West Dunbartonshire Community Health & Care Partnership

CHCP Committee 20th October 2010

Report By: CHCP Director

Vale of Leven Monitoring Group

1 Recommendations

The CHCP Committee are recommended:

(1) to note for their interest the Minutes of the Meetings of the Vale of Leven Monitoring Group held on 26th July and 30th August and the papers submitted for the meetings of the Group on 1st October; and

(2) to consider any issues arising that the Committee Chair and Director (as members of the Monitoring Group) should raise on behalf of the CHCP Committee at the next meeting of the Group on 25th October which has been arranged to deal with the substantive business carried forward from the meeting held on 1st October.

2 Background

The Vale of Leven Monitoring Group was established in 2009 by the Cabinet Secretary for Health and Wellbeing to monitor the implementation of the Vision for the Vale of Leven Hospital as approved by the Cabinet Secretary.

The Vision set out a number of proposals for NHS services on the Hospital site as follows:

- Changes to unscheduled care services, retaining 70% to 80% of the previous service;
- A major repatriation of outpatient, day case and diagnostic episodes of care back to the Vale from the RAH in Paisley and other Glasgow Hospitals;
- The retention of the Community Midwifery Unit with a programme to increase the usage of the unit for new births;
- The retention of in patient mental health services for older people; and
- The development of a new Health & Care Centre to replace the existing medical centre in Alexandria

The group was also given a role to ensure that the new and changed services that were to be provided at the Hospital were appropriately publicised.

Lastly the Group were given a role to monitor the level of need for adult in-patient mental health services. The NHS Board had originally proposed that these in-

patient services should be re-provided at the new Gartnavel Royal Hospital because of the likely significant reduction in the need for in patient admissions with the development of a comprehensive range of community base mental health services.

The Board estimated that in due course the need would be c. 12 beds; at such a low level the Cabinet Secretary had accepted that such a small ward was not sustainable. She gave the Group the role to monitor the usage of these Adult mental health beds (Christie Ward).

3 Discussion

Membership of the Monitoring Group comes from a wide variety of local interests and includes West Dunbartonshire Council (represented by Cllrs. Ronnie McColl, David McBride and George Black); West Dunbartonshire CHP (now CHCP) (represented by the Director and the Clinical Director); and the Public Partnership Forum of the CHCP (Anne Ferguson and Lily Kennedy).

The full membership of the Group is contained within the attached papers for the last meeting of the Group (appendix 1). The group is chaired by Mr. Bill Brackenridge who is also the Chair of the Argyll and Bute Community Health Partnership.

A key responsibility of the membership is to report back to their nominating organisations on the activities of the Group. For the former CHP this took the form of copies of all papers (including Minutes of Meetings) of the Group being circulated to meetings of the CHP Committee. These would be supplemented verbally at meetings as in many instances the Monitoring Group met a day or so before the CHP Committee.

From a West Dunbartonshire Council perspective a briefing note for members was produced after each meeting.

With the creation of the CHCP Committee it is proposed to continue the practice of presenting all the papers of the Monitoring Group with a covering paper from the Director setting out the current issues. As the CHCP Committee papers are available to all members of the Council this should also serve as a briefing on the work of the Monitoring Group.

4 Current position

As many members will know, over the past few weeks much of the attention of the Monitoring Group (as well as others) has been concentrated around the consequences of the fire that destroyed a large part of Christie Ward on Sunday 11th July.

As a result of the incident all patients had to be transferred to Gartnavel Royal Hospital.

Members will see from the Minutes of the meetings of the Monitoring Group on 26th July and 30th August that fire incident has been the most significant item of business for the Group. Following on from representations made on behalf of the Monitoring Group to the Cabinet Secretary she subsequently replied providing clarification on two substantive points that had concerned the group.

Firstly she has stated that it would take a further period of some 8 - 10 months for the reduced need for beds to be regarded as providing evidence that the downward trend was sustainable.

Secondly she advised that she did not think it was reasonable for NHSGGC to reinstate the Christie Ward beds at the Vale of Leven in the short term.

A copy of the Cabinet Secretary's letter, along with the original letter from the Chairman of the Monitoring group are attached as appendices 2 and 3 to this report.

