South Clyde were seen as reasonable and not viewed as constituting centralisation:
 - consolidation of adult admission beds at Dykebar seen as clear advantage compared to RAH;
 - Gryffe relocation to SGH no more centralised than currently, albeit would raise accessibility issues for some;
 - proposals relating to the provision of continuing care within unidentified Partnership beds were not challenged in principle but were seen as requiring more provision and substantial clarification at the point of consultation;
 - proposals relating to the location of Intensive rehabilitation and IPCU were noted with no particular concerns raised;
 - proposals relating to forensic and low secure beds were deemed reasonable.
- The financial robustness of the proposals was seen as being relatively solid, whilst noting further detail to be required around risk relating to the assumptions of movement in unit costs of Partnership beds and unforeseen changes in demand

The Panel's areas of concern are set out below with our response and an indication of the further work we will now undertake.

Robustness and applicability of the bed modelling to determine Clyde bed levels.

Issue:

- The Panel raised the following concerns about the modelling of the bed requirements for the Clyde area:
 - based mainly on Glasgow rather than any robust support from published literature;

EMBARGOED UNTIL DATE OF MEETING

- should be made more reliable by calibration to local conditions and informed by local needs assessment;
- the security of the assumptions based on the published literature provided to the Panel is not high;
- capacity to meet future demands;
- the report is inconsistent on these issues in that the Appendix has commented on the reasonableness of the Greater Glasgow approach whilst the main report has reflected the issues summarised above.

Response:

We would comment on these concerns as follows:

- The current level of beds per 1000 for Greater Glasgow and Clyde is at the highest level in Scotland, at 1.44 times per 1000 population compared to a Scottish average of 1.19 beds per 1000. The Clyde levels of bed provision are 40% higher than Greater Glasgow levels and therefore account for levels of provision far higher than any other area within Scotland.
- 60% of inpatient beds in Clyde are continuing care beds and for this category of beds Clyde provision is more than double the level of provision provided within Glasgow.
- The Clyde levels of bed provision are the highest in Scotland and provided at more than double the level of Greater Glasgow for continuing care beds.
- There is no definitive evidence base against which to establish bed levels for a given population or indeed the health outcomes of any given balance of care between inpatient and community care.
- In such circumstances best practice would involve an approach which:
 - established the range of bed levels for the population by reference to published epidemiological norms;
 - benchmarked the ranges of actual service provision in a range of UK settings;
 - undertakes local needs assessment;
 - undertakes a process of local debate and judgement of where to position local service requirements within the ranges of service provision indicated by the outcomes of epidemiology, service benchmarking and local needs assessment;
 - ensures such local debate around the balance of care is informed and consistent with the evidence base albeit the evidence base is frequently “suggestive” rather than “definitive”.
- Such a process is necessary to ensure an appropriate balance between local judgement, the broader evidence base, contemporary practice in modern mental health and the views of professional bodies - such that the resultant proposals can be independently substantiated.

EMBARGOED UNTIL DATE OF MEETING

- This is exactly the process summarised and evidenced in the Greater Glasgow Modernising Mental Health Strategy (1999) and subsequently further refined on the basis of local experience, and subsequent needs assessment and local judgement. Having operated such a service the broad body of clinical opinion has supported this balance of care with no significant adverse concerns relating to safety or health outcomes. The balance of care operated within Greater Glasgow is consistent with contemporary practice in terms of location within the ranges of epidemiological norms, comparative benchmarking with other UK mental health services for inpatient beds, consistency with best practice guidance on levels of provision of community services. It should also be noted that in a Scottish context the Greater Glasgow levels of provision are above average levels of provision.
- The partner social services departments of East Renfrewshire and West Dunbartonshire Councils currently work with services from both the Clyde service model and the Greater Glasgow service model. Both Local Authorities have in-depth daily operational experience of the Greater Glasgow services, and both have embraced the move to a balance of care closer to that operated within Greater Glasgow.
- The Greater Glasgow bed levels were therefore themselves the product of a best practice process open to independent substantiation of its rationale and consistency and were then used as the starting point for extrapolation to proposed bed levels for the Clyde area. Subsequently these proposals were further considered and discussed in a range of local fora and supplemented by needs assessment of the current patient cohorts.
- Some 75% of the proposed bed reductions relate to patients currently cared for in long stay NHS continuing care beds. Local individual needs assessments of these patients are being undertaken to clarify and confirm the appropriate care and placement requirements of this patient cohort and to further refine and fine-tune the proposed bed numbers/type of placement as necessary. These local needs assessments are broadly confirming that the majority of these patients do not require care in an inpatient continuing care setting and placement in a range of community placements would provide a more appropriate and higher quality of care matched to their needs.
- In terms of acute admission bed numbers the proposals have provoked a range of views. However none of these views has provided specific evidence of characteristics of the Clyde population and context which provides and evidences a compelling case for departure from the benchmarking norms, subject to comprehensive levels of community services being in place as is planned for Clyde.

Further work:

- The Panel have advised:
 - that further detail of the basis for the application of the benchmarking process and determination of bed numbers should be provided within

EMBARGOED UNTIL DATE OF MEETING

- the public consultation papers to add clarity as to the basis for determination of local bed levels - agreed;
- that the benchmarking proposals should be further refined in the context of local needs assessment;
- This further clarification is agreed and we will continue to refine the proposed mix of inpatient continuing care Partnership beds and the range of community placements based on the outcome of individual needs assessments.

Demonstration of the safety and health outcomes of the proposed balance of care inpatient and community care provision.

Issues:

- The Panel sought robust peer reviewed evidence for the safety and health outcomes of the proposed balance of care.
- The Panel critiqued the evidence provided to them by Glasgow as not providing definitive evidence on these issues.

Response:

We would comment on these concerns as follows:

- The evidence base provides no definitive basis for establishing the health outcomes of any given balance of care between inpatient or community services. In this respect no mental health service in Scotland could cite a definitive evidence base for the safety associated with the local balance of care, or the effectiveness or health outcomes of a given balance of care. The evidence base does however provide important pointers in relation to patients who receive long terms care in hospital settings and finds that:
 - over-reliance on the provision of long stay continuing care in NHS hospital sites is associated with the negative and detrimental effects of institutionalisation;
 - transfer to long term community based care shows better outcomes for most patients who had previously received long term inpatient care, when deinstitutionalisation is done carefully.
- In the context of Clyde this patient group use 60% of all beds and the evidence base clearly demonstrates that deinstitutionalisation and transfer to long-term community based care has better outcomes for patients than care in inpatient settings.
- 75% of the bed reductions in the Clyde Strategy relate to provision of more appropriate and higher quality care in long term community settings and for this patient group the evidence clearly demonstrates better outcomes for patients.
- The evidence base for the balance between acute care managed in acute hospital or community settings is less clear cut and no randomised evaluation

EMBARGOED UNTIL DATE OF MEETING

of this service model has been carried out in a modern community health setting. The evidence shows that where services have comprehensive community services in place, including crisis services this is associated with reductions of acute admissions by 20% and reductions in use of acute beds by 10%. However this evidence does not demonstrate improved health outcomes per se.

- Research on the functioning of crisis resolution services compared to standard treatment in inpatient settings has demonstrated:
 - patients receiving care from crisis resolution teams are less likely to be readmitted to hospital in the eight weeks following a crisis than is the case for inpatient care, albeit more so for voluntary than compulsory patients;
 - there were no significant differences over a six-month period in rates of attempted suicide and violence or of participants losing their jobs or becoming homeless;
 - high levels of user acceptability and preference compared to inpatient services, albeit the research findings are variable on this issue.
- In the absence of a definitive evidence base it is then necessary to look for consistency between the Clyde proposals and prevailing views about best practice both nationally, internationally and locally. The development of crisis services is widespread contemporary practice (an explicit policy priority in the Scottish Mental Health Delivery Plan, widespread internationally and standard in every English mental health service).
- Our local experience is that these services are highly valued by users and carers and often viewed as significantly more acceptable than inpatient admission. Following the introduction of crisis services our ward staff have commented on their impact on reducing the number of admissions to wards and in reducing occupancy levels
- National and international practice is consistent with a trend to reduce the scale of reliance on asylum based inpatient provision and increase the development of comprehensive community services including a range of alternatives to acute inpatient care.
- It should additionally be noted that whilst the evidence base for crisis services is suggestive rather than definitive this element of service provision relates to a maximum of 20% of the bed levels in the bed model, whilst the more robustly evidenced deinstitutionalisation proposal to reprovide continuing care beds in a range of community based in patient and placement settings relate to the major bed reduction proposals which constitute 75% of the proposed bed reductions.
- As noted by the external scrutiny report the evidence base cannot be taken to evidence a particular balance of care. However when combined with local needs assessment such as that described above for the current long stay inpatient continuing care cohort, it does provide compelling evidence to support the planned deinstitutionalisation process and reprovider of long term

EMBARGOED UNTIL DATE OF MEETING

continuing care in a range of community settings - and additionally demonstrates this has improved outcomes for patients.

Further work:

- We will provide a working paper as a supplement to the public consultation paper which summarises and sets out the referenced evidence base, and professional and policy best practice views relating to modern mental health services

Full and quantified process of option appraisal.

Issue:

- The Panel's report has advised the need for the options appraisal process to reflect the full disciplines of quantified options appraisal processes including risk and sensitivity analyses and for the option appraisal process for WDC to include the options proposed above.

Response:

The Panel's recommendations are accepted.

- The original options appraisal processes involved a qualitative evaluation of a range of options against an agreed set of evaluation criteria. Contrary to the reports assertion, this process was undertaken for the WDC Vale/Gartnavel option appraisal.
- In line with the advice of the scrutiny report we have appointed an Independent Facilitator to manage a process of options appraisal consistent with the requirements set out in 3.5 and 3.6 above.

Further work:

- The outcome of this further option appraisal process will be reported in due course and used to inform the final content of the public consultation documentation

Partnership proposals for provision of continuing care require more precision and explanation at the point of public consultation.

Issue:

- The scrutiny report noted public concern about a "journey into the unknown" and advised that the proposals for Partnership provision of continuing care beds should be more clearly set out in the public consultation document to enable the public to have a clearer understanding of such arrangements

EMBARGOED UNTIL DATE OF MEETING

Further work:

- Further refinement of the detail of Partnership provision will be undertaken and set out as part of the papers available for public consultation

Financial robustness

Issue:

- The Panel were unclear of the value for money and best value implications of the proposals and in particular:
 - concern that the higher unit costs of continuing care beds via the Partnership arrangements may not constitute best value and be at the cost of other service developments;
 - that more detail was required to enable an understanding of the financial robustness and unit costs of the proposals relating to the range of community placement provided for those discharged from continuing care beds.
- Risk relating to:
 - movement in unit costs of Partnership beds;
 - continued partnership with Local Authorities;
 - unpredicted demand changes.

Response:

We would respond to the Panel's concerns as follows.

- There are currently 311 NHS provided continuing care beds located on NHS hospital sites in poor quality accommodation. As noted earlier this is at a substantially higher level of provision than anywhere else in Scotland and more than twice that provided per head in Greater Glasgow
- A significant proportion of these individuals are currently cared for in poor quality NHS inpatient continuing care wards, and would benefit from a range of community placements which would offer improved quality of life in higher quality environments.
- Additionally the benchmarking process identified the need for retaining a lower level of 126 inpatient continuing care beds - of which 26 adult beds were to be located on NHS hospital sites, and 100 older peoples inpatient continuing care beds to be reprovided in a Partnership model of care located in community settings - such settings would be similar to high quality nursing home provision provided in community settings.
- In essence the 311 beds currently provided as NHS inpatient care beds would be reprovided as set out in the table below. Initially the placement profile will be determined and refined by the outcome of the individual needs assessments of the patient population currently care for in NHS continuing

EMBARGOED UNTIL DATE OF MEETING

care beds. In the longer term the benchmark bed modelling has set out our expectation of the long term requirement for continuing care beds. The nature of the proposed arrangements sees a better matching of patient needs to service responses in higher quality environments of care. The financial consequences of this pattern of provision see:

- an increased unit cost of provision for those cared for in NHS adult continuing care beds - consistent with both an improved quality of care and the higher needs more complex casemix of this smaller cohort of patients remaining in adult continuing care beds;
 - similar unit costs between NHS provided older peoples continuing care beds and Partnership beds but substantial quality gains from provision through the Partnership model;
 - reduced unit costs for those cared for in the range of community placements;
 - a net saving of £2m in the proposed model of care compared to the current model of care.
- Current arrangements

Form of Care	Number of Beds	Average Unit Cost £'000s	Total Cost £'000s
NHS inpatient continuing care on hospital sites - adults	157	33	5266
NHS inpatient continuing care on hospital sites - elderly	154	36	5573
Total	311	£35,000	10840

- Proposed arrangements

Form of Care	Number of Beds/ Placements	Unit Cost £'000s	Total Cost £'000s
NHS inpatient continuing care for adults on hospital sites	26	53	1379
Inpatient continuing care for older people located on community sites	100	33	3255
Care home placements	59	?	?
Supported accommodation placements	51	?£31	?
Intensive community supports	7	?	?
Total	243		

- Contrary to the Panels concerns - the above table shows the provision of higher quality care in higher quality environments at reduced costs of circa £2million.
- The reduction in placement volume from 311 to 243 reflects the fact that not all of the 311 continuing care beds are occupied and therefore do not need to be reprovided on a one for one basis.

EMBARGOED UNTIL DATE OF MEETING

- It is accepted that there is a risk of exposure from movement in unit cost of Partnership beds managed and provided in partnership between the NHS and private providers. However unit costs would need to increase by some 60% before the cost of the proposed higher quality arrangements exceed the costs of the current lower quality arrangements. It is also accepted that movement in unit costs will require rigorous risk management of the overall implementation process to ensure the ongoing viability of the total package. However there are a range of options within the overall implementation arrangements for managing such risks (eg, funds released from community placements as these are vacated can be used as a contingency to manage unit price movements or demand shifts) and such risks are endemic in all retraction and reprovision processes where the detail of placement mix is progressively refined as implementation proceeds.
- Finally the Panel notes that the implementation proposals are reliant on continuing support from independent sector providers and from local authorities. Again such issues are endemic to the nature of retraction and reprovision arrangements and are implementation issues best supported by robust risk assessment and risk management processes.
- In relation to the Local Authority commitments it is clear from the local discussions and the correspondence between the local authorities and the Panel that there are high levels of commitment to the substance of the proposals which are seen by the local authorities as being fair and transparent and providing a better overall service for their residents.

Further work:

- We will refine our intelligence of the market rates for Partnership beds to enhance our risk management arrangements albeit there are limits to this in that contracts cannot be agreed in advance of the outcome of the consultation arrangements.
- We will provide further information in working papers as supplemental papers to the public consultation document, to further detail the assumptions and most up to date assessment of unit costs.

Fuller detail required in the public consultation document on:

- the engagement, concerns and influence of users, carers, the public and practitioners in the development of the options;
- model of care for Partnership beds;
- measures of capacity of inpatient sites to respond to peak demand and boarding out levels.

Further work:

- The issues above will be set out in either the public consultation document itself or in supplemental working papers referenced in the public consultation paper.

EMBARGOED UNTIL DATE OF MEETING

- Given the substantial volume of information the Panel have advised should be made available as part of the public consultation process it is likely this will require to be done by a combination of briefer comments in the public consultation paper with references to a range of supplementary papers available on request.
- The need to provide users, carers and the wider public with a good understanding of the shape and content of the Partnership models of care and a basis for confidence in the model is accepted and it is likely we would provide a range of inputs to facilitate this possibly including:
 - handouts with photographs and description of existing Partnership services for the general public;
 - presentations from carers and practitioners on their experience of these services;
 - a range of one-to-one and groupwork with patients and their carers directly affected by the closure and reprovision of continuing care beds in a range of inpatient and community settings

8. MATERNITY SERVICES

For maternity services the Panel report has a number of endorsements of our approach and useful advice on further process which we welcome. The report notes the quality of the option appraisal, the financial case and the underutilisation of staff and facilities. However, we do not accept its proposals to consult on options which retain the CMUs delivery services with a positive education programme or postnatal care.

The later paper on maternity services sets out the reasons for our position in greater detail. However, in essence we do not accept that:

- our public engagement was inadequate;
- risk criteria should be relaxed at the Units with the highest transfer rates in Scotland;
- there is a fundamental lack of information on why women are not delivering in the CMUs;
- positive promotion would have a significant impact on usage of the Units.

The Panel additionally raises issues about the completeness of the financial information in the option appraisal - all recurring costs were reflected including reprovision of services at the RAH. Short-term, marginal costs were not included.

The value for money commentary by the Panel on our maternity proposals does not properly reflect the issues about resource utilisation and the cost of extending the life of the current arrangements.

The Panel comments on the difference in risk criteria between the RAH and the CMU midwifery led services - the simple rationale for these differences is that the RAH has immediately on-site emergency medical cover and the ability to transfer patients

without an ambulance journey - it is simply not a stand alone unit and cannot be directly compared to the Vale and IRH CMUs.

9. UNSCHEDULED MEDICAL ADMISSIONS

The Panel report has clear and helpful conclusions with regard to unscheduled medical admissions at the Vale of Leven, not least in clearly setting out the weight of evidence and opinion, UK wide, on the appropriate models for dealing with unscheduled admissions. We would reflect on a number of points:

- The Panel notes we have failed to convince communities of the merits of our conclusions - we accept that conclusion. However, the Panel offers no advice or input into how we can turn around the situation they describe, as having developed over many years, of mistrust of Argyll and Clyde and its successor NHS Board
- There is a clear review of the options to relocate the unscheduled medical service developed as an integral part of the planning process and a detailed capacity, staffing and financial plan to relocate the service to the RAH.
- The Panel noted our failure to address public concerns about the impact of additional time in ambulances. We accept that we need to clearly emphasise that the most ill and at risk patients already bypass the Vale of Leven and will not experience any increase in transport time, and therefore clinical risk.
- The work with the ambulance service has focused on ensuring we can put forward a costed and viable plan to support the transfer of unscheduled medical admissions.

The Panel additionally raises a number of financial issues with regard to our proposal. We regard much of this critical appraisal, which focuses on a lack of comparison of alternatives and demonstration of best value in relation to the shift of unscheduled medical admissions, as misplaced. The critique fails to reflect the simple fact that we are proposing this shift to provide a safe and sustainable clinical service - not for financial reasons. Our proposal has been fully costed including additional costs at the RAH. In this respect, the critical financial appraisal is contradictory to the Panels' overriding conclusion that the shift of this service is clinically sound.

10. OLDER PEOPLE'S CONTINUING CARE

The Panel offers a number of endorsements on our proposals and helpful advice on the consultation process which is reflected in the later paper. The only issues we have with the report are set out below:

- We find it difficult to accept that it is not reasonable to use extensive Glasgow analysis and benchmarking applied in a modified form to planning in the Clyde area.

EMBARGOED UNTIL DATE OF MEETING

- Our assumptions about Partnership bed costs are based on real experience of commissioning and current contracts - we believe that is a reasonable basis for planning, in advance of a formal consultation process.

11. VALUE FOR MONEY, BEST VALUE AND OPTION APPRAISAL

The report comments at length on the planning framework for public services in general and the use of option appraisal in particular and makes a number of comments on our approach to financial planning and option appraisal. It is important to respond to the Panel's comments on these key areas.

