Renfrewshire Council

To: Audit, Scrutiny and Petitions Board

On: 19 September 2016

Report by: Lead Officer

Heading: Review of Ward 15 (Children's Ward) Royal Alexandra Hospital

1. Summary

1.1 At its meeting on 30 November 2015, the Audit, Scrutiny and Petitions Board agreed to provide an informed, evidence-based Council view of any consultation regarding the future of Ward 15 at the Royal Alexandra Hospital in Paisley.

1.2 The following report outlines the progress made by the Lead Officer in terms of taking forward the review since the last meeting on 6 June. The key areas of progress have included:

- Additional information provided by NHS Greater Glasgow and Clyde on questions arising from the Audit, Scrutiny and Petitions Board meeting in May;
- Output from Renfrewshire Council's online consultation on Ward 15; and
- Recent decisions taken by NHS Greater Glasgow and Clyde regarding public engagement on service changes at the Royal Alexandra Hospital, Ward 15.

1.3 In light of these additional developments a final draft "Review of Ward 15 (Children's Ward) Royal Alexandra Hospital" will be brought to this Board on Monday 28 November for approval.

2.1 Recommendations

2.2 It is recommended that the Audit, Scrutiny and Petitions Board:

- Notes the progress of the review;
- Notes the additional information provided by the NHS Greater Glasgow and Clyde following their presentation to Board in May 2016;
- Notes the output of the online consultation;

- Notes the decision of the NHS Greater Glasgow and Clyde Board to agree an approach to public engagement on a series of service changes, including the review of paediatric inpatient services at the Royal Alexandra Hospital, Ward 15.

3. Information Gathering - NHS Greater Glasgow and Clyde

3.1 At the special meeting of the Audit, Scrutiny and Petitions Board held on 23 May 2016 members received a presentation by representatives from NHS Greater Glasgow and Clyde (NHS GGC) on the services provided at Ward 15.

3.2 Both parties agreed that the session had been helpful with colleagues from NHS Greater Glasgow and Clyde agreeing to provide:

- An overview of how any future consultation would be conducted;
- Additional documentation on the Clinical Services Review;
- Further information on transport links and car parking capacity;
- Detailed explanatory notes on the statistical data provided in the presentation, i.e. the Quality – Healthcare Standards Dashboard slide; and
- Activity maps identifying where the occupants of in-patient beds in Ward 15, RAH came from.

3.3 A detailed response from NHS Greater Glasgow and Clyde to this information request can be found at Appendix 1.

3.4 Colleagues from NHS Greater Glasgow and Clyde have indicated that there was no further documentation available in terms of the Clinical Services Review.

4. Online Consultation

4.1 Individuals or groups, who wished to contribute to the review, were invited to complete an online survey in the form of an electronic form was used to capture this information. The form was made available through the Renfrewshire Council website. A copy of the consultation form has been included in Appendix 2. The survey was also highlighted via the Council's Facebook page and Twitter feed.

4.2 The survey was published on the website on 14th April 2016 and remained online until the 20th June 2016. There were 15 submitted responses. All respondents had home postcodes within the Renfrewshire area, spread across Paisley, Renfrew, Johnstone and Bridge of Weir. 14 of the respondents were Parent / Guardians and the other respondent was a service user who had been treated in Ward 15 as a child.

4.3 The most common themes arising from the responses were as follows:

- there was a need for local services to be kept local;
- local families required the services; and
- services provided at Ward 15 were seen as invaluable to the hospital and to the people of Renfrewshire and surrounding villages and towns.

noted that Children in Clyde requiring complex care should have access to the same specialist services that young patients in Greater Glasgow receive.

5.6 Following a vote of the board, it was agreed that the services changes outlined in the Plan should be brought to the August 2016 Board meeting for approval to launch a process of public engagement. With this, the Local Delivery Plan 2016/17 was approved by the Board. The full board paper has been attached at Appendix 3.

5.7 On 16 August 2016 the NHS Greater Glasgow and Clyde Board agreed an approach to public engagement on the series of service changes agreed at its meeting in June 2016. The full board paper has been attached at Appendix 4.

5.8 The Board paper proposed that inpatient and day case care from the Royal Alexandra Hospital (RAH) be moved to the Royal Hospital for Children (RHC). 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).

5.9 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.

5.10 The impact of these changes are seen as follows:

- Just under 7,500 attendances self present at A&E, these will continue to be seen at the RAH.
- Just over 2,500 attendances are GP referrals or come by ambulance and will go directly to the RHC.
- 16% of A&E attendances (1,570) currently result in an admission – these will transfer to the RHC
- All emergency admissions (inclusive of the 1,570 attendances above) will transfer to the RHC.
- All elective and day case activity, 667 episodes will move to the RHC
- For outpatients the 1,520 new and 3,043 outpatient appointments, total 4,563, will continue to be delivered at the RAH.

In summary, and based on NHS greater Glasgow and Clyde data from 2015/16, a total of around 8,006 episodes of care will transfer to RHC and 12,063 will continue to attend RAH.

5.11 The NHS Greater Glasgow & Clyde has recognised that access for the RAH catchment population to the RHC will be a significant concern. They are currently

4.4 In addition, respondents identified a number of specific issues relating to the review. They included:

- The ability to have local consultations at Ward 15 in the Royal Alexandra Hospital;
- Ward 15 staff were seen to be providing added value to families during difficult times;
- Respondents highlighted that having a range of services and specialties within the staff of Ward 15 meant there was no need for referrals to the Royal Hospital for Children
- Retaining services at Ward 15 was also seen to have benefits for people who had limited transport means;
- Recognition of the economic and financial constraints faced by some parents in Renfrewshire;
- Consideration of the strong links that Ward 15 had formed over many years within the community in terms of the services and jobs provided locally;
- The benefit to child recovery of having their parents / guardians living close to the hospital;
- Other respondents thought it made sense to retain the services at both Ward 15 and the new services provided at the Royal Hospital for Children;
- Only one comment saw more benefits arising from the Royal Hospital for Children.

5. **NHS Greater Glasgow and Clyde Board Decision**

5.1 In their presentation to the Audit, Scrutiny and Petitions Board meeting on 23 May, colleagues from NHS Greater Glasgow and Clyde noted that a decision on the future of Ward 15 would be considered as part of the NHS Greater Glasgow and Clyde's Local Delivery Plan proposals and that these would be considered by their Board at its meeting on 28 June.

5.2 The Local Delivery Plan outlines how NHS Greater Glasgow and Clyde will deliver the priorities set for the NHS. The proposed plan highlighted a number of areas of risk reflecting the fact that they did not yet have a fully balanced financial plan across NHS Greater Glasgow and Clyde.

5.3 A number of service change proposals were outlined in the plan including a review of Royal Alexandra Hospital paediatric services. The proposal sought to retain the current full range of general and specialist outpatient children's services at the Royal Alexandra Hospital with inpatient care to be provided at the Royal hospital for Children.