The NHS Board will consider a report on the Christie Ward situation at its next meeting on 26th October. A further special meeting of the Monitoring Group has been arranged for Monday 11th October at 7.30pm.

This meeting will consider the draft report that is being prepared for the NHS Board and will provide the opportunity for the specific views of the members of the Monitoring Group to be directly incorporated into the final Board report. A verbal report on the outcome of that meeting will be made to the Committee.

It is clear however that the recommendation to the NHS Board will be that patients from the Vale catchment area who need to access an adult in-patient mental health bed should continue to access this service at Gartnavel Royal Hospital until the 8 – 10 month period of monitoring the need for beds has been completed.

While in the most recent weeks much attention has been concentrated on Christie Ward, the changes that were proposed to unscheduled care services have continued to be developed to the point where the new model of care is ready to be implemented.

The Monitoring Group heard at its meeting on 1st October that the implementation date for the new arrangements was now set for mid November and a major publicity campaign setting out the agreed changes is being planned. This will include local press publicity and an explanatory booklet being distributed to every household in the Hospital's catchment area.

R Keith Redpath
Director

THE VALE MONITORING GROUP

FRIDAY 1 OCTOBER 2010, 9.30AM

Victoria Halls, Helensburgh

AGENDA

The Vale Monitoring Group

The Cabinet Secretary required the establishment of the Monitoring Group to ***oversee the development and delivery of the 'Vision for the Vale'*** as a condition of her approving that Vision.

The Group meets every two months, alternating between Dumbarton and Helensburgh. The Group is required to keep the Cabinet Secretary appraised of

- The development of plans to implement The Vision and
- The delivery of these plans.

The Group will remain in existence until the service changes outlined in The Vision are delivered.

The Group's meetings are held in public to help ensure the process is open and transparent. The Group's meetings are not "public meetings"; there is no provision for members of the public to make a contribution to the Group's deliberations.

The membership of the group is set out at the foot of this agenda.

1. Chairman's welcome

2. Apologies

3. Minute of Meeting of 26 July 2010

4. Matters Arising

5. Feedback from Membership:

Acumen	D Harrison
Argyll & Bute CHP	D Leslie
Argyll & Bute Council	G Freeman
Argyll & Bute PPF	M Harvey
Helensburgh & Lomond Patients	D Bruce
Mental Health Partnership	A Hawkins
NHSGG&C	J Grant
United Campaigns Group	J Pollock
WD Mental Health Forum	H McCormack
West Dunbartonshire CHP	K Redpath
West Dunbartonshire Council	G Black
West Dunbartonshire PPF	A Ferguson

6. Adult Mental Health – paper attached — A Hawkins

7. Acute Services Update – paper attached — J Grant

8. Activity Monitoring Update – paper attached — J Grant

9. Communication Plan Update - paper to follow — A McLaws

10. Out of Hours Services – paper to follow — G Archibald

11. Alexandria Health and Care Centre Update — K Redpath

12. Ambulance Service — G Fraser

13. Any other competent business (to be proposed to the Chairman in advance of the meeting).

14. Proposed Schedule of Meetings for 2011:
Monday 24th January in Dumbarton
Monday 28th March in Helensburgh
Monday 13th June in Dumbarton
Monday 25th July in Helensburgh
Friday 30th September in Dumbarton
Monday 28th November in Helensburgh

15. Date of Next Meeting: Monday 29 November 2010

Membership:

Chairman	Bill Brackenridge
Argyll & Bute CHP	Derek Leslie
	Mike Hall
	Stephen Whiston
	Anne Helstrip
West Dunbartonshire CHP	Keith Redpath
	Alison Wilding
NHSGG&C	Jane Grant
NHSGG&C Mental Health Partnership	Anne Hawkins
MSP	Jackie Baillie
Argyll & Bute Council	Al Reay
	George Freeman
	Vivien Dance
West Dunbartonshire Council	Ronnie McColl
	David McBride
	George Black
Argyll & Bute PPF	Mairi Harvey
	Margaret Cameron
West Dunbartonshire PPF	Anne Ferguson
	Lily Kennedy
Helensburgh & Lomond Patients Gp	David Bruce
Hospitalwatch	To be confirmed
United Campaigns Group	Jackie Pollock
West Dun Mental Health Forum	Harry McCormack
Acumen	David Harrison