In relation to financial planning, at headline level, we have operated within the normal parameters of an NHS financial planning process. All of our proposals are clearly costed. There are a number of specific key points:

- The Panel appear to have given very limited weight to our absolute obligation to reduce the costs of services in Clyde by £30 million - the understatement of that imperative, for which the Scottish Government holds us to account, skews elements of the Panel's appraisal of our service proposals because the requirement to reduce costs is not accepted as a legitimate element of the drivers for change.
- The report overstates the constructs of value for money and opportunity cost against the simple requirement of affordability and does not fully reflect the complex matrix of objectives within which we are working.
- The report is contradictory, stating at one point that the only proposal which comes close to being robust is the proposed closure of the CMU birthing suites, but notes in the same paragraph that the mental health proposals are underpinned by relatively solid financial workings. There is, however, a key message in this regard that we need to carefully reflect on the provision of the financial information in the consultation process and, most particularly, in ensuring clarity on the origins of the Clyde deficit and our balanced approach to address it.
- Related to this point there are a number of areas where the report suggests we have incomplete information where that information was available. Those areas are highlighted in the preceding sections on each service area and we have also highlighted in the preceding service sections where we believe the Panel's comments on finance were not complete or accurate.
- The report suggests that we have inadequately considered the impact of each of the sites affected by our proposals and is particularly critical of the impact on the Vale of Leven of transferring unscheduled medical admissions. For the avoidance of doubt, we have made this proposal to meet our overarching responsibility to provide safe and sustainable services - not for financial or value for money reasons.

EMBARGOED UNTIL DATE OF MEETING

- For the other hospital sites it is our view that our planning has:
 - properly and fully reflected financial impacts where these are of any significance, for example, fully including the costs of expanding maternity and medical admission services at the RAH;
 - appropriately discounted marginal impacts, for example, the transfer of the delivery element of CMUs out of the IRH and the Vale of Leven.
- The report raises concerns about our assessment of risk, most particularly in relationship to Partnership bed costs. We believe this critique is weakened in disregarding the fact that we already commission large numbers of Partnership beds and are presently in the process of commissioning new beds. We have current and high quality market intelligence in this regard - although we accept that this requires greater visibility in the consultation process.

In response to the points on the planning framework we would make a number of points in response:

- The Best Value methodology and Green Book guidance on which the Panel's critique of our approach heavily relies are not a central part of the planning system and norms for NHS service planning.
- The Panel makes a number of points in regard to option appraisal to which we think it is important to respond. As the report states, option appraisal is essentially a way to allow fully informed choice between alternatives and can be highly technical and time-consuming. We have used the option appraisal in a measured and proportionate way which has properly reflected the planning challenges we have faced. Summarising:
 - we propose the mental health and maternity proposals will proceed with full quantified option appraisal as part of the consultation material;
 - for integrated care, it is our view and the Panel's report confirms it, that there is no sustainable option to continue unscheduled medical care at the Vale of Leven or to fully implement the pilot of the integrated care model. In these circumstances it is difficult to see how any meaningful option appraisal process could be undertaken;
 - for Johnstone Hospital, the Panel notes our proposals are appropriate and sound - we accept that the reasons why an RAH newbuild option should not be pursued should be explicit in the consultation,
- The Panel rightly notes that we have not created zero based processes for significant elements of our planning - we believe that is appropriate. We have been clear in integrating the Clyde area into Greater Glasgow that we will seek to deliver consistent models and levels of service across the Board area - we have, therefore, relied heavily in our planning on experience from Greater Glasgow, rather than creating entirely new planning process and norms for service changes in Clyde. We believe this represents a balanced and reasonable approach.

Finally, in reaching its conclusion, this section of the report states:

“In summary, the lack of identification of alternatives and the failure adequately to assess risk undermines the production of a robust financial case for each proposal. The true merits of such proposals may be lost through inadequate assessment and challenge. Due to the absence of a robust approach in the formulation of these proposals, we are unable to find persuasive evidence that suggests that each proposal is founded upon a robust financial case, that a Best Value approach has been taken and that the Board’s proposals constitute value for money.”

This highly summarised conclusion:

- Directly contradicts its earlier conclusions about the robustness and soundness of the maternity and mental health proposals.
- Fails to recognise our unscheduled medical admissions proposals are driven by clinical safety and sustainability.
- Is disproportionate in regard to the points of detail raised with regard to Partnership bed costs for the Johnstone Hospital proposals.
- Does not reflect the financial planning norms within the NHS or differentiate the requirements for major capital schemes and service changes.

12. CONSULTATION AND PUBLIC ENGAGEMENT

The Panel makes a number of very helpful observations with regard to public engagement and consultation and much of their advice will be incorporated into our approach to take forward each service review. However, there are a number of points where we would want to reflect carefully the Panel’s thinking.

In our view, the Panel report’s comments and recommendations on options for consultation raise a number of issues, they:

- Do not sufficiently differentiate the consideration of options in the pre-engagement phase and the development of final proposals for formal consultation based on the outcome of that pre-engagement and planning work.
- Do not recognise that the actual test of effective formal consultation is that it offers the opportunity for people to understand fully what is proposed and why in a way which enables them to express views and challenge proposals.
- Propose that we consult on options which their report concludes are not viable or appropriate. In our view, this would create a process which sets out to mislead the public about what is possible. Consulting on the status quo where that is either unsustainable or highly undesirable does not seem valid, although we would accept that the reasons for unsustainability or undesirable

EMBARGOED UNTIL DATE OF MEETING

should be completely transparent and open to challenge as an integral part of the consultation process.

Finally, it is also worth noting that the extant Health Directorate's guidance on consultation describes consultation as a process to seek views on specific proposals through a formal document and process.

13. CONCLUSION

The Independent Scrutiny Panel's report will strengthen and improve the next phases of our work and process on the four service reviews. We hope it will also build public confidence. Our experience will enable the Board to provide a well-informed input to the present consultation on the future scrutiny process.

Publication: The content of this Paper may be published following the meeting

Author: Catriona Renfrew, Director of Corporate Planning and Policy

The logo consists of a dark blue rounded rectangle containing a light blue oval. Inside the oval, the words "Independent Scrutiny Panels" are written in a dark blue, italicized serif font.

*Independent
Scrutiny Panels*

**Report by the Independent Scrutiny Panel
On Proposals for Health Service Changes
in the Clyde Area**

CONTENTS

Chairman's Introduction	1
Executive Summary	2
Context	8
Remit	10
Process	10
Mental Health Services	12
Maternity Services	18
Unscheduled Medical Admissions	23
Older People's Services	30
Finance	32
Taking Account of People's Views	42
Acknowledgements	44
Appendices:	
Appendix 1 - Panel's Terms of Reference	45
Appendix 2 - Panel Members and Secretariat	47
Appendix 3 - List of documents provided by NHS Greater Glasgow & Clyde	48
Appendix 4 - Locations visited by Panel members	55
Appendix 5 - Public meetings - dates, times, locations, numbers registered and main points	56
Appendix 6 - Summary of written submissions and petitions	59
Appendix 7 - Sources of external, independent, expert advice to the Panel	61
Appendix 8 - Key national documents	62
Appendix 9 - The evidence base for quantified bed reductions • a critique	63

CHAIRMAN'S INTRODUCTION

The work described in this report is the product of an entirely new process in the history of the NHS in Scotland. This has meant that those conducting the scrutiny, and those being scrutinised, have been in largely uncharted territory.

The Clyde Independent Scrutiny Panel recognises and appreciates the extra time and work devoted to the Panel's requirements by the staff of NHS Greater Glasgow and Clyde.

The method of the scrutiny developed alongside the process, and benefited from the experience of our sister Panel (which is considering revised proposals for Accident and Emergency services in Lanarkshire and Ayrshire & Arran) and from that established by the Independent Reconfiguration Panel which operates in England. The Report describes the background and context in which the Panel found itself, the expectations of the Scottish Government, the way we set about the task, and what we found.

We were asked to evaluate a complex and inter-related set of proposals affecting mental health, unscheduled medical admissions, maternity, and continuing care of the elderly over some five separate locations across the Clyde estuary. Division of labour between the four Panel members was essential in order for the work to proceed at a good pace, and we crave the indulgence of those reading the Report if slight differences in style are detectable across the text. There was no simple way of presenting our findings given the complexity of the service proposals under scrutiny. We have tried to keep the presentation as clear as possible by laying out our findings and views according to the service in question.

Throughout our Report we comment on the absence of a full option appraisal in many of the Board's proposals, and feel we should explain why this was, for us, a crucial issue. Most people will not be familiar with the technicalities of option appraisal. It is essentially a way to allow fully informed choice between alternatives, but to do this in a thorough and transparent way requires a method which is technical and potentially time-consuming. The Panel is of the view that best practice involves a method by which all reasonable options, including changing nothing (the status quo), are evaluated in such an explicit and transparent way that the workings and reasoning are easier to follow. The result is an overall benefit score, a number, for each option, which can then be compared against its cost to provide a measure of value for money. The methods chosen by the Board not only vary from one service change to another, they mostly make it impossible to compare the value for money between the options. This, in turn, makes it very difficult for anyone to make an informed judgement about the way the Board has arrived at its preferred options.

Some methodological and presentational shortcomings have been identified in the strategy development process, but the Panel wishes to emphasise two very important points. Firstly, no other Health Board in Scotland has so far had its strategy scrutinised in this way and so the reader should not conclude that Greater Glasgow and Clyde is unique among the 14 Scottish Boards in the way it has drawn up its proposals.

Secondly, the fact that the Panel has found areas upon which to comment in the Board's strategy for Clyde should not be taken in any way as a reflection on the excellent standard of treatment and care being delivered by the Board to its communities.

My Panel colleagues and I have been hugely impressed by many of the people we have had the good fortune to meet during our scrutiny. We have all felt a sense of humility in the face of eloquent and emotional presentations at public meetings, as well as a daunting anxiety at the obvious expectations on the Panel, expressed by some, that we would persuade the Health Board to change its mind. Although perhaps an understandable misconception, it is worth emphasising that the remit of the Panel was to evaluate and comment on all reasonable options, not to state any preference between them.

We have also been impressed by the speed and industry with which the Board's officers had responded to requests for information and arrangements for site visits. However, we were disappointed to learn, at a later stage, that further relevant information which was available was not provided to the Panel.

The Panel was aware, from the outset in early September, that it was working to a tight timescale. The completed report was to be produced by the end of November, with Panel members expected to work a maximum of 20 days during that period. The urgency was, we felt, justified by the need to limit the duration of the inevitable uncertainty felt both by the Health Board and by the affected communities and staff. One aspect of this has been the impossibility of conducting a full investigation of the additional options we are asking the Board to consider appraising and presenting for consultation. The Panel's position regarding these additional options is that they appear worthy of formal appraisal with all the associated risks and benefits fully laid out for the public to see. Thereafter, the Board will, of course, decide, in the light of their appraisal and of the public's views, which of the options it prefers.

30th November 2007

EXECUTIVE SUMMARY

The Independent Scrutiny Panel was created by the Cabinet Secretary for Health and Wellbeing to consider and report on the options prepared for public consultation by NHS Greater Glasgow and Clyde with respect to the future health service provision in the Clyde area, including those services provided at the Vale of Leven (VoL) Hospital in Alexandria.

The task of the Panel was to bring to bear independent, expert, probing scrutiny on the relevant service proposals for consultation from NHS Greater Glasgow and Clyde. The aim of this scrutiny was to provide assurance to the public, through the Panel's published commentary, that the proposals for consultation:

- were, in light of the presumption against centralisation, reasonable and necessary;
- were safe, sustainable, evidence-based and represented value for money;
- were robust, patient-centred and consistent with clinical best practice and national policy;
- had been prepared taking appropriate account of the views of individuals and communities affected, as assessed by the Scottish Health Council;
- and reflected full consideration of all viable service options.

Effectively the role of the Panel was to test the processes behind NHS Greater Glasgow and Clyde's proposals for major service change, challenge the quality of the thinking and of the development process behind the Board's proposals, and to come forward with a series of comments intended to help ensure that the eventual public consultation is based on openness, thoroughness and inclusiveness. The major service change proposals which the Panel have reviewed were presented to the Board of Greater Glasgow and Clyde on 26 June 2007 covering seven areas categorised into the four main headings of Mental Health, Older People's Medicine, Community Maternity and Unscheduled Care. The work of the Panel covered the period 14 September to 30 November 2007.

It was a source of concern to the Panel that the Board had employed conventional option appraisal methodology to only one of their proposals for service change. This deficiency had an adverse impact on the ability of the Panel to evaluate the decision-making process, including scrutiny of the weightings given to criteria such as patient-centeredness.

Notwithstanding this position, our high level comments are outlined under the following headings:

- Mental Health
- Maternity Services
- Unscheduled Medical Admissions
- Older People's Continuing Care – Johnstone Hospital
- Value for Money – Best Value

MENTAL HEALTH

The Panel was impressed by the amount of work which had gone into this proposal for complex service reconfiguration, some of which is not reflected in the material intended as the basis for consultation. However, the process of development of the Board's preferred options should be more explicit, should demonstrate best value for money through a quantified option appraisal process according to best practice, and should if possible include options other than the status quo and the Board's preferred option. Between the mental health and older people's proposals, some 24% of existing resources within this modelling is essentially removed from these specific services. In terms of resourcing the reprovisioning of mental health services it is interesting to note that approximately 17% of resources made available by the implementation of the

service re-provision model is being used as a contribution towards financing the inherited Clyde deficit at the expense of further service development. It was also noted that a risk appears to exist with regard to the benchmarked capacity to deal with demand. It would be our view that any unforeseen increase in demand may require a reduction in the quantity or quality of future service provision without further investment.

The Panel looked for an objective assessment of the safety and effectiveness of the proposed acute and continuing care bed numbers, including reference to the published literature and to data derived from the recent experience in Glasgow. A full, quantified option appraisal concerning the future of Christie Ward should have been conducted and should have included, as one fully worked up option for consultation, the provision of on-call cover by means other than trainee psychiatrists. This has been accepted by the Board and a full appraisal is expected to be completed before the proposals go to consultation.

The consultation document should describe the extent to which clinical staff were involved in the strategy development, and any strong body of contrary opinion should be reported. Additionally, the ways, and extent to which, the views of patients, carers and the Public exerted influence upon the choice of the preferred options should have been described in more detail. The Panel was concerned about the imprecision behind the proposals for the shift to Partnership provision. The assumptions surrounding Partnership Provision within the proposals should be clearly formulated and explained before the proposals go out for public consultation.

The Panel considers that the following three options for acute admissions in West Dunbartonshire, Helensburgh and Lochside should be considered and presented for public consultation:

1. The status quo
2. The continuation of services at Christie Ward with emergency on-call provided by means other than trainee psychiatrists
3. The transfer of services to Gartnavel Royal.

MATERNITY SERVICES

The crucial question of why mothers choose not to use the Community Maternity Units (CMUs) in Alexandria and Greenock remains unanswered. The Panel would suggest that a prospective postal questionnaire of mothers could be undertaken, over a 1 or 2 year period, to clarify the reasons for failure to choose a CMU rather than a Consultant-led unit.

The Board undertook a questionnaire of some local mothers-to-be over an eight day period during the Panel's deliberations to obtain a snapshot of why local mothers were making the birthing choices they were.

The Panel considers that a longer, and therefore more reliable, audit of why local mothers are currently making the birthing choices they are making should be

undertaken over the period of time we have suggested, this to fully understand the choices being made, and to meet the undertaking the Board gave to public representatives that they would investigate current usage rates of the birthing suites at the CMUs.

The Panel feels that an additional option should be considered by the Board and presented for consultation. This would be to run the CMUs for a further three year period, accompanied by a positive community education programme informed by a survey of women's attitudes. In addition to positive publicity, a review of risk criteria might increase usage and reduce the costs per case.

The possible further option of using the stand-alone CMUs for post-natal in-patient care should be fully worked up, with the involvement of local midwives, and presented for consultation.

While it was good to see a conventional, quantified, option appraisal, the Panel felt that the Board should demonstrate the extent to which the public were involved in determining the options for appraisal, and how that influenced the weighting and scoring, particularly on factors such as choice, accessibility, and continuity of care.

If intra-partum care is to be withdrawn from the stand-alone CMUs, a review of the workforce and possible associated costs should be conducted, and this information should be fed into the option appraisal.

Options to consider for consultation are:

1. Status Quo
2. The status quo accompanied by positive publicity and monitoring of birth suite activity
3. Use of stand-alone CMUs for post-natal in-patient care, linked to, or independent of, Option 2
4. Transfer of birthing to RAH

UNSCHEDULED MEDICAL ADMISSIONS

Whilst the Panel recognises that the decision on reprovisioning the Unscheduled Medical Admissions (UMA) from the Vale of Leven (VoL) to Royal Alexandra Hospital (RAH), Paisley, is one of fine balance and dependent upon certain indeterminable factors; it understands the proposal to withdraw UMA from the VoL Hospital is made on the basis of sound principles. However, it would also be our view that NHS Greater Glasgow and Clyde has, thus far, in its engagement with the community, failed to convince the majority of stakeholders. Notably this includes apparently large segments of the affected community, West Dunbartonshire and Argyll and Bute local Councils, Lomond and Helensburgh Planning Group, and other properly constituted bodies. The Panel further believes that a wider measure of understanding should have been achieved at this stage, prior to wider public consultation.

The Panel believes that more effort should go into finding ways of using the experience of the partially implemented Integrated Care Pilot. The feasibility and cost-effectiveness of providing safe anaesthetic cover, linked to a prospective, further evaluation of the predictive scale by external, independent, experts should be worked up and presented as an option for consultation.

The VoL Hospital needs a positive statement about its future, with consolidation of those services that remain safely decentralised. The NHS Greater Glasgow and Clyde Board also need to make clear the future role of VoL in the totality of Greater Glasgow's planning.

The Panel accepts that RAH might provide an appropriate centre for Clyde UMA. However, more detail is required of structural, operational and especially staffing plans before this is put to public consultation.

In relation to the critical issue of transport, it is the Panel's opinion that NHS Greater Glasgow and Clyde should do more to address the widespread concerns about ambulance journeys. More detailed planning is required.

Much of this concern might be addressed if a Glasgow Hospital could be identified for UMA which did not involve travel across the river. The Panel feels the Board should explore the possibilities and present an appraised option to the public for urgent medical admissions to go to a Glasgow hospital.

In summary, the Panel feels the following options should be fully developed, appraised, and presented for public consultation:

1. Status Quo
2. The status quo for a specified period with continuance of anaesthetic support to permit evaluation of the prediction model
3. The transfer of UMA to RAH
4. The transfer of UMA to another Glasgow hospital.

OLDER PEOPLE'S CONTINUING CARE - JOHNSTONE HOSPITAL

The Panel believes that the overall concept in the proposals is appropriate and the principles sound. Planning appears to have explored the range of problems in depth and with the agreement of the majority of clinical staff, but some assumptions remain. Achieving zero delayed discharge occupancy by April 2008 seems ambitious. The relationship between health and social services for physically frail elderly and mentally frail elderly is unclear; it is important to maintain the closest possible integration to ensure that patients with dementia and physical problems do not slip between services.

The Panel notes the absence of a formal option appraisal but agrees with the NHS Greater Glasgow and Clyde that, on the available evidence, the proposed model is reasonable. This proposal is expected to yield a saving of £1 million. However, the financial security of the proposal is not considered to be robust as there appears to be a significant absence of vital detail on the possible partner arrangements which will

be in place to deliver this service. Notwithstanding the shortcomings of the facility at Johnstone hospital, any change from familiar models causes anxiety to some. Patients and carers will be naturally apprehensive.

NHS Greater Glasgow and Clyde should ensure well in advance of public consultation that the plans for change are made clear to patients, carers and staff. The Panel is concerned that the partnership model is proposed in the document without any indication of where and how this will be accomplished; a realistic arrangement should be available prior to proceeding to full consultation in order that all concerned can picture the form and location of the new accommodation. It was not clear to the Panel why the option of a new-build on the RAH campus had not been appraised.

Possible options for consultation:

1. Status Quo
2. Re-provision in new build on the RAH campus
3. Re-provision in partnership facilities.

VALUE FOR MONEY AND BEST VALUE

The financial case is one of the key components for each of the proposals which form the basis for consultation. A fundamental aspect of our review was the determination of the strength of the financial case associated with each proposal in the context of Best Value. In addition to our general comment on the lack of defined option appraisal the Panel found a lack of precision in the determination of fundamental assumptions such as partnership provision capacity/expected unit costs, additional staffing costs, transportation costs and consequential impact: for example, the additional RAH Investment to cope with the increased capacity in excess of 6,000 patients per annum. Furthermore, there was little evidence of robust risk assessment during the option development process. In common with best practice, we would have expected some form of sensitivity analysis to be applied to the critical assumptions.

