

CONSULTATION DOCUMENT

Balance of older people's care: Johnstone Hospital

Consultation on the closure of Johnstone Hospital and
the transfer of its services to more modern accommodation



1. **PURPOSE**

- 1.1 This paper is derived from the original NHS Board Paper from 26th June 2007 and its purpose is to:
- set out the proposal to consult on changes to the NHS continuing care provision for frail older people in Renfrewshire, including the closure and transfer of services at Johnstone Hospital;
 - outline the background, context and key drivers to this change;
 - address issues raised through the Independent Scrutiny Panel process and subsequently endorsed by the NHS Board on 18th December 2007, in NHS Board paper 2007/61.

2. **BACKGROUND**

- 2.1 In November 2006, NHS Greater Glasgow and Clyde confirmed that the next step in the ongoing review of the balance of care for older people's services across Renfrewshire would be to review the provision of frail elderly continuing care services located at Johnstone Hospital.
- 2.2 This review would be set in the context of a wider balance of care programme of work being led by the Joint Planning, Performance and Implementation Group for Older People (OPJPPIG) within Renfrewshire. This is a joint group between Renfrewshire CHP (RCHP), Clyde Acute Services, Mental Health Services, Voluntary sector and Renfrewshire Council and has responsibility for the development of the joint strategy for older peoples services and its implementation. This group sits within a wider arrangement of joint planning of services across Renfrewshire.
- 2.3 These joint planning arrangements for older people's services have made substantial progress towards delivering a number of important outcomes including:
- additional services for patients to improve health and wellbeing;
 - transparency over finances
 - joint plans, priorities and decision making;
 - strengthening clinical involvement in these arrangements;
 - joint ownership, by NHS and Social Work, of service pressures and challenges.
- 2.4 In February 2007, an engagement event was held with key stakeholders, family members and carers, following which a short life working group was established to take forward the review of frail elderly continuing care bed provision. This short life working group has reported directly to the Joint Planning, Performance and Implementation Group, described in 2.2 above. A subsequent engagement event was held in May 2007.
- 2.5 The focus of this event was to update key stakeholders, family members and carers on:
- the review process;
 - key issues arising from the review;
 - proposals for change.
- 2.6 The two engagement events were attended by 74 individuals / groups. Written feedback was shared with all attendees and other interested parties. The Scottish Health Council have been active participants in the process.
- 2.7 The engagement process has also included a number of meetings with staff at Johnstone Hospital to ensure that they were fully briefed on:
- the engagement process;
 - how the review and potential outcomes may affect them.

- 2.8 Members of the Staff Partnership Forum have been actively involved in the work to date.
- 2.9 A key link with this review is the work programme relating to service provision for older people with mental illness. The proposals for these services are addressed in a separate paper; Clyde Mental Health Strategy: Adult and Older Peoples Mental Health Services for Inverclyde, Renfrewshire, West Dunbartonshire and East Renfrewshire. (See NHS Board paper of 26 June 2007 number 2007/26 Annex 4).
- 2.10 The NHS Board, at its meeting on 18th December 2007, noted the outcome of the Independent Scrutiny Panel process as it related to the proposed service change for Older People's Services. The Board agreed that this consultation paper would:
- enable participants to express their view on our appraisal of the shortcomings of the status quo i.e. no change (see section 8.3);
 - describe fully the partnership model (see section 9);
 - describe the relationship between health and social services for physically frail elderly and mentally frail elderly (see section 5.3);
 - ensure that the rationale for our preferred option is clear and the issues with regard to an RAH new build option are transparent for comment (see section 8.2 and 8.4);
 - ensure that our plans for change are made clear to patients, staff and carers in advance of public consultation commencing (arrangements will be made for meetings to take place before the start of formal public consultation on 18th February 2008).

3. POLICY CONTEXT AND DRIVERS

- 3.1 There are a number of key policy influences that have shaped the ongoing and wider review of the balance of care of older peoples services across Renfrewshire.
- 3.2 These include All Our Futures: Planning for a Scotland with an Ageing Population (Scottish Executive 2007), Better Outcomes for Older People: Framework for Joint Services (Scottish Executive 2005) and Delivering for Health (Scottish Executive 2005).
- 3.3 A key element of NHS guidance on which we have based our proposals relates to the provision of continuing care. This states that:
- 3.4 Continuing care is where the complexity, nature or intensity of the person's health needs (ie, medical, nursing and other clinical needs) or the need for frequent, not easily predictable clinical interventions, requires the regular specialist clinical supervision of a consultant, specialist nurse or other NHS member of the multi-disciplinary team (CEL 2008) 6 the NHS should provide continuing care.
- 3.5 Through these policy documents, there are a number of principles, which have shaped our work. These include:
- providing services as close to peoples homes as possible;
 - supporting more people at home via an improved range of community based services as an alternative to institutional care, where appropriate;
 - ensuring specialist service provisions focused on those with most complex needs;
 - delivering better use of existing older peoples bed capacity;
 - delivering a better network of linked services between Health and Local Authority;
 - reducing inappropriate admissions to hospital where possible and enabling supported