THE VALE MONITORING GROUP

MONDAY 26 JULY 2010, 9.30AM

Dumbarton Burgh Hall, 17 Castle Street, Dumbarton

DRAFT MINUTE

Present:	Bill Brackenridge	Chairman
	Keith Redpath	West Dunbartonshire CHP
	Derek Leslie	Argyll & Bute CHP
	Vivien Dance	Argyll & Bute Council
	David Bruce	Helensburgh Patients Group
	Mairi Harvey	Argyll & Bute PPF
	Sandra Bustillo	GGCHB
	Grant Archibald	GGCHB
	Harry McCormack	West Dun Mental Health Forum
	David Harrison	Acumen
	Linda Watt	Mental Health Partnership
	George Freeman	Argyll & Bute Council
	Ronnie McColl	West Dunbartonshire Council
	Jackie Pollock	The United Campaigns Group
	Margaret Cameron	Argyll & Bute PPF
	David McBride	West Dunbartonshire Council
	Mike Hall	Argyll & Bute CHP
	Jackie Baillie	Scottish Parliament
In Attendance:	Logan Taylor	Independent Media Adviser
	Lorna Fitzpatrick	Minute

Action:

1. Chairman's Welcome

The Chairman welcomed the Monitoring Group members to the fifth meeting of the group. In particular, he made reference to Linda Watt who is attending on behalf of Anne Hawkins, Grant Archibald attending for Jane Grant and Sandra Bustillo attending on behalf of Ally McLaws. The Chairman also welcomed Lily Kennedy who has replaced Tom Nimmo representing West Dunbartonshire PPF.

2. Apologies

Apologies were intimated on behalf of Gary Fraser, Anne Hawkins, Jane Grant and Ally McLaws.

3. Chairman's Statement re Representation from Hospitalwatch

The Chairman read from a prepared text and after both Jackie Baillie and Vivien Dance expressed disappointment that they did not have prior sight of the statement and a request to change the content re the future of the Vale site and the situation re Hospitalwatch, the amended statement is reproduced here:

"I want to make a statement to you all today about Hospitalwatch – about that organisation not yet being a member of this Group. It is not my wont to read from a prepared text but that is what I am doing today so that my precise words can be placed on record in our minutes, which, as you all know, are published on our website.

Many of you have asked me privately why Hospitalwatch is not yet represented on the Group. I have outlined privately to those enquiring my many communications with Jim Moohan, whom I understand to be the Co-Chair of Hospitalwatch. I did not think it appropriate to put the detail, or indeed the nature, of the correspondence in the public domain – and I still do not think that would be appropriate.

Many of you will have seen in the *Lennox Herald* published just after our last meeting what I took to be an open letter to me from Jim Moohan of Hospitalwatch. For those of you who did not see the letter in the newspaper, a copy of the text is available. It seems a bizarre way to communicate with me. I am sad that it seems to indicate that Hospitalwatch no longer seeks to be represented on the Vale Monitoring Group. However, given his open letter in the *Lennox Herald*, I thought that you all should know about my considerable correspondence with Hospitalwatch since August, 2009.

As you are all aware, the Cabinet Secretary wanted members of this Group to be representative of organisations with an interest in the Vale. She did not set this Monitoring Group up as a collection of individuals; rather she set it up as a Group of people representing organisations. She left membership of this Group ultimately to myself.

You will recall that I asked all organisations represented on this Group to evidence to me that their chosen nominee was the settled choice of their organisation. All of you here today have done that, albeit in a number of different ways.

Since August of last year I have received seven letters from Hospitalwatch about their membership of this Group and have written to them on five occasions. There have been many other

e-mail and telephone exchanges. I am disappointed that the membership of Hospitalwatch has not yet met to determine who will take up their single seat on this Group.

This saddens me for I well recognise the tremendous contribution made by Hospitalwatch to the Vale of Leven.

Nevertheless, no individual can have a bye to this table. All members must represent organisations. If the Hospitalwatch membership cares to meet and decide which single person will represent them, that representative will be more than welcome at this table. This table is incomplete without Hospitalwatch. I understood in a letter from Jim Moohan on 15th April that Hospitalwatch was about to meet to determine their single representative. I welcomed that meeting. Sadly, as I understand it, no such meeting has taken place and, as I understand it from Mr Moohan's letter in *The Lennox Herald* the organisation no longer wishes to join this Group.