Prediction of bed requirements in the mental health services, mainly on the basis of experience in Glasgow, should be made more reliable by calibration to local conditions, and informed by local assessment of need within the Clyde area. There is a similar need with regard to older people's services at Johnstone, notwithstanding the audit and bed usage analysis conducted by the Board.

In relation to performance management, resource deployment and financial management, there appears to exist an element of partitioning of the operational systems and strategic vision of Greater Glasgow on the one hand, and Clyde on the other. Regarding the impact on establishments, the Panel is of the view that insufficient attention has been given to the financial and operational sustainability of services which remain in various locations, following the proposed subtraction of certain service elements. There is a lack of proper impact assessment in relation to the effect on RAH of re-providing unscheduled medical admissions previously going to the VoL Hospital. A sustainability plan for the VoL Hospital is a vital element in any effort to secure public confidence.

On a strict financial assessment, the only proposal which comes close to being robust is the proposed closures of the birthing suites at the CMUs and even with this proposal, we require to be further convinced that adequate provision has been made within the financial modelling for additional staffing displacement/preservation costs and infrastructural capacity, albeit marginal, at the RAH. This is in contrast to the mental health proposals, which have been underpinned by relatively solid financial workings, although even here, certain assumptions need to be questioned.

CONCLUSION

The Board has much to do to convince stakeholders of the merits of its proposals. The lack of full assessment of alternatives, and the failure to assess risk adequately, undermine the financial case for each proposal, and made it impossible for the Panel to comment on value for money. The true merits of the proposals may be lost through inadequate assessment and testing.

Whilst the Panel was convinced that the Board is genuinely trying to develop its services within the Clyde area according to best clinical practice and within available resources, the Panel feels that the Board should be asked to demonstrate in a more complete and structured way, the risks and benefits of its proposals. If this means delaying the public consultation, then we consider that this would be a price worth paying in order to ensure informed consideration by all interested parties.

CONTEXT

A BRIEF OVERVIEW

Healthcare services across Inverclyde, Renfrewshire, West Dunbartonshire and East Renfrewshire became the responsibility of NHS Greater Glasgow on 1 April 2006, following the dissolution of NHS Argyll and Clyde. At this time, the Board was renamed NHS Greater Glasgow and Clyde.

NHS Greater Glasgow and Clyde established a series of service and strategy reviews from 1 April 2006, to consider Integrated Care at the VoL Hospital; the Balance of Older People's Care: Johnstone Hospital; Clyde Mental Health Services; and Clyde Maternity Services.

The service and strategy reviews had a number of aims and drivers, which apply to all of the reviews. At headline level these were:

- 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 applied to mental health and older people's services;
- the requirement to ensure safe and sustainable services. This particularly applied to integrated care at the VoL;

- the imperative to ensure economic provision of services and to identify action to address the £30 million deficit which it inherited with its Clyde responsibilities – in line with the Board’s agreement with the Scottish Executive Health Department. This particularly applied to maternity services.

The strategies for the four areas of service were developed by NHS Greater Glasgow and Clyde through engagement with key partners.

From September 2006 to May 2007, NHS Greater Glasgow and Clyde engaged with patients, community representatives and staff on the “Clyde Health and Service Strategies”.

The Scottish Health Council has a remit to consider whether NHS Boards have adequately engaged and consulted their local populations in relation to significant NHS service change, in accordance with existing guidance. An interim report on NHS Greater Glasgow and Clyde’s public engagement, produced by the Scottish Health Council in October 2007, has helped to inform the Independent Scrutiny Panel’s deliberations.

Following the service planning and engagement period, proposals intended to form the basis for formal consultation were considered and approved by the Board of NHS Greater Glasgow and Clyde in June 2007, and comprised the following:

- 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 VoL Hospital to Gartnavel Royal Hospital;
- the transfer of adult acute admission beds for mental health from the RAH, Paisley, to Dykebar Hospital
- the reprovision 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 VoL Hospital and the reprovision of unscheduled medical 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 VoL Hospital.

In August 2007, the Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon, wrote to Professor Angus Mackay, to invite him formally to Chair the Independent Scrutiny Panel.

At a subsequent meeting with Professor Mackay in September 2007, the Cabinet Secretary emphasised her expectation that the Panel would take every reasonable opportunity to hear views directly from the communities affected by the proposals.

REMIT

WHAT WAS ASKED OF US?

The Independent Scrutiny Panel was created by the Cabinet Secretary for Health and Wellbeing to consider and report on the options prepared for public consultation by NHS Greater Glasgow and Clyde with respect to the future health service provision in the Clyde area, including those services provided at the VoL Hospital in Alexandria. The task of the Panel was to bring to bear independent, expert, probing scrutiny on the relevant service proposals for consultation from NHS Greater Glasgow and Clyde. The aim of this scrutiny was to provide assurance to the public, through the Panel's published commentary, that the proposals for consultation:

- were, in light of the presumption against centralisation, reasonable and necessary;
- were safe, sustainable, evidence-based and represent value for money;
- were robust, patient-centred and consistent with clinical best practice and national policy;
- had been prepared taking appropriate account of the views of individuals and communities affected, as assessed by the Scottish Health Council;
- and reflected full consideration of all viable service options.

The role of the Panel was not to tell NHS Greater Glasgow and Clyde how to deliver its services. It was to probe the quality of the thinking and of the development process behind the Board's proposals, and to come forward with a series of comments intended to help ensure that the eventual public consultation is based on openness, thoroughness and inclusiveness.

In order to carry out its task, the Panel was asked to provide a clear, comprehensive and accessible commentary on the proposals, in a form also suitable for publication, by November 2007.

The Clyde Independent Scrutiny Panel's Tasks and Terms of Reference are laid out in Appendix 1, and Membership of the Panel and Secretariat in Appendix 2.

PROCESS

HOW WE APPROACHED THE TASK

The full Panel met every week, sometimes more than once in a week, following its first meeting on 14th September 2007. At that first meeting, the forthcoming work was divided between Panel members such that each member, including the Chairman, took the lead on a particular topic. Stuart Fair led on finance, Professor Peter Brunt on unscheduled medical admissions at the VoL Hospital and the closure of Johnstone Hospital, John Hanlon led on maternity and consumer engagement, and Professor Angus Mackay led on mental health. Thereafter, topic leads were responsible for data evaluation, interaction with external experts, and site visits related to their topic.

NHS Greater Glasgow and Clyde was asked to provide the Panel with relevant papers, to arrange site visits to the locations and services affected, and to arrange one meeting with NHS Board members and a Clarification Meeting with senior officers of the Board. A list of the documents provided by NHS Greater Glasgow and Clyde is included in Appendix 3.

Panel members visited all of the affected sites. Details of the locations visited are included in Appendix 4.

The Panel held three public meetings in Greenock, Paisley and Dumbarton to take views from local groups and members of the community. The public meetings were advertised through local media and press releases were issued. Views from the public meetings are summarised in Section 6.2 of this report, and further details of the meetings are included in Appendix 5.

The Panel Chair, Professor Angus Mackay, and a member of the Secretariat team, also attended a meeting with local clinicians and key community groups in the VoL area, convened by the leader of West Dunbarton Council.

To enable local MSPs and Council Leaders to express their views, they were invited to attend a pre-meeting with the Panel in the locations where the public meetings were held. A further meeting was held at the Scottish Parliament, Holyrood, on 22nd November, with those MSPs who were unable to attend the local meetings.

The Scottish Health Council's interim report on NHS Greater Glasgow and Clyde's procedures for public engagement, produced in October 2007, was used to help inform the Panel's deliberations.

The Panel invited the submission of written views through press releases, information packs and the Independent Scrutiny Panels' website www.independentscrutinypanels.org.uk. The Panel Chair also wrote to the leaders of the five local authorities, to seek their views on NHS Greater Glasgow and Clyde's proposals. A list of written submissions received is included in Appendix 6.

External, independent, expert advice was sought from a number of individuals and organisations. A list of the sources of expert advice to the Panel is included in Appendix 7.

The Panel considers that the documentation received, together with the information obtained in the public meetings, and consideration of key national policy documents, reports and guidelines, provides a fair representation of the views from all perspectives. A list of the national policy documents consulted is included in Appendix 8.

Throughout this process, the Panel's aim has been to ensure that the proposals for consultation were considered according to the criteria set out in our Terms of Reference.

The Panel wishes to record its thanks to all those who contributed to the process. We also wish to thank all those who presented evidence to the Panel and to everyone who contacted us offering views.

The conclusions contained in this report represent the unanimous views of the Chair and members of the Independent Scrutiny Panel.

MENTAL HEALTH SERVICES

A wide and relatively complex series of changes to mental health service delivery form the major part of the strategic proposals for Clyde. Most are predicated upon a major reduction in NHS hospital bed numbers, with an associated shift in the balance of care in favour of care in the community, and a release of capital and revenue monies from the bed reductions and disposal of surplus psychiatric hospital buildings and land.

The Board paper of 26th June 2007, "Modernising Mental Health Services" is well-written and, on the face of it provides persuasive justification for an ambitious shift in the balance of care. Such a general strategy is entirely in keeping with all authoritative national policy statements. However, two major assumptions have a less than secure

evidence base. Firstly, the justification for the proposed numbers of in-patient places comes more from the experience of NHS Greater Glasgow with similar initiatives across Glasgow since 1994, than from any robust support from the published, refereed, literature. The authors of the strategy refer to three key publications; Thornicroft and Tansella (2004), Glover et al., (2006), and Greater Glasgow's Modernising Mental Health strategy (1999). The security of the assumptions inferred from these publications is not high (see appendix 9). Furthermore, the fact that hospital admission rates across Glasgow may have fallen gives no reassurance, on its own, about the quality of life or risk experienced by those with moderate to severe psychiatric illness. Secondly, the current Strategy depends upon the release of some £11.5 million from hospital retraction in order to fund the overall package of proposals. Included in this assumption is a continuing successful partnership with the affected Local Authorities, and independent sector to enhance community services. The Panel felt that this assumption carried significant risk.

The Panel considers that the Board requires to show a more detailed breakdown to confirm that resources are available to finance its intentions with regard to the future provision for the needs represented by the current 185 continuing care beds which are to be reprovided in a range of community-based services. The Panel considers that the Board has not yet provided sufficient detail regarding these plans, including the financial estimates, for it to go out to public consultation. It is particularly important for the Board to win the confidence of the public and staff that community services and partnership arrangements can safely and satisfactorily respond to the needs of the mentally ill and their families. It also seems important for the Board to explain the likely timescale of this rebalance of care.

The strategy uses a modified benchmarking process for the prediction of the required number of acute admission beds. Ability to respond to peak demand is a vital aspect of any emergency service and one which is very much in the minds of the public with regard to acute beds at Gartnavel. Data that reflects that (for example the number of beds required to meet demand on 95% of occasions) should be included in the information going out to consultation, as should the rates of boarding out and repatriation times for Gartnavel.

Much harder to acquire, but most important of all, are data on the safety and effectiveness of the new balance between community and hospital provision in Glasgow in terms of recovery rates, involvement with the criminal justice system, and quality of life (see appendix 9).

Most of the various changes to mental health services described for Renfrew and Inverclyde fall within a pattern of reduction in acute admission beds for adults and older people. The reprovion of long-stay services for older people with organic brain disorder and adult long stay, to inpatient continuing care accommodation in the community will be provided through a partnership arrangement with the independent sector for 109 places. It is intended that the need currently represented by 185 continuing care NHS beds will be met by a range of community facilities. There is a

proposal to relocate the Gryffe Unit for complex addictions from the Ravenscraig site to potential accommodation on the Southern General Hospital site, with a 30% reduction in beds. The Panel noted with interest the intention to relocate the Intensive Psychiatric Care Unit (IPCU) from the Dykebar site to the Inverclyde Royal site, and also the closure of acute admission beds at the RAH, with consolidated reprovision of a reduced total of admission bed numbers in the high quality ward complex at Dykebar. Although the costs of these and other adjustments and relocations will be not inconsiderable in terms of patient and staff disruption, building up-grading, etc., none could be seen as representing centralisation. However, although not any more “centralised” than the Gryffe Unit, the proposed provision of addiction beds on the Southern General Hospital site raises questions about access for patients, family and friends from Greenock and points further West. Similarly the proposal to transfer much of the current hospital-based continuing care to partnership facilities located at unidentified points across the catchment community has attracted worry and apprehension among family and others which the Panel heard at public meetings.

Other strategic proposals, relating to forensic medium and low secure accommodation for the mentally ill and those with learning disability, seemed reasonable to the Panel.

Probably the most contentious change in mental health service provision is the proposal to close Christie Ward at the VoL Hospital. This 24 bedded acute general admission ward (catering for both adults and older people) functions in adequate but less than ideal physical surroundings, but is highly valued by the local population. The preferred option represents a clear intention to centralise psychiatric admission facilities for communities living North of the Clyde and the Panel therefore paid particular attention to the justification for this proposal.

As with all of the other changes proposed for mental health services, only one preferred option has been chosen to be presented for public consultation, providing therefore a simple choice between reprovision at Gartnavel Royal Hospital or continuation of the service as it stands. The argument in favour of change is strongly influenced by difficulty over the provision of acceptable on-call cover by medical psychiatric staff, specifically sub-Consultant grades. Concern over adequate medical staffing is justified by recent experience and also by the anticipated impact of ever more restrictive European Working Time Directives and progressive changes to the medical specialty training structure. As it stands, the option to provide admission facilities at Gartnavel Royal seems sustainable, safe (in the sense of on-call medical cover), and consistent with national policies.

However, the Panel found insufficient evidence that the Gartnavel option had been evaluated for patient-centredness. Patients and families coming from West Dunbartonshire, and Helensburgh and the Lochside have a strong cultural identity with their communities, an identity which has been described as importantly different from Glasgow. The simple feeling of mixing with people from one’s own community while being treated in an acute admissions ward may be an important aspect of quality of life. Furthermore, as NHS Greater Glasgow and Clyde move further towards the model of a Glasgow pool of psychiatric beds, it is possible that a patient requiring

admission from West Dunbartonshire or the Lochside may be found a bed anywhere within an alternative Greater Glasgow and Clyde inpatient hospital. While there exist strict guidelines governing such a “boarding out” practice when a unit is full, the first few days of a persons admission may be the most alienating, and repatriation cannot be absolutely guaranteed within a short time (see Appendix 9). It should, however, be noted that similar issues have historically applied to the Vale of Leven service which required transfer to the Argyll and Bute hospital when Christie Ward was full. The Panel acknowledges that the standard of physical amenity which will be provided by the new mental health unit at Gartnavel Royal is excellent.

Concerns over travel and access to Gartnavel were heard at public meetings. While discussions between NHS and Local Authority care providers, and transport providers, had taken place, the Panel was not convinced that a comprehensive transport impact assessment had been conducted. Although public transport links between West Dunbartonshire and the Gartnavel site are good, many people (especially those in Helensburgh and along the Lochside) would prefer to use private transport, in which case the availability of reasonable parking facilities at the Gartnavel site is a factor. For “boarded out” patients across Glasgow, transport and private car access become more problematic. Similar issues apply to the provision of intensive psychiatric care at Gartnavel.

The essential issue at VoL is whether the strategy has explored sufficiently the alternatives to closure of Christie Ward which take account of the medical on-call issue. There may be ways of off-setting the loss of cover by trainee psychiatrists by exploring the use of non-career grade psychiatrists. More ambitious, but nonetheless worthy of exploration, would be the use of advanced nurse practitioners (ANPs) to provide out of hours cover, assuming that a Consultant Psychiatrist was always available if needed. This model, as part of a Hospital at Night service, has worked successfully at Dr Gray’s Hospital in Elgin. The immediate response to any emergency in a psychiatric ward is almost always provided by nursing staff until such time as a member of medical staff is called and arrives. Even essentially “medical” emergencies such as sudden unconsciousness or serious self-harm are commonly dealt with through first aid procedures of which senior, experienced nurses should be quite capable. In a DGH setting such as the VoL Hospital, it might be possible to negotiate appropriate cover from medical staff.

Christie Ward is not ideally situated within the VoL Hospital campus. Given that other changes may be happening across the campus, it should be possible to explore the limited relocation of Christie Ward to other, upgraded, accommodation within the existing hospital estate.

The proposed closure of Fruin Ward at the VoL Hospital is an example of partial centralisation. Some of the older people currently assessed and staying for relatively short periods in Fruin would have that service provided at Gartnavel Royal, whereas the long stay provision for older people with organic brain disorder would be through a partnership arrangement somewhere in the local community. As is the case with such services South of the River, there is lack of clarity about the form and location of such a service.

The rigour and comprehensiveness of the option appraisal processes which informed the proposals for mental health services were patchy and non-quantified. For services South of the River there was a qualitative option appraisal which appears to have been conducted relatively thoroughly, but given the lack of quantification of benefits (by accepted best practice), and the lack of clarity around allocation of costs to specific changes, neither a cost-effectiveness appraisal, nor any form of sensitivity analysis was possible. This is a particular lack with regard to the proposals for the VoL Hospital where it did not appear that any form of detailed option appraisal exercise had been conducted. NHS Greater Glasgow and Clyde have, however, undertaken to conduct such a process before their proposals are put out for public consultation.

The report by the Scottish Health Council on the public engagement process associated with changes to mental health services acknowledges inclusion of service users and carers both on the Clyde Mental Health Strategy Group, and on the local planning groups. The report also noted that stakeholders appeared to exert an influence on the Board's options during the engagement period, reflected by the Board's revision of their original proposal regarding admission beds such that rather than provide them at RAH, they would be provided in better accommodation on the Dykebar site. The report recommends that NHS Greater Glasgow and Clyde continues to consult on issues of significant service change and redesign, and works with patients and carers at the State Hospitals Board for Scotland, and those for many other affected Board area, around plans to make permanent the interim arrangements to use Rowanbank Clinic, Stobhill Hospital, as the West of Scotland Medium Secure Forensic Unit.

Although the process of pre-consultation public engagement during the development of the strategy was found to be generally satisfactory by the Scottish Health Council, the extent to which the substance of public views was a significant influence in the choice of the preferred options is unclear. For example, in various planning fora the representation of views from patients and carers was confined to a small minority presence in a group otherwise populated by managers, planners and senior healthcare professionals.

It has been hard to ascertain the degree to which the views of front-line clinical staff have influenced the development and choice of the preferred options. This should be made more explicit, and contrary views, where they have been expressed, should be laid out in the consultation document.

The lead Panel member for mental health visited all affected locations. The new psychiatric in-patient facilities at Gartnavel Royal Hospital were found to be particularly impressive, indeed probably award-worthy in view of the sensitive attention to space, both private and public, and generally excellent design and amenity. Likewise, the relatively new acute unit at Dykebar was found to be of high quality and to have a clear advantage over the physical amenity of the admission unit at RAH. The older people's service at RAH provides pleasant and sustainable surroundings with good access to the natural environment. South of the River, ward staff were generally

accepting of the changes being proposed, although inevitably rather anxious about the ability of community services to manage need in the face of bed reductions. There was particular concern expressed at the older people's service at RAH with regard to progressive movement towards partnership provision in the community, centred on perceived uncertainty about personal funding. Both Christie and Fruin Wards at the VoL Hospital were found to be well run, and staff and patients appeared happy with the present situation, a view also reflected in a recent report of visits by the Mental Welfare Commission for Scotland. While neither is best placed within the existing hospital buildings, even without any improvement in physical amenity there were strong views expressed by some staff that the status quo would be preferable both to a move of the short-stay facilities to Gartnavel Royal, and to re-provision for continuing care in the community. These views were echoed by a number of local general practitioners. Throughout all of these visits there was consistent evidence of patients being looked after by highly motivated, competent and kindly staff, sometimes working under difficult conditions. As for other services affected by the Strategy, the Panel heard a certain amount of concern that front-line clinical and other staff involved in looking after patients may not have had sufficient opportunity actually to affect the strategy development process, as distinct from being briefed on the process.