5.4 The NHS Greater Glasgow and Clyde Board debated whether the Plan should or should not include the proposed service moves. Concerns were expressed by some members that they were being included when similar proposals made previously had not been supported at government level. Local councillors wished also to record the local reaction to proposals which would see services being re-located.

5.5 The Board heard that these service change proposals were being brought forward because of an emerging clinical consensus that changes were necessary. It was

updating previous analysis so this can be scrutinised and debated as part of the engagement process and considered in final decision making. They 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.

Proposed Engagement

5.12 The NHS Greater Glasgow and Clyde's proposed approach for the engagement process 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 will 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 this is agreed the consultation process would run from the end of October for 3 months with a report back to the NHS Greater Glasgow and Clyde's Board in February Board for decision;

5.13 The case for change which was set out in both the NHS GGC's Board papers in June and August will form the basis for engagement and the feedback from the engagement will inform the consultation material. That material will be developed by a stakeholder reference group (SRG). The group 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 groups for Renfrewshire, Inverclyde and West Dunbartonshire Health and Social Care Partnerships.

5.14 The Group will also have responsibility for working with NHS Greater Glasgow and Clyde to shape the consultation process which will be set out and discussed with stakeholders after the engagement process is complete. NHS Greater Glasgow 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. Next Steps

6.1 It is the intention to submit a final draft "Review of Ward 15 (Children's Ward) Royal Alexandra Hospital" to this Board on Monday 28 November for approval.

Implications of this report

1. **Financial Implications – none.**

2. **HR and Organisational Development Implications – none.**

3. **Community Plan/Council Plan Implications – none.**

4. **Legal implications – none.**

5. **Property and Assets implications – none.**

6. **Information Technology implications – none.**

7. **Equal & Human Rights implications –** The recommendations contained within this report have been assessed in relation to their impact on equalities and human rights. No negative impacts on equality groups or potential for infringement of individuals' human rights have been identified arising from the recommendations contained in the report because it is for noting only. If required following implementation, the actual impact of the recommendations and the mitigating actions will be reviewed and monitored, and the results of the assessment will be published on the Council's website.

8. **Health and Safety implications – none.**

9. **Procurement implications – none.**

10. **Risk implications – none.**

11. **Privacy impact – none.**

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List of background papers: None

Appendix 1

Renfrewshire Council
Audit, Scrutiny & Petitions Board

Ward 15, Royal Alexandra Hospital

Follow up information to session on 19 May 16

Neil Ferguson, Head of Planning
[South Sector and Women & Children's Services]

Planned Consultation Process

Date	Activity
16 August 2016	Board decision to proceed with informing and engaging on the proposal to transfer paediatric inpatient and day case care from the Royal Alexandra Hospital, Paisley to the Royal Hospital for Children, Govan
Early September 2016 -4 October 2016	Informing and engaging with people on the proposal, including: · Formation of a Stakeholder Reference Group. The group will be made up of patients and carers or representatives from patients' and carers' groups, or community groups, that have an interest in this area. Its purpose is to advise and support NHSGGC in its approach to informing and engaging with stakeholders on the proposal · An information leaflet which is clear, easy to read and written in plain English describing engagement undertaken to date · A dedicated web page on the Board's website with details of the proposal; details of the new facilities at the RHC; and a timeline for the engagement · Use of social media to connect with, and raise awareness of the proposal among stakeholders · Press releases to local media · Dissemination of information leaflet to wider community via agencies databases · On site engagement with children, young people and their families on Ward 15 at the Royal Alexandra Hospital · Outreach to local parenting and youth groups.
18 October 2016	Report to Board describing the informing and engaging process, and what we have heard. NHS GGC Board decision on whether to proceed to formal 3 month public consultation on the proposal to transfer paediatric inpatient and day case care from the Royal Alexandra Hospital, Paisley to the Royal Hospital for Children, Govan
November 2016 – February 2017	If the Board decides to proceed to consultation, a twelve week consultation period culminating with Board decision to accept recommendations in February.

Quality - Healthcare Standards Dashboard

NHS Greater Glasgow and Clyde

Infection Control Report

NHS GG&C Infection Control team operate a regime of unannounced inspections to patient areas. This report captures the outcome of these inspections for Children's services.

The audit will be repeated within 12 months.

SICPS- Standard Infection control Procedures:

GAP- Represents the gap between the old version of this audit and the new one.

TBP- Includes audits on the management of linen and waste

Quality Improvement- Includes an audit on Peripheral Venous Cannula (PVC) and Central Venous Catheter (CVC) compliance

Infection Control :	Print Data Capture Sheet					
Thresholds						
<=65%	66% - 79%	80% - 90%	91% - 100%			
Re-Audit in 3 months	Re-Audit in 6 months	Re-Audit in 12 months	Re-Audit in 12 months			
Full Audits						
Hospital	**Ward**	SICP	GAP	TBP	Quality Improvement	Overall Score
Glasgow Royal Infirmary	Prm SCBU	90%	82%	100%	50%	89%
Queen Elizabeth University Hospital Glasgow	Neo Icu	90%	89%	97%	50%	91%
Royal Alexandra Hospital	Scbu	93%	87%	100%	N/A	92%
Royal Alexandra Hospital	**Ward 15**	84%	81%	94%	100%	86%
Royal Hospital for Children	Area 1C / Day Care Unit	96%	100%	100%	N/A	97%
Royal Hospital for Children	Ward 1D	89%	77%	97%	100%	88%
Royal Hospital for Children	Ward 1E	91%	71%	100%	50%	86%
Royal Hospital for Children	Ward 2A	94%	73%	100%	100%	91%
Royal Hospital for Children	Ward 2C	95%	76%	97%	0%	89%
Royal Hospital for Children	Ward 3A	86%	74%	100%	N/A	86%
Royal Hospital for Children	Ward 3B	90%	70%	100%	100%	88%
Royal Hospital for Children	Ward 4	88%	79%	100%	N/A	87%

Quality - Healthcare Standards Dashboard

NHS Greater Glasgow and Clyde

Team	Date Confirmed to Programme:	Months in Programme:	EWS	Safety Brief	SBAR Use	SBAR Quality	PVC Maint	PVC Insert	CVC Maint
RAH-15	Jan-13	40	SD	SD	SD	SD	3	E	n/a
RHC-01a	Jun-15	11	5	5	5	5	5	n/a	n/a
RHC-01c	Jan-14	28	SD	SD	SD	SD	n/a	SD	E
RHC-01e	Jan-13	40	SD	SD	SD	SD	2	n/a	E
RHC-02a	Jan-13	40	SD	SD	SD	SD	SD	n/a	5
RHC-02b	Nov-13	30	5	SD	SD	SD	n/a	SD	SD

Report relates to the **Scottish patient safety paediatric** programme work. Ward 15 were an early adopter for this work and so have been in the programme since the start which is 40 months.

