NHS Greater Glasgow & Clyde

NHS Greater Glasgow and Clyde

NHS BOARD MEETING
16th August 2016

Paper No: 16/45

Director of Planning and Policy
Director of Nursing
Medical Director

Proposed Approach to Engagement on Service Changes

Recommendation: the Board agreed in June 2016 to proceed with public engagement on a series of service changes, this paper invites the Board to approve the proposed approach to public engagement.

1. Background and Purpose

1.1. The June Board approved the Local Delivery Plan which proposed four service changes requiring processes of public engagement. The purpose of this paper is for the Board to consider and approve the proposed approach to public engagement for each of the service changes.

1.2. The attachments to this paper provide a more detailed description of each service change covering the:-

- Current pattern of service;
- Proposed service change and the clinical case for the proposed change;
- Proposed approach to engagement;

1.3. These proposals for service change reflect the Board's Clinical Services Strategy (CSS) approved in January 2015. The approval of the Strategy concluded an extensive 3 year Clinical Services Review process. The Strategy provides the framework for future service planning and the development of detailed service change proposals. It also provides the strategic clinical context for working with the Integration Joint Boards.

1.4. The CSS sets out the high level service models to shape service provision and identifies the key approaches to underpin the future service planning for the populations served by NHS Greater Glasgow and Clyde. The principles it sets out are:-

- Improving health and prevention of ill health; empowering patients and carers through the development of supported self care
- Developing primary care and community service models; simplification of community models; focus on anticipatory care and risk stratification to prevent crisis
- Improving the interface between the community and hospital to ensure care is provided at the right time in the right place; community and primary care services inward facing and hospital services outward facing; focused on patient and carers needs
- Developing the ambulatory approach to hospital care, with inpatient hospital care focused on those with greatest need ensuring equitable access to specialist care
- Redesign of specialist pathways to establish a consistent service model delivering the agreed clinical standards and good practice guidelines

- Developing the rehabilitation model based on need not age; working across the service within primary and secondary care and with partner organisations to provide rehabilitation in the home setting where clinically appropriate
- Changing how care is delivered - patient centred care; shifting the paradigm to deliver care differently for patients particularly for patients who have multiple conditions; helping patients and the public to develop and understand the new approaches to care

The CSS established a clear framework to redesign, improve and modernise the Board's clinical services. It set key objectives for future service change:

- Care which is patient focused with clinical expertise focused on providing care in the most effective way at the earliest opportunity within the care pathway;
- Services and facilities have the capacity and capability to deliver modern healthcare with the flexibility to adapt to future requirements;
- Sustainable and affordable clinical services can be delivered across NHS Greater Glasgow and Clyde.

1.5. The clinical services review was underpinned by extensive engagement and involvement activity. A large number of events were held over a two year period 2012-4 and included a Primary Care Event, Third Sector development events, regular Patient Reference Groups, public and patient representation on the Clinical Steering Groups, meetings with Public Partnership Forums and various community groups, forums and carers groups.

1.6. The National Clinical Strategy (NCS) was published in February 2016 following an extensive programme of development and engagement. The Strategy sets out a framework for the development of health services across Scotland for the next 10-15 years. It gives an evidence-based high level perspective of why change is needed and what direction that change should take. The Strategy sets out the case for:-

- Planning and delivery of primary care services around individuals and their communities;
- Planning hospital networks at a national, regional or local level based on a population paradigm;
- Providing high value, proportionate, effective and sustainable healthcare;
- Transformational change supported by investment in e-health and technological advances.

1.7. The proposed service changes outlined in this paper are in line with the direction set by the national clinical strategy and with service specific national strategies, for example, Reshaping Care for Older People.

2. Proposed Service Changes

The attachments to this paper set out the details of four proposed service changes to:-

- Paediatric services at the Royal Alexandra Hospital;
- Rehabilitation services in NE Glasgow: Lightburn Hospital
- Delivery services in the Community Maternity Units
- In patient care at the Centre for Integrative Care:

3. Public and Patient Engagement

3.1. The proposed approaches for each change reflect the national guidance "INFORMING, ENGAGING AND CONSULTING PEOPLE IN DEVELOPING HEALTH AND COMMUNITY CARE SERVICES". The guidance requires appropriate and proportionate processes which reflect the scale and impact of the change proposed.

3.2. Broadly two phases are expected for changes which impact on patients, a development and engagement phase which is then followed by formal public consultation if a change is substantial.

3.3. The key requirements of the guidance are that for any service change:-

- The Board can demonstrate the case for change is explained and options/proposals are developed with engagement with all stakeholders.
- Users and public representatives will have been involved in the development of any options/proposals prior to these being more widely engaged or consulted on.
- Patient and public representatives are fully involved in the engagement and consultation process undertaken by the board.

3.4. Major Service change: There are additional steps in process for proposals which are major service change. The SG guidance says Where a proposed service change will have a major impact on a patient or carer group, members of equalities communities or on a geographical community, the Scottish Health Council can advise on the nature and extent of the process considered appropriate in similar cases. Boards should, however, seek advice from the Scottish Government Health Directorate (SGHD) on whether a service change is considered to be major and, for those that are, Ministerial approval on the Board's decision will be required. Prior to seeking the Scottish Government Health Directorate's advice on whether the proposed service change is major, Boards should use the Scottish Health Council's guidance "Guidance on Identifying Major Health Service Changes" to help inform their own considerations. The Health Councils criteria for major service change are set out below:-

The following issues should be considered when identifying whether a proposed service change ought to be regarded as major. They are intended simply to provide a framework for discussion. Please note that these issues are not ranked in order of importance. Some of the issues may appear to overlap, but each should be considered. Any evaluation as to what extent these issues apply will involve a level of subjectivity. It is intended that NHS Boards and other stakeholders should consider each of the issues in the context of the particular local circumstances. As a general rule, the more issues that apply, the more likely it is that a service change should be considered as major. There are prompts under each of the issues. These are not intended to be exhaustive.

- ***Impact on patients and carers***
  Consider the number of patients that will be affected as a proportion of the local population, and assess the likely level of impact on those patients, together with any consequential impact on their carers.

  Where it appears that a relatively small number of patients is affected, it may still be necessary to consider the level of impact on those individuals, particularly where their health needs are such that they are likely to require to continue to access the service over a longer period of time.

  The particular impact of the proposed change on patients that may experience discrimination or social exclusion should also be taken into account.

- ***Change in the accessibility of services***

Consider whether the proposed change involves relocation, reduction or withdrawal of a service.

Assess the likely impact of the proposed change in terms of transport (in relation to patients, carers, staff, goods / supplies).

- ***Emergency or unscheduled care services***
  Consider whether the proposals involve, or are likely to have a significant impact on, emergency or unscheduled care services, such as Accident and Emergency, Out-of-Hours or maternity services.

  Assess the potential impact on the delivery of services provided by the Scottish Ambulance Service.

- ***Public or political concern***
  Assess the likelihood that the proposals will attract a substantial level of public concern, whether across the local population, or amongst particular patient groups.

  Take account of any views expressed by Public Partnership Forums, local community groups or elected representatives.

  Consider any views reflected in the local media.

  Are there likely to be complex evidence issues that could be open to challenge or dispute?

- ***Conflict with national policy***
  Do the proposals run counter to national policy, for example, the presumption against the centralisation of health services?

- ***Change in the method of service delivery***
  Do the proposals involve the use of new or contentious technology?

  Are changes proposed in relation to practitioner roles?
  Might there be changes in settings, such as moving a service from a hospital to a community setting, or vice versa; or other changes in the care process e.g. moving to 'one stop clinics' for services which have traditionally been provided separately?