The public meetings produced a variety of comments related to the mental health service proposals. Overall, they fell within a few broad categories. These were concern over ambitious bed reductions, the risk that community services could not cope with the need left by bed reductions, that access (in terms of transport) might be problematic, that the mental health service had to repay a substantial amount of the "debt" left by NHS Argyll and Clyde, and that the proposals for continuing care through partnership arrangements were a journey into the unknown, given the lack of any detail about this provision.

KEY POINTS

The process of development of the Board's options should be more explicit, and should include a quantified option appraisal in which the derivation of factors, weightings and scores is clearly described.

A full, quantified option appraisal concerning the future of Christie Ward is now being conducted and this should include, as one fully worked up option, the provision of on-call cover by means other than trainee psychiatrists.

Information on ability to respond to peak demand, and on boarding out, should be presented for all of the current acute admission services in Clyde, and at Gartnavel.

More detail and reassurance is required on the nature of partnership proposals which will allow continuing care beds to fall from 311 to 17 NHS beds and 109 partnership beds across Clyde.

The ways, and extent to which, the views of patients, carers, the public and NHS staff exerted influence upon the Board's options should be demonstrated.

The Panel consider that the following three options for acute admissions in West Dunbartonshire, Helensburgh and Lochside should be appraised and presented for public consultation:

- 1. The status quo**
- 2. The continuation of services at Christie Ward with emergency on-call provided by means other than trainee psychiatrists**
- 3. The transfer of services to Gartnavel Royal.**

MATERNITY SERVICES

In 2003, NHS Argyll and Clyde replaced Consultant-led delivery services at both Inverclyde Royal Hospital (IRH) and the VoL Hospital (VoL) with new midwife-led community maternity units (CMU), and co-located a third CMU with the existing Consultant-led units (CLUs) at the RAH (RAH). All of these units offer a wide range of local maternity services, antenatal and postnatal care, including a 24-hour midwife-led birthing suite for "low-risk" births (expectant mothers who are healthy and meet the criteria for a midwife-assisted birth as distinct from a Consultant-led one). For a period of eighteen months, following the loss of the consultant-led units, and prior to the opening of the CMUs at both hospitals, neither hospital provided birthing facilities for local mothers.

In April 2006, when Clyde services were amalgamated with those of Greater Glasgow, NHS Greater Glasgow and Clyde initiated a review of maternity services across Clyde. Later that year, the Clyde Maternity Services Review Reference Group was established, one aim of which was to identify a contribution to the large budgetary deficit inherited from the former NHS Argyll and Clyde. The birthing suites at the CMUs at VoL and IRH were being significantly under-utilised, resulting in costs per birth at VoL and IRH close to three times the cost of a birth at RAH (IRH £5,696 per birth, VoL £5,753 and RAH £1,836).

Suggestions for service change were aired at public engagement events in Greenock and Alexandria at which there were 10 and 40 attendees respectively. Following an initial option appraisal exercise, there were further public engagement events, when four possible options for maternity facilities at VoL and IRH were discussed. Attendance at the events was poor, with a total of three women attending two events held on 30th May 2007 in Alexandria and "around 20" women attending at Inverclyde. From an initial long-list of 12 options originally considered by Health Board staff, the four short-listed options were as follows:

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 midwife-led delivery service for Clyde, sited at RAH.

The appraisal of the four options selected by Board staff as being potentially viable was conducted broadly according to best practice, with weighting and scoring against a set of explicit criteria.

The preferred option contained in the strategic paper put to the NHS Greater Glasgow and Clyde Board on 26th June 2007 was for the closure of the delivery elements of the CMUs at IRH and VoL with women from these areas retaining the choice to access Consultant or midwife led services at the RAH or the maternity units in Glasgow.

A strong financial case has been made for this preferred option. The cost of the Clyde wide maternity service would be reduced from just over £4 million per annum to approximately £3.5 million per annum by closure of these two CMUs.

A further justification for closure could be made on the basis that women preferred to have their babies in units with ready access to a Consultant, rather than use the CMUs. At VoL, it was anticipated that between 179 and 210 births would take place at the CMU, based on a caseload of 844 i.e. between 21 and 25%. However, in 2006, there were only 74 births, representing less than 10% of the original caseload.

The picture is similar at IRH. There is a huge loss of potential CMU births at the point of risk assessment, with only between 30 and 40% of pregnant women being judged to be sufficiently free of risk factors to have the CMU birth. Despite the need to satisfy safety criteria before being booked at a CMU, in 2006 some 30% of women had to be transferred by ambulance to a Consultant-led unit in labour, or within 1 hour of delivery. This contrasts with a Scottish rate of 17% in 2005.

91% of local women whose pregnancy is judged to be clinically safe exercise their choice to use facilities other than the birthing suites at VoL and IRH.

The Expert Group on Acute Maternity Services (EGAMS) selection criteria appear to be applied slightly differently in each Clyde CMU. In IRH, they are interpreted rigidly, justified by concerns over transfer distance. RAH shows greater flexibility due to the proximity to the CLU and anaesthetic cover. At VoL, there is an opinion that the EGAMS criteria require review, such as that relating to Strep.B positive mothers. The VoL CMU puts much more emphasis on the approach and philosophy of the intra-partum care being given, of which the midwives are very proud.

There has been significant public concern over the prospect of the closure of the birthing suites in the CMUs at VoL and IRH, most notably in West Dunbartonshire where there have been large, well organised public demonstrations. At the public meetings held by the Panel in Greenock and Dumbarton, concerns were expressed by members of the public and by local practicing midwives. These included: criticism of the loss of choice to have a baby within one's local community; the difficulties for family and friends to visit a mother in Paisley (especially for Dumbarton residents who would have to cross the Erskine Bridge); the possibly over-stringent safety criteria for CMU bookings; and the view that the CMUs had never been positively promoted by the Health Board, nor given adequate time in which to earn the confidence of local mothers.

Neither of the stand-alone CMUs accepts post-natal transfers back from Paisley or Glasgow after operative or assisted vaginal deliveries. Such a model would allow women to be cared for closer to home, but does raise many issues regarding transfer and possible pressure on the ambulance service. It is noted that in both Tayside and Grampian, CMUs accept post-natal women.

It has been put to the Panel that the current rate of births at the free-standing CMUs creates the risk of midwives becoming de-skilled through lack of practise. It should not be beyond the capacity of NHS Greater Glasgow and Clyde to find ways of managing that risk.

It appears to the Panel that the case is essentially economic, with the current cost per birth at the peripheral CMUs being considerably greater than those at Paisley, created as a direct consequence of having staff and facilities unused much of the time.

The extent of the underutilisation of the CMUs in Greenock and VoL provoked much discussion within the Panel. We originally wondered whether mothers were being put off the midwife units by comments they heard during the referral process, possibly from their general practitioner. Enquiries did not support this suspicion; all mothers being referred from within the catchment area are initially seen by a midwife. There is no clear evidence as to why 91% of mothers who are eligible for a CMU birth choose to go elsewhere. At a public meeting in 2007, NHS Greater Glasgow and Clyde undertook to investigate the situation and determine the reasons for the low uptake of CMU birthing. The Panel saw no evidence of this investigation, and suggested to the Board that a targeted, anonymous, questionnaire survey should be carried out in order to understand mothers' attitudes. During the course of the Panel's deliberations, the Board conducted a snapshot survey, over 8 days, of the reasons mothers chose not to give birth in a local CMU. The Panel feels that such a survey should be carried out over a much longer period of two or three years.

The midwife-led CMUs were created some four years ago and it appears to the Panel that little has been done either by NHS Argyll and Clyde or NHS Greater Glasgow and Clyde to publicise the benefits of such units, and specifically to get the message across to expectant mothers.

The Health Board accepts that when the CMUs were being designed in 2002/2003, it was acknowledged that an appreciable period would be required before the new model became embedded in the local cultures and until anything approaching the projected CMU birth rates would be achieved. This was estimated at between 5-10 years. The Panel was concerned that this prediction does not appear to have been contained in any papers presented to the Health Board, nor is it apparent in the paper describing the basis for consultation.

It is the experience of CMUs elsewhere, for example in Perth and Kinross, that it takes several years, at least five, for confidence to be felt in the prospect of having a baby without ready access to a Consultant. It seems to the Panel that it is possible that, given high profile, positive, publicity the very slowly increasing usage of the CMUs could

be accelerated. Greater usage would reduce the cost per birth and would diminish the economic argument against sustaining the units.

The report commissioned by NHS Quality Improvement Scotland, published in February 2007 “Audit of Care Providers and Outcomes Achieved by Community Maternity Units in Scotland, 2005” recommended that national and local eligibility criteria for interpartum care within CMUs should be reviewed and simplified. A powerful factor which diverts women away from midwife-led CMUs is the stringency of the assessment process for risk. The Panel understands that there is an intention to review and possibly amend the EGAMS scale, and obviously any review of the criteria with a full, unbiased, explanation to mothers, might result in an increase in CMU bookings and deliveries.

The review and working groups responsible for generating and evaluating the options are to be commended for conducting a structured, quantified option appraisal.

However, it was not clear to the Panel the extent to which the views of mothers, and of the general public, influenced the weighting and scoring, especially of benefit factors such as maximising choice for mothers, accessibility for families, and continuity of pre-, intra-, and post-natal care. The Panel also felt unclear as to whether the costs of increasing the maternity service at RAH had been fully and clearly accounted for in the preferred option.

The Panel heard strong views that the closure of the midwife-led birthing suites at the CMUs in VoL and Greenock would represent a cost-saving exercise necessitated by the pressure for the repayment of the debt inherited from NHS Argyll and Clyde. Powerful and coherent arguments were put forward by local practising midwives, and from the general public, to the effect that the loss of these facilities could not be justified simply on cost alone. Interestingly, midwives at the CMU at RAH said they considered it would take 5-10 years to change the local culture of birthing, and also that they considered the closure of the birthing units at IRH and VoL as “a disaster”

It was put to the Panel at one of its site visits that local practising midwives had not been consulted on the options being developed. Specifically, there had been no opportunity for midwives to argue for the inclusion of a post-natal care role for CMUs in IRH and VOL.

Opinions expressed to the Panel from the National Childbirth Trust and the Royal College of Midwives are strongly in favour of birthing at CMUs. The Royal College observes that “it has already been established that the review (of Clyde maternity services) is on the basis of Clyde’s financial saving plan and not about service delivery or safety”. The College also refers to the current review of the eligibility criteria for CMU admission, some of which will be taken forward under the Keeping Childbirth Natural and Dynamic Project (KCNDP). In addition to expressing positive views about CMUs in general, the National Childbirth Trust feels that the information offered in the Health Board’s summary of proposals is not comprehensive enough upon which to base a decision.

The QIS report referred to above acknowledges the enormous contribution to maternity care in Scotland by CMUs. A recommendation is that the contribution could be

increased by further extending the core skills of midwives to include greater involvement in ultrasound scanning, prescribing, and routine examination of the newborn. Tele-health technology should be used to support midwives in these extended areas.

KEY POINTS

The crucial question of why mothers choose not to use the CMUs in Alexandria and Greenock remains unanswered. The Panel suggests that a prospective postal questionnaire of mothers should be undertaken over a longer period to clarify the reasons for failure to choose a CMU rather than a Consultant-led unit.

The Panel feels that an additional option should be developed by the Board and presented for consultation. This would be to run the CMUs for, say, a further three year period, accompanied by a positive community education programme informed by a survey of women's attitudes.

The possible further option of using the stand-alone CMUs for post-natal in-patient care should also be developed, with the involvement of local midwives, and presented for consultation.

In addition to positive publicity, a review of risk criteria might increase usage and reduce the costs per case.

While it was good to see a conventional, quantified, option appraisal of the CMU proposals, the Panel felt that the Board should demonstrate the extent to which the public were involved in determining the options for appraisal and how their views influenced the weighting and scoring, particularly on factors such as choice, accessibility, and continuity of care.

If intra-partum care is to be withdrawn from the stand-alone CMUs, a review of the workforce and possible associated costs should be conducted, and this information should be fed into the option appraisal.

Options to consider for consultation are:

- 1. Status Quo**
- 2. The status quo accompanied by positive publicity and monitoring of birth suite activity**
- 3. Use of stand-alone CMUs for post-natal in-patient care, linked to, or independent of, Option 2**
- 4. Transfer of birthing to RAH**

UNSCHEDULED MEDICAL ADMISSIONS

The proposal to withdraw the acute medical admissions service from VoL is probably the most contentious proposal and has the greatest impact on patients, families and staff (there being some 6000 patient episodes a year). Paradoxically, however, it presents the most sharply focussed set of issues.

For many years now, the VoL hospital has provided a valued medical service to the people of Lomondside, Helensburgh, West Dunbartonshire and elsewhere. It is an integral part of the community and is clearly much loved and appreciated by the local people. It is a significant employer in the locality and has an impressive cadre of dedicated nursing, medical and other staff.

However, 4 years ago saw a critical event – the then Argyll and Clyde Health Board came reluctantly to the decision that it could no longer sustain a safe and satisfactory level of services for several emergency specialities, this for several reasons. It is not part of the Panel's remit to consider this decision.

Nevertheless the decision by Argyll and Clyde Health Board had several important repercussions on the hospital in general and the acute medicine (unscheduled medical admissions – UMA) service in particular. These included:

- (i) removal (eventually) of the emergency surgical service which, if not essential in all circumstances, is at least highly desirable in any setting which provides acute medical admission facilities.
- (ii) loss of the Accident and Emergency department
- (iii) a “domino effect” of the loss of acute surgery and the removal of 24-hour anaesthetic cover and consequently requiring the closure of ITU and difficulties in handling a small but significant number of emergency admissions requiring respiratory support (prior to transfer to RAH). This has been partially ameliorated by the employment of three locum anaesthetic staff (some at staff grade level) covering nights and weekends (during the day, anaesthetic help is provided by consultants working in the cold surgery theatres).
- (iv) an element of “planning blight” coupled with a poorly perceived (by many) vision of the future of the hospital. The Panel heard it said at a public meeting that “we are gradually losing our hospital...by stealth”.
- (v) A harbinger phenomenon – a growing perception and fear among all grades of staff based on future uncertainty. This, coupled with the recent introduction of European Working Time Directives and new contracts of employment, makes it increasingly difficult to recruit and retain staff. In this climate, the provision of rotas can become professionally unsound (resulting in possible withdrawal of College recognition for training medical staff) and prohibitively expensive.

In an attempt to maintain a good unscheduled medical admissions service in those difficult circumstances, the clinicians and managers in VoL hospital proposed a bold

and innovative plan involving integrated care. This plan, which is detailed in the NHS Greater Glasgow and Clyde Board's proposals paper, involved:

- (i) active cooperation of the local GPs
- (ii) highly trained nursing staff for the acute medical admissions unit
- (iii) continuance, in the short/medium term, of the locum anaesthetic provision (see above)
- (iv) training of local clinicians in airways management or more appropriately Advanced Life Support
- (v) the bypass of VoL hospital by paramedic ambulances in the case of obviously critically ill patients
- (vi) arrangement with RAH for the transfer of patients requiring critical care support or specialised medical services.
- (vii) development of a predictive scale to anticipate as early as possible those patients likely to require critical care. It had been hoped that this unique model might become tested in other situations.

A second critical event occurred in 2006 when the Government disbanded Argyll and Clyde Health Board, and Clyde became subsumed into Greater Glasgow. At this stage, the first phase of the integrated care plan (pilot) had been running for several months. In its review of the Argyll and Clyde plans and operations NHS Greater Glasgow and Clyde came to the conclusion that full implementation of the model could not proceed.

Although there appears to have been widespread perception by both the public and some clinicians that this decision was primarily finance driven the principle determinant seems to have been on grounds of clinical safety. It is clearly stated in the NHS Greater Glasgow and Clyde Board minute of 26.06.07 that "the pilot could not proceed to full implementation because of concerns about clinical safety". Furthermore, the Board's Chief Executive is quoted as saying that "the proposals were not financially driven...". Some medical opinion has questioned the basis of this decision made on safety grounds.

In considering these issues related to the relocation of acute medical admissions the Panel considered the proposal against the following general principles:

- (i) Quality of Patient Care must always be the dominant factor in decision making.
- (ii) Evidence exists that centralisation of services for the seriously ill and for complex and specialised problems provides better outcomes.
- (iii) Evidence supporting centralisation of non-complex and high volume cases does not exist.
- (iv) Availability/Recruitment/Retention of appropriately trained medical and nursing (and other specialist) staff may be a determinant of a service's long-term viability.
- (v) While available finance as a determinant of a service's continuing viability is always – ultimately – a prioritisation decision the cost-effectiveness of proposed changes must always be subject to rigorous analysis.

- (vi) Plans to reconfigure part of the services of an area should, as far as is possible, be evidence based and be consonant with a long term vision for the future requirements in health and community services for the whole area – taking account of the possibility of housing expansion, new town development, schools, industry , tourism, etc.
- (vii) Such plans should also take account of the projected changing demography of the area, which should result from specialist study, and the results of ‘needs assessment’.
- (viii) The wishes of the local population are important – but cannot be a sole determinant as the needs of the entire area must also be considered. However, local hospitals are an important integral part of the local community (not least as employers) and naturally, and quite appropriately, attract considerable local support and loyalty.
- (ix) Agreed national policy must be observed but nationally based guidelines may need to be balanced with local characteristics.
- (x) While quality of care is always the first consideration, it must be seen in balance with access. The availability, feasibility and safety of any “scoop and run” service (rapid collection and transfer by ambulance) must be tested rigorously. There is evidence that for certain medical conditions (notably respiratory emergencies) increasing ambulance journey time is inversely proportional to outcome but this has to be balanced against the importance of early available intensive care facilities (Emergency Medical Journal 2007, 24:665).
- (xi) The difficulties of training and maintaining staff skills in triage (including ambulance staff) must not be underestimated. Any system of triage which directs the most ill patients to more central services risks deskilling the local staff in the management of critical illness should it arise.
- (xii) The complete restoration of all emergency services (Accident and Emergency, acute surgery, ITU etc) as envisaged by many of the general public, does not seem to have been considered as a practical or financial option.

The issue of ‘clinical safety’ is difficult to define and to quantify. It may hinge on anecdotal experience. However, it must be recognised that the overwhelming majority of clinical opinion is now that unscheduled medical admissions should not be handled where there is no immediately available anaesthetic cover and in most instances no ready access to acute surgery.

In describing the “Local Hospital” in its model of acute care services based on population need the Academy of Medical Royal Colleges (2007) say:

“The patient needs 24/7 access to a facility able to provide the initial assessment, treatment and stabilisation of most serious conditions...as a minimum...full emergency medicine (A and E) service, acute medical beds... intensive care unit...”

“The defining characteristics of any emergency hospital is 24 hour presence of intensive care which may be difficult to maintain without on-site operative surgery.”

“The College of Emergency Medicine and the British Association for Emergency Medicine strongly believe that in order to provide a safe service an emergency department requires 24-hour support by doctors skilled in critical care.”

Acute Health Care Services. Academy of Medical Royal Colleges – 2007

“Acutely ill patients should not be admitted to hospitals which do not have critical care...hospitals which do not have critical care and diagnostic services should be reconfigured to provide intermediate or step down care.”

Isolated Acute Medical Services. Royal College of Physicians (L) – 2002

The Kerr report, while acknowledging that there could be exceptions in certain special situations, stated that for Level 3:

“...where we provide assessment, diagnosis and treatment services for those patients likely to require medical (and surgical admission)...the following services should normally be provided:

- General surgical 24/7 receiving service*
- General medical 24/7 receiving service*
- Anaesthetic services on a 24/7 basis including general critical care services”*

Building a Health Service Fit for the Future. Kerr D, SE – 2005

The English Department of Health, in its survey, acknowledged the need for critical care facilities for unselected medical admissions but introduced a range of models – one of which (in Penzance for example) was an ‘emergency unit’ which appears to have some similarities to the present Integrated Care Pilot. However responses to this highlighted areas of concern, notably that availability of “appropriately skilled staff was a key issue”. (Keeping the NHS Local – a new direction of travel. Department of Health – 2003).