EWS- Early warning scoring measures if patient observations are abnormal by collectively scoring heart rate, temperature, Blood pressure, respirations and conscious level. This data has two parts- is the score complete? Has appropriate escalation taken place? Ward 15 have evidenced a reliable process in place and so have stepped down (SD) from monthly data collection to quarterly as per SPSP national guidance.

Safety Brief- Effective employment of reliable system (SD) to ensure at every shift handover (nursing and medical) safety briefs flag any potential issues are highlighted e.g. 2 patients with same name, drug name change, child protection issue.

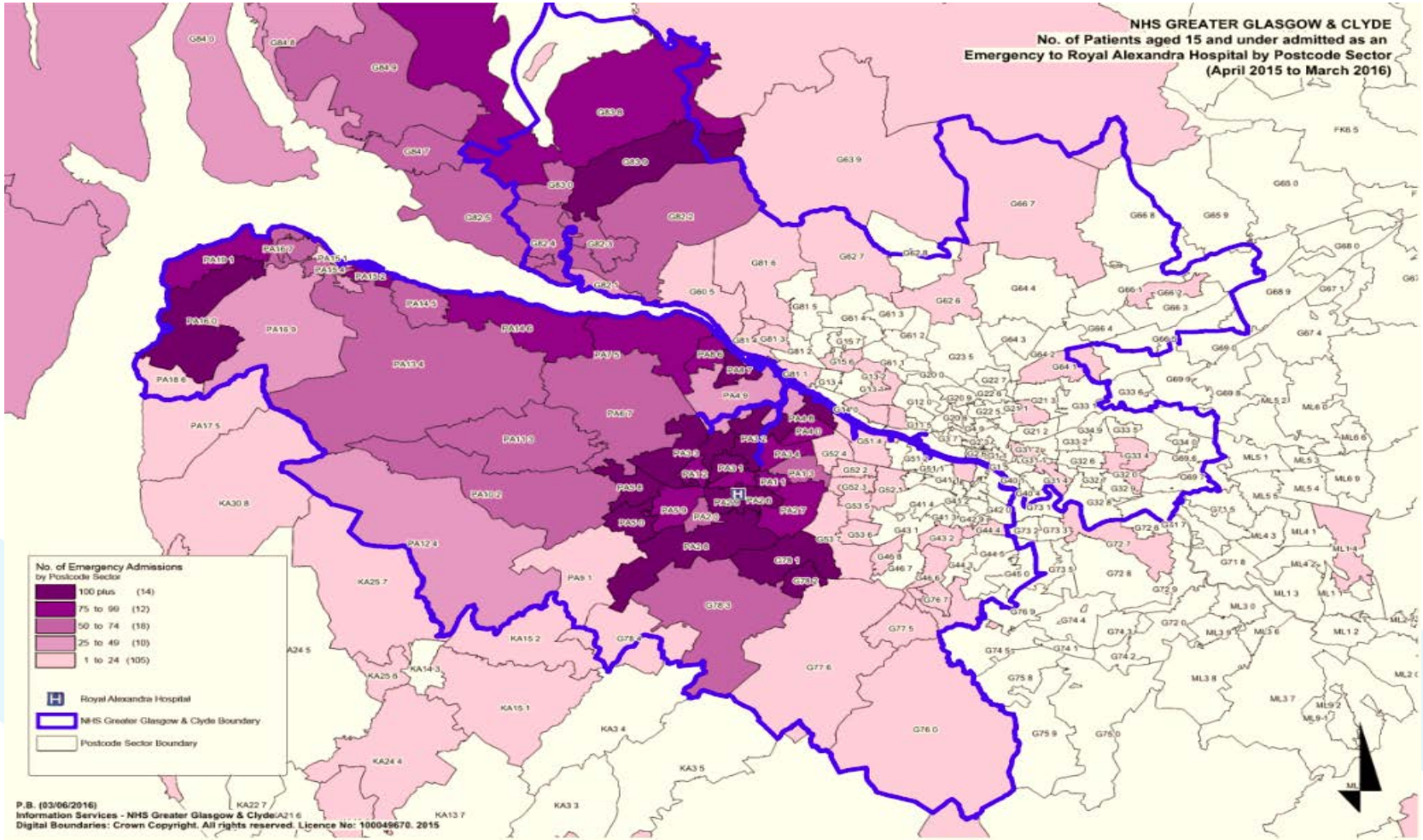
SBAR & SBAR Quality- Situation, Background, Assessment and Recommendation. Format of reporting to ensure consistent quality of information.

PVC Maintenance- Peripheral Venous Cannula Maintenance Bundle. This data is collected based on the completion of the 'pvc paperwork' and on inspection of a random sample of 20 pvc's a month. The pvc and documentation are both checked to ensure the appropriateness of the pvc remaining insitu, that it does not show signs of infection, that the dressing is clean and intact and that appropriate care is being taken when staff are accessing the pvc. Ward 15 have demonstrated >95 % capability, but not yet reliably. The team are working closely with the SPSP team to achieve reliability.