discharge through step down and effective rehabilitation services;

- ensuring older people receive an improved quality of care and faster access to a wider range of services;
- more effectively involving and supporting service users and carers;
- providing NHS continuing care with ready access to specialist clinical input when required.

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

- a joint District Nursing and Social Work Care Management project focused on patients with chronic disease who are at risk of multiple hospital admission. This is aimed at enabling more proactive disease/disability management in partnership with the service user, thereby preventing avoidable hospitalization;
- further enhancement of the Community Alarms Service will provide 24-hour support for vulnerable people at risk, of emergency or multiple hospital admissions, through planned and emergency interventions at home and by use of more sophisticated assistive technology;
- introduction of two Gerontology Nurse Specialists providing specialist advice and clinical support to Care Homes and staff is a key function of these roles thereby preventing inappropriate hospital admission from care home settings;
- introduction of Interface Pharmacist Roles to provide specialist pharmaceutical knowledge, advise and clinical interventions and promote medication compliance in elderly patients, ultimately achieving more effective treatment and reduction in adverse drug reactions and reducing emergency and multiple hospital admission;
- introduction of Extra Care Housing facilities:
 - three Extra Care Housing units will be introduced in 2008/2009 in Renfrewshire. These units will provide a 24 hour care and meals service, whilst replicating the advantages of remaining at home, such as having own front door; security of tenure; access to social networks and housing support. This model of accommodation and intensive support is designed as an alternative to care home admission;
 - the first unit, of 25 flats, is expected to be available for tenancy in early 2008 with the second development scheduled for the same time;
 - access to the service is through a comprehensive needs assessment. Eligibility is restricted to people who are primarily elderly and have complex health and social care needs including dementia;
- social work currently provides around 800 day care places a week for frail older people and those with dementia. The service model has remained unchanged for over ten years, although a programme of refurbishment and upgrading of day centres is almost complete. Day care continues to be a popular choice for older people and their carers as a means of maintaining independence and social supports. A strategic review of Social Work day care services is at an early stage and will now be progressed on a joint basis with health. The review is examining current and future needs for both frail and dementia day care and will present proposals on the role and scale of local day care services over the next 5 to 10 years. The timing and scope of this review presents an opportunity to dovetail with the review of NHS continuing care services for older people and, in particular, the review of day hospitals.

3.7 All of the above initiatives are inter-related in terms of providing best value and care outcomes.

They are aimed at enabling older people to remain at home for as long as possible and prevent avoidable hospital admission, reduce length of stay and offer a real alternative to care home admission.

3.8 Access to these services is underpinned by comprehensive and shared assessments of:

- patient/client needs;
- other mainstream social care services;
- medical and nursing services provided by local GPs and District Nursing Services.

3.9 **Delayed Discharges**

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

Table 1 - Summary of Number of Delayed Discharges in Renfrewshire

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

3.9.2 Our performance in relation to short stay patients, in the same period, was slightly short of the target. While we are confident we can continue to improve performance on delayed discharges, the new target of zero by April 2008 is an extremely challenging one to achieve, particularly in the context of a growing elderly population and higher levels of bed activity and throughput of patients. Further improvements will be achieved by continuing to implement our joint strategy for older people as well as streamline joint operational processes and systems for recording, referral and care planning. This work is underway.

3.9.3 A joint protocol on patient choice has been endorsed by the Council, the CHP and the Acute Division and was launched in May 2007. It is intended that this will be rigorously applied by hospital-based staff working closely with colleagues in Renfrewshire Council and will positively impact on the numbers of people delayed awaiting a care home of their choice in future.

3.9.4 As these improvements continue and are sustained, it is clear that we must review how resources previously tied up by delays in discharge can be redirected.