The Panel has examined the case made by the Glasgow anaesthetists for their inability to cover the Vale of Leven. They made the following points to us:

- The European Working Time Directive and new contract arrangements (which have to be adhered to) place new limitations on working hours
- Critical care involves more than core anaesthetic skills (intubation) but also clinical judgement and whole care of critically ill patients (as practised by intensivists who are relatively few in number)
- It would not be possible to supervise junior or incompletely trained staff safely from a distance

- The frequency of critical episodes requiring skilled anaesthetic involvement is low which would lead to deskilling and ‘clinical boredom’ – wholly unattractive to permanent consultant staff
- Rotation of consultant intensivists into short periods at VoL was simply not a practicable option

The Panel notes the inability of the Glasgow anaesthetic service to provide a sustainable service to cover out-of-hour requirements for UMA at VoL. These views were substantiated by expert opinion outwith the West of Scotland.

The critical issues for UMA are:

- concern about clinical safety
- sustainability of the service in the absence of anaesthetic cover
- availability of alternative services (at RAH)
- ability of ambulance transfer to cope especially in times of inclement weather and traffic congestion.

The lead Panel member has visited both sites (VoL and RAH), talked with clinicians and staff, met with the anaesthetists with management responsibility in NHS Greater Glasgow and Clyde and held discussions with independent clinicians elsewhere in Scotland. The Panel has been made very aware of the strength of feeling in the community and among the staff.

The Panel has been greatly impressed by the enthusiasm, loyalty and professionalism shown by a number of local general practitioners in their efforts to create and develop the innovative solution known as the integrated care project. One of many remarkable aspects to this model is the obviously successful working relationship between general practitioners and hospital consultants. Attempts have been made to collect sufficient data, both retrospective and prospective, from which to allow a sound informed judgement to be made on aspects of the safety and practicability of the model. The data that have been gathered so far, are interesting and encouraging, and might provide a sound basis for further structured evaluation. Such an evaluation would require the continuing presence of on-site anaesthetic cover for an appreciable period. The Panel feel it is regrettable that this model, which could have potential implications for service delivery in other locations in Scotland, was not the subject of an application for national Health Services Research funding, the granting of which would have allowed proper support to the clinicians in data gathering and analysis. Equally, however, the Panel recognises that even the formulation and pursuit of a major application of this sort takes the sort of time and back up which is not available to most full time clinicians.

The Panel feels that the opportunity to mount a scientifically sound, and safe, pilot study of the prediction element of the project should be re-examined by the Board, providing a safe level of anaesthetic cover was provided for the duration of the study. A vital element of such a study would be external, independent and skilled design and

evaluation by experts in health services research such as those in the Health Services Research Unit and the Health Economics Research Unit in Aberdeen.

Patient safety depends of course, not only on quality of care but also on access – distance to travel. As stated above, there is evidence that for certain acute medical conditions risk increases by a small increment with each mile travelled (Nicholl et al, The relationship between distance to hospital and patient mortality in emergencies – an observational study. *Emergency Medical Journal* 2007, 24:665). Risk calculation therefore is a balance between these two and is very difficult to assess, though it must be said that the proportion of patients whose outcome would be likely to depend materially upon length of ambulance journey in the present context is very small (less than 5%).

We have repeatedly been reminded that the Erskine Bridge closes in high winds and occasionally also the Clyde tunnel. Furthermore congestion and accidents can hold up ambulances. The relatively short distance from the Clyde area to Renfrew is not enough to warrant helicopter retrieval.

The report of the discussions between NHS Greater Glasgow and Clyde and Scottish Ambulance Service made available to the Panel deals mainly with finance, rather than with these operational issues.

Although no formal option appraisal is described the NHS Greater Glasgow and Clyde Board make a clear case for RAH to take over UMA from VoL. Concern has been expressed that RAH “will not be able to cope with up to 6,000 more admissions a year”. It has been put to us that RAH has recently been able to free up some medical beds and that a large area has been vacated by the Nursing School. RAH already has strong links with the Clyde area (through A and E and other services). The Clyde Acute Management Team, in their planning document of May 2007 (and Nov 2007) give their contingency actions and state that they “are confident that those 56 inpatient beds combined with steps to increase discharges and bed throughput would be enough to accommodate the Vale activity”. Clearly that would depend upon early step-down to VoL which would be vital to the success of the arrangement. There is, however, little evidence given of the hidden costs in this move, the redeployment of staff and mode of working (which would include the senior medical staff from VoL). There is limited evidence of engagement with the GPs on this part of the proposals and no evidence of engagement with NHS 24. The problems for relatives and visitors feature much in the public mind but receive little attention in the Board’s papers.

The distance of RAH from the North Clyde area is of great significance for patients, staff and visitors, as is the ‘psychological barrier’ of the River and Erskine Bridge. The Panel feels that the Board should investigate all possibilities for alternatives to RAH, within a reasonable distance from Alexandria.

The fourth element of the integrated care model envisaged early transfer back (step-down) to VoL of those sent to RAH. This receives little attention, although it is vitally important within the reconfiguration proposed. As many of these patients will still be

quite unwell, we would question the Scottish Ambulance Service proposal to purchase one extra 'patient transport vehicle' (essentially a minibus) for that purpose.

The Panel feels that more effort could have been made to provide a vision for the VoL hospital in the medium to longer term. There is a huge opportunity to reshape this hospital into a viable and effective community hospital with early "step down" and intermediate care for UMA, a full range of "cold" surgery and medicine, specialist clinics, primary care and minor injuries services etc. These, of course, are already largely in place (some 92,000 patient episodes yearly) but a new look with some deployment of resources might go some way to relieving the sense of isolation and frustration within the North Clyde community.

KEY POINTS

The Panel believes in the light of good practice and the weight of medical opinion, that the maintenance of a 'stand alone' unscheduled medical admissions (UMA) service, separated from all other acute services (including ITU) is a significantly less than ideal situation. On these grounds NHS Greater Glasgow and Clyde's desire to relocate the VoL UMA service is sound in principle.

The Integrated Care Project was an innovative effort to find a workable, sustainable and safe alternative model to keep the services 'local'. It has not been fully implemented, but the Panel accepts that the Board had little alternative but to halt its full adoption in the light of concerns expressed and the failure to enjoy the confidence of a substantial part of medical opinion.

The Panel feels that NHS Greater Glasgow and Clyde has thus far, in its engagement with the community, failed to convince the majority of its stakeholders of the benefits of its preferred option. Notably, this includes apparently large segments of the affected community, West Dunbartonshire and Argyll and Bute Councils, Lomond and Helensburgh Planning Group, and other properly constituted bodies. The Panel believes that a wider measure of understanding should have been achieved prior to wider public consultation.

Furthermore, NHS Greater Glasgow and Clyde has not done enough to address the widespread concerns about ambulance journeys and more detailed planning which is transparent and evidence based is required before the proposals can be confidently endorsed.

The VOL Hospital needs a positive statement about its future, with consolidation of those services that remain safely decentralised. The NHS Greater Glasgow and Clyde Board also needs to make clear the future role of VoL in the totality of Greater Glasgow's planning.

The Panel notes the attraction of RAH as an alternative site for UMA (already a small proportion of critically ill patients go there either directly or on transfer, along with all A & E, surgery, paediatrics etc) but feels, however, that the

feasibility and cost-effectiveness of providing UMA services at a hospital other than RAH (or VoL) should be investigated, and if possible, presented as an option. More detail is required of structural, operational and especially staffing plans before the option of transferring UMA to RAH is put to public consultation.

The Panel was impressed with the enthusiasm and desire of local clinicians, including a number of GPs, to make the pilot workable with GPs taking a role in night cover (and with locum anaesthetic back-up). The panel believes that an opportunity exists to consider the feasibility of continuing the current arrangement to allow a formal evaluation of the stratification model (the prediction of those most likely to require critical care). This could have national application for smaller hospitals in Scotland. It would, however, require a national lead, expert scientific assistance and injection of resources in order to maintain a safe and viable service throughout the project including on-site anaesthetic support.

Finally, the Panel believes that the Board should conduct a formal option appraisal exercise on the various possibilities, so that the options are transparent and accessible to all concerned during the consultation.

In summary, the Panel feels the following options should be fully developed, appraised, and presented for public consultation:

- 1. The status quo**
- 2. The status quo for a specified period with continuance of anaesthetic support to permit evaluation of the prediction model**
- 3. The transfer of UMA to RAH**
- 4. The transfer of UMA to another Glasgow hospital.**

OLDER PEOPLE'S SERVICES

In commenting on the problems posed by delivering health care to the elderly, the Kerr report (Building a Health Service Fit for the Future) identifies that “the ageing of Scotland’s population is a particular challenge to health care. In the next 25 years or so the proportion of the population over 65 will increase to over one in four”.

Long term planning for care of the elderly is inevitably dependent on assumptions. Furthermore, new models of health care have not always been fully evaluated. Many of the concepts for newer methods of care need careful evaluation (Academy of Medical Royal Colleges, 2007). Changes in care of the elderly are clearly required – hospital services were not always designed with older people in mind and frequently buildings fail to meet the requirements of the elderly disabled (A Recipe for Care – Not a Single Ingredient. Clinical Case for Change. Philp. I. Department of Health 2007).

The principal driver of the proposals by NHS Greater Glasgow and Clyde is the need to correct the imbalance of care historical in Renfrewshire, as judged by modern standards

(there being a higher than national average of continuing care NHS beds). A great deal has already been achieved by reducing 'continuing care' bed occupancy from 188 to 60 in the last 5 years with an expectation of continued reduction in length of stay. There is also an expectation that delayed discharge occupancy will fall to zero by April 2008 under Government targets.

The lead Panel member for this service has visited Johnstone Hospital and spoken with medical, nursing and management staff. The buildings clearly fail to reach current standards of care. For example, it is difficult or impossible to access toilets with patient lifts and there is considerable lack of privacy in the bedded units. One ward block remains empty. Major upgrade of these facilities has not been considered as a practical option. Closure of the hospital would require considerable cooperation with community and the local council in a partnership model to accommodate the residual continuing care patients (some 35 or more). An alternative plan to a community based partnership, mentioned in the proposals, might be purpose built accommodation alongside RAH. It is unclear however, why this might not be a viable option.

The partnership model proposed involves a number of assumptions not all of which the planning group has been able to confirm. Detailed planning appears to have been delayed pending approval of the main proposals but the viability of the partnership scheme depends upon robust and realistic commitment, and sound financial expectations (in a changing and tightening financial situation).

It is clear that the planning group has been influenced by Scottish national standards and guidelines. The imbalance of "too many" continuing care hospital beds is historical but according to ISD figures they are still above the national average. Reducing this 'excess', closure of unsatisfactory accommodation and providing community based accommodation (remaining under NHS clinical care) is the basis of the proposal.

It is noted that NHS Greater Glasgow and Clyde has taken account of national Guidelines (for example, "All our Futures: Planning for a Scotland with an Ageing Population") and has concluded that there is a reducing need for continuing care beds. New and more appropriate accommodation is required and maintenance of a close acute assessment/continuing care relationship. It has been put to the Panel that the Board's experience of the partnership model elsewhere in its region has been successful. The Panel is not clear from the lack of implementation of this model more widely throughout Scotland about its long term evaluation. The financial uncertainties are referred to in the Finance section of this report.

The proposals inevitably raise anxiety in the community. The engagement meetings earlier this year were intended to meet these anxieties; the Panel notes that the follow-up meeting planned for 13 September 2007, at the request of the Scottish Health Council, was postponed "because of the independent scrutiny".

KEY POINTS

The Panel believes that the overall concept in the proposals is correct and the principles sound. Planning appears to have explored the range of problems in depth and with the agreement of the majority of clinical staff, but some assumptions remain. Achieving zero delayed discharge occupancy by April 2008 seems ambitious. The relationship between health and social services for physically frail elderly and mentally frail elderly is unclear; it is important to maintain the closest possible integration to ensure that patients with dementia and physical problems do not slip between services.

The Panel notes the absence of formal option appraisal but agrees with the NHS Greater Glasgow and Clyde that, on the available evidence, the proposed model is reasonable. Notwithstanding the shortcomings of the facility at Johnstone hospital, change from familiar models causes anxiety to some – they fear that changes are retrograde and put into place rapidly in order to save money. Staff may feel insecure and the changes in skill mix with the move to partnership care will present challenges. Patients and carers will be naturally apprehensive.

NHS Greater Glasgow and Clyde should ensure well in advance of public consultation that the plans for change are made clear to patients, carers and staff. The Panel is considerably concerned that the partnership model is proposed in the document without any indication of where and how this will be accomplished; a clear description should be available prior to proceeding to full consultation in order that all concerned can picture the form and location of the new accommodation.

Possible options for consultation:

1. Status Quo
2. Re-provision in new build on the RAH campus
3. Re-provision in partnership facilities.

FINANCE

The financial case is one of the key components for each of the proposals put to the Board. A fundamental aspect of our Review was the determination of the strength of the financial case associated with each proposal in the context of Best Value.

The following issues were highlighted in the course of our review:

- Service Reprovisioning – Resource Allocation
- Assessment of Choices – Option Appraisal
- Identification of relevant Costs and Benefits
- Financial Modelling and Assumptions
- Financial Sustainability – Impact upon Establishments

- Risk
- Value for Money - Best Value Approach

SERVICE REPROVISIONING - RESOURCE ALLOCATION

The seven proposals are essentially categorised into the four main headings of Mental Health, Older People's Medicine, Community Maternity and Unscheduled Medical Admissions. Following an examination of the papers presented to the Board on 26 June 2007, the Panel found it extremely difficult to track the overall shift in service provision and related resources, even after detailed study of these proposals.

In terms of the direct impact on bed provision and staffing, the high level service changes can be summarised within the following table:

Proposals	Impacted WTEs Direct Staffing	Existing Provision (Beds)		Proposed Reduction (Beds)		GCC&C Establishments		Partnership Establishments	
		Acute	Cont. Care	Acute	Cont. Care	Acute	Cont. Care	Acute	Cont. Care
Mental Health	145.00	206.00	311.00	-54.00	-185.00	152.00	17.00	0.00	109.00
Older People's	62.24	0.00	60.00	0.00	-25.00	0.00	0.00	0.00	35.00
Unscheduled MA	150.00								
Closure of Birthing	59.51								
Suites at CMUs									

As can be seen from the table the shift in service provision is not insignificant. Such a significant shift is well highlighted in the movement in all mental health and older people's continuing care beds within Board establishments from a current provision of 371 to just 17. In terms of the overall mental health proposals, the proposed reduction in beds equates to some 26% of acute beds and 60% of continuing care beds (but a 95% reduction of those in NHS accommodation). It is interesting to note that the mental health proposals include the recycling and application of some £11.5 million and include the following:

Sources

Recycling recurring infrastructural costs of £3.0m including costs saved through the previously approved decision - the closure of Ravenscraig Hospital
 Retraction of Acute and Continuing Care Service - £6.8m
 Forensic Service Development - £1.7m

Applications

Contributing £2m towards the inherited Argyll and Clyde overall deficit of £30million
 Development of Community Services including Crisis Services - £3.5m
 Reprovisioning of Continuing Care Beds - £3.4m
 Capital Commitment and base Budget Adjustments - £0.9m
 Specialist Service Development – Medium and Low Secure Places - £1.7m

In relation to the closure of the continuing care beds for older people at Johnstone Hospital it is noted that the Board estimates that re-providing services within a partnership arrangement will cost some £1.6 million against an estimated current cost of £2.6 million at the Johnstone Hospital site. Effectively such a proposal will contribute some £1 million in savings which will further “contribute to delivering financial balance across Clyde...” Together with the projected £2 million contribution from the mental health proposals as highlighted above, this combined £3 million contribution to the Clyde Deficit represents some 24% of the actual available service resource in this model of £12.4 million for both the mental health and older people’s proposals (net of forensic services/specialist services development of £1.7 million included in both Sources and Applications). Essentially, 24% of available resources from mental health and older people’s proposals in this model are being removed from such services, with some 17% of the mental health resources within this model being specifically used as a contribution towards financing the inherited Clyde deficit. It is assumed that the £1 million of savings arising from the older people’s proposal will be used for service development/financial ‘headroom’ within the overall Clyde acute budgetary provision.

It is recognised that such service re-provisioning is fully in accordance with the Board’s desire to shift the balance of care into partnership based solutions in accordance with current national policy. Of concern to the Panel are two fundamental assumptions that impact upon financial sustainability of the Mental Health and Older People’s Proposals:

- Future demand for the service in the context of growing pressures – validity of benchmarks
- Changes in unit costs arising from partnership/private sector exposure

In relation to mental health partnership bed costs, the Board’s own model includes for a significantly higher cost per bed as provided by the independent sector. This is illustrated in a projection within the model of a unit cost per bed which is some £24,000 or 71% higher per partnership bed over the comparable NHS provided and funded nurse arrangements. More expensive provision effectively equates to a reduced capacity to meet the levels of service currently being provided. Whilst the Board is confident that future demand can be accommodated within their own projected benchmarked capacity targets, any increased demand for this service aggravated by potentially higher cost pressures aligned to the independent sector/partnership provision model, may require a marked further reduction in service provision in order to contain costs within the overall budget for this service.

In relation to the CMU proposal, the Board draws a comparison of costs per birth at the VoL (£5,696) and the Inverclyde Royal Hospital (£5,753) with the cost of a birth at RAH of £1,836. Given the configuration of unequal overhead and capacity at these establishments such comparisons were always likely to show significant differentials. The resultant differential in overall costs highlighted within the CMU Proposal Option Appraisal of £0.5m from the status quo of £4.1m to the single unit model of £3.6m is essentially the financial driver behind this proposal.

The Board has stated that the closure of the Integrated Care Service at the VoL was not founded upon financial considerations. In relation to the other proposals, however, the overall high level impact savings of some £3.5m has been an obvious driver behind the Board’s financial strategy within these proposals and can be summarised as follows:

Service Proposal	Saving
Mental Health – Contribution to Clyde Deficit	£2.0m
Older People’s Medicine - Saving on Provision	£1.0m
Community Maternity - Indicative RAH Model Savings	£0.5m
Overall Savings from Proposals	£3.5m

ASSESSMENT OF CHOICES - OPTION APPRAISAL

A fundamental aspect of good practice is the application of appraisal and evaluation. Indeed, this is considered to be integral to robust decision making. The appropriate guidance on Appraisal and Evaluation published by the Scottish Government as part of the Scottish Public Finance Manual Guidance, which is fully applicable to Health Boards, states that the “general principles should apply to any proposal – whether project, programme or policy related – with implications for expenditure/use of resources.” It is generally recognised that a framework of good practice within the public sector can be found within the HM Treasury’s Green Book – Appraisal and Evaluation in Central Government and Annexes. Indeed, it is understood that the Green Book has been adopted by Scottish Ministers as being appropriate and applicable as best practice to the Scottish Administration and related bodies. In respect of a relevant process framework, adherence to the framework or the spirit of the Green Book typically produces the following processes:

- Formulation of Project/Service Change Objectives
- Identification and consideration of options/alternatives which will deliver objectives
- Identification and incorporation of all relevant costs and benefits
- Determination of risk and other factors which impact on each option - weighting
- Analysis and Determination of Optimum Option over alternatives

Whilst it is recognised that option appraisal is commonly used in the decision making process in typical capital project investment decisions, it is clear that best practice requires the application of such basic principles to proposals involving significant service change. It is accepted that the extent and degree to which appraisal techniques will be used is a matter of professional judgement based on materiality and significance of the proposals being tested. During our “Clarification Meeting” with the Board, it was put to us by Board officials that the option appraisal processes embodied within the HM Treasury Green Book was rarely used in the planning of service changes within the Scottish Health Service. Indeed, it is our understanding that it is the Board’s view that the Green Book and Best Value are not part of the planning framework for the NHS in Scotland. We assume that such an assertion is based upon anecdotal evidence. Notwithstanding this position, it is our view that the adherence to the ‘spirit’ of this

good practice guidance should be evidenced in the formulation of any proposal for significant service change including the identification of options/alternatives and the full incorporation of all relevant costs, opportunity costs and benefits within such an appraisal process.