  Has the proposed change been demonstrated to work in other areas?

  Identify whether there are examples of working models elsewhere, which would help to inform discussions.

- ***Financial implications***
  Consider in broad terms the level of investment, or savings, associated with the proposed changes.

  Take account of the implications for the NHS Board(s) involved and for other agencies e.g. local authorities.

- ***Related changes in recent years***
  Take account of the cumulative effect of the proposed changes, when considered alongside other changes that have taken place over recent years.

- ***Consequences for other services***

Consider the effect the proposals could have on decisions about the development or location of other services. Identify whether the proposals will impact on other NHS Boards.

Decisions on whether a service change is major are made by Scottish Government. In our view the position for each of our proposed changes is as follows:-

- The changes to ward 15 were previously deemed by the Board to be major and the process to date has reflected that as does the final step outlined in this paper of formal public consultation.

- We will continue to discuss with Scottish Government their view of the Lightburn proposals. The similar proposals for Drumchapel, closing that site and transferring beds and services to GGH were not deemed major service change. In any event, the extensive processes we are proposing would meet the requirements for a major service change.

- In our view the changes to the CMUs do not meet the criteria for major service change. The impact is on very small numbers of patients and the proposed process reflects that position and the fact there has been extensive prior process.

- The CIC changes do not affect the range or location of services for patients and are in line with national policy to shift care to ambulatory delivery, we do not believe the change meets the criteria for major service change.

3.5. Engagement: The attachments to this paper set out the approach for each proposed change. The material which we will use for the engagement and consultation will be developed from the content of this paper. For each proposal we are putting in place a stakeholder reference group to work with us on the engagement material and processes.

3.6. Scottish Health Council. The Scottish Health Council (SHC) is responsible for providing advice to Boards on engagement. Discussions with the SHC have shaped the approach to each proposal outlined in the paper. Our final approach to engagement for each proposals will be agreed with the SHC before engagement gets underway at the beginning of September.

4. Conclusion

This paper enables the Board to establish the processes to explore with our patients and the public a range of service changes which are driven by clinical considerations. The Board will carefully consider the outcome of that engagement for each of the proposed changes.

Attachment 1

REVIEW OF PAEDIATRIC INPATIENT SERVICES AT ROYAL ALEXANDRA HOSPITAL

1. Introduction

In 2012 there was a proposal by the Women and Children's Services Directorate to move the Paediatric Inpatient Services in Ward 15 at the Royal Alexandra Hospital, Paisley to the Royal Hospital for Sick Children, Yorkhill. Following engagement on the proposal and options with patients/parents, families and professionals, the preferred option was to transfer the inpatient service when the new Royal Hospital for Children opened on the new Queen Elizabeth University Hospitals Campus. This paper updates and restates the basis of the proposal to enable re engagement in advance of formal public consultation on the proposed transfer.

2. Current Service

2.1. Outpatient service

A full range of paediatric outpatient clinics are held at Ward 15. These include the following:

General Paediatrics	Diabetes
Endocrine	Cystic Fibrosis
Rheumatology	Neonatal
Neuro-developmental	Neurological
Renal	Allergy
Paediatric Dermatology	Paediatric Dietetics
Clinical Genetics	

2.2. Planned Care

Ward 15 also provides planned care services where children can be admitted for day surgery and elective procedures or can be admitted for planned investigations or treatment on a day case or elective inpatient basis.

Day treatments include allergy testing, infusions and transfusions; endocrinological investigations; cystic fibrosis annual review; micturating cystograms; and general blood/urine/stool testing. To support this there are day care area comprising of 4 beds and 2 chairs.

2.3. Emergency Care and Medical Assessment

Ward 15 operates a 24 hour Short Stay Medical Assessment facility for assessing children as well as admitting patients for inpatient emergency care.

There are 16 inpatient beds and a short stay assessment facility consisting of 5 beds and 1 chair. In 2015/16 there were 4839 short-stay patient episodes in Ward 15.

Emergency patients are admitted in a number of ways:

- Direct referral by GP
- Following presentation and assessment in the Emergency Department (ED).
- Transfer from Inverclyde Royal Hospital ED or the Vale of Leven Minor Injury Unit and from community hospitals throughout Argyll and Bute.

The level of Acute Activity in 2015/16 is shown in the table below:

	Activity	Bed days	Average LOS
Outpatients	4563	n/a	n/a
Day Case	542	n/a	n/a
Elective Inpatient	125	447	3.8
A&E Attendances	10045	n/a	n/a
Emergency Inpatient	4839	3379	1.8

2.4. Specialist Community Paediatric Services – PANDA Centre

Co-located with Ward 15 is the PANDA centre hosts complex neurodisability and neurodevelopmental services, and provides facilities for a range of general community paediatric clinics including physiotherapy, occupational therapy, speech and language therapy

3. Clinical Case for Change

This proposal is driven by clinical considerations; the rest of the section outlines the clinical case for change and sets out the new clinical model which we are proposing to implement.

3.1. The Royal Hospital for Children

The new Royal Hospital for Children (RHC) provides a state of the art facility and is one of the largest paediatric teaching hospitals in the UK and the largest in Scotland. The entire focus of RHC is around children and young people, with care provided in a child friendly environment with:-

- The latest technology and specialist children's equipment, such as the MRI scanners, CT scanner, dedicated paediatric interventional radiology facilities and five state of the art laparoscopic theatres.
- All paediatric medical, surgical and anaesthetic subspecialties including emergency specialists, general medical paediatrics, cardiology, neonatology, neurology, nephrology, respiratory, endocrinology, gastroenterology, immunology and infectious diseases, dermatology, haematology/oncology (including a dedicated teenage cancer unit), rheumatology, metabolic medicine, audiology, ophthalmology, ENT surgery, orthopaedics and general paediatric and neonatal surgery.
- Child and adolescent psychiatry and AHP services facilities are located within the campus. Children who self harm and may require admission to hospital are now treated on the RHC site.
- An integrated neonatal medical and surgery unit as well as a paediatric critical care unit of 20 nationally funded intensive care beds and 2 high dependency beds are available on the RHC site to ensure that children who are or become very unwell receive world class care.
- A dedicated paediatric theatre complex, comprising 9 full theatres, interventional and cardiac catheterization labs.
- Dedicated diagnostic facilities providing the full range of imaging services including ultrasound, CT, MRI and nuclear medicine studies on site.
- On site access to the full range of diagnostic laboratory facilities including haematology, blood bank, biochemistry, microbiology, virology, histopathology and genetics.
- 17 national designated services which are accessed from children across Scotland and are delivered from the hospital including cardiac surgery and interventional cardiology, bone marrow and renal transplantation, ECLS (extracorporeal life support) and complex airway service and cleft surgery.

- A full range of dedicated children's services and facilities which cannot be replicated in a local district general hospital, such as the RAH located approximately 7 miles from the new RHC.
- A number of specialist adolescent facilities which are not replicated in the RAH: most notably zone 12, medicinema and dedicated young people workers. There are also dedicated age appropriate facilities for younger children such as the teddy hospital. In addition, educational support is offered.
- Amalgamation of Ward 15 medical staff with the acute receiving and hospital at night teams will strengthen resilience of the clinical team, supporting rota to be compliant with recommended staffing levels.
- The capacity within the new RHC will support the transfer of RAH paediatric inpatient activity to RHC. The Emergency Department has been sized to accommodate 65,000 attendances.
- Single rooms with ensuite patient accommodation within the RHC offer dedicated facilities to support parents with fold down beds. Whilst access to self-catering facilities, shops and food outlets on site add further convenience.