3.10 **Day Hospital Review**

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

3.11 **Assessment and Rehabilitation**

3.11.1 In recent months, work has been undertaken to improve the assessment and rehabilitation

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

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

- 4.1 Historically the number of residential care and inpatient beds for older people in Renfrewshire has been similar to the national averages. However, this has masked a higher than average level of NHS continuing care provision. Currently, we have 60 NHS continuing care beds for frail older people at Johnstone Hospital.
- 4.2 There are 24 care homes for older people in Renfrewshire; 17 of which are privately owned, 3 are owned by the voluntary sector and 4 by the Local Authority. These 24 homes provide a total of 1426 beds of which Renfrewshire Council purchases 1039. The balance of 387 is accounted for by residents placed by other Local Authorities, vacant rooms and double rooms with single occupancy. In addition, the care home beds within Erskine Hospital are viewed as a national resource, but are used significantly by Renfrewshire.
- 4.3 Earlier balance of care studies for older peoples services were updated and approved on a joint basis between NHS Argyll and Clyde and Renfrewshire Council in 2002 and 2004. Since then, NHS continuing care provision in Renfrewshire has reduced. Through the ongoing work of the Older Peoples Joint Planning Performance and Implementation Group, it is accepted by partner organisations represented, that there remains an over provision and dependency on NHS continuing care beds. This view is based on the analysis of current patterns of need and dependency set against how these should be met in the future.

Table 2 - Summary of the beds 2002 - April 2007

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

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

5. RENFREWSHIRE RESIDENT POPULATION AND ACCESS

5.1 Resident Population

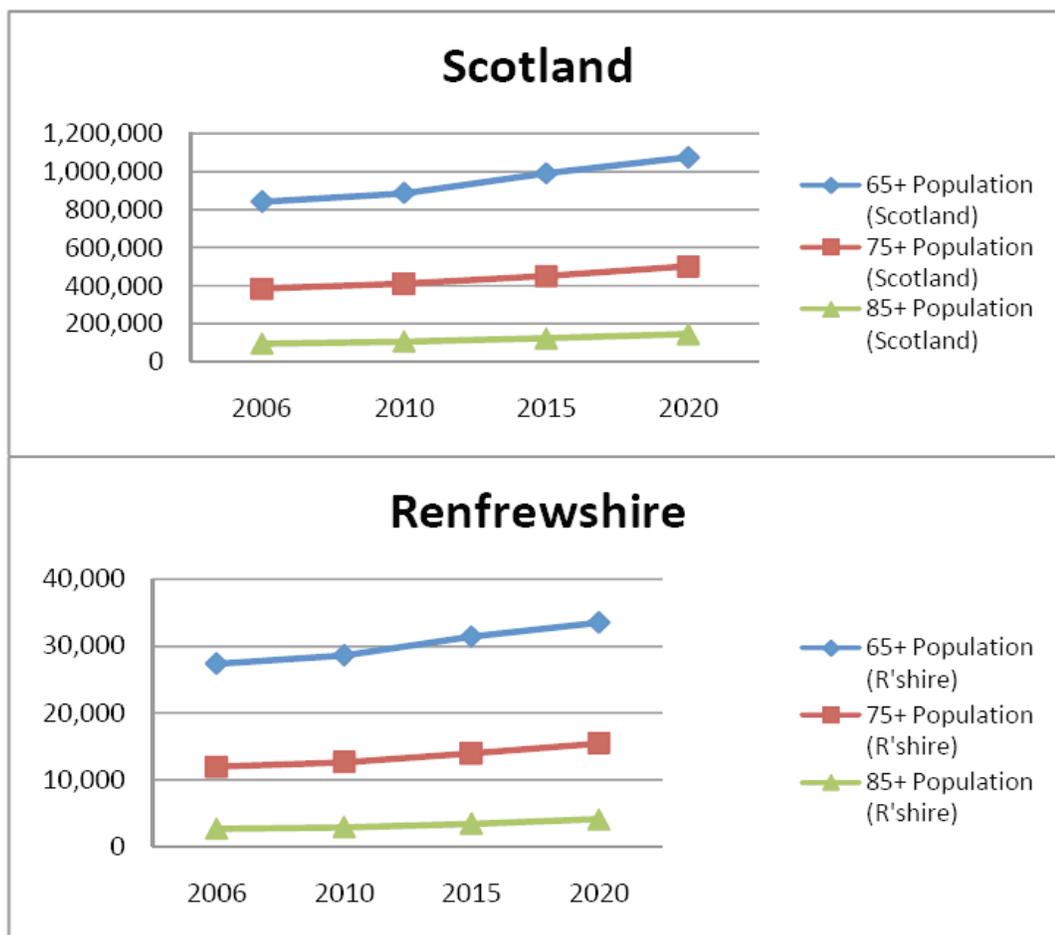
5.1.1 Demography – National

Table 3 shows the projected population rise in older people in Scotland and Renfrewshire between 2006 and 2020. The older population in Renfrewshire is set to rise considerably, however not at the same rate as Scotland as a whole.

