Appendix

Greater Glasgow and Clyde NHS Board

Board Meeting
Tuesday 18th December 2007

Board Paper No. 2007/56

Director of Corporate Planning and Policy

CLYDE SERVICE CHANGES: REPORT OF THE INDEPENDENT SCRUTINY PANEL

Recommendation:

The Board:

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

1. BACKGROUND AND PURPOSE

In April 2006, at the point of dissolution of Argyll and Clyde NHS Board and the migration of the Clyde area and services into Greater Glasgow, we established a series of service and strategy reviews which had a number of aims and drivers which apply to all of the reviews. At headline level these were:

- the need to modernise services in Clyde and ensure the right balance of local community and inpatient care and social and health care;
- the requirement to ensure safe and sustainable services;
- the imperative to ensure economic provision of services and to identify action to address the £30 million deficit we inherited with our Clyde responsibilities - in line with our agreement with the Scottish Executive Health Department.

Our service and strategy reviews were conducted on the basis of the extant planning and public engagement guidance of the Scottish Executive. Following the May election, and the establishment of the Scottish Government, the new Cabinet Secretary for Health and Wellbeing announced a new process of external scrutiny for proposals for service change. It is important to note that the final process for external...
scrutiny is presently subject to wide consultation but the principles articulated has been applied to our situation.

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

2. CONTEXT

Following the integration of the Clyde area with the Greater Glasgow NHS Board area, the new NHS Greater Glasgow and Clyde announced its commitment to set out options for the future of services in the Clyde area to give staff and patient certainty following several years of debate stemming from NHS Argyll and Clyde’s planning and consultation processes. The rest of this section sets the service and financial context.

Integrated Care at the Vale of Leven

Argyll and Clyde had submitted proposals for acute services following an extensive planning, development and consultation process. These proposals had not been endorsed by the Health Minister and, therefore, had not been implemented, leaving a range of services in unstable and unsustainable arrangements. The pilot of the Integrated Care model was one element of those services. In September 2006, when it became clear that the integrated care pilot at the Vale of Leven could not proceed to full implementation because of concerns about clinical safety, we established a substantial planning and community engagement process to consider the future of the pilot.

Clyde Mental Health Modernisation

We inherited incomplete strategies for mental health services from the former Argyll and Clyde, which had variable levels of Local Authority engagement and commitment, particularly in relation to arbitrarily imposed financial savings which were not supported by detailed plans. The services across Clyde were characterised by under developed community services and an over reliance on beds, providing services to patients of variable quality and accessibility. A substantial review and planning process developed our proposals to modernise mental health across the Clyde area, strengthening community services and reviewing the provision of hospital care.

Balance of Older People’s Care and Services at Johnstone Hospital

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

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

A relatively new pattern of maternity services was in place with Community Maternity units having replaced the previous Consultant led delivery services at the Vale of Leven and Inverclyde Hospitals. Our review considered the impact on Clyde services of planned changes in Glasgow hospitals and also the issues in relation to the utilisation of the IRH and Vale Community Midwifery Units, where substantially less births are occurring than was projected.

**Financial Position**

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

3. **PRINCIPLES**

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

**Safe and Sustainable**

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

**Shifting the Balance of Care**

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

**Accessible**

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

**Economic**

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

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

National Policy

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

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

4. DRIVERS FOR CHANGE

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

Acute Hospitals

- Changing clinical practice:
  - there are many more opportunities for treatment and care to be given in people’s homes or local communities rather than being admitted to a hospital;
  - fewer hospital doctors are now trained to deal with a wide range of problems. Instead, they specialise in treating a similar number of conditions. Such specialisation produces more skilled and experienced staff with improved results for patients. However, this often requires services to be brought together in one place to enable essential skills to be shared and maintained.

- Changing workforce:
  - “Shaping the Future” described that in 2004 Scotland, along with the rest of the UK, faced overall shortages of clinical staff and serious shortages in some areas including radiology and pathology. It highlighted how unfilled posts disrupt services and increase waiting times. Changes in medical training and practice can lead to difficulties in attracting and keeping staff to provide certain services.
• The impact of employment legislation
  - the European Working Times Directive places an obligation on employers to reduce the number of hours staff are allowed to work. Historically, the NHS has relied on doctors working very long hours - sometimes as much as 100 hour per week. This is no longer allowed and therefore services need to be redesigned.