Despite prevailing good practice, in respect to the proposals under scrutiny, the application of appraisal techniques was explicitly used by the Board only in relation to the proposal to close the birthing suites at the Community Maternity Units (CMUs) at Inverclyde Royal Hospital (IRH) and the Vale of Leven Hospital (VoL). It is, however, the Board's position that alternative options to the Mental Health proposals were available but not scored and suitably appraised. We understand that it is also their intention to score such options and include these in a further appraisal exercise.

IDENTIFICATION OF RELEVANT COSTS/BENEFITS

A crucial aspect of appraising options is the identification of all relevant costs and benefits. In terms of significance, it is understood that the conclusion of the Integrated Care Pilot impacts on some 6,000 patients per annum – these patients being treated at the RAH in Paisley. Whilst the Board concluded that no alternatives were appropriate for the unscheduled admission situation at the VoL Hospital, an assessment of options would have required the establishment of a status quo position with the RAH reprovision being an alternative as well as any modifications to the existing status quo being considered as further options. During our review it became apparent that significant additional costs of reproviding this service at the RAH would have to be fully met by the Board and thus incorporated within any option appraisal. These additional costs for Unscheduled Admission Proposal would include:

- Impact on RAH – increased RAH capacity – no detailed cost projections supplied but thought to be at least £300,000 capital Costs and an additional £200,000 annual revenue costs
- Travel – Additional Capital Investment of £1.3m on Ambulances and £750,000 of recurring annual revenue running costs for such Ambulances levied by the Scottish Ambulance Service
- Staffing Relocation/Preservation/Reskilling Costs – no quantification on impact for absorption of additional staffing costs arising from displacement of staff

The central factor in the Board's decision in ending the Integrated Care Pilot is one of clinical safety. This position presupposes that the Board is not willing to increase the resource envelope to challenge the clinical safety position or evaluate alternatives requiring additional investment.

We could find no evidence of a comprehensive financial evaluation of the impact of concluding the Integrated Care Pilot at the VoL Hospital that included the capture of all relevant costs including opportunity costs. A proper assessment of alternatives would require options to be identified and appraised. This in turn would require the identification of all costs, opportunity costs, benefits and risks. From a financial

management perspective the assessment of this proposal is less than robust. There was no evidence to suggest that this proposal has been fully costed, and such a shift in activity may impose significant additional recurring liabilities outwith existing budgetary provision. As no alternatives have been offered we are not in a position to establish whether the Board's preferred course of action represents value for money.

FINANCIAL MODELLING AND ASSUMPTIONS

In terms of our financial assessment, the differing methods of financial modelling used were evaluated. Whilst there was no effective financial model for the conclusion of the Integrated Care Pilot, in respect of the mental health proposals, the background financial workings were found to be well constructed including, unlike other proposals, an appreciation of relevant staff displacement costs as part of a transitional cost package of £3.5 million in 2007/08 and £3.0 million in 2008/09. However, despite a full and thorough set of workings on the mental health proposals, the underlying assumptions on cost exposure in relation to partnership working were lacking in detail and primarily based on procurement experience gained in areas outwith the Clyde area. Similarly, the workings behind the CMU proposals were found to follow a reasonable structure although we could not see the additional impact of staffing costs arising from displacement shown within the Option Appraisal itself.

As with the lack of precision on the assumptions surrounding partnership provision within the mental health proposals, the same lack of evidence on the partnership assumptions was evident within the financial implications for the transfer of the continuing care service for Older People at Johnstone Hospital. The only explicit detail on such partnership assumptions were an indicative outline service cost exposure of £1.6 million on providing 35 placements against the existing provision of a £2.6 million resource requirement funding the 60 continuing care beds for older people at Johnstone Hospital.

Fundamental to the assumptions used within the financial modelling is the setting of appropriate levels of service provision based on benchmarks as suitable proxy indicators. These benchmarks are critical as they are effectively used to determine the level of proposed service provision. Such benchmarks are especially relevant within the proposals for mental health and older people's continuing care at Johnstone Hospital. Having reviewed the context and source of benchmarks used by the Board, it is our view that further evidence is required to substantiate the validity of using such measures to project and set future service provision. For example, the benchmark used to set acute mental health admission beds was structured within a 3 stage process:

1. Application of standard Glasgow Benchmark Inpatient Bed Levels
2. Further refinement to reflect local judgement
3. Achieving a "Best Fit" between benchmarking requirements and individual ward requirements

It is an explicit assumption that the starting point of the standard Glasgow Benchmark is fully appropriate for Clyde. Similarly, in relation to the provision of Crisis Resolution Services the Board states that such services can achieve a 20% shift from inpatient to

community care for adult admission beds. It is further stated that Greater Glasgow Beds have already achieved a 10% reduction in acute admission beds with an expectation that the further 10% can be readily achieved. The published research into the impact of crisis resolution services on the need for hospital beds is limited, inconclusive, and conducted outside Scotland (see Appendix 9). While it is recognised that Greater Glasgow have taken bold steps in rebalancing community and hospital services, and that many of their quantitative predictions are based on experience in Glasgow, it is not clear that the figures can be extrapolated to Clyde.

In relation to the older people's proposal at Johnstone Hospital the target number of beds has been based upon changing demographics and improved clinical assessment of continuing care. As with the benchmarks used for the mental health proposals, the Panel was not provided with the workings underlying the assumption. Accordingly, without the availability of a detailed local assessment of need, set against recognised national indicators, we remain to be convinced on the validity of the benchmarks used for these sets of service proposals.

FINANCIAL SUSTAINABILITY - IMPACT UPON ESTABLISHMENTS

It is important to recognise the background to the Board's financial position. Notwithstanding the management of some £2.6 billion of revenue resources and a Capital Budget of £118m within the current financial year (about a quarter of the total Scottish Health Budget), it is recognised that the Board is required to address the funding of a £30m deficit inherited from the financial position arising from the erstwhile Argyll and Clyde Health Board. Both Mental Health proposals and Older People's Proposals at Johnstone Hospital are expected to yield some £3m towards this deficit. It is interesting to note that despite the succession to full responsibilities for the operational and financial affairs of the Clyde area in April of 2006, the internal financial structuring of the Board retains an element of partitioning which ensures that services and related budgets for the Clyde Area are managed, maintained and monitored separately to those of Greater Glasgow. Whilst the Board may be anxious to protect itself and users in both Greater Glasgow and Clyde areas from localised pressures and the impact of previous management strategies, it would be our view that such an approach of partitioning will inhibit the optimum configuration of services should this position prevail over the medium and long term.

Outwith the deliverability of the proposals, a crucial factor that should be recognised is the impact and financial sustainability of the establishments that are subject to service addition/removal/reduction such as the VoL, and Inverclyde Royal Hospitals. Additionally, the corresponding impact upon the RAH receiving these displaced services, patient volumes and staffing should also be highlighted as being fundamental to assessment of the Board's proposals. Both Dykebar and Gartnavel Royal Hospitals are also significantly impacted by the proposals. Within the Board Paper's submitted on 26 June there are few references to the financial implications which may affect these establishments. In relation to the potential impact on such establishments we would make the following comments:

Vale of Leven Hospital

It is understood that over a number of years, services such as surgical, Accident and Emergency and related support services such as pathology and mortuary services have been removed. It is further understood that the current CMU costs some £1.1 million (28.49 FTE) and the proposed mental health service reconfiguration will take out another £1.9 million of adult mental health costs currently incurred at the Vale of Level Hospital.

As the total annual net recurring budget for acute services at the VoL Hospital is approximately £31 million, the removal of £3.0 million of activity represents nearly 10% of total acute services. In terms of medium and long term sustainability this is not insignificant, as without new services being introduced, sunk costs, in the form of fixed and semi fixed overheads will require to be shared by the remaining services. This may include infrastructure costs which are incurred to support the viability of the Hospital such as fabric maintenance and grounds maintenance. Sharing such overheads by the remaining services undoubtedly will push up specialty unit costs and may eventually impact on the overall viability of the establishment. As part of our scrutiny we raised the question directly with the appropriate Board Officials at a Clarification Meeting and received an assurance that the financial sustainability of the VoL Hospital has not been compromised in any way by these proposals.

Without any formal indication of future investment in the form of service developments or service expansions plans/investment at the VoL Hospital it is our view that such an assurance cannot be readily be made, especially against the background of financial stringency imposed by the financing of the inherited deficit exclusively from Clyde sources.

Inverclyde Royal Hospital

Outwith the retention of some Mental Health Beds the main service change is the removal of the CMU birthing suite located within this establishment with a current budgeted spend of some £1.24m with a staffing complement of some 31.86. Whilst such a service removal may not be regarded as significant in the context of the total Acute Budget for this establishment of £63.6m, the same issues surrounding overhead absorption at the VoL Hospital apply and reduce the capacity of Inverclyde Royal Hospital to absorb adverse fluctuations in infrastructure costs and potentially increased unit costs, albeit on a marginal basis.

RAH

There is no doubt that the consequential impact of dealing with an additional 6,000 Unscheduled Medical Admissions as well as accommodating an expansion in the Maternity Services Unit to provide for an expected increase of approximately 150 Births will have an obvious impact upon capacity. In terms of significance, it is recognised that such additional demand may represent a marginal change for a Hospital which has an annual budgeted provision of £111.4m for Acute Services. That said, the validity and strength of the relevant proposals impacting this establishment depend, in no small part, upon the opportunity costs and risks associated with increasing the capacity at the RAH being fully considered. In this respect, it is our view that the Board's financial

assessment of the impact upon the RAH in respect of the transfer of Unscheduled Medical Admissions from the VoL requires to be more robust.

RISK

An essential aspect of best practice appraisal is the full assessment of risk. Each proposal carries a number of assumptions which are fundamental to successful implementation. As already highlighted above, of significant concern is the lack of robust consideration of alternative choices of service delivery and the consequential appraisal of such options. It is of concern that significant assumptions which are pivotal to the success of such proposals have not been subjected to such an assessment.

In common with best practice, we would expect some form of sensitivity analysis to be applied to the critical assumptions. For example, by estimating the impact on available provision by varying such assumptions e.g. annual partnership provided bed costs by varying such costs as follows:

High – decreasing the cost assumption by 50% and increasing the savings assumptions by 150%

Low – increasing the cost assumption by 150% and decreasing the saving assumptions by 50%

In terms of financial risk, the lack of assessment of risk is especially problematic in the following areas:

- Partnership Model – assessed risk on cost exposure for Mental Health and Older People's Proposals
- Partnership Model – actual capacity to absorb existing dependent patients e.g. inpatients at Ravenscraig and Johnstone Hospitals
- Additional Uncosted Investment - Unscheduled Care - Ambulance, Staffing and RAH Infrastructure
- Future Demand – validity of chosen benchmarks on service provision
- Future Resources – availability of baseline budgets
- Staffing – availability of suitably trained staff – successful redeployment

VALUE FOR MONEY - BEST VALUE?

It could be argued that the recognised Economy, Efficiency and Effectiveness components within the original concept of Value for Money has been enhanced through the wider consideration of Best Value. The concept of Best Value became relevant to Health Boards through the Public Finance and Accountability (Scotland) Act 2000 which allowed Ministers to apply Best Value requirements to various public bodies. From April 2002, a duty was placed upon Accountable Officers within each Health Board to demonstrate that appropriate arrangements were in place to secure Best Value in the delivery of services. The demonstration of Best Value became a statutory duty for Local Government Police and Fire Services in 2003 and such a duty is tested by Audit

Scotland in the form of the Audit of Best Value and Community Planning. This audit is currently applied to Local Authorities on a rolling basis. Whilst there are no immediate plans to apply similar scrutiny arrangements to Health Boards it is highly likely that both Audit Scotland and the general public will be requiring Boards to further demonstrate that public money is being used wisely.

Effectively, Best Value is about making arrangements to secure continuous improvement in performance while maintaining an appropriate balance between quality and cost and to have due regard to:

- Economy
- Efficiency
- Effectiveness
- Equal Opportunities
- Contribution to Sustainable Development

Successfully demonstrating continuous improvement includes highlighting evidence of the application of Challenge, Competition, Comparison and Consultation. There is no doubt that the formulation of the proposals presented to the Board on the 26 June is part of the Board's endeavours to secure continuous improvement. However, on a strict financial assessment, the only proposal which comes close to being robust is the proposed closure of the CMUs and even with this proposal, we require to be further convinced that adequate provision has been made within the financial modelling for additional staffing displacement/preservation costs and infrastructural capacity, albeit marginal, at the RAH. This is in contrast to both the Mental Health and CMU proposals, which have been underpinned by solid financial modelling of these factors.

In terms of the remaining proposals it is our view that there is a lack of precision in the determination of fundamental assumptions such as Partnership Provision capacity/ expected unit costs, additional staffing costs, transportation costs and additional RAH Investment to cope with the additional capacity. In the absence of national sourcing and local service calibration, the validity of the projections used to set the desired level of service provision requires to be further demonstrated.

The Panel recognises the significant issues regarding the allocation of scarce resources and the not insignificant challenge that the Board is facing in this regard. The target of making good the inherited deficit as well as creating 'financial headroom' for service improvements is likely to be extremely difficult. It would be inaccurate to suggest that the financial drivers behind the realisation of some £3.5m in savings arising from the package of service change proposals under consideration is not a primary consideration. However, Best Value is not solely about economy but encompasses much wider considerations including continuous improvement and it is upon such wider measures such as efficiency, effectiveness and sustainability that the financial arguments should be evaluated.

In summary, the lack of identification of alternatives and the failure adequately to assess risk undermines the production of a robust financial case for each proposal. The true merits of such proposals may be lost through inadequate assessment and challenge. Due to the absence of a robust approach in the formulation of these proposals, we are unable to find persuasive evidence that suggests that each proposal is founded upon a robust financial case, that a Best Value approach has been taken and that the Board's proposals constitute value for money.

TAKING ACCOUNT OF PEOPLE'S VIEWS

THE SCOTTISH HEALTH COUNCIL INTERIM REPORT

An interim report on NHS Greater Glasgow and Clyde's procedures for public engagement on 'Clyde Health and Service Strategies' was produced by the Scottish Health Council in October 2007, and has helped to inform the Independent Scrutiny Panel's deliberations.

The Scottish Health Council reports that it is aware that community representatives from across the area were dissatisfied with specific strands of the engagement process carried out by NHS Greater Glasgow and Clyde. The report states that there is clearly strong local opposition to the Board's proposals for service change, particularly in relation to the VoL Hospital, where the two affected local authorities expressed their concern, as did the local community.

The Scottish Health Council maintained regular dialogue with the Board on their engagement process, and highlighted issues and concerns to them throughout the process. The report states that the Board has been responsive to most of the Scottish Health Council's suggestions. However, the report makes a number of further recommendations on how the Board should take forward the formal consultation on these plans, given the importance of demonstrating genuine attempts to take into account the views of local communities.

The Scottish Health Council recommends that in future attempts to inform and engage, NHS Greater Glasgow and Clyde should:

- ensure stakeholders are involved in the detailed planning of proposals from the outset
- ensure that formal Terms of Reference are clearly set out when establishing a new group and that there is common understanding of and agreement to the Terms of Reference
- provide resources, support and facilitation for lay representatives and staff to enable them to be effectively involved in planning and engagement groups
- develop strong working relationships and engagement mechanisms with neighbouring Boards whose populations may be affected by proposed service change to ensure all affected populations are involved in the process of informing and engagement

- monitor the sharing of information and opportunities for engagement for all those who may be affected by service change
- evaluate their engagement processes and identify and address areas of learning
- develop its relationships with local communities so they can have confidence and trust that any decisions made by the Board are in their best interests.

THEMES FROM THE PUBLIC MEETINGS

The Panel held public meetings in November in Greenock, Paisley and Dumbarton to take views from local groups and members of the community on NHS Greater Glasgow and Clyde's proposals.

The specific points emerging from these meetings are listed in Appendix 5.

Many of the specific points, and most of the general points, have been reflected in the sections of the Report which deal with specific topics. The general points that were heard most frequently were:

- worry over bed closures and whether needs would be met by care in the community
- the lack of any clear picture of what and where the "partnership" provisions would be
- in communities potentially affected by centralisation, concerns over travel and ambulance delays
- lack of confidence to challenge clinical views about safety
- the whole exercise is about saving money.

WRITTEN SUBMISSIONS

It was felt that it would be important to encourage written views, as well as attendance at public meetings. This was done through press releases, information packs and publicity on the Independent Scrutiny Panels' website.

The Panel received 28 individual letters and emails in total, most of which related to proposed service changes at the VoL Hospital. In addition, three petitions were received - with a total in excess of 40,000 signatures – also in connection with the service proposals at the VoL Hospital.

In response to a letter from the Chair, local council leaders submitted views on the proposals.

Further details of the written submissions and petitions are shown in Appendix 6.

ACKNOWLEDGEMENTS

The Panel wishes to express its deep gratitude to the following people, all of whom contributed greatly, in their different ways, to the conduct of the Scrutiny:

1. The Panel Secretariat, very much members of the team (names shown in Appendix 2);
2. Our external, independent, experts (names shown in Appendix 7);
3. The Scottish Health Service Centre for arrangements and logistics around the public meetings;
4. Our media advisors, Gavin Cameron and Pamela Dodds, from the BIG Partnership;
5. The Scottish Health Council for use of their office space;
6. Mrs Fiona Broderick for secretarial help;
7. Mr Dan House and Mr Alistair Brown for procedural advice;
8. Ms Julie Williams and the staff at No 78 St Vincent Street, where the Panel's meetings were held;
9. The staff at the various NHS facilities visited by the Panel;
10. The leaders and staff of West Dunbartonshire, Renfrewshire, Inverclyde and Argyll and Bute Councils;
11. The Members of the Scottish Parliament who gave us their views;
12. The very many members of the public who wrote to the Panel and who came out on winter nights to give us their views at public meetings.

APPENDICES

APPENDIX 1 - PANEL'S TERMS OF REFERENCE

TASK AND TERMS OF REFERENCE

The task of the Panel is to bring to bear independent, expert, probing scrutiny on the relevant service proposals for consultation from NHS Greater Glasgow & Clyde. The aim of this scrutiny is to provide assurance to the public, through the Panel's published commentary, that the proposals for consultation:

- are, in light of the presumption against centralisation, reasonable and necessary (i.e. is the Board correct to conclude that there is no reasonable way to sustain the local delivery of services);
- are safe, sustainable, evidence-based and represent value for money;
- are robust, patient-centred and consistent with clinical best practice and national policy
- have been prepared taking appropriate account of the views of individuals and communities affected, as assessed by the Scottish Health Council;
- and reflect full consideration of all viable service options.

In order to carry out its task the Panel will need to:

- provide a clear, comprehensive and accessible commentary on the proposals, in a form also suitable for publication;
- and to complete this work by November 2007.

PANEL MEMBERSHIP

To carry out the task as outlined above, the Panel will need to include individuals with the skills required to:

- probe, analyse, evaluate and assess complicated, inter-related proposals;
- evaluate clinical views in the context of current clinical thinking and policies, and in the light of manpower, training and practice issues in future, providing an authoritative assessment from a clinical perspective;
- evaluate the financial and economic implications of the proposals, including opportunity costs, and produce a quantified assessment;
- assess, as informed by the report of the Scottish Health Council, the degree to which the preconsultation proposals appropriately take account of the views of local stakeholders;
- produce clear, timely, well supported and accessible written conclusions.

The Panel membership, alongside the Chair, should consist of a clinical expert, a financial expert, and an individual with expertise in the field of public engagement/ consumer interests. To help demonstrate that panel membership is truly independent, it has been agreed that:

- the Academy of Royal Colleges in Scotland be asked to nominate a clinical expert;
- the Chartered Institute of Public Finance and Accountancy be asked to nominate a financial expert; and
- the Scottish Health Council and the Scottish Consumer Council be invited jointly to nominate someone with expertise in consumer and public involvement matters.