Table 3

Population	2006	2010	2006-10	2015	2020	2006-20
65+ Population (Scotland)	840,041	884,592	5%	988,350	1,072,787	28%
65+ Population (R'shire)	27,384	28,624	5%	31,403	33,526	22%
75+ Population (Scotland)	382,926	407,566	6%	450,338	499,975	31%
75+ Population (R'shire)	11,973	12,655	6%	13,996	15,483	29%
85+ Population (Scotland)	94,738	106,123	12%	122,299	144,928	53%
85+ Population (R'shire)	2,741	2,974	9%	3,443	4,117	50%

Source - GRO population projection 2004 based



5.1.2 These data show an increase in the actual number and proportion of people aged 75 years and over and a marked increase in the over 85 age group. It is clear that the care needs of our older population are set to increase over the next 5 to 10 years.

5.1.3 By 2013, it is anticipated that at least 230 additional older people (from 2005 level) will require the level of care that a care home provides. Based on the current profile of the present care home population, it is estimated that around 70% of these people will require support with mental health needs and 30% will have complex physical care needs.

5.1.4 It is against this population analysis that the joint planning processes have sought to focus on how we best target resources to enable needs to be met and for specialist services to be targeted at those with the most significant and complex needs.

5.2 Access

5.2.1 The Johnstone Hospital site is relatively isolated from the other centres of population of Renfrewshire in the context of long-term care provision. Currently, we have 60 NHS continuing care beds at Johnstone Hospital of which 30 to 35 residents at any one time are categorised as requiring NHS continuing care. The profile of the addresses of origin of the current patients demonstrates that 90% are Renfrewshire based with the majority being from the combined greater Paisley and Renfrew areas.

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

5.3 Frail Elderly and Mentally Frail Elderly Services

- 5.3.1 Section 3 and 4 of this paper set out the services we provide for the frail elderly population in Renfrewshire. There are a number of older people in our population who live with a mental health condition, such as Dementia. These people are often referred to as elderly mentally ill (EMI).
- 5.3.2 Within Renfrewshire there are a range of services to support older people presenting with a mental health condition. These include a Joint Older Adult Community Mental Health service with Renfrewshire Council. We also provide a range of continuing care services for patients who require inpatient care and have the more complex needs. Although the services for frail elderly and elderly mentally ill are separate, the strategies and service planning for services is undertaken jointly through the Older Peoples Joint Planning, Performance Implementation Group (see section 2.4). This ensures that the balance of care and a joint and co-ordinated approach to service planning and delivery remain paramount. These arrangements are regularly monitored, through a joint meeting of the CHP and Social Work Senior Management Team. This Joint Management Group (JMG) is accountable to the CHP Committee for the effectiveness of the joint planning structure and process that bind the CHP and Local Authority.

6. **CURRENT SERVICE CHALLENGES**

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

major cost of upgrading.

7. **WHY CHANGE PROVISION OF CONTINUING CARE SERVICES?**

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

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

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

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

8. **PROPOSED CHANGES TO FRAIL ELDERLY CONTINUING CARE**

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

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

- reduce the number of Frail Elderly continuing care beds in Renfrewshire from 60 to a new target in the region of 35. The exact number will be determined through ongoing prospective audit of continuing care patients and by close monitoring of our work to shift the balance of care;
- re-provide these continuing care beds into modern accommodation using a partnership model. This model would be a partnership using accommodation available through the Local Authority (see paragraph 9), independent or voluntary sector. These beds would be located within Renfrewshire and ideally in a central location, such as Paisley or Renfrew, to provide improved access to our population. This service would continue to be NHS Consultant-led and staffed by NHS nurses. While the alternative option of re-provision on the RAH site would meet a number of our criteria, there is no prospect of suitable accommodation in the short to medium term;
- subject to the outcome of the consultation, we will finalise the service specification for the required model. A process to finalise a location and provider for the future service will follow this. This process will be agreed through the OP JPPIG and will specifically involve approaches being made to the Local Authority, Private and Voluntary providers;
- ensure that NHS continuing care within a partnership model is focused on the needs of those people assessed as requiring NHS continuing care services, consistent with the definition set out in 3.4 above.