Shifting the Balance of Care

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

Modern Facilities

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

Financial Issues

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

5. PROPOSALS FOR CONSULTATION

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

• Mental Health:
  - the transfer of low secure learning disability services from Dykebar Hospital to Leverndale Hospital;
  - the transfer of adult and elderly acute admission beds for mental health at the Vale of Leven to Gartnave Royal Hospital;
  - the transfer of adult acute admission beds for mental health from the RAH to Dykebar Hospital;
  - the reprovision of continuing care beds for older people's mental health from Dykebar Hospital to partnership facilities.

• Integrated Care at the Vale of Leven:
  - the conclusion of the Integrated Care Pilot at the Vale of Leven Hospital and the reprovision of unscheduled care at the RAH.

• Older People’s Services:
  - the transfer of the continuing care service for older people at Johnstone Hospital to partnership facilities.
6. OUTCOME OF INDEPENDENT SCRUTINy

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

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

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

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

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

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

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

“IT IS IMPORTANT TO NOTE THE LENgTHY PERIOD OF DEVELOPMENT OF THESE PROPOSALS AND THE IMPORTANCE OF BEING ABLE TO PROGRESS THEM WITHOUT UNDUE DELAY. RAPID PROGRESS IS IMPORTANT BECAUSE OF PRESSING ISSUES OF SAFETY AND SUSTAINABILITY, SERVICES WHICH REQUIRE MODERNISATION AND AT PRESENT ARE NOT FIT FOR PURPOSE OR
of best quality for patients and the need to provide services in an economic way and within the Board’s financial allocation.”

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

7. MENTAL HEALTH

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

- The proposals for relocation of beds in South Clyde were seen as reasonable and not viewed as constituting centralisation:
  - consolidation of adult admission beds at Dykebar seen as clear advantage compared to RAH;
  - Gryffe relocation to SGH no more centralised than currently, albeit would raise accessibility issues for some;
  - proposals relating to the provision of continuing care within unidentified Partnership beds were not challenged in principle but were seen as requiring more provision and substantial clarification at the point of consultation;
  - proposals relating to the location of Intensive rehabilitation and IPCU were noted with no particular concerns raised;
  - proposals relating to forensic and low secure beds were deemed reasonable.

- The financial robustness of the proposals was seen as being relatively solid, whilst noting further detail to be required around risk relating to the assumptions of movement in unit costs of Partnership beds and unforeseen changes in demand.

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

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

Issue:

- The Panel raised the following concerns about the modelling of the bed requirements for the Clyde area:
  - based mainly on Glasgow rather than any robust support from published literature;
- should be made more reliable by calibration to local conditions and informed by local needs assessment;
- the security of the assumptions based on the published literature provided to the Panel is not high;
- capacity to meet future demands;
- the report is inconsistent on these issues in that the Appendix has commented on the reasonableness of the Greater Glasgow approach whilst the main report has reflected the issues summarised above.

Response:

We would comment on these concerns as follows:

- The current level of beds per 1000 for Greater Glasgow and Clyde is at the highest level in Scotland, at 1.44 times per 1000 population compared to a Scottish average of 1.19 beds per 1000. The Clyde levels of bed provision are 40% higher than Greater Glasgow levels and therefore account for levels of provision far higher than any other area within Scotland.

- 60% of inpatient beds in Clyde are continuing care beds and for this category of beds Clyde provision is more than double the level of provision provided within Glasgow.

- The Clyde levels of bed provision are the highest in Scotland and provided at more than double the level of Greater Glasgow for continuing care beds.

- There is no definitive evidence base against which to establish bed levels for a given population or indeed the health outcomes of any given balance of care between inpatient and community care.