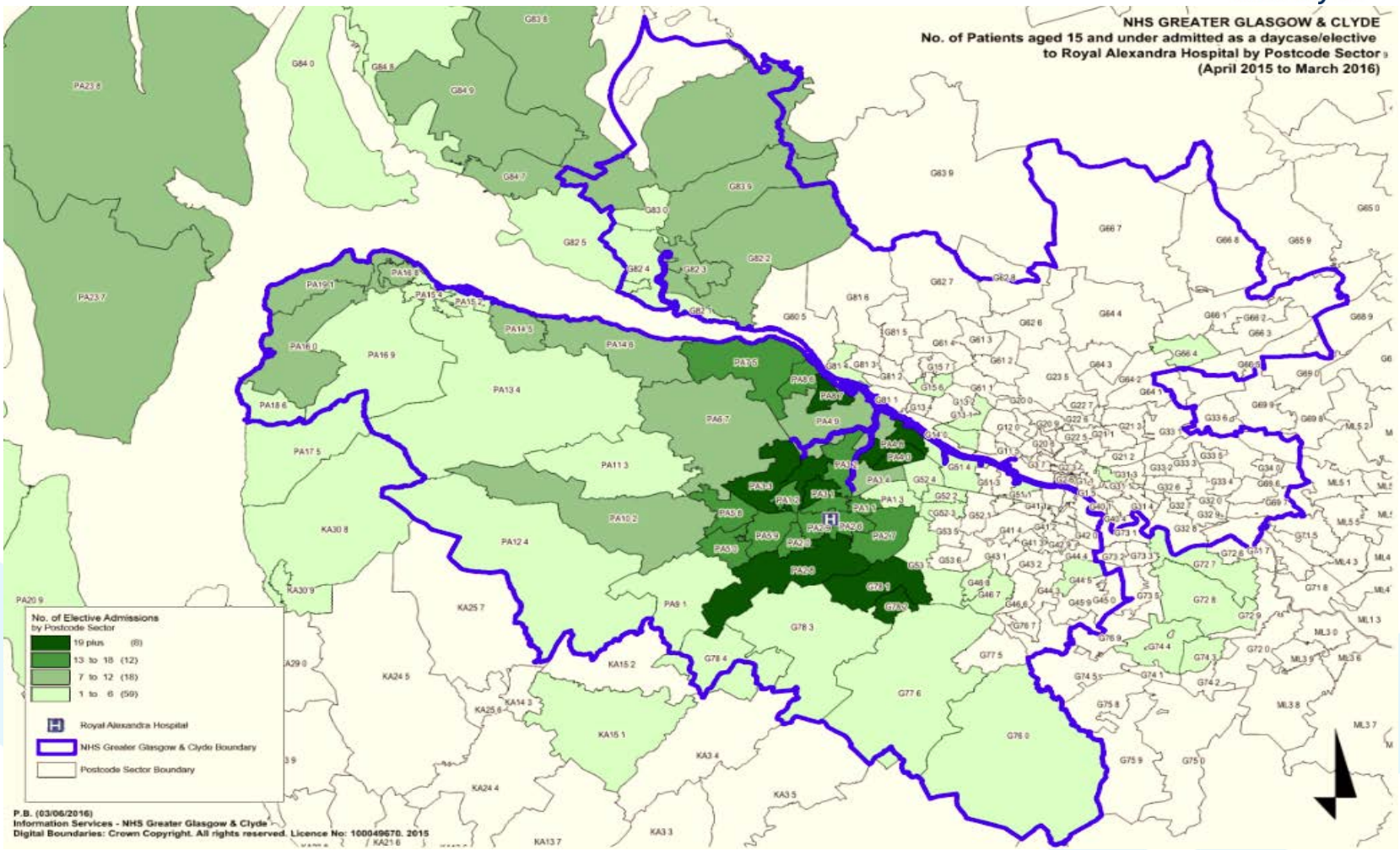
PVC Insert- - Peripheral Venous Cannula Maintenance Bundle. The paperwork is currently being implemented and the team at ward 15 are engaged in this process (E)

CVC Maintenance – Central Venous Catheters. Ward 15 do not look after enough patients with cvc's to collect data on this bundle.

Residency by postcode of Children admitted as an emergency to RAH



Residency by postcode of Children with a planned admission to RAH



Car Parking & Public Transport

Car Parking

The QEUH & RHC campus has patient and visitor car parking capacity for:

- 1924 (incl. 217 disabled)

The RAH has:

- 461 spaces

Bus Services to Royal Hospital for Children

- McGill's Bus Service 17: Glasgow City Centre - Charing Cross - Sandyford - Kelvingrove (for Yorkhill **Hospital**) - Partick Bridge (for **University** of Glasgow, Western Infirmary and West End) - Partick - Thornwood Roundabout – Linthouse - **Queen Elizabeth University Hospital** - Shieldhall - Cardonald (Paisley Road West) - Crookston - Oldhall - Barshaw Park - Paisley - [**University** of the West of Scotland (Paisley Campus)] - [Ferguslie] - [Elderslie] - [Johnstone Community Sports Hub] - [Milliken Park]

- McGill's Bus Service 21: [Inchinnan] - Paisley - Reid Kerr College - Abbotsinch - Dean Park - Newmains - Renfrew - Braehead Centre - Shieldhall - **Queen ElizabethUniversity Hospital** - Linthouse - Govan - [Inchinnan]

- *McGill's Bus Service 23A*: Glasgow City Centre - Tradeston - Kingston (for Springfield Quay) - Pacific Quay (for Glasgow Science Centre and SECC) - Govan - Linthouse -**Queen Elizabeth University Hospital** - Shieldhall - Braehead Centre - Renfrew - Inchinnan Business Park - Red Smiddy - Park Mains - Erskine Bridgewater Centre - Rashielee - Bargarran - North Barr (commuter service)

Appendix 2 Online Renfrewshire Council Consultation

Royal Alexandra Hospital Ward 15

1. Ward 15 - Children's Ward

1. What is your home postcode?

2. Are you...?

A service user?	A patient?	A parent / guardian?	A relative?	A friend?	A member of a local group?
○	○	○	○	○	○

Other (please specify)

3. Please tell us about your own views of the services provided at Ward 15 (Children's Ward), Royal Alexandra Hospital, Paisley?

Appendix 3

NHS GREATER GLASGOW & CLYDE

Paper No: 16/34

Board Meeting: 28 June 2016

Report of the Director of Planning & Policy, Catriona Renfrew

LOCAL DELIVERY PLAN: DRAFT FOR APPROVAL

Recommendation

The Board agree submission of the Local Delivery Plan.

1. Purpose of Paper

The attached final draft Local Delivery Plan (LDP) outlines how the Board will deliver against the annual planning guidance issued by Scottish Government. Much of the format of the Plan is prescribed and our approach has been to ensure the plan links to the wide range of other critical documents. The next section of this short covering paper briefly draws out in the key issues from the plan.

2. Points to Highlight

This section briefly highlights key issues which have been highlighted during the planning process as follows:

- A series of **financial issues** and risks which are described in more detail in the financial plan.
- Challenges to deliver **targets and standards** the Board has committed to a major review of unscheduled care to improve our performance, for scheduled care the LDP includes information on deliverable performance within the available recurring resources.
- Continuing reduction in the **level of delayed discharges.**

In addition to these issues, during development of the plan members sought reassurance on a number of points:

- Decisions on **over the counter medication and access to gluten free products** will be taken in national processes not by NHSGG&C.
- The proposals in the **service change** section will be considered in detail at the August Board meeting.
- The changes to **GP out of hours services** reflected in the financial plan relate to increased efficiency and reduced support costs not to reductions in clinical services.

3. Next Stages

The plan will be submitted to Scottish Government, much of the implementation is already underway and the Board will be regularly updated.

LOCAL DELIVERY PLAN

1. INTRODUCTION

This Local Delivery Plan (LDP) brings together:

- An appraisal of our strategic position and context.
- Principles established to frame the development of our plans for 2016/17 to ensure that we make decisions which are coherent with our strategic direction and priorities.
- An appraisal of the detailed service and financial planning we have underway to deliver this plan and an outline of service and financial risks and challenges which we face for 2016/17.

1.1 This LDP, including the financial planning, has been developed in concert with the Integrated Joint Boards (IJBs). The Board now shares responsibility for strategic planning with the IJBs but retains responsibility for the allocation of the NHS budget between the services for which we retain direct operational responsibility and those managed by IJBs. IJBs need to develop and approve integrated service and financial plans for the NHS and Council services which are legally delegated to them. IJBs also have a central role in working with the NHS Board on the planning and financing of the acute sector and our Plan cross references to Partnerships Strategic Plans.