3.2. National Clinical Standards

In Facing the Future Report the Royal College of Paediatrics and Child Health (RCPCH) set out a number of standards as the requirement to ensure high quality health care is delivered to children and young people. It is believed that the implementation of these standards will contribute to better outcomes for children and young people and at the same time ensure greater efficiency of the service, maximising the contribution consultants and other health professionals make to providing effective future services. Some of the key standards are set out below:

- Every child or young person admitted to a paediatric department with an acute medical problem is seen by a paediatrician on the middle grade or consultant rota within 4 hours of admission.
- Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician (or equivalent staff, specialty and associate specialist grade doctor who is trained and assessed as competent in acute paediatric care) within the first 14 hours.
- All Short Stay Paediatric Assessment Units (SSPAUs) have access to a paediatric consultant (or equivalent) opinion throughout all the hours that they are open.
- A paediatric consultant (or equivalent) is present in the hospital during times of peak activity.
- All children and young people, children's social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least a level 3 safeguarding competencies) available to provide immediate advice and subsequent assessment, if necessary for children and young people under 18 years of age where there are child protection concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported with a written report.
- At least two medical handovers every 24 hours are led by a consultant paediatrician.

The Report also set out the concerns facing the paediatric workforce within the UK. It recognised the significant pressures across the paediatric service nationally, which are seriously challenging the services' ability to:

- Staff in a safe and sustainable way all of the inpatient rotas that currently exist
- Comply with the European Working Time Directive (EWTD)
- Continue with the present number of consultants and trainees

The Royal College of Paediatrics and Child Health (RCPCH) recognise that the current number of paediatric inpatient units is not sustainable. The 'Facing the Future' Standards of Care for Paediatric Emergencies set out clear expectations for

the skills, expertise and specialist opinion which should be available for children in all emergency settings.

We need to ensure that we meet the required range of specialist paediatric services for all children presenting as emergencies and those requiring inpatient care. The move to the new Royal Hospital for Children on the Queen Elizabeth University Hospitals campus will allow this to happen.

It will extend the range of specialist treatment, in a dedicated child friendly environment and with specialist paediatric trained staff across a range of services and disciplines. In addition, there are a range of consultants who are on call for specialist services e.g. dermatology, rheumatology, Specialist Child Protection Service and many other specialties at the RHC which children can access directly. Our proposal will therefore enable us to deliver these standards

3.3. Enhanced Opportunities for Training

Impact of Modernising Medical Careers is a major reform of postgraduate medical education and is having an impact on medical staff provision in clinical areas across West of Scotland Boards.

Currently, within GGC and across neonatology and in medical paediatrics, it is not uncommon for consultants to have to provide unplanned extended day working and, in extreme situations, 24/7 middle grade shift cover as a result of these emerging rota gaps. This senior medical cover when used as such is at a financial and workforce capacity premium to the wider system. It is not sustainable in the mid to long term as a counter solution to managing what will become a more frequent occurrence.

NHS GGC has recruited additional consultants in all specialties and also developing the role of specialty doctor, advanced nurse/allied health professional practice, e.g. advanced neonatal and paediatric nurse practitioner role.

The single site provides opportunities for enhanced training for medical and nursing staff. Meeting RCPCH standards with consultants contributing to emergency care at peak times allows trainees to benefit directly from senior support. General paediatric outpatient training will be enhanced on both sites as a consequence.

Both registered and unregistered nurses currently based at the RAH will benefit from exposure to specialist patient groups, many of whom are nationally unique to the RHC site. With over 10 nurse educators and a broad pool of senior staff, the opportunities for on-going development, nurse mentoring and continued education are readily available. Nurses become part of the broader community of expertise prevalent throughout the RHC.

A single site will allow Advanced Nurse Practitioners (ANP) to attain and consolidate core competencies in addition to having access to specialist skills within paediatric subspecialties.

3.4. Emergency care

Management of emergency care is evolving to provide alternatives to and prevent unnecessary admission. These centre around early access to dedicated General Paediatric Consultants and are supported by access to urgent outpatient appointments, development of nursing roles, closer working across acute and community services, earlier discharge and an ethos of supporting children at home wherever is possible and appropriate.

The impact of these changes is to reduce the likelihood of children being admitted unnecessarily and speed up their discharge home.

4. Future Services at the RAH and in Renfrewshire

4.1. Our proposal is to move inpatient and day case care from the Royal Alexandra Hospital(RAH) to the Royal Hospital for Children (RHC), this will allow effective use of our clinical teams to maintain strong clinical presence in outpatient services at the RAH and compliance with Royal College standards at both sites.

4.2. Children's services will continue to be provided at the Royal Alexandra Hospital (RAH) as follows:-

- A&E will continue to receive paediatric patients who self present;
- Outpatient clinics will continue to be provided;
- Specialist Community Paediatric services (PANDA Centre);

4.3. Services that will transfer to the Royal Hospital for Children (RHC) will be:

- Emergency inpatient admissions, including short stay medical assessment
- Elective inpatient admissions
- Day case activity including day surgery and planned investigations

4.4. The impact of these changes will be:

- Just under 7500 attendances self present at A&E, these will continue to be seen at the RAH.
- Just over 2500 attendances are GP referrals or come by ambulance and will go directly to the RHC.
- 16% of A&E attendances (1570) currently result in an admission – these will transfer to the RHC
- All emergency admissions (inclusive of the 1570 attendances above) will transfer to the RHC.
- All elective and day case activity, 667 episodes will move to the RHC
- For outpatients the 1520 new and 3043 outpatient appointments, total 4563, will continue to be delivered at the RAH.

Summary of activity changes

	Stay at RAH	Move to RHC
Outpatients	4563	
Day Case		542
Elective Inpatient admissions		125
A&E Attendances	7500	2500
Emergency Inpatient admissions		4839

4.5. In summary, a total of around 8006 episodes of care will transfer to RHC and 12063 will continue to attend RAH.

4.6. We are aware that access for the RAH catchment population to the RHC will be a significant concern. We are updating previous analysis so this can be scrutinised and debated as part of the engagement process and considered in final decision making. It is important to note that the RHC already provides these services for the rest of the Greater Glasgow and Clyde population and the hospital is relatively accessible to the Renfrewshire area.

4.7. Neonatal Intensive Care Unit

Neonatal intensive care/special care is located on campus in the separate maternity hospital. There is no planned change to neonatal or wider maternity services provided in the RAH as a result of this proposal. The neonatal service at RAH will become consultant led by the amalgamation of the workforce across the neonatal units at the QUEH maternity unit and RAH to provide a joint workforce model of patient care.

5. Proposed Engagement

This proposal was originally made in 2012 and there was an extensive programme of engagement at the time with patients/parents, families and professionals. This included an option appraisal from which the preferred option was to transfer the inpatient service in 2015 when the new Royal Hospital for Children opened on the new Queen Elizabeth University Hospitals Campus as there were real concerns about access to the RHSC at Yorkhill.

Our proposed approach to this further engagement has two phases:-

- Establish an extensive programme of communication with all stakeholders to describe the proposed change and give visibility to all elements of the previous process, particularly the option appraisal. The purpose of this phase is to ensure that all of the key interests have an opportunity to understand the proposal and make further comment. This process would run from the beginning of September until mid October with a report going to the October Board for a decision on proceeding to public consultation and the approach to consultation;

- If we proceed to consultation that process would run from the end of October for 3 months with a report back to the February Board for decision;

The case for change set out in this attachment will provide the basis for the engagement and the feedback from the engagement will inform the consultation material. That material will be developed by a stakeholder reference group (SRG).