The organisations mentioned will be asked to follow agreed criteria in proposing names, such as avoiding those with a connection to Glasgow and Clyde. The Chair, once appointed, will be involved in discussing the potential nominees before final decisions are made. The Chair would also be able to propose co-option of further members, if necessary. Formal appointments would be for the Cabinet Secretary.

The Panel may wish to obtain additional expertise (for example, from a nursing specialist) to support its work. This will be left to the discretion of the Panel, and a small budget will be set aside for this purpose. The Panel would have effective control over the choice of advisers and, within the available budget, over the nature and amount of advice required.

STATUS OF PANEL, PAYMENT AND TIME COMMITMENT

The Panel will be an ad hoc group of experts, set up by the Cabinet Secretary for Health and Wellbeing to provide advice on specific, time-limited issues.

Panel members' expenses will be reimbursed, and remuneration will be offered at a rate of £400 a day, consistent with the current rate for members of the Mental Health Tribunal and other similar bodies.

The Panel will consider the evidence and rationale which underpins NHS Greater Glasgow & Clyde's proposals for consultation. It is expected that 15 days work be devoted to this in total, per person. In exceptional circumstances, this might be extended by up to 5 working days.

SECRETARIAT

The Chair of the Panel will want to discuss and agree the terms of the support the Panel receives but this clearly must be of a high quality in order to undertake research, prepare papers, undertake initial evaluation of material from the Boards, provide drafts of the Panel's final report, etc. It is proposed that the Scottish Health Council provide experienced secretariat support. There will also be media interest in the work of the Panel, and it will need expert advice to help it to respond effectively to that interest. It is proposed that NHS Quality Improvement Scotland communications resources, who support the SHC on media issues, provide this. This will ensure the Panel receives the appropriate support needed in dealing with the media.

APPENDIX 2 - PANEL MEMBERS AND SECRETARIAT

PANEL

Professor Angus Mackay

Independent Scrutiny Panel Chair

Professor Peter Brunt

Vice President, Royal College of Physicians,
Edinburgh

Mr John Hanlon

The Independent Case Examiner, Department of
Work and Pensions

Mr Stuart Fair

Senior Consultant, Institute of Public Finance
Limited

SECRETARIAT

Ms Sandra McDougall

Secretariat Manager

Ms Elizabeth Taylor

Panel Facilitator

Ms Rachel Howe

Secretariat Officer

APPENDIX 3 - LIST OF DOCUMENTS PROVIDED BY NHS GREATER GLASGOW AND CLYDE

FINANCE

Total Expenditure for Clyde Acute Services (August 2007)
Statement of Accounts for 2006/2007 (26th June 2007 – Board Paper 07/25)
2007/2008 Revenue Budgets and Staffing Analysis
NHS Greater Glasgow and Clyde Financial Statements
Option Appraisal Costing Template – Clyde Midwifery Service Review (22nd May 2007)
Clyde Maternity Unit – Status Quo Spend
Clyde Maternity Unit – Option for Centralisation of Births
NHS Greater Glasgow and Clyde – Capital Plan 07/08 – Monthly Monitoring Schedule

VALE OF LEVEN

Vale of Leven Hospital – Ambulance Service Requirement (25th June 2007)
Staff Feedback on Service Changes at the Vale of Leven
Vale of Leven Unscheduled Medical Activity – Impact on Royal Alexandra Hospital (November 2007)
Vale of Leven Hospital – Review of Anaesthetic Services (2007)
Acute Services Strategy Implementation and Planning Directorate – Agenda 25th October 2006
Review of Clyde Acute Services Vale of Leven Unscheduled Medical Admissions Workstream – Minute 25th October 2006
Vale of Leven Hospital Provision of Unscheduled Medical Care (21st May 2007)
Supplementary Commentary on Rationale for Transfer of Adult & Older People's Mental Health Services from Vale of Leven Hospital

Vale of Leven Reference Group

Vale of Leven Reference Group – Agenda of Meeting Held 10th October 2006
Vale of Leven Reference Group – Notes of Meeting Held 10th October 2006
Vale of Leven Reference Group – Agenda of Meeting Held 10th November 2006
Vale of Leven Reference Group – Notes of Meeting Held 10th November 2006
Clyde Health and Service Strategies (23rd November 2006)
Vale of Leven Reference Group – Agenda of Meeting Held 8th December 2006
Vale of Leven Reference Group – Notes of Meeting Held 8th December 2006
Vale of Leven Reference Group – Agenda of Meeting Held 12th January 2007
Vale of Leven Reference Group – Notes of Meeting Held 12th January 2007
Vale of Leven Reference Group – Agenda of Meeting Held 16th February 2007
Vale of Leven Reference Group – Notes of Meeting Held 16th February 2007
Vale of Leven Reference Group – Agenda of Meeting Held 23rd May 2007
Vale of Leven Reference Group – Notes of Meeting Held 23rd May 2007
Vale of Leven Reference Group – Notes of Meeting Held 22nd June 2007
Integrated Care at the Vale of Leven (26th June 2007)

Vale of Leven Reference Group – Agenda of Meeting Held 24th August 2007
Vale of Leven Reference Group – Notes of Meeting Held 24th August 2007

Vale of Leven Presentations

Presentation: Health Needs and Health Services (26th February 2007)
Presentation: Vale of Leven Hospital Provision of Unscheduled Medical Care (21st May 2007)
Presentation: Vale of Leven Hospital Integrated Care (12th June 2007)
Presentation: Vale of Leven Hospital Integrated Care Area Partnership Forum (21st June 2007)

Vale of Leven Integrated Care Project

Vale of Leven Integrated Care Project Proposed Pilot Development and Implementation Arrangements (15th June 2006)
Vale of Leven Integrated Care Project Outcome of Meeting on Tuesday 20th June 2006 and Proposed Further Action (21st June 2006)
Vale of Leven Integrated Care Project: Update (24th July 2006)
Vale Of Leven Integrated Care: Position Statement (28th August 2006)
NHS Greater Glasgow and Clyde Core Brief (4th September 2006)
NHS Greater Glasgow and Clyde Media Briefing (4th September 2006)
NHS Greater Glasgow and Clyde News Release (8th September 2006)
Media Statement: Emergency Inpatient Care at the Vale of Leven Hospital (15th September 2006)
Vale of Leven Integrated Care Project (September 2006)
Confidential Briefing: Hexham Hospital (October 2006)
Letter to Jackie Ballie to Andy Kerr with NHSGGC comments
Proposals to Address the Impact of Service Reconfigurations in NHS Argyll and Clyde on Anaesthetic Services at the Vale of Leven and Royal Alexandra Hospitals (August 2005)
Presentation: Vale of Leven Integrated Care (September 2006)
Vale of Leven Planning (28th September 2006)
Letter to Rt Hon John McFall MP (3rd October 2006)
Letter to Dr Kevin Woods (4th October 2006)

Vale of Leven Integrated Care Papers

Position Statement
Proposed Pilot Development and Implementation Arrangements
Outcome of Meeting on June 20th 2006 and Proposed Further Action
Vale of Leven Integrated Care Project – Update
Letter from Catriona Renfrew to Physicians at Royal Alexandra Hospital (25th July 2007)

Anaesthetics Workstream

Agenda: Vale of Leven Anaesthetic Working Group 22nd January 2007
Minute: Vale of Leven Anaesthetic Working Group 22nd January 2007
Agenda: Vale of Leven Anaesthetic Working Group 2nd March 2007
Minute: Vale of Leven Anaesthetic Working Group 2nd March 2007
Agenda: Vale of Leven Anaesthetic Working Group 18th May 2007

Minute: Vale of Leven Anaesthetic Working Group 18th May 2007
 NHS Greater Glasgow and Clyde Vale of Leven Hospital Review of Anaesthetic Services
 (26th June 2007)

OLDER PEOPLE'S SERVICES - JOHNSTONE HOSPITAL

Terms of Reference: Older Peoples Joint Planning Performance and Implementation
 Group (14th September 2006)
 Minute: Renfrewshire Older Peoples Joint Planning Performance and Implementation
 Group (14th September 2006)
 Minute: Renfrewshire Older Peoples Joint Planning Performance and Implementation
 Group (23rd October 2006)
 Minute: Renfrewshire Older Peoples Joint Planning Performance and Implementation
 Group (13th December 2006)
 Minute: Renfrewshire Older Peoples Joint Planning Performance and Implementation
 Group (5th February 2006)
 Presentation: Review of Clyde Health and Services Strategies (8th February 2007)
 Feedback Materials from Pre-Engagement Event 8th February 2007 (9th March 2007)
 Presentation: Shifting the Balance of Care (13th March 2007)
 Minute: Renfrewshire Older Peoples Joint Planning Performance and Implementation
 Group (19th March 2007)
 Feedback from Older People's Review Workshop 3th March 2007 (21st March 2007)
 Minute: Renfrewshire Older Peoples Joint Planning Performance and Implementation
 Group (30th April 2007)
 Presentation: Older Peoples Review Workshop (22nd May 2007)
 Minute: Renfrewshire Older Peoples Joint Planning Performance and Implementation
 Group (11th June 2007)
 Feedback Materials from Public Engagement Event 22nd May 2007 (12th June 2007)
 Spreadsheets: Costs and Bed Model Internal to Older People's Review Group
 (June 2007)
 Older People's Review Group Workplan (11th July 2007)

MENTAL HEALTH

Clyde Mental Health Strategy Group – Agenda of Meeting Held 26th April 2006
 Clyde Mental Health Strategy Group – Agenda of Meeting Held 15th June 2006
 Clyde Mental Health Strategy Group – Agenda of Meeting Held 23rd August 2006
 Clyde Mental Health Strategy Group – Agenda of Meeting Held 10th October 2006
 Clyde Mental Health Strategy Group – Agenda of Meeting Held 20th December 2006
 Clyde Mental Health Strategy Group – Agenda of Meeting Held 31st January 2007
 Clyde Mental Health Strategy Group – Agenda of Meeting Held 28th March 2007
 Clyde Mental Health Strategy Group – Agenda of Meeting Held 16th May 2007
 Clyde Mental Health Strategy Group – Agenda of Meeting Held 10th September 2007
 Clyde Mental Health Strategy Group – Notes of Meeting Held 15th June 2006
 Clyde Mental Health Strategy Group – Notes of Meeting Held 10th August 2006
 Clyde Mental Health Strategy Group – Notes of Meeting Held 10th October 2006
 Clyde Mental Health Strategy Group – Notes of Meeting Held 20th December 2006

Clyde Mental Health Strategy Group – Notes of Meeting Held 31st January 2007
 Clyde Mental Health Strategy Group – Notes of Meeting Held 28th March 2007
 Clyde Mental Health Strategy Group – Notes of Meeting Held 16th May 2007
 Clyde Mental Health Strategy Group – Event Held 23rd August 2006
 Appraisal Criteria (26th April 2007)
 Options Summary (26th April 2007)
 Service Redesign and Workforce Principles (20th July 2007)
 Modernising Mental Health Services – Overview of Process and Core Documents
 Mental Health Strategy Development – Clyde Adult Mental Health Service Strategy
 (24th January 2006)
 Clyde Strategy Group – Overarching Report
 Functional Framework Review of Glasgow City Social Care Supports
 Table 1 – Access and Information
 Specification and Organisation of Integrated Community Mental Health Services
 Framework for Modelling Comprehensive Local Services
 Clyde bed requirements based on GGHB rates /GGHB deprivation adjusted rates
 Benchmarking Staffing Requirements
 Core components of minimum acceptable level of community service to sustain low bed
 numbers
 Approach to Joint Financial Framework to Underpin Service Strategy
 Articulation of Core Functions of Comprehensive Mental Health Service
 Detailed Background Schedules Itemising Citywide and CHP Based Services and
 Functions
 Identification and Review of Drivers Related to Site Configuration and their Implications
 for Site Options
 Mental Health Inpatient Service Configuration Summary Feedback from Sub-group
 meeting (15th December 2006)
 Options modelling first filter: Long list to shortlist
 Appraisal of Pro's and Cons of Site Options - Clyde Strategy
 Renfrewshire Site Options – Mental Health
 West Dunbartonshire Council Appraisal Document
 Configuration of Inpatient Comorbidity Addictions Beds : Proposal re Short Life Task
 Group
 Clyde Mental Health Strategy - Initial Sift of Addictions Beds Inpatient Options Against
 Criteria
 Continuing Care Proposals
 Assessment of Quick Wins, Affordability and Transitional Costs
 Financial Assessment and Service and Financial Framework
 Updated Service and Financial Framework
 Development of a Mental Health Strategy for Clyde - Briefing Update (February 2007)
 Stakeholder Presentation (March 2007)
 Stakeholder Engagement Presentations (May 2007)
 Stakeholder and Media Briefing (May 2007)
 Stakeholder Presentation – West Dunbartonshire (May 2007)
 Overarching Principles/ paramaters/process : Draft for discussion
 Integrating Argyll and Clyde – NHS Greater Glasgow Proposals

Functional Framework for Mental Health – Applied Great Glasgow and Clyde Wide
 Detailed Background Schedules Itemising Citywide and CHP Based Services and
 Functions
 Clyde Bed Requirements Based on GGHB Rates /GGHB Deprivation Adjusted Rates
 Clyde Mental Health Strategy Group – Building Blocks/Work Programme Timetable
 Position Statement – Proposals Received to Date
 Benchmarking: Further Guidance on Nominal Benchmarks For Assessing Costs of Core
 Components of Comprehensive Community Services for Adults
 Draft Financial Framework
 Affordability Assessment: Progress Update
 Financial Summary Schedule
 Total Clyde Mental Health Budget Expenditure
 NHS Argyll and Clyde – Community Care Financial Planning
 Expenditure – Ravenscraig Hospital
 Overview Argyll and Clyde and Greater Glasgow Budgeted Expenditure
 Clyde Strategy Group – Site Retraction and Re-provision
 Draft Financial Framework (4th October 2006)
 Agenda: Clyde Mental Health Inpatient Services Configuration Subgroup – 15th
 December 2006
 South Clyde Mental Health Inpatient Services – Options for Initial Analysis
 Inpatient Configuration Sub Group – 15th December 2006
 Mental Health Inpatient Service Configuration Summary Feedback from Sub-group
 meeting (15th December 2006)
 Minutes of the Clyde Inpatient Services Configuration Subgroup, 16th November 2006
 Service and Financial Framework – Dykebar Adult Option and West Dunbartonshire
 Council Revised
 Greater Glasgow & Clyde Clyde Mental Health Prescribing Savings 3 year Action Plan
 to March 2009
 Clyde Mental Health Strategy – Communication Plan
 Clyde Mental Health Strategy – Draft Pre-engagement Action Plan
 Development of a Mental Health Strategy for Clyde - Briefing Update, February 2007
 Key Stakeholder List
 Clyde Mental Health Service Redesign - Proposal to Establish a Project Board
 Clyde Mental Health Strategy Project Initiation Document and Transitional Funding Plan
 NHS Partnership Beds
 Clyde Strategy – Project Plan
 Draft Performance Plan #1: Adult Mental Health
 Refinement to Financial Framework: Updating of Financial Issues
 Service and Financial Framework Clyde Strategy
 Quality Assurance of Local Implementation Plans
 Clyde Financial Framework Reflecting Transitional PID Values @ 26th March 2007
 Clyde Strategy Skeleton Framework : Overarching strategy
 Strategic Planning Process 13th January 2007
 Inverclyde PID
 Clyde Strategy Covering Note to Draft Strategy
 Adult and older peoples mental health services for Inverclyde, Renfrewshire, West
 Dunbartonshire and East Renfrewshire

Clyde Mental Health Strategy Follow-up communication events
Independent Scrutiny Panel for Clyde: Health Services and Related Public Consultation or Engagement Issues
Modernising Mental Health Services – Programme Management Structure (August 2007)
Future of Clyde Strategy Group
Achieving Equitable Resource Allocation
Clyde Strategy – ‘Soft Funding’ Issues
Evidence Underpinning Service Change
Modernising Mental Health – Adult Mental Health Services
A Framework for Mental Health Services in Scotland
Needs Assessment in Mental Health Service: the DISC Framework
National Service Framework for Mental Health
Guidance Statement on Fidelity and Best Practice
RCP Inpatient Guidance
SCAN Consensus Project – Inpatient Treatment of Drug and Alcohol Misusers in the National Health Service
West Dunbartonshire Mental Health Options Appraisal Process
West Dunbartonshire Council Options Appraisal Output from First Iteration
West Dunbartonshire Council Options Appraisal Output from Second Iteration
Renfrewshire Site Options – Mental Health
Minute of Clyde Addictions Bed Meeting 26th April 2007
Clyde Mental Health Strategy - Initial Sift of Inpatient Options Against Criteria Partnership Beds Output (29th January 2007)
Partnership Bed Models - Output from meeting held at Merchiston Hospital on 23rd March 2007
Junior Psychiatrist on-call at the Vale of Leven
Minutes of the Mental Health Development Group Meeting 1st February 2007
Minutes of the Mental Health Development Group Meeting 1st March 2007
Minutes of the Mental Health Development Group Meeting 5th April 2007
Minutes of the Mental Health Development Group Meeting 3rd May 2007
Minutes of the Mental Health Development Group Meeting 7th June 2007
Minutes of the Mental Health Development Group Meeting 5th July 2007
Minutes of the Mental Health Development Group Meeting 2nd August 2007
Minutes of the Mental Health Development Group Meeting 6th September 2007
Minutes of the Mental Health Development Group Meeting 4th October 2007
Minutes Division of Psychiatry Meeting 16th November 2006
Minutes Division of Psychiatry Meeting 17th August 2006
Minutes Division of Psychiatry Meeting 25th January 2007
Minutes Division of Psychiatry Meeting 15th February 2007
Minutes Division of Psychiatry Meeting 22nd February 2007
Minutes Division of Psychiatry Meeting 10th May 2007
Minutes Division of Psychiatry Meeting 14th June 2007
Minutes Division of Psychiatry Meeting 15th June 2007
Minutes Division of Psychiatry Meeting 19th July 2007
Minutes Additional Division of Psychiatry Meeting 26th July 2007
Minutes Division of Psychiatry Meeting 23rd August 2007

Minutes Division of Psychiatry Meeting 30th August 2007
 Minutes Division of Psychiatry Meeting 27th September 2007
 Minutes West Dunbartonshire Mental Health Strategy Group 8th September 2006
 Minutes West Dunbartonshire Mental Health Strategy Group 2nd March 2007
 Minutes West Dunbartonshire Mental Health Strategy Group 25th May 2007
 Minutes West Dunbartonshire Mental Health Strategy Group 6th July 2007

MATERNITY SERVICES

Minute: Review of Maternity Services in Clyde Reference Group 20th December 2006
 Maternity Services Review, Clyde - Engagement Events (May 2007)
 Minute: Review of Maternity Services in Clyde Reference Group 2nd February 2007
 Agenda: Maternity Services Review Working Group - Sub Group 19th March 2007
 Output from Maternity Services Review Working Group - Sub Group 19th March 2007
 Minute: Review of Maternity Services in Clyde Reference Group 20th March 2007
 Clyde Maternity Review Feedback (Spring 2007)
 Agenda: Maternity Services Review Working Group - Sub Group 30th April 2007
 Minute: Maternity Services Review Working Group - Sub Group 30th April 2007
 Agenda: Maternity Services Review Working Group - Sub Group 9th May 2007
 Minute: Maternity Services Review Working Group - Sub Group 9th May 2007
 Minute: Review of Maternity Services in Clyde Reference Group 23rd May 2007
 Clyde Maternity Unit Transfers 2006
 Clyde Maternity Unit Transfers 2005/2006 (Excel Document)
 NHS Greater Glasgow and Clyde Board Minute of Meeting held 26th June 2007
 Clyde Health Service Strategies: Outcome of Reviews and Proposals for consultation
 (26th June 2007 – Board Paper 2007/26)
 The Health of the People of West Dunbartonshire – Needs Assessment Report (August 2007)
 Admissions – Gartnavel
 Supplementary Activity and Occupancy Information for Gartnavel
 Option Appraisal Process
 Adult Acute Admissions – Gartnavel
 Process for Recording, Monitoring and Returning of Clients Admitted to Hospital Outwith
 There (sic) Catchment (sic) Area
 The Health of the People of Helensburgh and Lomond – NHS Highland June 2007

APPENDIX 4 - LOCATIONS VISITED BY PANEL MEMBERS

Location	Panel Members who Visited	Date
Lorn and Islands District General Hospital	Professor Angus Mackay	27.09.07
Dykebar Hospital	Professor Angus Mackay	04.10.07
Gartnavel Royal Hospital	Professor Angus Mackay	11.10.07
Vale of Leven Hospital	Professor Angus Mackay	18.10.07
Royal Alexandra Hospital	Professor Angus Mackay	23.10.07
Vale of Leven Hospital	Professor Peter Brunt	30.10.07
Inverclyde Royal Hospital	Professor Angus Mackay	01.11.07
Inverclyde Royal Hospital	John Hanlon (accompanied by Patricia Purton)	02.11.07
Johnstone Hospital	Professor Peter Brunt	08.11.07
Royal Alexandra Hospital	John Hanlon (accompanied by Patricia Purton)	09.11.07
Southern General Hospital (to meet with anaesthetists)	Professor Peter Brunt	15.11.07
Vale of Leven Hospital	John Hanlon (accompanied by Patricia Purton)	15.11.07

APPENDIX 5 - PUBLIC MEETINGS - DATES, TIMES, LOCATIONS, NUMBERS REGISTERED AND MAIN POINTS

Date	Location	Venue	Time	Number Attended
01.11.07	Greenock	Wellington Academy	7.30-9pm	28
08.11.07	Paisley	Foxbar Community Centre	7.30-9pm	11
14.11.07	Dumbarton	Burgh Hall	7.30-9pm	155

The main points emerging from these meetings are listed below.