1.2 This plan highlights a number of areas of risk reflecting the fact that we do not yet have a fully balanced financial plan across NHSGG&C, a substantial programme of work continues to identify the required level of savings, and to put in place the necessary actions, to achieve financial balance in 2016/17.

2. STRATEGIC POSITION AND CONTEXT

2.1 The Board has a detailed strategic direction which sets our purpose as to:

> "***Deliver effective and high quality health services, to act to improve the health of our population and to do everything we can to address the wider social determinants of health which cause health inequalities."***

2.2 That purpose is amplified with five strategic priorities to move us towards achieving that purpose, these are:

- Early intervention and preventing ill-health
- Shifting the balance of care
- Reshaping care for older people
- Improving quality, efficiency and effectiveness
- Tackling inequalities.

2.3 A key purpose of this LDP is to set out the detailed service change plans which we have developed to deliver that purpose and those priorities. Those plans will deliver better services for patients and will progress the delivery of:

- The mental health strategy progressed through the final capital development to deliver modern mental health services.
- The clinical service strategy, which maps out a clear direction for acute services, updated to reflect the National Clinical Strategy and translated into detailed service change plans. Implementing service change is critical to our ability to meet unscheduled and scheduled care targets and to deliver high quality care.

- Continuing the pattern of change in community services which has improved the range and efficiency of those services but not yet the more radical developments to enable us to reshape the acute sector.
- The development of primary care in line with the national direction, local priorities identified through our recent engagement exercise and work being developed in each HSCP.

2.4 The aim of the approach set out in this LDP is to make changes which align with our strategic direction, priorities and clinical strategies and enable us to deliver financial balance.

2.5 In addition to this LDP we are working on a d elivery plan for our Acute Division, which alongside the implementation plans which IJB's are deriving from their strategic plans, will provide more details of the challenges we need to address and the changes we need to deliver in 2016/17.

2.6 It is also our intention to use the platform of the publication of the National Clinical Strategy to establish a pl anning process - **why "establish", the June Board paper does this** during the autumn of 2016 to deliver a change plan for acute services for the period 2017/20 and a longer term acute services plan which can drive capital investment.

2.7 The financial position is summarised in section six of this LDP.

3. PRINCIPLES FOR PLANNING

3.1 In order to ensure our planning and financial decisions align with our strategic direction the Board established the principles set out in this section. These have shaped our approach to developing this LDP.

Our overriding principle is to give absolute priority to patient facing services and ensuring these are always high quality and safe.

Our further principles are to:

- Make financial decisions for 2016/17 which are in line with and enable us to move in coherence with our purpose, strategic direction and related strategies all of which are focussed on ensuring our services are focussed on the needs of patients.
- Continue to play our part in trying to reduce the inequalities which affect our population and have a strong focus on equality impacts in making our decisions.
- Ensure that our decisions do not have unintended consequences such as unplanned transfers of pressures, responsibilities or costs to other parts of the system.
- Aim to continue to deliver the key Scottish Government targets.
- Focus first on changes which make clinical and service sense and increase efficiency and productivity and reduce our unit costs.
- Ensure that where we propose to restrict access to services or stop planned developments we will have a clear framework for prioritisation of patient care linked to clinical benefit.
- Shift the balance of care and r esources but also recognise the pressures on acute services.
- Test all new national initiatives and proposals which have financial implications against our strategy and report to Board for decision.
- Underpin our decision making with evidence about what delivers the safest, highest quality and most cost effective healthcare.
- Explicitly consider risks and benefits in making decisions.
- Remain committed to the importance of innovation and research to shape changes in the way we deliver care.

- Work across boundaries with other Health Boards and public bodies to identify ways in which we can deliver services more efficiently.
- Take a whole system approach not localised savings targets, that approach driven by:
  - cost scrutiny in every part of the organisation, led by the local teams
  - a whole system programme of change to deliver cost reduction.

We recognise that the scale of the challenge we face means that we are entering a period of significant change. Fundamental principles of our decision making are:

- A commitment to engagement with patients and the wider public.
- A commitment to fully engage with our staff and their representatives in shaping, planning and delivering the changes to services which will be required.

4. SERVICE CHANGES

This section gives a brief summary of service changes which will require public engagement. The changes outlined move forward the Board's Clinical Service Strategy. The strategy provides the basis for future service planning and the development of detailed service change proposals. The strategy sets out the high level service models to shape the service provision and identifies the key approaches to underpin the future service planning for the populations served by NHSGG&C:

- 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.
- 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 NHSGG&C.

Proposals setting out the detail of the service changes outlined below will be brought to the August Board meeting to enable the required public engagement to be approved.

Review of RAH paediatric services: proposal to retain the current full range of general and specialist outpatient children's services at the RAH, with inpatient care to be provided at the new children's hospital.

Review of Clyde Birthing Services: proposal to retain all ambulatory services at the CMUs with deliveries offered in our midwife led units in RAH, PRMH and the QEUH or at home; finalising proposals on these services will include work with the CMO to look at

midwifery delivery services across NHSGG&C and decisions will be made in the light of the outcome of the national review of maternity services.

Review of CIC Inpatient Services: proposing to deliver the full current range of CIC services on an ambulatory care basis, this reflects the fact that the vast majority of patients are now local to Greater Glasgow and Clyde.

Review of inpatient rehabilitation services: proposing to transfer inpatient rehabilitation from Lightburn to the new centre of excellence at Gartnavel General Hospital with ambulatory care continuing to be delivered in the East End as part of developing plans with the new Health and S ocial Care Partnership for new community facilities. The current Parkinson's service will continue to be delivered in the East End.

5. LOCAL DELIVERY PLAN REQUIRED CONTENT

This section sets out *in italics* the LDP guidance requirements with links to each of the documents used to support the delivery of the specific areas identified.

5.1 Health Inequalities and Prevention

The LDP should set out local priorities for how they will address health inequalities and improving prevention work based on the needs of their local population and own workforce. Plans should focus on those communities where deprivation is greatest. The plan should outline how these will be achieved setting out improvement aims, levels of activity, and demonstrating how the activity is embedded into routine practice. The plan will also include information about how the Board and its partners prioritise action and monitor progress. Plans should set out what is being done to tackle the preventable causes of the costs to the NHS and society of preventable disease. Alongside the public health themes addressed by the existing LDP standards, Boards are asked to provide details of their priorities for actions to address the unsustainability of the burdens arising from poor diet and weight management.