- In such circumstances best practice would involve an approach which:
  - established the range of bed levels for the population by reference to published epidemiological norms;
  - benchmarked the ranges of actual service provision in a range of UK settings;
  - undertakes local needs assessment;
  - undertakes a process of local debate and judgement of where to position local service requirements within the ranges of service provision indicated by the outcomes of epidemiology, service benchmarking and local needs assessment;
  - ensures such local debate around the balance of care is informed and consistent with the evidence base albeit the evidence base is frequently "suggestive" rather than "definitive".

- Such a process is necessary to ensure an appropriate balance between local judgement, the broader evidence base, contemporary practice in modern mental health and the views of professional bodies - such that the resultant proposals can be independently substantiated.
• This is exactly the process summarised and evidenced in the Greater Glasgow Modernising Mental Health Strategy (1999) and subsequently further refined on the basis of local experience, and subsequent needs assessment and local judgement. Having operated such a service the broad body of clinical opinion has supported this balance of care with no significant adverse concerns relating to safety or health outcomes. The balance of care operated within Greater Glasgow is consistent with contemporary practice in terms of location within the ranges of epidemiological norms, comparative benchmarking with other UK mental health services for inpatient beds, consistency with best practice guidance on levels of provision of community services. It should also be noted that in a Scottish context the Greater Glasgow levels of provision are above average levels of provision.

• The partner social services departments of East Renfrewshire and West Dunbartonshire Councils currently work with services from both the Clyde service model and the Greater Glasgow service model. Both Local Authorities have indepth daily operational experience of the Greater Glasgow services, and both have embraced the move to a balance of care closer to that operated within Greater Glasgow.

• The Greater Glasgow bed levels were therefore themselves the product of a best practice process open to independent substantiation of its rationale and consistency and were then used as the starting point for extrapolation to proposed bed levels for the Clyde area. Subsequently these proposals were further considered and discussed in a range of local fora and supplemented by needs assessment of the current patient cohorts.

• Some 75% of the proposed bed reductions relate to patients currently cared for in long stay NHS continuing care beds. Local individual needs assessments of these patients are being undertaken to clarify and confirm the appropriate care and placement requirements of this patient cohort and to further refine and fine-tune the proposed bed numbers/type of placement as necessary. These local needs assessments are broadly confirming that the majority of these patients do not require care in an inpatient continuing care setting and placement in a range of community placements would provide a more appropriate and higher quality of care matched to their needs.

• In terms of acute admission bed numbers the proposals have provoked a range of views. However none of these views has provided specific evidence of characteristics of the Clyde population and context which provides and evidences a compelling case for departure from the benchmarking norms, subject to comprehensive levels of community services being in place as is planned for Clyde.

Further work:

• The Panel have advised:

  - that further detail of the basis for the application of the benchmarking process and determination of bed numbers should be provided within
that the benchmarking proposals should be further refined in the context of local needs assessment;

• This further clarification is agreed and we will continue to refine the proposed mix of inpatient continuing care Partnership beds and the range of community placements based on the outcome of individual needs assessments.

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

Issues:

• The Panel sought robust peer reviewed evidence for the safety and health outcomes of the proposed balance of care.

• The Panel critiqued the evidence provided to them by Glasgow as not providing definitive evidence on these issues.

Response:

We would comment on these concerns as follows:

• The evidence base provides no definitive basis for establishing the health outcomes of any given balance of care between inpatient or community services. In this respect no mental health service in Scotland could cite a definitive evidence base for the safety associated with the local balance of care, or the effectiveness or health outcomes of a given balance of care. The evidence base does however provide important pointers in relation to patients who receive long terms care in hospital settings and finds that:

  - over-reliance on the provision of long stay continuing care in NHS hospital sites is associated with the negative and detrimental effects of institutionalisation;
  - transfer to long term community based care shows better outcomes for most patients who had previously received long term inpatient care, when deinstitutionalisation is done carefully.

• In the context of Clyde this patient group use 60% of all beds and the evidence base clearly demonstrates that deinstitutionalisation and transfer to long-term community based care has better outcomes for patients than care in inpatient settings.

• 75% of the bed reductions in the Clyde Strategy relate to provision of more appropriate and higher quality care in long term community settings and for this patient group the evidence clearly demonstrates better outcomes for patients.