The detail and final timing of this programme will be agreed with the Scottish Health Council

The SRG will include representatives from:-

- Kids Need Our Ward
- Action for Sick Children
- Women's and Children's Family Council
- Parents Support Group, Renfrewshire Carers.
- A public partner representative from each of the patient engagement for Renfrewshire, Inverclyde and West Dunbartonshire Health and Social Care Partnerships.

The Group will also have responsibility for working with us to shape the consultation process which will be set out and discussed with stakeholders after the engagement process is complete.

We will look at how patients can be engaged in the group with outreach to the young people on Ward 15 ensuring that their views, queries or comments are fully fed into the process. If required focus groups of children and young people will be facilitated.

6. Conclusion

The above proposals enable NHSGGC to provide equity of access for all children to emergency and specialist paediatric assessment; inpatient and operative procedures, in a dedicated children's hospital whilst maintaining local access to suitable urgent assessment (via ED) and ambulatory outpatient care for the majority of children in Clyde.

Attachment 2

Changes to rehabilitation services in NE Glasgow: Lightburn Hospital

1. Introduction and current services

1.1. This paper outlines our proposals for North East Glasgow which will:-

- Reshape inpatient rehabilitation services in the North East of Glasgow;
- Deliver a new extended care home model to enable direct discharge from acute care to local facilities;
- Modernise day hospital care for older people;
- Integrate outpatient services and Parkinson's disease care with new facilities being developed by the Glasgow City HSCP at Parkhead Hospital.

The detailed operational delivery of this proposal for an improved model of rehabilitation services in North East Glasgow has been developed with the multi disciplinary teams of consultants, nurses and allied health professionals delivering the current service. The implementation and the sustainable delivery of the new service model will be clinically driven.

These changes require the reshaping of the services currently provided at Lightburn, these are as follows:-

- Two 28 bedded inpatient wards providing rehabilitation for older people predominantly transferred from the GRI: In 2015/6 there was a total of 714 inpatient episodes.

- An outpatient department providing three consultant led clinics per week, one nurse led outpatient clinic per week and one fortnightly consultant led clinic: In 2015/6 there was a total of 417 new patients with a total of 1,084 attendances

- A Day Hospital providing multi disciplinary assessment and rehabilitation for older people: In 2015/6 there was a total of 436 new patients with a total of 3,787 attendances.

- The site also provides accommodation for the local Parkinson's support group as well as office accommodation for a number of local staff.

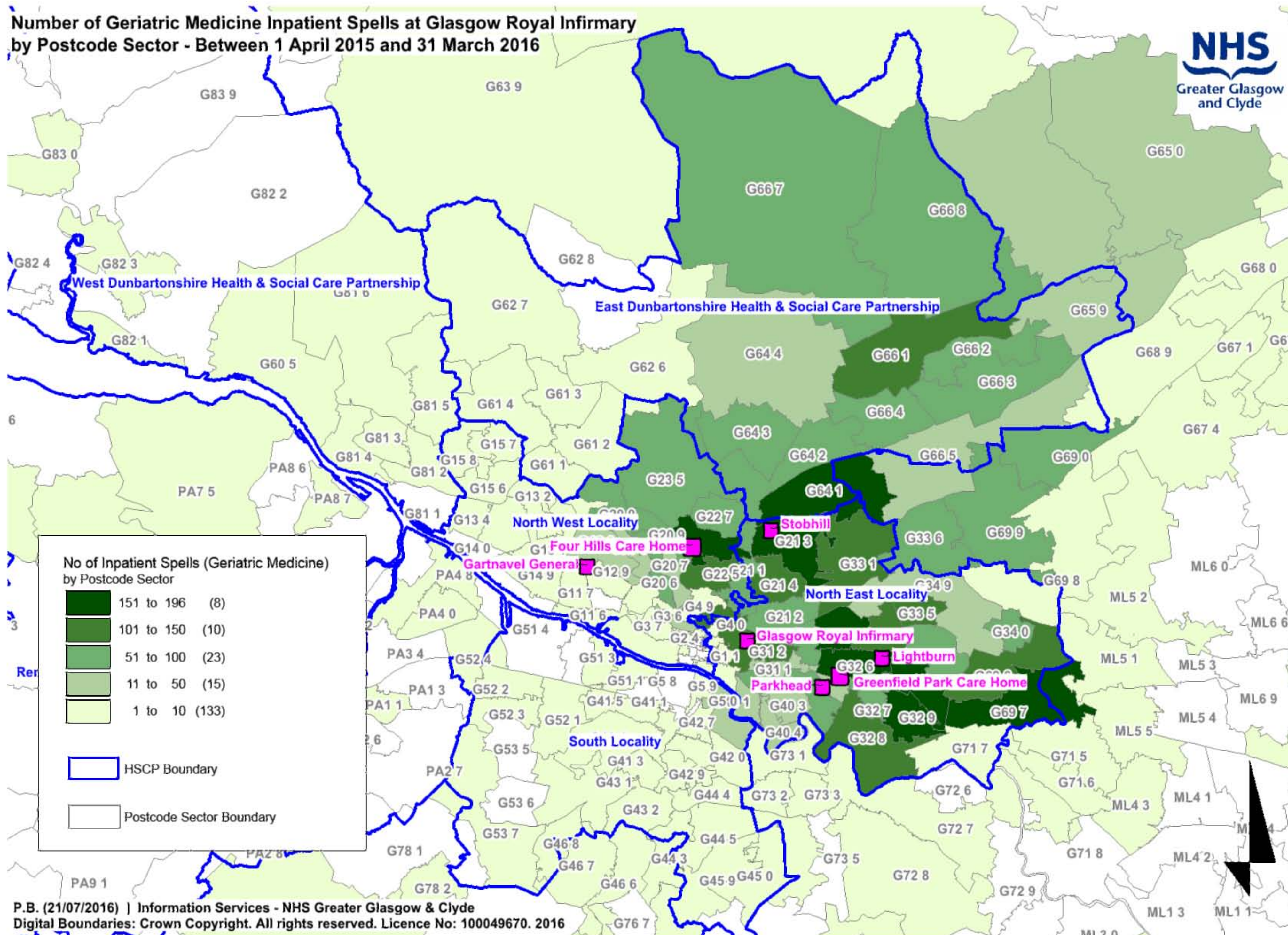
The rest of this section describes in more detail the current pattern of older people's admission and rehabilitation services.

1.2. Inpatient Rehabilitation: Current Services

Patients who are admitted to the GRI and require inpatient rehabilitation access services at Stobhill and Lightburn Hospitals. Patients who require geriatric rehabilitation after orthopaedic surgery from across Glasgow are admitted to Gartnavel General Hospital. The service at Lightburn is provided in two inpatient wards. The maps and tables below show the patient home postcode pattern of geriatric admissions to the GRI and Lightburn Hospitals and the number of patients admitted.

The information illustrates a number of key points:-

- All admissions for rehabilitation are first admitted through the GRI which serves a wide catchment area;
- The majority of geriatric admissions are discharged without transfer for rehabilitation;
- Admissions to the rehabilitation services which support acute care at the GRI cover a wide geographical patient population across the north and east of the City;
- The current facilities at Greenfield Park and the former Parkhead site provide local access for patients from the city's East End.
- Patients admitted to Lightburn come from a wide catchment area.