Our Approach

- Early Intervention and Prevention is an established strategic priority across NHSGG&C. Our priorities in addressing health inequalities and prevention across NHSGG&C are outlined on our 2015-16 Equality Monitoring Report alongside our 2016-20 A Fairer NHS Greater Glasgow & Clyde – Equality Outcomes Framework. In addition, our Strategic Direction for Health Improvement details the extensive programme of Health Improvement Activity aimed at delivering this strategic priority. This priority is also the focus of the Joint Strategic Commissioning Plans for each of the six Health and Social Care Partnerships (HSCPs) detailing the actions in place to tackle Health Inequalities and Prevention for the Partnership areas (Renfrewshire HSCP:draft); Inverclyde HSCP; Glasgow City HSCP; East Renfrewshire HSCP; East Dunbartonshire HSCP; and West Dunbartonshire HSCP). In addition, these priority areas will also be the primary focus for the development of the IJB Equality Outcome Plans currently under development (Renfrewshire Equality Outcomes; Inverclyde Equality Outcomes; Glasgow City Equality Outcomes; East Renfrewshire Equality Outcomes; East Dunbartonshire Equality Outcomes and West Dunbartonshire Equality Outcomes).
- In finalising our financial plan we are assessing the impact of the reduced national allocation for prevention and health improvement and reductions in national funding for services which are critical to tackling inequalities, including those for people with drug and alcohol problems.

5.2 Antenatal Care and Early Years

The LDP should set out the local actions to be taken to ensure that the relevant parts of the workforce will have the capacity, training and relevant protocols to carry out these duties under the Act by August 2016. The LDP should also set out plans for health visitors including baselines and additional numbers being recruited through to 2018.

Our Approach

- HSCPs are currently working together to deliver the GIRFEC work plan and the major challenges to be overcome to deliver the new pathways.
- Maternity services have progressed preparations and joint arrangements with health visiting services to ensure readiness to deliver GIRFEC commitments.
- Our programme of service reviews also includes considering the deliverability of the national policy to increase health visitor numbers and to continue the Family Nurse Partnership programme. Details of this are outlined in our Health Visitors Investment Plan.

5.3 Safe Care

The LDP should set out how the Board is taking forward one of the three points of care where data submission is supplementary. These are:

- *Venous Thromboembolism (VTE)*
- *Heart Failure*
- *Surgical Site Infection (SSI).*

Detail should include plans for spread and sustainability, the impact this area is having, and will have on patient care and how Boards are collecting data to drive local improvement. This should include an example from each Scottish Patient Safety Programme of how safety of care has improved in the last 12 months. In recognition of the contribution which NHS Boards can make to wider quality improvement across the integrated health and social care landscape, Boards are asked to provide detail on how they are engaging with Local Authorities and care providers to achieve the aim of achieving a 50% reduction in grade 2 - 4 pressure ulcers acquired in hospital or care home by end of 2017.

Our Approach

- NHSGG&C is committed to providing safe high quality care that our staff and patients can be proud of. Over recent years the Scottish Patient Safety Programme has provided a shared platform through which our clinical services have collaborated and developed improvement in the safety of care. Over the next few years we wish to develop an NHSGG&C Clinical Safety Programme, which will build on our experience and the support of the national programme, but allow us to integrate other useful developments such as our clinicians work in reviewing quality of care through morbidity and mortality meetings. The Safe Care Plan details our plans for spread and sustainability, the progress we are making and the next steps.

5.4 Person Centred

The LDP should set out how services will deliver person-centred care. This may be done with reference either to:

- *How Boards will deliver a positive care experience in accordance with the five "must do with me" principles of care: What matters to you? Who matters to you? What information do you need? Nothing about me without me, and service flexibility or*
- *The Strategic Framework for Action on Palliative and End of Life Care.*

The LDP should also outline the action that will be taken locally to support staff and the public to be open and confident in giving and receiving feedback, comments, concerns and complaints, with a particular focus on how the Board will involve people meaningfully in reviewing how themes emerging from feedback and complaints can be used to improve healthcare services, and how it will demonstrate the improvements made as a result of feedback.

Our Approach

- We have developed a Person Centred Care Action Plan to take forward the Strategic Framework for Person Centred Care with an extensive programme of activity underpinning the delivery of this.
- We are developing an action plan to take forward the Strategic Framework for End of Life Care with Partnerships.

5.5 Primary Care

The LDP should provide progress on those priority actions identified in 2015-16 LDP alongside any new actions being pursued to manage as much care 'out of hospital' as possible, including the resources identified to achieve this aim. This should include action taken to support the introduction of the post QOF (Transitional Quality Arrangements) revisions to the GMS contract in 2016-17 and the implementation of Sir Lewis Ritchie's review of out of hours primary care services. The plan should also identify where national action would help local delivery.

Our Approach

- In September 2015, we launched a programme of engagement for a wide range of interests to develop a direction for GP Services across NHSGG&C. The output from these engagement events clearly identified the pressures within Primary Care GP services. We are working with IJBs to develop an action plan to address the issues identified.
- In January 2015 a major project to test new ways of structuring primary care services was launched in Inverclyde. The pilot will look at how the role of the GP can be refocused, reducing the time they spend on tasks that could be more appropriately done by other health professionals and examining how these staff can support patients in the community.
- We have a programme of work to implement the 2016/17 GMS contract and we are integrating into that our proposals for the primary care transformation fund. Our approach is to begin to mitigate pressures on GPs while we develop longer term plans for primary care. Our approach will aim to develop strong relationships between IJBs and GPs and to reduce workload and improve morale.
- Out of hours: IJBs are considering how the national review will be reflected in their forward plans and we are working on a number of changes to GP OOH in 2016/17 to continue to provide a safe and sustainable service.
- IJB plans include proposals to develop and reshape primary care and community services.
- There are significant risks in relation to primary care and community services including:
  - the extent to which the immediate demand pressure on GPs can be mitigated to secure services to enable a more transformational programme of change.
  - the pressures and focus on acute services continue to create real challenges to shift the balance of care.

- the financial pressures which we have set out in this plan require us to generate savings in community services.
- there are significant pressures on social care services which have the potential to directly impact on NHS services.
- the primary care transformation fund is a welcome additional resource but much more major investment in primary care is required.

5.6 Integration

The LDP should set out a summary of how the delivery of national and local standards/ targets will be aligned between the local planning and operational structures.

Our Approach

- Work is currently underway with each of the six HSCPs to ensure the delivery of key national and local standards/targets that they have lead responsibility for delivering. There is agreement that these standards will also be embedded within each of the six Strategic Commissioning Plans and reported routinely to their respective IJBs and internal reporting arrangements and links will be made to each. Our need to continue to build and strengthen our joint working and operational structures with each of the partnerships will be reflected to ensure the delivery key targets including delayed discharges. Included is a risk narrative in relation to the Smoking Cessation and Alcohol Brief Intervention Local Delivery Plan Standards.
- We have whole system planning arrangements with our IJBs, including to develop the financial plan.
- We have not yet finalised allocations to IJBs, therefore there are financial risks for the IJB strategic plans and their operational service delivery responsibilities.