• The evidence base for the balance between acute care managed in acute hospital or community settings is less clear cut and no randomised evaluation
of this service model has been carried out in a modern community health setting. The evidence shows that where services have comprehensive community services in place, including crisis services this is associated with reductions of acute admissions by 20% and reductions in use of acute beds by 10%. However this evidence does not demonstrate improved health outcomes per se.

- Research on the functioning of crisis resolution services compared to standard treatment in inpatient settings has demonstrated:
  - patients receiving care from crisis resolution teams are less likely to be readmitted to hospital in the eight weeks following a crisis than is the case for inpatient care, albeit more so for voluntary than compulsory patients;
  - there were no significant differences over a six-month period in rates of attempted suicide and violence or of participants losing their jobs or becoming homeless;
  - high levels of user acceptability and preference compared to inpatient services, albeit the research findings are variable on this issue.

- In the absence of a definitive evidence base it is then necessary to look for consistency between the Clyde proposals and prevailing views about best practice both nationally, internationally and locally. The development of crisis services is widespread contemporary practice (an explicit policy priority in the Scottish Mental Health Delivery Plan, widespread internationally and standard in every English mental health service).

- Our local experience is that these services are highly valued by users and carers and often viewed as significantly more acceptable than inpatient admission. Following the introduction of crisis services our ward staff have commented on their impact on reducing the number of admissions to wards and in reducing occupancy levels

- National and international practice is consistent with a trend to reduce the scale of reliance on asylum based inpatient provision and increase the development of comprehensive community services including a range of alternatives to acute inpatient care.

- It should additionally be noted that whilst the evidence base for crisis services is suggestive rather than definitive this element of service provision relates to a maximum of 20% of the bed levels in the bed model, whilst the more robustly evidenced deinstitutionalisation proposal to reprovide continuing care beds in a range of community based in patient and placement settings relate to the major bed reduction proposals which constitute 75% of the proposed bed reductions.

- As noted by the external scrutiny report the evidence base cannot be taken to evidence a particular balance of care. However when combined with local needs assessment such as that described above for the current long stay inpatient continuing care cohort, it does provide compelling evidence to support the planned deinstitutionalisation process and reprovision of long term
continuing care in a range of community settings - and additionally demonstrates this has improved outcomes for patients.

Further work:

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

Full and quantified process of option appraisal.

Issue:

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

Response:

The Panel’s recommendations are accepted.

- The original options appraisal processes involved a qualitative evaluation of a range of options against an agreed set of evaluation criteria. Contrary to the reports assertion, this process was undertaken for the WDC Vale/Gartnavel option appraisal.

- In line with the advice of the scrutiny report we have appointed an Independent Facilitator to manage a process of options appraisal consistent with the requirements set out in 3.5 and 3.6 above.

Further work:

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

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

Issue:

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

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

Financial robustness

Issue:

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

- Risk relating to:
  - movement in unit costs of Partnership beds;
  - continued partnership with Local Authorities;
  - unpredicted demand changes.

Response:

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

- There are currently 311 NHS provided continuing care beds located on NHS hospital sites in poor quality accommodation. As noted earlier this is at a substantially higher level of provision than anywhere else in Scotland and more than twice that provided per head in Greater Glasgow.

- A significant proportion of these individuals are currently cared for in poor quality NHS inpatient continuing care wards, and would benefit from a range of community placements which would offer improved quality of life in higher quality environments.

- Additionally the benchmarking process identified the need for retaining a lower level of 126 inpatient continuing care beds - of which 26 adult beds were to be located on NHS hospital sites, and 100 older peoples inpatient continuing care beds to be reprovided in a Partnership model of care located in community settings - such settings would be similar to high quality nursing home provision provided in community settings.