Number of Geriatric Medicine Inpatient Spells at Glasgow Royal Infirmary
by Postcode Sector - Between 1 April 2015 and 31 March 2016
NHS
Greater Glasgow and Clyde
West Dunbartonshire Health & Social Care Partnership
East Dunbartonshire Health & Social Care Partnership
North West Locality
North East Locality
South Locality
Stobhill
Four Hills Care Home
Gartnavel General
Glasgow Royal Infirmary
Lightburn
Greenfield Park Care Home
Parkhead
No of Inpatient Spells (Geriatric Medicine)
by Postcode Sector
151 to 196 (8)
101 to 150 (10)
51 to 100 (23)
11 to 50 (15)
1 to 10 (133)
HSCP Boundary
Postcode Sector Boundary
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Number of Inpatient episodes at Lightburn Hospital by Postcode Sector of residence (at time of episode)
April 2015 to March 2016 (Source: Origin Data Warehouse, Inpatient Episodes)

West Dunbartonshire Health & Social Care Partnership

East Dunbartonshire Health & Social Care Partnership

North West Locality

North East Locality

South Locality

Four Hills Care Home

Gartnavel General

Stobhill

Glasgow Royal Infirmary

Lightburn

Greenfield Park Care Centre

Parkhead

No. of Inpatient Episodes at Lightburn Hospital by Postcode Sector

Shading	No. of episodes (sectors)
darkest	41 to 48 (2)
dark	31 to 40 (3)
medium	21 to 30 (2)
light	11 to 20 (17)
lightest	1 to 10 (52)

NHSGGC HSCP Boundary

Postcode Sector Boundary

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Glasgow Royal Infirmary

Number of Geriatric Medicine Inpatient Spells 2015/16

Total		**5,055**
East Dunbartonshire Health & Social Care Partnership		**915**
G66	Kirkintilloch, Lennoxtown, Lenzie, Milton of Campsie	498
G64	Bishopbriggs, Torrance	351
G65	Croy, Kilsyth	41
G61	Bearsden	20
G62	Milngavie	5
Glasgow Health & Social Care Partnership - North East Locality		**3,046**
G32	Carmyle, Tollcross, Mount Vernon, Lightburn, Sandyhills	733
G33	Carntyne, Craigend, Cranhill, Millerston, Provanmill, Riddrie, Robroyston, Ruchazie, Stepps	623
G21	Barmulloch, Cowlairs, Royston, Springburn, Sighthill	453
G31	Dennistoun, Haghill, Parkhead	341
G69	Baillieston, Garrowhill, Gartcosh, Moodiesburn, Muirhead	311
G40	Bridgeton, Calton	190
G22	Milton, Possilpark	152
G34	Easterhouse	122
G4	Calton, Cowcaddens, Drygate, Kelvinbridge, Townhead, Woodlands, Woodside	104
G1	Merchant City	14
G71	Bothwell, Uddingston	3

Glasgow Health & Social Care Partnership - North West Locality		**711**
G20	Maryhill, North Kelvinside, Ruchill	335
G22	Milton, Possilpark	218
G23	Lambhill, Summerston	72
G3	Anderston, Finnieston, Garnethill, Park, Woodlands, Yorkhill	22
G13	Anniesland, Knightswood, Yoker	17
G12	West End, Cleveden, Dowanhill, Hillhead, Hyndland, Kelvindale, Botanic Gardens	15
G2	Blythswood Hill	9
G4	Calton, Cowcaddens, Drygate, Kelvinbridge, Townhead, Woodlands, Woodside	9
G11	Broomhill, Partick, Partickhill	5
G15	Drumchapel	5
G14	Whiteinch, Scotstoun	3
G1	Merchant City	1
North Lanarkshire Health & Social Care Partnership		**198**
Other HSCPs		**185**

Lightburn Hospital

Number of Geriatric Medicine Inpatient Episodes 2015/16

Total		**714**
East Dunbartonshire Health & Social Care Partnership		**74**
G66	Kirkintilloch, Lennoxtown, Lenzie, Milton of Campsie	39
G64	Bishopbriggs, Torrance	29
G61	Bearsden	6
Glasgow Health & Social Care Partnership - North East Locality		**483**
G32	Carmyle, Tollcross, Mount Vernon, Lightburn, Sandyhills	157
G33	Carntyne, Craigend, Cranhill, Millerston, Provanmill, Riddrie, Robroyston, Ruchazie, Stepps	89
G69	Baillieston, Garrowhill, Gartcosh, Moodiesburn, Muirhead	70
G31	Dennistoun, Haghill, Parkhead	55
G21	Barmulloch, Cowlairs, Royston, Springburn, Sighthill	28
G40	Bridgeton, Calton	28
G34	Easterhouse	25
G4	Calton, Cowcaddens, Drygate, Kelvinbridge, Townhead, Woodlands, Woodside	18
G22	Milton, Possilpark	10
G1	Merchant City	3
Glasgow Health & Social Care Partnership - North West Locality		**88**
G20	Maryhill, North Kelvinside, Ruchill	48
G22	Milton, Possilpark	23
G23	Lambhill, Summerston	7
G3	Anderston, Finnieston, Garnethill, Park, Woodlands, Yorkhill	5
G13	Anniesland, Knightswood, Yoker	3

G15	Drumchapel	1
G4	Calton, Cowcaddens, Drygate, Kelvinbridge, Townhead, Woodlands, Woodside	1
North Lanarkshire Health & Social Care Partnership		**34**
Other HSCPs		**35**

2. Case for change and proposed services

2.1. There are a number of local and national strategic drives which frame these service change proposals

- The Scottish Government's 2020 Vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting and, that we will have a healthcare system where:
- Caring for more people in the community and doing more procedures as day cases where appropriate will result in a shift from acute to community based care. This shift will be recognised as a positive improvement in the quality of our healthcare services, progress towards our vision and therefore the kind of service change we expect to see.
- The integration of health and social care is leading to the development of new services and care pathways.
- There is a focus on prevention, anticipation and supported self management
- Acute hospitals are focussing only on the most acutely ill patients. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of readmission
- We need to prioritise support for people to stay at home/in a homely setting as long as this is appropriate and avoid the need for unplanned or emergency admission to hospital wherever possible.
- We need to make sure people are admitted to hospital only when it is not possible or appropriate to treat them in the community.
- Improve the quality and consistency of care for patients, carers and families
- To provide seamless, joined up care that enables people to stay in their homes, or another homely setting, where it is safe for them to do so; and
- To ensure resources are used effectively and efficiently to deliver services that meet the needs of the growing population of older people with longer term and often complex needs;
- The need for the highest quality specialist care in hospital;
- A need for changes to current service provision that would better support people to return home from hospital as soon as possible;
- The importance of organising services to aid effective communication and coordination of care and reduce fragmentation of care
- Facilitating good links between hospital and community/Primary Care services to better coordinate care

This range of drivers for change was considered as a core part of our Clinical Service Review in the older people’s work programme. This programme gave the opportunity to explore these drivers in relation to our local circumstances and engagement with older people was central to the development of our thinking on new models of care. Options for the future were discussed and refined throughout the two year engagement process. For example, initial engagement activity specifically for older people’s services highlighted the need for greater coordination of services and improvements in planning discharge from hospital.

These views were further explored in subsequent engagement sessions with the public and community groups. This work emphasised the need for greater recognition of the impact of multi morbidity on older people and specifically:

- The need for the highest quality specialist care in hospital
- A need for changes to current service provision that would better support people to return home from hospital as soon as possible
- The importance of organising services to aid effective communication and coordination of care and reduce fragmentation of care
- Facilitating good links between hospital and community/Primary Care services to better coordinate care.