8.3 It is against this backdrop that we believe the status quo has shortcomings which necessitate this proposed change to service.

These include:

- the critical importance of providing continuing care services in modern accommodation that is fit for purpose and fully reflects the national care standards and the principles of dignity,

respect and privacy;

- the analysis undertaken clearly points to the need for a reduced continuing care capacity in Renfrewshire. This is supported by senior clinicians and senior managers from the NHS and Local Authority;
- the existing service sits away from other related services and is less accessible than more central locations;
- the opportunity and need for change will enable resources to be released to support investment in other community based services for older people. The drivers for this are set out in 3.5. Current service developments are shown in 3.6. By not changing, we will not be able to deliver against these.

8.4 We also explored whether it would be possible to transfer services to the Royal Alexandra Hospital site in Paisley. However, after examining this option in more detail, we found there is not space within the site to build the type of new facility required. This hospital site has significant limitations for new build. Additionally, it is estimated that a new facility would cost in excess of £5m to build and consume significant additional revenue costs per year. Upgrading an existing ward would not provide single rooms of the desired standard.

8.5 On this basis, we believe that this level of capital is unaffordable and unavailable within the NHS for such a development in the short to medium term. The additional revenue required for such a new facility would divert resources away from services.

8.6 It is on this basis that we believe a new build option at the RAH is not deliverable in the short to medium term.

8.7 The rationale therefore for our preferred model is shaped by:

- providing NHS staffed continuing care services;
- the benefits of working in partnership with an established service provider;
- using the available resource to secure continuing care accommodation and find an appropriate venue.

8.8 We would aim to deliver the proposed model during 2009. To deliver this change considerable planning for the implementation phase would be required. This process will be steered by the Older Peoples Joint Planning, Performance and Implementation Group, with input from operational managers and clinicians. This would include close working with patients and their family members and carers. A detailed implementation plan would also address the changes as they impact on workforce, transport and access, communication, linkages between services and finance.

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

9. **A PARTNERSHIP MODEL**

9.1 As indicated above, there are a number of attractions to providing an NHS service within a partnership setting.

9.2 In the following we have described the partnership model for NHS continuing care.

- A modern accommodation setting that meets national care standards and enables the principles of dignity, respect and privacy to be actioned. This will be commissioned through a

detailed specification, tender process and subsequently confirmed through a Central Legal Office Agreement between NHS Greater Glasgow and Clyde and the successful provider.

The specification could include:

- facilities management such as catering, domestic/cleaning services, portering and grounds management;
 - utilities management, namely gas, electricity and communications;
 - in addition policies, procedures and health and safety requirements will be stipulated and monitored.
- A service that is staffed by NHS nurses and clinicians and is NHS consultant led to meet the health needs of our most complex frail older people.
 - Potentially sits alongside other related services, such as nursing home care and community based older people's services. Through this ensure greater synergy between linked but separate services.

10. **FINANCE**

10.1 NHS Greater Glasgow and Clyde - through Renfrewshire Community Health Partnership and Acute Services and the Mental Health Partnership - has been developing a joint financial framework for Older Peoples Services (which include services for frail older people and for older people with a mental illness, such as Dementia) in partnership with Renfrewshire Council (See attachment 1).

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

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

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

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

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

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

- to secure a service in modern accommodation that offers high quality and value for money;
- to release resource that contributes to NHS Greater Glasgow and Clyde delivering financial balance across Clyde-based Services;
- to invest resource in a joint plan with partners that delivers an improved balance and range of for older people across Renfrewshire.

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

11. **WORKFORCE**

- 11.1 Current staffing levels on the Johnstone Hospital Site for continuing care services are 62.24 whole time equivalent staff trained and untrained nursing staff. In addition, other services and staff are located on this site.
- 11.2 Throughout the implementation of the changes proposed, work will continue with staff and their representatives to manage the impact of change if this is confirmed following consultation. This will be done within the context of the national and local organisational change policies, which are based on the principle of 'no detriment'.
- 11.3 Once staff directly affected by the changes proposed are identified, in addition to meetings with the trade unions, one to one meetings/individual redeployment interviews will be held. NHS Greater Glasgow and Clyde has a successful track record in redeploying staff taking into account individual's skills and personal circumstances. Redeployment will be the first consideration with the aim of securing alternative employment for displaced staff as a result of service change. Based on this detailed redeployment principles will be agreed and a process of vacancy management will be put in place to secure alternative employment in alternative departments and locations.
- 11.4 Redeployment may be to a post at a lower grade and in these circumstances protection of earnings will apply. Redeployment will also be supported by a training and development plan, which will include induction and orientation programmes, and retraining/skills updating where necessary.
- 11.5 Regular briefing sessions will be held with staff throughout the period of implementation.