- In essence the 311 beds currently provided as NHS inpatient care beds would be reprovided as set out in the table below. Initially the placement profile will be determined and refined by the outcome of the individual needs assessments of the patient population currently care for in NHS continuing
care beds. In the longer term the benchmark bed modelling has set out our expectation of the long term requirement for continuing care beds. The nature of the proposed arrangements sees a better matching of patient needs to service responses in higher quality environments of care. The financial consequences of this pattern of provision see:

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

• Current arrangements

<table>
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<tr>
<th>Form of Care</th>
<th>Number of Beds</th>
<th>Average Unit Cost £'000s</th>
<th>Total Cost £'000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS inpatient continuing care on hospital sites - adults</td>
<td>157</td>
<td>33</td>
<td>5266</td>
</tr>
<tr>
<td>NHS inpatient continuing care on hospital sites - elderly</td>
<td>154</td>
<td>36</td>
<td>5573</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>311</strong></td>
<td><strong>£35,000</strong></td>
<td><strong>10840</strong></td>
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• Proposed arrangements

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

• Contrary to the Panels concerns - the above table shows the provision of higher quality care in higher quality environments at reduced costs of circa £2million.

• The reduction in placement volume from 311 to 243 reflects the fact that not all of the 311 continuing care beds are occupied and therefore do not need to be reprovided on a one for one basis.
• It is accepted that there is a risk of exposure from movement in unit cost of Partnership beds managed and provided in partnership between the NHS and private providers. However unit costs would need to increase by some 60% before the cost of the proposed higher quality arrangements exceed the costs of the current lower quality arrangements. It is also accepted that movement in unit costs will require rigorous risk management of the overall implementation process to ensure the ongoing viability of the total package. However there are a range of options within the overall implementation arrangements for managing such risks (eg, funds released from community placements as these are vacated can be used as a contingency to manage unit price movements or demand shifts) and such risks are endemic in all retraction and reprovision processes where the detail of placement mix is progressively refined as implementation proceeds.

• Finally the Panel notes that the implementation proposals are reliant on continuing support from independent sector providers and from local authorities. Again such issues are endemic to the nature of retraction and reprovision arrangements and are implementation issues best supported by robust risk assessment and risk management processes.

• In relation to the Local Authority commitments it is clear from the local discussions and the correspondence between the local authorities and the Panel that there are high levels of commitment to the substance of the proposals which are seen by the local authorities as being fair and transparent and providing a better overall service for their residents.

Further work:

• We will refine our intelligence of the market rates for Partnership beds to enhance our risk management arrangements albeit there are limits to this in that contracts cannot be agreed in advance of the outcome of the consultation arrangements.

• We will provide further information in working papers as supplemental papers to the public consultation document, to further detail the assumptions and most up to date assessment of unit costs.

Fuller detail required in the public consultation document on:

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

Further work:

• The issues above will be set out in either the public consultation document itself or in supplemental working papers referenced in the public consultation paper.
Given the substantial volume of information the Panel have advised should be made available as part of the public consultation process it is likely this will require to be done by a combination of briefer comments in the public consultation paper with references to a range of supplementary papers available on request.

The need to provide users, carers and the wider public with a good understanding of the shape and content of the Partnership models of care and a basis for confidence in the model is accepted and it is likely we would provide a range of inputs to facilitate this possibly including:

- handouts with photographs and description of existing Partnership services for the general public;
- presentations from carers and practitioners on their experience of these services;
- a range of one-to-one and groupwork with patients and their carers directly affected by the closure and reprovision of continuing care beds in a range of inpatient and community settings

8. MATERNITY SERVICES

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

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

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

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

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

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

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

- The Panel notes we have failed to convince communities of the merits of our conclusions - we accept that conclusion. However, the Panel offers no advice or input into how we can turn around the situation they describe, as having developed over many years, of mistrust of Argyll and Clyde and its successor NHS Board.

- There is a clear review of the options to relocate the unscheduled medical service developed as an integral part of the planning process and a detailed capacity, staffing and financial plan to relocate the service to the RAH.

- The Panel noted our failure to address public concerns about the impact of additional time in ambulances. We accept that we need to clearly emphasise that the most ill and at risk patients already bypass the Vale of Leven and will not experience any increase in transport time, and therefore clinical risk.

- The work with the ambulance service has focused on ensuring we can put forward a costed and viable plan to support the transfer of unscheduled medical admissions.