5.7 Scheduled Care and Unscheduled Care

The LDP should set out a summary of the local work that will be carried out during 2016-17 under the National Scheduled Care Programme (sustainability). The LDP will provide a clear summary of actions being taken forward through the local six Essential Actions programme in 2016-17. This will include references to local plans including six Essential Actions, Winter and Joint Strategic Commissioning plans.

***Our Approach*:**

For both scheduled and unscheduled care our new pattern of hospital services has been established during 2015/16 and we are now taking stock of capacity and performance issues which have emerged. Given the financial position and demand pressures there are significant risks to meeting performance standards in 2016/17.

- We are continuing to review and assess capacity requirements in the light of the increasing pressure on scheduled care, sustaining current levels of activity will prove challenging in the light of the pressures on unscheduled care and the financial position.
- We will work closely with the Scottish Government's Access Support Team that has been established as part of the 'Getting Ahead' – sustainable whole systems management for elective services' programme. Our submission to the programe is on link here, these levels of activity have been underpinned by substantial non recurrent resources which will not be available in 2016/17 given the Board's financial position.
- During 2015/16 we had significant challenges in meeting the unscheduled care target. We have worked closely with Scottish Government colleagues to improve our performance and we have a process underway to review the delivery of our unscheduled care plan and assess areas for improvement, with Partnerships. The additional levels of non recurring funding in currently in play for unscheduled care are not included in this plan on a recurring basis.

5.8 Mental Health

Performance on the mental health access standards continues to show a considerable rise in the number of people starting treatment. A Mental Health Improvement Programme to support NHS Boards to improve access to services and meet the waiting times standard sustainably has been announced. The programme will be delivered by Healthcare Improvement Scotland which will establish a Mental Health Access Improvement Support Team (MHAIST). MHAIST will work in partnership with NHS Boards to identify enablers and barriers to the Board being able to deliver improved access and meet the waiting times standard, and support Boards to review their mental health access improvement plans in light of that joint consideration of local enablers and barriers to delivery. In advance of the MHAIST starting its work in 2016-17, the LDP should provide information focusing on reducing waiting times and on improving access to mental health services in line with local need. The plans should include an assessment of the level of access currently provided by the Board and with the anticipated level of need locally – including benchmarking with other boards in Scotland. We expect the plans to include a workforce development plan with evidence of the current workforce capacity in Child & Adolescent Mental Health Services (CAMHS) and psychological therapies and how that will be developed.

Our Approach

- NHSGG&C currently performs better than most areas of Scotland in relation to access targets for psychological therapies and CAMHS community services. The CAMHS Report outlines the performance and improvements made during the past two years alongside the detail of how this will be maintained or further improved with access to the new Scottish Government funds and initiatives once the detail of these have been made available. The Psychological Therapies Report highlights actual performance during the past four years and how we will manage the risks associated with the delivery of this target. Linked to the ongoing delivery of these targets will be our work with the MHAIST during 2016-17.
- To date the achievement of the targets have been linked to agreed funding, however, if there is an overall shortfall in the funding of mainstream services, including the consequences of 'bundled' funding reductions, then these services cannot be ring fenced or excluded from the consequences of financial challenges with potential to affect the current good performance in delivering the access targets.

5.9 Community Planning

Boards must indicate how they will continue to strengthen their approach to community planning during 2016-17, through both their contribution to integration and how they demonstrate leadership within the broader CPP. This should focus on playing a strong and leading contribution within the CPPs to improve local priority outcomes which relate to health and wellbeing, and how they shift activity and spend towards tackling inequalities, prevention and community empowerment.

Our Approach

- Health related activity around Community Planning will be led by Partnerships where close links have already been established to ensure the delivery of local priority outcomes relating to health and w ell being. NHSGG&C's contribution is evident through the activity identified in each of the Single Outcomes Agreements) in each of the partnership areas (Renfrewshire SOA; Inverclyde SOA; Glasgow City SOA; East Renfrewshire SOA; East Dunbartonshire SOA; and West Dunbartonshire SOA) alongside the Strategic Commissioning Plans.
- The Board is also engaging with Councils to establish wider relationships for community planning across the NHS system.

5.10 Workforce Planning

Boards are required to provide information on two key workforce areas in the LDP this year.

- *Delivering Everyone Matters: 2020 Workforce Vision: NHS Boards should provide a short outline of their local implementation plans for 2016-17 to deliver the five priorities in the Everyone Matters: 2020 Workforce Vision Implementation Plan 2016/17. The five priorities are: Healthy Organisational Culture, Sustainable Workforce, Capable Workforce, Workforce to Deliver Integrated Services and Effective Leadership and Management.*

- *NHS Boards should indicate any workforce areas where there is a risk to delivering service. Specifically Boards are asked to make clear reference to:*
  - *the use of Nursing and Midwifery Workload and Workforce Planning tools, recruitment issues, vacancy rates or concerns - professions or groups of professions affected, services affected - steps being taken or national approach required.*
  - *areas in which services are being developed which may have specific implications for the NHS workforce, or for individual professions as appropriate, and steps taken to manage these locally e.g. Health Visitors, School Nurses, Advance Nurse Practitioners and Health Care Support Workers.*
  - *demographic information i.e. age of workforce impacting on service delivery, local pressures, staff numbers, other workforce factors influencing the sustainability or otherwise of services.*
  - *how workforce factors are being dealt with as part of action being taken to address services which are under stress e.g. A&E, Oncology and Radiology.*

The Board will continue to be required to publish their wider workforce plan during 2016 and are reminded that the application of the Nursing and Midwifery Workload and Workforce Planning Tools are mandatory and should be used and documented in the development of Workforce Plans and workforce projections.

Our Approach

- We face a series of workforce issues these include junior and senior medical workforce recruitment issues; clinical sickness absence levels and the age profile of key parts of our workforce, including GPs.
- Delivering a sustainable financial plan will require significant workforce redesign as will progressing regional and national initiatives to share services.
- The Workforce Planning Report outlines how we continue to realise the 2020 Workforce Vision through our 2016-17 Workforce Vision Implementation Plan alongside identifying those workforce areas where there could be a risk to delivering services.

6. FINANCIAL PLAN

6.1 The Scottish Government set out its budget to the Scottish Parliament in December 2015. This set out an up lift of £511 million or 5.3 % to the Health budget.

6.2 For NHSGGC, this resulted in a funding up lift of £92.8m. However, as £59.1m of this was Social Care Funding and was "passed straight through" to our 6 IJBs, the uplift to the Board was £33.7m (1.7%).