2.2. Further important points of context are that:-

- Substantial reductions in delayed discharges and agreement with IJBs to make further reductions;
- The Glasgow City HSCP investment in services to reduce demands on acute care including in intermediate care;
- Consolidation of beds for patients requiring acute rehabilitation onto our acute sites with access to a full range of clinical support services;
- We need to improve senior and junior doctor cover;
- Shifting the balance of care with more services and resources being directed to keep patients at home;
- As we focus hospital care only on the most acute part of the patient pathway, it is important that care is provided on sites where we can deliver the full range of acute hospital services;

2.3. Inpatient Rehabilitation

These proposals would see a redesign of the rehabilitation pathway across the north east sector which supports a more community based approach to rehabilitation in line with the described national and local strategies.

This approach is clinically driven and underpinned by evidence gathered in our work on the day of care and current occupancy. An audit of the current bed occupancy across North East facilities has been undertaken and each patient was clinically assessed to consider the requirement for location in an acute rehabilitation facility or whether their care needs may be better delivered in a community or homely setting.

The results of this audit was that of 104 acute patients clinically reviewed, 54 required acute hospital rehabilitation and 31 were clinically suitable for rehabilitation in a more homely setting (the other beds were vacant at the time of the audit).

- The proposed model sees a reconfiguration where patients requiring acute inpatient rehabilitation receive their care on an acute hospital site, providing immediate access to a greater range of support services than is currently available at Lightburn Hospital, including:

  - Lab medicine and phlebotomy
  - Imaging and Diagnostic services
  - Orthotics
  - Pharmacy
  - Cardiology; and
  - Liaison from a range of other specialties

  This acute rehabilitation would be provided within GRI, Stobhill Hospital and through access to a small number of beds at Gartnavel General Hospital, providing a spread of local geographical provision to patients living across the west, east and central areas of the north sector catchment.

- Patients no longer requiring the support services of an acute hospital, but still requiring rehabilitation would be transferred to local community facilities for their ongoing care. There are currently suitable facilities for this level of care at Greenfield Park and Fourhills, where a strong focus would be on re ablement within a homely setting. This model of providing care and rehabilitation has proven successful in recent years in enhancing rehabilitation and helping people to return home at the earliest opportunity;

- Using a model of community based rehabilitation will further strengthen links between clinicians within the acute sector and community services and complement the approach with community based intermediate care and the emerging models for complex community care.

This new model of care is an evidenced based approach to enable:

- Early intervention from specialists in the care of older people focussed on frailty assessment, followed by;
- Rapid commencement of multi disciplinary assessment and rehabilitation within appropriately resourced rehabilitation facilities which enable fast access to the full range of investigations and specialist advice as required for patients with multi morbidity; and
- Early planning for the transfer of care from hospital to community services involving all appropriate stakeholders

This approach is designed to ensure an individual's stay in hospital is for the acute period of care only and people are supported to return to their community as soon as possible. The new models of acute care require hospital facilities that provide ready access to a broad range of clinicians and diagnostic services. With limited diagnostics facilities at Lightburn Hospital and medical staff covering a number of hospital sites NHSGGC is unable to provide the level of acute care required to deliver the new models of care. The new model of service delivery will provide high quality services that are more tailored to individual needs. For patients requiring acute care this will be delivered in facilities providing access to the full range of acute and diagnostic services without the need for additional ambulance transfers as happens at present at Lightburn Hospital.

This wider provision of services will enable a greater range of patients to access the rehabilitation services and substantially reduce the current need to transfer patients who require such services from Lightburn to the GRI to access support services.

The majority of North and East Glasgow patients will be discharged from their assessment ward directly home without requiring a longer period of rehabilitation in hospital. This will mean for most people there will be no change from these proposals as their inpatient care will be provided at Glasgow Royal Infirmary.

2.4. Day Hospital Services

Our proposals for the provision of current Lightburn Day Hospital services would see provision combined in to a single Day Hospital on the Stobhill site. This would bring the service into line with all other Day Hospitals across Glasgow by providing modern facilities with access to a range of services that support Day Hospital activity including:

- Lab medicine and phlebotomy
- Imaging and Diagnostic services
- Orthotics
- Pharmacy; and
- Liaison from a range of other specialties

The modern model of day hospital provision is a more medicalised model requiring access to the full range of clinical investigations as part of assessment and treatment. For this reason it is important that services are delivered within facilities with those services on site. Lightburn Hospital has a very limited range of clinical support services and cannot deliver this modern, medicalised model of day hospital care.

2.5. Outpatient Services and Other Services

Glasgow City HSCP is planning a substantial development of an integrated community hub on the Parkhead hospital site. We will work together to further develop this proposal to include provision for high quality accommodation for outpatient services currently provided in the Lightburn site, with the potential for the development of a further range of community outreach services on that site.

Should this proposal proceed, as an interim arrangement until this new local hub can be delivered, we will put in place arrangements to ensure outpatient services provided from Lightburn and the Parkinson's support service can continue to be provided locally in the East End.

Previous work on surveying patient day and outpatient transport patterns showed the following distribution for Lightburn patients:

Day Hospital Arrival Method	Percentage (%)
Ambulance/Patient Transport	81%
Car	17%
Taxi	2%

Outpatients Arrival Method	Percentage (%)
Car	38%
Taxi	25%
Ambulance/Patient Transport	19%
Bus	12%
Walk	6%

This study is currently being updated to inform the engagement process.

3. Proposed Engagement

3.1. There have been previous proposals and public engagement processes with regard to the future of Lightburn Hospital. However, this is a new proposal with a different context in terms of acute and community service delivery, the advent of HSCPs and a different pattern of acute care across NHS Greater Glasgow and Clyde and is in line with the direction of the national and local clinical strategies. We are therefore proposing a substantial engagement programme with interests across the local area. Our proposal therefore is that there should be extensive engagement considered by the Board in advance of any formal public consultation.

3.2. As the acute service changes are an integral part of changes to the totality of older peoples care for this population, we would want to deliver the engagement process with the HSCP.

3.3. The engagement phase will include:

- Wide distribution of engagement material;
- Engagement with local Councillors;
- Option appraisal workshops;
- Drop in sessions;
- Visibility of the proposals at key public locations across the East End;

The process will draw on the relevant local networks and ensure the proposals are set in the wider context of local community health and social care services.
The material for the engagement will be drawn from the content of this paper.

3.4. The engagement will run from the beginning of September 2016 until the beginning of December 2016 and the outcome will be reported to the December 2016 Board which will then make a decision on public consultation and the process for that consultation. The development of the engagement will be supported by a Stakeholder Reference Group (SRG) which will include:-

- Representatives from North and East Glasgow Older Peoples Groups
- Representatives from Carers Association
- Representative from Parkinson's Support Group
- Public Partner Representatives from Glasgow HSCP

3.5. The SRG will:

- Support the detailed development of the engagement programme outlined above
- Arrange and facilitate site visits for SRG members
- Help draft communications plan and information resources,
- Advise on a carer or patient perspective on access issues
- Advise on the best means of engaging with those affected and local communities,
- Attend and participate in public engagement events
- And provide feedback from their peers or contacts on the process as it progresses.