12. **PUBLIC CONSULTATION**

- Public consultation on these proposals was launched on 18th February 2008 and will run until 5th May 2008.
- 12.1 This will build on the programme of engagement events that commenced in February 2007 (detailed in section 2.4 of this paper). It is important to note that throughout this process the Scottish Health Council has provided oversight and advice to ensure that we meet the requirements of national policy with regard to informing and engaging. The Health Council has asked us to ensure that detailed information is available on the planning work underlying these proposals and we will ensure that is the case. We will also ensure that the process outlined in section 8 of this paper achieves full engagement with individual patients and their relatives.
- 12.2 SUMMARY LEAFLET - A leaflet summarising our proposed changes to frail elderly continuing care services will be widely distributed within Renfrewshire via our existing database of contacts, our Public Partnership Forum, GP practices, pharmacies/other primary care providers, community clinics/health centres and through Local Authority facilities. Copies of the leaflet are available on our website (www.nhsggc.org.uk/renfrewshireolderpeople) or by calling 0800 027 7246 during normal office hours.
- 12.3 ALTERNATIVE FORMATS AND LANGUAGES - if you would like copies of this document or the summary leaflet in alternative formats such as large print or audio tape, British Sign or would like translations of the text into languages other than English, please call 0141 201 4461.
- 12.4 PUBLIC EVENT - A public consultation meeting will be held on Thursday 13 March 2008 at the Glynhill Hotel, 169 Paisley Road, Renfrew between 5.30 and 7.30pm. If you would like to attend you must register in advance by calling 0800 027 7246 during normal office hours. If more people wish to attend than the venue can accommodate, a second meeting will be organised. A separate meeting is also being organised specifically for the families and carers of existing patients.
- 12.5 ADVERTS - adverts will be placed in the local papers following the launch the consultation

period to raise awareness of the proposed changes, provide details of the public event and highlight contact points for further information.

12.6 WEBSITE - All materials will be available on the NHS Greater Glasgow and Clyde website, consultation response page will be provided.

12.7 Meetings and Briefings for Individual Stakeholders will be arranged as required.

12.8 **Responding to the Consultation**

Comments on all aspects of the consultation paper are welcome. You can either email your comments to us at:

renfrewshireolderpeople@nhsggc.org.uk

or write to:

John Hamilton
Head of Board Administration
NHS Greater Glasgow and Clyde
Dalian House
350 St Vincent Street
Glasgow
G3 8YZ

The closing date for comments is Monday 5th May 2008

13. **WHAT NEXT - AFTER CONSULTATION**

We will carefully consider all of the feedback received during the public consultation period. This will inform the development of a final set of proposals which will be submitted to the NHS Greater Glasgow and Clyde Board for approval. If approval is given, our proposals will then be submitted to the Cabinet Secretary for Health and Wellbeing for a final decision. If this is granted, we would aim to begin implementation in line with the timescales outlined in this document.

If you would like this document in Braille or audio-tape format, please contact:

If you would like this document in another language, please contact:

Ma tha sibh ag iarraidh an fhiosrachaidh seo ann an cànan eile, cuiribh fios gu:

如果您需要该信息的其它语言版本，请联系：

اگر این اطلاعات را به زبانی دیگر میخواهید لطفاً با این آدرس تماس بگیرید:

إذا رغبت في الحصول على هذه المعلومات بلغة أخرى، الرجاء الاتصال بـ:

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਦੂਜੀ ਭਾਸ਼ਾ ਵਿਚ ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸੰਪਰਕ ਕਰੋ:

اگر آپ یہ معلومات کسی اور زبان میں حاصل کرنا چاہتے ہیں تو براہ مہربانی رابطہ کریں:

Eğer bu bilgiyi bir başka dilde istiyorsanız lütfen bağlantı kurunuz:

Jeśli chcesz uzyskać te informacje w innym języku skontaktuj się z:

0141 201 4461