6.3 The Board also faced reductions in "bundled funding" and the New Medicines Fund. When offset against 2016/17 cost pressures of £96m, the majority constituted of pay cost growth (£50m) and prescribing cost growth (£25m), the Board is facing the significant challenge of requiring to save £69m of recurrent savings in order to break even.

6.4 The Board also continues to face severe financial challenges and financial risks, including the cost of new medicines, including those for Hepatitis C, and orphan / ultra-orphan and end of life medicines.

6.5 The Acute division continues to experience significant cost pressures in Medical pay where significant expenditure on agency and locum cover has been incurred to support activity levels. Actual non elective and elective inpatient activity continues to increase significantly, together with long-term vacancies, difficulties recruiting and the requirement for waiting list initiatives to achieve TTG targets. Nursing pay also continues to be a significant cost pressure, with excess bank and agency spend driven by activity levels and accentuated by higher than average sickness/absence rates.

6.6 As outlined above, a comprehensive planning process involving all Directors and a wide range of managers, and in concert with the IJBs, commenced in the Autumn 2015. This involved identifying savings schemes to address the financial gap, and various presentations and discussions at Board Seminars and away days through October 2015 to April 2016. A process of engagement was also conducted with staff side and with the Scottish Government Health Directorate.

6.7 At the time of drafting this document, "green and amber" savings totalling £43.5m full year effect (£34.5m part year effect) have been identified. In addition, a range of "red rated" schemes have been identified, including some service redesign propositions outlined elsewhere in this document that require further work and consultation, totalling £11.5m full year effect (£8m part year effect).

6.8 In addition, Acute Division Management implemented a £10m cost containment programme in December 2015 to take effect before the 31st March 2016 in order to start the new financial year at, or close to, balance. However, this has proved extremely challenging, not least through the continual use of winter beds which have remained open to help manage demand and capacity. As such, £7.5m of non-recurring coverage will be required through 2016/17. In addition, the Acute Division underachieved projected 2015/16 recurrent savings by £3m and HSCPs underachieved by £7m. These were covered non-recurrently in-year by each Division. However, further work and discussions are currently on-going to establish if these can be covered internally again in 2016/17.

6.9 The table below is a summary of the current position;

TABLE 1: The overall savings position 2016/17

NHSGCC	CYE	FYE
Savings Summary	**16/17**	**16/17**
	£m	**£m**
2016/17 Savings Target	**69.00**	**69.00**
Savings summary achievability		
Green	20.08	20.35
Green/Amber	9.40	12.85
Amber	5.50	11.63
Total Green and Amber	**34.98**	**44.83**
Red	8.63	11.73
Total savings identified to date	**43.61**	**56.56**
Remaining gap - further savings required	**25.39**	**12.44**
Revisions to initial assumptions/investments	-3.30	-3.30
	22.09	9.14
Acute Division - cost containment cover	7.50	0.00
Cash requirement in-year	**29.59**	**9.14**

6.10 It is clear from the above table that in addition to £11.7m of complex and challenging "red risk" rated schemes, on a full-year effect for 2016/17, the Board still has a savings gap of £9.1m (rounded up to £10m). It is proposed at this stage that these savings maybe realised through the National Workstreams.

National Workstreams

6.11 Through the joint work of the Chief Executives, Directors of Finance and Scottish Government colleagues a number of workstreams have been developed both to support Boards in their local delivery of savings plans, and to examine whether a national approach to certain propositions can be agreed and delivered. Work is on-going to determine whether these national initiatives will have a further positive impact locally.

6.12 A number of these workstreams are already incorporated in our local schemes (and 2016/17 cost containment programme) but a small number could deliver savings to NHSGGC. This includes a review of effective prescribing medicines and Shared Services for both corporate and clinical support functions.

6.13 However, until the outcome of these national workstreams become clear and for the purposes of achieving financial balance, the £10m will be allocated proportionately, and the three parts of the business are therefore required to identify additional schemes to close the gap – and present these to the October 2016 Board meeting. Should the national workstreams subsequently deliver the projected savings in-year, these additional local savings schemes will be deferred into 2017/18.

Managing in-year

6.14 As outlined above, Directors and Managers continue to work to address the remaining savings gap and finalise a balanced Plan. Due to the timing of the implementation and impact of these schemes in-year, the Board have again recognised the need to cash manage the business towards the realisation of these savings.

6.15 This will be achieved through the further utilisation of non-recurring provisions and reserves. For 2016/17, this will include a timing benefit repayable in future years through the reversal of historic provisions totalling £32.5m for NHSGGC. This was identified as part of the national Balance Sheet Flexibility Group and involves reclassifying the funding source of pre-2010 provisions, particularly in relation to Pension and Injury Benefit provisions. This does not impact on the actual level of provision, just the funding source, and will involve a charge to the RRL as the liabilities crystallise over a number of future years.

Managing the Risk

6.16 It is clear from the above detail there is a real risk the Board will not achieve financial break-even in 2016/17. To have a chance of break-even, all these risks must be managed. In addition, definitive management action and tangible results must be achieved around the following key risks;

- Achievement of the Acute cost containment programme, locum agency spend and sickness absence rates driving nurse bank and agency spend;
- Continued support from the Scottish Government around the achievement of key waiting times targets, particularly in the winter period;
- Managing any changes to the unscheduled care model within the current financial envelope;
- Achievement of all savings schemes outlined above, including service redesign propositions;
- Continued work to finalise, consult, approve and deliver the “red” rated schemes; and
- Achievement of £10m savings from the National Workstreams and/or identification, presentation and delivery to the October 2016 Board meeting of additional schemes equal to that sum from the three key areas of the business.

6.17 In terms of quantifying risk inherent in achieving break-even, and in addition to the £10m FYE gap outlined above, it is estimated the Plan carries financial risk of between £20m to £25m. Should this risk crystallise, there are insufficient reserves to provide cover. It would require receipts from projected land sales to ensure financial balance. However, the complexity and uncertainty over the timing and level of receipt of land sales must also be highlighted.

6.18 Whilst the Board at this point continues to work toward a balanced budget for 2016/17, it is apparent that again in 2016/17 the Board will be reliant on non-recurring sources of funding and reserves to achieve in-year balance. This position is clearly not sustainable. The continued use of non-recurring funds and reserves in 2016/17 to fund day-to-day business will create a significant risk to the sustainability of the Board into 2017/18 and beyond. There is a real risk the Board enters 2017/18 with minimal reserves.

Financial Planning 2017/18 and Beyond

6.19 There is a need for a change in financial planning for 2017/18 and beyond. This will require the development and embedding of a more collegiate, continuous improvement environment that delivers savings on a more consistent basis. The Board has an excellent track record of achieving savings and improving efficiency. However, due to the scale of the financial challenge and underlying recurring financial imbalance, a transformation programme will be required to deliver a step change in the size and scale of recurring savings and efficiencies needed in 2007/18 and beyond.

Appendix 4

NHS Greater Glasgow & 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.