3.6. The engagement process will explore the following areas:

- Patient Pathways: what aspects are important to patients and carers/relatives to facilitate a good transfer of care between the GRI and the rehabilitation facilities?
- Access: we know there are substantial local concerns about access, we need to understand and appraise those issues in the context that we will retain and develop as much service as possible in the local area. The engagement will identify how the changes raise concerns about access and identify issues that need further consideration; for example transport and access for visiting?
- Communication: how might coordination of care between hospital and community services be further improved?
- Future Developments: to listen to suggestions for any further development of services and explore thoughts on the future use and purpose of the Lightburn Hospital site

Attachment 3

Changes to delivery services in the Community Maternity Units

1. Current services

Midwife led care has been well established in CMUs since the inception of the community maternity units in 2004. Both CMUs are busy services providing a wide range of maternity care to all women in each locality with around 5000 non birth contacts in each year. These services offer high quality local outpatient and day care which is described in further detail in the rest of this section.

Midwifery Teams: Midwives work within geographical teams providing antenatal and postnatal care to a defined caseload of women. They provide first point of contact for early booking to the maternity services and provide continuity of carer with a maximum of three midwives for scheduled visits. CMU midwives are highly skilled, working autonomously but within a multidisciplinary context across antenatal, intrapartum and postnatal care. They maintain these skills by frequent in-house updates and attendance at Scottish Maternity Multidisciplinary Development Programme (SMMDP) courses.

Antenatal Care: Midwives are the first point of contact for all women as part of Keeping Childbirth Natural and Dynamic (KCND) care pathway they provide:-

- midwife led care to women on the low risk pathway
- shared care to women with an obstetrician as lead clinician
- parent education classes for women and their partners
- breast feeding support and workshops
- Preparation for labour and birth
- a home birth service for those women who meet the evidence based criteria
- care for vulnerable women supported by the Special Needs in Pregnancy Service (SNIPS)
- Liaise with other multidisciplinary agencies e.g. GPs, health visitors, social work, perinatal mental health and child protection unit
- day care assessment and early pregnancy assessment
- support high risk obstetric clinics
- Fulfil the health improvement imperatives of the public health agenda e.g. alcohol brief intervention, smoke free and carbon monoxide (CO) monitoring, breast feeding, cot death, referral to other agencies

Postnatal care: Midwives provide:-

- postnatal care to mother and baby
- detailed examination of the newborn and newborn blood spot screening
- infant feeding advice and support
- Management of jaundice within West of Scotland guidelines
- Liaison with GP and health visitor and other agencies as required
- formal handover to health visitor at day 10 or when appropriate

The Units both currently provide intrapartum services for women. These include providing:-

- telephone triage advice in early labour to support timely and appropriate admission to the CMU or Labour ward
- 1 to 1 care in labour in a freestanding midwife led birthing suite environment
- low risk care, including water birth and support for women using alternative therapies for labour and birth. Enabling women to be mobile with minimal interventions. This reduces the risk of unnecessary medical intervention and also enhances the woman's birth experience

Importantly all midwives must maintain the required knowledge and skills in dealing with obstetric and neonatal emergencies, keeping woman and baby stable until ambulance transfer to a consultant led obstetric or neonatal unit can be arranged as required

Numbers of women opting to use those delivery services have continued to decline from the planned level of around 200 for each Unit. During 2015/16, there were only 17 deliveries in IRH and 43 at VOL. The overwhelming majority of women choose to have their ante and post natal care in the Units but opt for delivery in hospital, as the table below sets out:-

Births to Greater Glasgow and Clyde residents in Inverclyde and VOL Catchments

Deliveries	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Inverclyde HSCP Residents	835	808	789	776	765	738	711	685
Delivered at IRH	94	107	67	63	42	34	26	11
% at IRH	**11%**	**13%**	**8%**	**8%**	**5%**	**5%**	**4%**	**2%**
Vale of Leven HSCP Residents	822	829	745	836	761	695	740	679
Delivered at VOL	96	112	81	103	93	77	33	35
% at VOL	**12%**	**14%**	**11%**	**12%**	**12%**	**11%**	**4%**	**5%**

Total Deliveries at Inverclyde Royal Hospital and Vale of Leven Hospital

Total Deliveries	2014/15	2015/16	2016/17 (to June)
Inverclyde Royal Hospital	27	17	**3**
Vale of Leven	39	43	**7**

Following the previous public consultation the Board agreed to undertake an extensive programme of communication to try to increase the number of women opting to use the delivery services. Midwifery staff at both CMU's have actively promoted birth within the units and this has included:

- Discussion with all women at booking visit offering information around choice of place of birth which is reinforced with a patient information leaflet
- Option to leave decision about place of birth until later on in the pregnancy
- Leaflet distribution on services provided to local libraries, GP & Dental Practices, commercial premises and leisure facilities
- Visits to local school nurseries and mother and toddler groups
- Open days within the unit
- Stall at local supermarkets
- Variety of features in Greenock Telegraph

The Vale Vision committed us to continue the delivery service until at least 2011 and also included a commitment to retain the service for three years to try to increase numbers. As the table above illustrates those efforts have not succeeded.

2. Case for Change and Proposed Service

2.1. The proposal is to retain all ambulatory services at the CMUs with midwife led intrapartum care in RAH, PRMH and the QEUH or at home. The birthing facilities in the Vale and the IRH CMU's will cease to operate.

- The RAH CMU has approximately 300 births per year and has the provision to expand from 3 postnatal beds and 4 birthing rooms up to 6 postnatal beds to meet the transfer of birth activity from IRH and Vale CMU's.

- Currently there is a dedicated home birth team which covers Glasgow and this will be extended to a GGC home birth team. Again there is an evidenced based criteria for home birth. There have been no recruitment issues for staff in the homebirth team and as this is their only function they are able to maintain their intrapartum care skills. In parallel to this work we will review arrangements for midwifery led births in our QEUH and PRMH sites to ensure informed choice and that all pregnant women we care for have full range of care and birth options available to them

The reasons we are proposing changes are set out in the rest of this section.

2.2. The demographics of the Maternity population has changed and there are fewer women who meet low risk criteria. The reduction in numbers of women who choose to give birth in the CMU's reinforces the clinical and service challenges in sustaining safe CMU birth facilities. Challenges include staff recruitment, retention and skill maintenance and there have been adverse clinical incidents.

2.3. When complications arise ensuring safe and prompt transfer of ill neonates or women in labour to the consultant units can be problematic. The Vale and IRH CMUs are free standing. If there is a requirement for medical/anaesthetic or neonatal assistance in the intrapartum and immediate postnatal period, the mum and / baby require to be transferred to the Consultant led unit at RAH. This may delay any necessary treatment and ultimately can affect care and influence morbidity. Some of the main reasons for transfer will include the requirement for epidural anaesthesia, delay in either the first or second stage of labour, concerns over fetal heart rate in labour, retained placenta requiring surgery, repair of an extensive perineal tear and transfer of the neonate for neonatal life support. These reasons also pertain to the homebirth service. All of these issues and the transfer rate are discussed with the woman at booking when she makes her choice over place of birth. Transfers do occur with our alongside CMU but the travel distance is minimal and some transfers can be avoided as medical staff are on site and can attend immediately to the CMU if required.

2.4. The Ombudsman's report following an adverse event in the Vale of Leven CMU in October 2013 (investigation report September 2015) evidenced this. A similar case in NHS Tayside is currently the subject of an FAI which should report in the autumn. The alternative services available at the RAH and QEUH enable women to opt for a midwife led birth. Importantly any woman who fits the criteria for a CMU birth can choose to have her baby at home.

2.5. Maintenance of intrapartum skills is challenging given the low number of births at IRH and Vale CMU's. Up to and including June this calendar year, there have been a total of 5 births at IRH and 13 births at the VOL and no home births**.** Given the low numbers of CMU and no home births the midwives have to rotate into the RAH CMU to maintain intrapartum competence and skills. The IRH and VoL CMU has an on-call system for out of hour's births.