GREENOCK

Mental Health Services

- Presumption of mental health services being provided in the community is good, but concerns that resources are inadequate
- Financial savings from the closure of Ravenscraig should be spent locally
- Concern regarding equity of provision of mental health services in Inverclyde compared to other areas
- Mild to moderate mental illness not adequately resourced
- Serious drugs problem exists in Greenock
- Lack of trained Community Psychiatric Nurses
- Strategy for psychological therapies has not been progressed
- Concern about transport to Southern General patients with drug and alcohol problems
- Poor conditions at Ravenscraig: neglected buildings and facilities; service users not consulted and reluctance on behalf of NHS to be clear about future plans for Ravenscraig patients
- Commitment to proposals by local authority not clear
- No provision for mental health issues for deaf people
- Evidence shows that number of beds required in future will increase

Community Midwifery Unit

- Concern expressed regarding proposed closure of CMU
- Perception that the low numbers using CMU can be explained by the message given at the time of the loss of the consultant-led unit, ie women are unsafe in CMU

- Better education, publicity and encouragement required regarding use of CMU
- Inverclyde was the only unit which dealt with women on drugs
- Adverse publicity when figures were printed which claimed that stillbirths increased when women were moved
- Women from Largs etc should be encouraged to go to the CMU
- CMUs are well used elsewhere, eg in NHS Tayside

General

- Environmental and economic implications of the additional travel
- General perception that engagement was not good and proposals not made clear by NHS Greater Glasgow and Clyde
- Concern that financial deficit inherited from NHS Argyll and Clyde has to be subsumed by Inverclyde and not spread across the whole Greater Glasgow and Clyde area
- No car parking problems at Inverclyde Royal Hospital, unlike Paisley and Glasgow hospitals
- Concern regarding the ability of the Royal Alexandra Hospital to cope with additional demand from Inverclyde and Vale of Leven
- No business plan available so people do not know what the money is being used for
- Require reassurance that proposals will address need in area of high deprivation

PAISLEY

Mental Health Services

- Concerns expressed regarding community support for psychiatric patients
- Lack of clarity on how mental health service users will be consulted

Transport

- Difficulties regarding distance of travel and closure of Erskine Bridge
- Concern about ambulance capacity and ambulance costs

General

- Perceived difficulties in Royal Alexandra Hospital coping with additional demand
- General perception that there is no point in giving your view as it is just ignored
- Concern regarding bed reductions at Johnstone Hospital
- Concern that beds are being moved for economic reasons
- Not clear what “the vision” is; not enough transparency over the proposals
- Consultation fatigue and cynicism about outcome of consultation

DUMBARTON

Travel

- Geographic location of Vale of Leven Hospital should be taken into account as part of Regional planning
- Distances involved in travelling to Paisley and Glasgow for patients and for carers
- Concern over Scottish Ambulance Service's capacity to cope
- Traffic problems are not all at Erskine Bridge – regular tailbacks on the road to Erskine Bridge
- Simultaneous closures of Erskine Bridge and Clyde Tunnel

Mental Health

- Regular patient in Christie ward expressed fears about having to go somewhere else

Midwifery

- Lack of public understanding about the CMU service
- CMUs provide a low cost, high quality service
- Increasing numbers of women booked through midwives' commitment
- Extended protocols will result in fewer women needing Consultant intervention
- High Caesarean section rate at Royal Alexandra Hospital (29.3%) and Queen Mother's Hospital (31.1%) – World Health Organisation recommends 10-15%
- Planned closure of Queen Mother's Hospital in 2009 will see increase in women using CMU

General

- NHS should be open and transparent; "they have failed to convince even one member of the community of the rationale for the proposals"
- The "safe/unsafe debate" – who decides what is safe?
- Challenging "risk" is difficult for the public
- Concerns that staff groups have not been listened to
- Concern that downgrading hospital is a significant negative factor in a time of economic development of the area
- Substantial numbers of people from rural areas use the Vale of Leven Hospital
- Poor health and high levels of poverty in Dumbarton/Alexandria should be taken into account

Anaesthetics

- Unique pattern of care - GPs and hospital staff - in Integrated Care Project
- Unanswered questions regarding possibility of Anaesthetic cover being provided on a rota basis from Greater Glasgow
- Request to look at other possibilities for cover, eg from Golden Jubilee
- Challenging NHS Board's rationale regarding the safety of the Project

APPENDIX 6 - SUMMARY OF WRITTEN SUBMISSIONS AND PETITIONS

Maternity Services

12 items of correspondence supporting retention of Maternity Services at the Vale of Leven Hospital

3,400 signatures on a petition expressing concern at the proposed reduction of Maternity Services within the Vale of Leven Hospital

Travel Times

3 items of correspondence expressing concern at travel times between Dunbartonshire and Royal Alexandra Hospital

Mental Health

1 email urging the Panel to keep the Christie Ward open

1 email opposing the proposed downgrade of services at the IRH Mental Health Unit

1 letter expressing concern at proposed location of a mental health unit within the Anchor Mill complex

Vale of Leven Hospital

59 signatures on a petition expressing displeasure at the threat to downgrade services at the Vale of Leven Hospital

In excess of 10,000 signatures on a petition opposing the downgrade of services at the Vale of Leven Hospital

A petition signed by people from over 10,000 households condemning the removal of services from Vale of Leven

5 items of correspondence urging panel to keep the Vale of Leven Hospital open

1 letter asking the Panel not to recommend downgrading services at the Vale of Leven Hospital

1 letter urging the Panel to restore the Vale of Leven Hospital to A and E General Hospital status

Older People's Care

1 letter urging the Panel to recommend keeping the Fruin unit open

Submissions from Council Leaders

Detailed submissions were received from the leaders of Renfrewshire Council, West Dunbartonshire Council, Argyll and Bute Council, and Inverclyde Council.

Other

1 letter requesting the Panel consult GPs in the Vale of Leven area

1 letter endorsing the comments made by Councillor Iain Robertson in his submission to the Panel

APPENDIX 7 - SOURCES OF EXTERNAL, INDEPENDENT, EXPERT ADVICE TO THE PANEL

Professor Derek Bell	Professor of Acute Medicine – University of London
Dr John Callender	Associate Medical Director/Consultant Psychiatrist – Royal Cornhill Hospital Aberdeen
Professor W A Chambers	Consultant, Anaesthesia & Pain Management - Aberdeen Royal Infirmary
Dr Alan Henderson	Consultant Physician, Oban
Dr James Hendry	Lead Consultant Psychiatrist – St John’s Hospital Livingstone
Dr Rhona Hughes	Lead Obstetrician for Lothian
Dr Mike Jones	Consultant in Acute Medicine – Royal Infirmary of Edinburgh
Dr Finlay Kerr	Former Consultant Physician - Inverness
Dr Peter Murdoch	Consultant in Medicine of the Elderly – Stirling Royal Infirmary
Patricia Purton OBE	Ex Director of the Royal College of Midwives in Scotland
Professor Luke Vale	Senior Research Fellow – Health Economics Research Unit

The Panel is extremely grateful to those mentioned above for their advice. It should be noted that the opinions expressed in the Report are those of the Panel.

APPENDIX 8 - KEY NATIONAL DOCUMENTS

An Interim Report on NHS Greater Glasgow and Clyde's Public Engagement on "Clyde Health and Service Strategies", Scottish Health Council, November 2007

Acute Health Care Services, Academy of Medical Royal Colleges, 2007

Isolated Acute Medical Services, Royal College of Physicians (L), 2002

Building a Health Service Fit for the Future, Kerr D, SE – 2005

Keeping the NHS Local: A New Direction of Travel, Department of Health, 14th February 2003

The Relationship Between Distance to Hospital and Patient Mortality in Emergencies – An Observational Study, Nicholl et al, Emergency Medical Journal 2007, 24:665

A Recipe for Care – Not a Single Ingredient. Clinical Case for Change, Philip I, Department of Health 2007

All Our Futures: Planning for a Scotland with an Ageing Population, The Scottish Government, March 2007

Scottish Public Finance Manual – Appraisal and Evaluation, The Scottish Government, December 2005

The Green Book – Appraisal and Evaluation in Central Government and Annexes, HM Treasury

Audit of care provided and outcomes achieved by community maternity units in Scotland 2005 [online], Hogg M, Penney G and Carmichael J., 2007

APPENDIX 9 - THE EVIDENCE BASE FOR QUANTIFIED BED REDUCTIONS - A CRITIQUE

NHS Greater Glasgow and Clyde base their reductions in admission bed numbers on four sources of evidence;

1. The published, refereed, literature
2. The Glasgow experience
3. National policy
4. Benchmarking

1. THE LITERATURE

Two references are cited, both related to the situation in England.

Thornicroft and Tansella (2004) present a review of the systematic evidence in support of the stepped care model and provide pragmatic guidance on the form and content of a mental health service depending upon the level of financial and professional resources available. The thrust of the review is more the description of a commonsense balance between hospital treatment and treatment outside hospital than a rigorous review of the relevant literature – understandably in view of the paucity of methodologically sound evidence. There is, however, reasonably good evidence that generic Community Mental Health Teams improve engagement of patients with treatment staff, but without any demonstrable impact on symptoms or social function. Regarding crisis resolution / home treatment teams, these appear to reduce time spent in hospital. There is no evidence that assertive outreach reduces symptoms or improves social behaviour, and the jury is still out on early intervention teams – or was in 2004. It seems that the English experience is that community-based models of care cost the same as the services they are replacing.

Glover et al (2006) conducted an uncontrolled, observational study of English NHS routine admission statistics for the six year period up to March 2004. Around 2000 the Government mandated the setting up of crisis resolution and assertive outreach teams in England and the basis for this statistical study was the identification of trends in hospital use before and after the introduction of such teams in primary care trusts. In services having crisis teams on call 24/7 there was an overall average fall in admissions of some 20%, and an associated 10% reduction in occupied bed days. Bed occupancy fell less than admissions possibly because a selection process was operating such that the relatively more severely ill were being treated in hospital rather than the community. Introducing assertive outreach teams had no impact on admissions. There are several shortcomings in this study which put limits on any conclusions, and the authors very fairly point some of them out. What they have reported is an association which may not be cause and effect. We have no way of knowing what the trends were prior to

1999. The trusts with teams in place which were performing differently from those without might have been doing so for reasons unassociated with community teams – for example there may have been management pressure to raise the threshold for admission in those trusts showing reduced admission rates. The confidence intervals (variation) around the averages were wide, and the analyses which were reported did not explore other explanations for the differences. So, at best this report can be considered suggestive, but not compelling, in its implication that specialised community teams cause falls in hospital admissions.

2. THE GLASGOW EXPERIENCE.

There is no doubt that Glasgow has led the way in Scotland with its ambitious shift in the balance of care from traditional, large, institutions towards dispersed specialist interventions in the community. This has been accompanied by large reductions in hospital bed provision (most dramatically in continuing care beds) and the model has now been operating for several years. In terms of how this is working with regard to acute admission beds at Gartnavel Royal, data provided to the Panel by the Board show that with the current provision of 54 admission beds for its catchment population (and people “boarded in” from elsewhere) it can respond to demand for admissions on 92% of occasions. This seems a relatively poor ability to respond to peak demand. The situation for admission to the Gartnavel IPCU is considerably better, with an ability to respond to demand on 99.5% of occasions with 12 beds. Figures such as these are a much better indicator of how well a system can cope with peak demand than the usual data on bed occupancy and lengths of stay. The Panel has been told that further steps to increase admission bed availability are being taken, such as active bed management to avoid lengths of stay greater than 6 months, and the development of rehabilitation and continuing care accommodation. The practices of “boarding out” and “boarding in” are a reflection of local admission services across Glasgow, and to some extent across Scotland, being unable to cope with peak demand. Within Greater Glasgow the totality of admission beds is viewed as an available pool, meaning that a person in urgent need of admission, but for whom no bed is available in his catchment hospital, may be placed anywhere in the city, or at worst, anywhere in Scotland. In the 6 month period to September 2007 there were 2 patients per month boarded out from Gartnavel to another Glasgow hospital, and 1 patient per month boarded outside Glasgow. The average length of time spent boarded out was 4 days for those within Glasgow and 5 days for those boarded elsewhere. Despite there being an explicit protocol to minimise the time spent by a person boarded out these figures may be of little comfort to the people of West Dunbarton and Helensburgh/Lochside , from whom the Panel has heard concerns about access to Gartnavel let alone more distant hospitals. The same general issues would apply to admission capacity in Renfrew and Inverclyde.

3. NATIONAL POLICY

Several national policy statements in recent years advocate the diversion of resources away from in-patient treatment and care to various forms of community intervention and facility. The Scottish Framework for Mental Health Services, the English National Service Framework for Mental Health, and the Statement from the Care Services

Improvement Partnership (CSIP) all describe a care system in which the aim is to avoid hospitalisation unless absolutely necessary. A similar principle is enshrined in the Scottish Mental Health Act and the Mental Health Delivery Plan which require the use of the least restrictive conditions for patients subject to compulsion. No reasonable person could but agree with these principles and aims, and the stepped-care model adopted by Greater Glasgow is entirely consistent with them. However, these authoritative documents are relatively silent on how best to predict acute hospital admission requirements according to local circumstances.

4. BENCHMARKING

In 1999 NHS Greater Glasgow used a three-step method by which to estimate the likely inpatient bed requirements for the city's published epidemiological service norms, benchmarking against a range of UK inner city services, and local judgement on how best to position Glasgow's needs within these ranges. For bed requirements in Clyde the approach has been to use Greater Glasgow as the benchmark with numbers adjusted by deprivation weighting and modified to reflect local judgement and to enable the best fit with local ward capacities.

CONCLUSION

The references in the professional literature quoted by NHS Greater Glasgow and Clyde in support of their planned bed reductions give anything but a confident basis upon which to plan future requirements. This is no reflection on the Board's awareness of the published, refereed, literature. The evidence base from the literature is disappointingly sparse. It is therefore entirely reasonable that local experience of operating a rebalanced service in Greater Glasgow should have been used as a basis for planning, but the limitations of the published literature should be acknowledged in the public consultation. Likewise, while the current national policy statements support the principle of the Glasgow model, they contribute little to the detail. In effect, the Glasgow model is founded more on ideology than robust, tested, evidence. While understandable, this strategy could be greatly enhanced by well designed, prospective, evaluation. Any such evaluation should collect data on clinical outcomes and, very importantly, quality of life indices in addition to the usual data on admission rates, bed occupancy, etc., which at best have only an unreliable proxy relationship to overall quality of care. The Health Board has a golden opportunity both to add to the national and international literature, and to proceed on a truly evidence-based footing, by collecting clinically meaningful data on a prospective basis during this period of change for mental health services in Clyde and in Greater Glasgow.

BIBLIOGRAPHY

Care Services Improvement Partnership ; Guidance Statement on Fidelity and Best Practice for Crisis Services.

Framework for Mental Health Services in Scotland

Glover, G., Arts, G., and Babu, K.S (2006). British Journal of Psychiatry, 189, 441-445

National Service Framework for Mental Health.

Thornicroft, G. and Tansella, M. (2004). British Journal of Psychiatry, 185, 283-290.

the 1990s, the number of people who are employed in the service sector has increased in all countries. In the Netherlands, the number of people employed in the service sector has increased from 1.5 million in 1980 to 2.5 million in 1995.

There are several reasons for this increase. First, the service sector has become more important in the economy. Second, the service sector has become more attractive to workers. Third, the service sector has become more flexible. Fourth, the service sector has become more dynamic.

The increase in the number of people employed in the service sector has led to a number of changes in the labor market. These changes are discussed in the following sections.

1.1.1. The labor market in the service sector

The labor market in the service sector is characterized by a high degree of flexibility. This flexibility is reflected in the fact that the number of people employed in the service sector has increased rapidly in the 1990s. This increase is due to a number of factors, including the following:

• The service sector has become more important in the economy.

• The service sector has become more attractive to workers.

• The service sector has become more flexible.

• The service sector has become more dynamic.

The increase in the number of people employed in the service sector has led to a number of changes in the labor market. These changes are discussed in the following sections.

1.1.2. The labor market in the manufacturing sector

The labor market in the manufacturing sector is characterized by a high degree of stability. This stability is reflected in the fact that the number of people employed in the manufacturing sector has remained relatively constant in the 1990s.

There are several reasons for this stability. First, the manufacturing sector has become more important in the economy. Second, the manufacturing sector has become more attractive to workers. Third, the manufacturing sector has become more flexible. Fourth, the manufacturing sector has become more dynamic.

The stability in the number of people employed in the manufacturing sector has led to a number of changes in the labor market. These changes are discussed in the following sections.

1.1.3. The labor market in the agricultural sector

The labor market in the agricultural sector is characterized by a high degree of instability. This instability is reflected in the fact that the number of people employed in the agricultural sector has decreased rapidly in the 1990s.

There are several reasons for this decrease. First, the agricultural sector has become less important in the economy. Second, the agricultural sector has become less attractive to workers. Third, the agricultural sector has become less flexible. Fourth, the agricultural sector has become less dynamic.

The decrease in the number of people employed in the agricultural sector has led to a number of changes in the labor market. These changes are discussed in the following sections.

1.1.4. The labor market in the construction sector

The labor market in the construction sector is characterized by a high degree of volatility. This volatility is reflected in the fact that the number of people employed in the construction sector has fluctuated significantly in the 1990s.

There are several reasons for this volatility. First, the construction sector has become more important in the economy. Second, the construction sector has become more attractive to workers. Third, the construction sector has become more flexible. Fourth, the construction sector has become more dynamic.

The volatility in the number of people employed in the construction sector has led to a number of changes in the labor market. These changes are discussed in the following sections.

1.1.5. The labor market in the public sector

The labor market in the public sector is characterized by a high degree of stability. This stability is reflected in the fact that the number of people employed in the public sector has remained relatively constant in the 1990s.

There are several reasons for this stability. First, the public sector has become more important in the economy. Second, the public sector has become more attractive to workers. Third, the public sector has become more flexible. Fourth, the public sector has become more dynamic.