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

10. OLDER PEOPLE’S CONTINUING CARE

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

- We find it difficult to accept that it is not reasonable to use extensive Glasgow analysis and benchmarking applied in a modified form to planning in the Clyde area.
Our assumptions about Partnership bed costs are based on real experience of commissioning and current contracts - we believe that is a reasonable basis for planning, in advance of a formal consultation process.

11. VALUE FOR MONEY, BEST VALUE AND OPTION APPRAISAL

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

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

- The Panel appear to have given very limited weight to our absolute obligation to reduce the costs of services in Clyde by £30 million - the understatement of that imperative, for which the Scottish Government holds us to account, skews elements of the Panel’s appraisal of our service proposals because the requirement to reduce costs is not accepted as a legitimate element of the drivers for change.

- The report overstates the constructs of value for money and opportunity cost against the simple requirement of affordability and does not fully reflect the complex matrix of objectives within which we are working.

- The report is contradictory, stating at one point that the only proposal which comes close to being robust is the proposed closure of the CMU birthing suites, but notes in the same paragraph that the mental health proposals are underpinned by relatively solid financial workings. There is, however, a key message in this regard that we need to carefully reflect on the provision of the financial information in the consultation process and, most particularly, in ensuring clarity on the origins of the Clyde deficit and our balanced approach to address it.

- Related to this point there are a number of areas where the report suggests we have incomplete information where that information was available. Those areas are highlighted in the preceding sections on each service area and we have also highlighted in the preceding service sections where we believe the Panel’s comments on finance were not complete or accurate.

- The report suggests that we have inadequately considered the impact of each of the sites affected by our proposals and is particularly critical of the impact on the Vale of Leven of transferring unscheduled medical admissions. For the avoidance of doubt, we have made this proposal to meet our overarching responsibility to provide safe and sustainable services - not for financial or value for money reasons.
For the other hospital sites it is our view that our planning has:

- properly and fully reflected financial impacts where these are of any significance, for example, fully including the costs of expanding maternity and medical admission services at the RAH;
- appropriately discounted marginal impacts, for example, the transfer of the delivery element of CMUs out of the IRH and the Vale of Leven.

The report raises concerns about our assessment of risk, most particularly in relationship to Partnership bed costs. We believe this critique is weakened in disregarding the fact that we already commission large numbers of Partnership beds and are presently in the process of commissioning new beds. We have current and high quality market intelligence in this regard - although we accept that this requires greater visibility in the consultation process.

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

- The Best Value methodology and Green Book guidance on which the Panel’s critique of our approach heavily relies are not a central part of the planning system and norms for NHS service planning.
- The Panel makes a number of points in regard to option appraisal to which we think it is important to respond. As the report states, option appraisal is essentially a way to allow fully informed choice between alternatives and can be highly technical and time-consuming. We have used the option appraisal in a measured and proportionate way which has properly reflected the planning challenges we have faced. Summarising:
  - we propose the mental health and maternity proposals will proceed with full quantified option appraisal as part of the consultation material;
  - for integrated care, it is our view and the Panel’s report confirms it, that there is no sustainable option to continue unscheduled medical care at the Vale of Leven or to fully implement the pilot of the integrated care model. In these circumstances it is difficult to see how any meaningful option appraisal process could be undertaken;
  - for Johnstone Hospital, the Panel notes our proposals are appropriate and sound - we accept that the reasons why an RAH newbuild option should not pursued should be explicit in the consultation,

- The Panel rightly notes that we have not created zero based processes for significant elements of our planning - we believe that is appropriate. We have been clear in integrating the Clyde area into Greater Glasgow that we will seek to deliver consistent models and levels of service across the Board area - we have, therefore, relied heavily in our planning on experience from Greater Glasgow, rather than creating entirely new planning process and norms for service changes in Clyde. We believe this represents a balanced and reasonable approach.
Finally, in reaching its conclusion, this section of the report states:

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

This highly summarised conclusion:

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

12. CONSULTATION AND PUBLIC ENGAGEMENT

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

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

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

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

13. CONCLUSION

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

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

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