2.6. **The challenge of maintaining an on call system** over the past five years has had a heavy toll on midwives within the CMU, and is becoming more and more difficult to sustain. This is due to a number of factors which includes the age profile of midwives, difficulty in recruiting midwives, placing a greater burden on the existing staff and an increased on-call commitment. It is also becoming difficult to recruit to the CMU's as midwives need to live within 50 minutes of the units in order to respond to a woman in labour.

2.7. **Staffing issues** the main compelling arguments for change are based on staffing issues – we are finding it difficult to recruit to the CMU's as you need experienced staff who live close enough to attend when a woman presents in labour out of hours (including weekends). Also due to the falling number of births, midwives are at risk of becoming deskilled in intrapartum care and must complete a rotational programme to the CMU at RAH. This rotation does affect the continuity of care for women in the antenatal and postnatal period and the benefits this provides. These issues all ultimately have an impact on the quality of care that women receive.

3. **National Review of Maternity and Neonatal Care** A national review of maternity and neonatal services was launched in February 2015 and is due to report in the summer of 2016. The Review is focused on creating a refreshed model of care and approach to maternity and neonatal services and it aims to examine choice, quality and safety of maternity and neonatal services in light of current evidence and best practice, in consultation with the workforce, NHS Boards and service users. The Review Group has just concluded and extensive programme of engagement with stakeholders and has identified a number of themes which will be reflected in the final Report.

- Continuity of care and carer
- Relationship-based, personalised care
- The remote and rural context
- Workforce – including education, skills, recruitment and age profile
- A multidisciplinary team approach and clear pathways for referral
- Supporting and keeping mums, babies and families together as much as possible

The Group have also highlighted the importance of facilitating normal births and normality, and addressing health inequalities to ensure alignment with the review we will:-

- Continue to work with the ChiefMedical and Nursing Officers to deliver the national priorities and ensure the promotion of midwife led care and birth facilities in our maternity units;
-
- draw on the National review material during our local engagement on the CMU delivery services will aim to time the reporting of the outcome of our engagement to the Board for decision with the publication of the National Review Report so that our decisions are made in that context.

4. **Proposed Approach to Engagement**

There has been extensive public engagement and formal public consultation on these changes and the proposals have raised limited concerns from the women who are likely to use the services. Our proposal is to have re engagement to ensure all key stakeholders are aware of the proposal and have the opportunity to offer their views. The proposed approach to this re engagement is to establish a two stakeholder reference groups, one for each service, which will with us on the engagement process which will include:-

- refreshing the outputs from previous public engagement ,
- local workshops enable stakeholders to hear and explore the proposal. This workshop will include explaining the issues with the option of retaining the status quo and enabling stakeholders to challenge our appraisal of those issues;
- A range of communication resources and a detailed communications plan;
- Ensuring the engagement enables all patient perspectives to be on access or other issues
- Advise on the best means of engaging with those affected and local communities,
- public engagement events including outreach to mums and toddler groups and parent support groups.

The focus of the engagement will be on potential patients but will also enable wider local interest to express their views.
The SRGs will include:-

- Current or recent patients of the CMU
- Representation from local Health and Social Care Users Forum or equivalent
- Identified public representatives of each HSCP

This approach to engagement will enable the Board to consider the local patient views of these proposed changes alongside the outcome of the national review of maternity services in reaching a decision.

Attachment 4

Centre for Integrative Care: moving to ambulatory care

1. Current Service

The Centre for Integrative Care currently has seven inpatient beds, which are open from Monday afternoon to Friday morning. The beds are used for small numbers of admissions. Patients admitted to the inpatient beds receive therapies such as group therapy sessions, nutrition and diet advice, massage, acupuncture, physiotherapy, psychological support and counselling. All of these services are available in the outpatient department.

Activity in 2015/16 is shown below.

	Inpatients	Outpatients			Inpatients as share of total activity
	No	New	Return	Total	
Greater Glasgow & Clyde	224	797	3273	4070	5.2%
Lanarkshire	50	85	742	827	5.7%
Ayrshire & Arran	28	62	260	322	8.0%
Forth Valley	14	32	153	185	7.0%
Highland	7	13	149	162	4.1%
Lothian	6	17	63	80	7.0%
Others	3	8	83	91	3.2%
TOTAL	**332**	**1014**	**4723**	**5737**	**5.5%**

2. Proposed Service and Case for Change

The proposal to close the CIC beds is based on the fact that:

- The Unit has reduced its inpatient service in recent years from a 15-bedded seven-day unit to only 7 beds, open 4 nights a week.
- The Centre has been very successful in developing an ambulatory model of care and all services are now available on that basis.
- Inpatient capacity is now underutilised delivering only 332 episodes of care each year. This will be further reduced by the continuing impact of decisions by other Boards to withdraw from the service, only 224 in patient episodes are provided for NHS GG and C residents.
- Inpatients account for only 5.2% of patient contacts for GGC residents. The majority of service delivery is already delivered in an outpatient setting.

The service will continue to provide the full range of current treatments and:

- Patient education courses will be provided as week-long outpatient programme.
- Mistletoe and homeopathic treatments will be provided as day treatment attendances.
- Acupuncture for inpatients is already provided as part of existing outpatient programmes.

Arrangements for admissions or overnight accommodation can be made in exceptional circumstances.

This change also enables the early development of a new centre for the Scottish National Residential Pain Management Programme within the released capacity. That service will integrate with and complement the services already provided in the CIC and will deliver:

- Pre-assessment for 100-120 patients per annum
- Bi-disciplinary assessment for 100 patients per annum conducted by a Clinical Psychologist and Physiotherapist.
- Residential programmes for around 80 patients per annum
    - Patients will attend a programme of 3 weeks in length.
    - Sessions will be tailored to the needs of each group, and to each individual within the group. Some will be conducted jointly by two professions working together, others will feature a single professional being assisted by a healthcare assistant (exercise and other practical sessions) and yet others will require sub-groups of patients working on different topics with different members of the team.
    - Where appropriate carers/relatives will attend with the patient in order to provide support. It is proposed that educational interventions will take place with these carers and these are expected to largely consist of helping these relatives better understand and manage the needs of the patient.

- Follow-up 80-100 patients per annum

3. Proposed Engagement

As outlined above our proposals retain the full range of current services and reflect and increasing trend to move to day care, which has already been reflected in the transition to a four night only inpatient facility. The impact on patients is therefore minimal. However, we know that there are real concerns that we are proposing significant change to the CIC services and a perception the Centre itself is at risk, this is not the case.

We want to ensure that there is extensive engagement with stakeholders to explain the proposal and hear their views and therefore, despite the minor scale of the change we will establish a stakeholder reference group to develop this engagement.

The SRG will act as a sounding board, to inform, advise on, and critique our engagement process. This group will include representatives from:

- Friends of Homeopathy
- Health and Social Care Alliance Scotland
- The two NHSGGC Managed Clinical Networks – Chronic Pain and Rheumatology.
- Pain Association Scotland
- Representation from the Acute Division Patients Panel and HSCP Public Partnership Fora.

The material in this paper will be developed to describe the range of current services and confirm that range will continue be delivered and will describe the new national chronic pain service and how it will be delivered within the CIC. The engagement process will include communication with current and previous patients and key interest groups and will include drop in sessions within the CIC.

We would conclude this engagement in early December and report the outcome of engagement to the December Board