I am glad to try to answer questions."

Jackie Pollock also asked that the fact that The United Campaign Group has also made an enormous contribution should be recorded.

The Chairman agreed to write to Hospitalwatch again. BB

4. Minute of Meeting of 7 June 2010

Under Item 2, there was an agreement that the ambulance transport would be on the agenda. This should be a standing item on future agendas. LF

Otherwise the Minute was accepted as an accurate record.

5. Feedback from Representatives:

West Dunbartonshire PPF
It was reported that the PPF had been reassured by the Update Booklet but that the group were still looking for reassurance on the new medical centre.

West Dunbartonshire Council
Ronnie McColl advised that a briefing note was prepared and issued along with the draft Minute to all members.

West Dunbartonshire CHP
Keith reported that the CHP Committee meets on Wednesday this week and the papers from this meeting have been shared with members.

West Dunbartonshire Mental Health Forum
Harry McCormack reported that the West Dunbartonshire Mental Health Forum have been discussing the fire at Christie Ward and asked that gratitude to the staff on the ward be recorded. He reported that the Forum have sent a card to staff offering their thanks. There was a meeting between Harry, Eileen Gory and the acting Chairman to discuss the monitoring group and Christie Ward.

United Campaigns Group
Jackie Pollock reported that the group had discussed patient transport and a report should be submitted to the Monitoring Group regularly. She asked for an update on the patient who was stranded in Paisley. She also expressed concern about the Alexandria Regeneration Forum requesting the Health Board to consider the Mitchell Way site for the new medical centre.

On transfers, Jackie asked that an interim shift be considered to cover those service users attending late clinics and who might be stranded in Glasgow.

In response, Grant Archibald described his role. In terms of the individual case, there has been a detailed investigation and a full apology will be offered. As a result of the incident, the Health Board has engaged with staff at both the RAH and the Vale to ensure that existing processes are complied with to try to avoid any repeat of this incident.

In terms of shifts, Grant confirmed that there is an absolute commitment to ensure that patients are delivered to hospital and returned safely home, particularly as such time and effort to get patient repatriation to the Vale is being undertaken.

Grant offered to address any individual issues with Jackie at the end of this meeting and the Chairman asked that a joint paper from Grant and the Scottish Ambulance Service be prepared for the next meeting of this group. GA/GF

There was a discussion around the fact that there is now no patient transfer room at the RAH and Grant was able to confirm that an investigation was ongoing to identify an appropriate room. An update paper will be provided for the next meeting of this group. GA

Vivien Dance asked for an assurance that where a patient is transported to hospital that the arrangements for their return journey are offered automatically and don't have to be requested. Grant undertook to review this.

NHS Greater Glasgow and Clyde
The Board continues to share Monitoring Group paperwork with management teams and with partnerships and to hold local meetings.

Mental Health Partnership
Monitoring Group papers will be shared with the next meeting of the Committee. Update papers and the Minute are routinely distributed to the Clyde Programme Board , the Senior management team and to the Staff Partnership Forum.

Helensburgh Patients Group
David Bruce advised that Pat Pollok Morris provided an update to the group at its meeting on 21 June 2010. The main concerns discussed at that meeting were around communication and he asked that mental health and transport issues should be prominent on future agendas. The group received an excellent presentation from the CMU and they undertook to make sure that its progress was kept at the foreground of the monitoring group.

Argyll and Bute PPF
The PPF are awaiting the results of a ballot to elect a new Chair and Vice Chair. The Chairman advised that those results were now known and he would report outside this meeting.

Argyll and Bute Council
George Freeman advised that Monitoring Group papers are available to all elected members in the Council and are also now being distributed to local Community Councils.

George requested that papers should go to primary care practitioners and Keith confirmed that the mechanism for this was via the Clinical Directors of Argyll & Bute CHP and West Dunbartonshire CHP who both sit on this group.

Argyll and Bute CHP
The main issue is around the downward trend in bed numbers and at what point this becomes sustainable. The clinical director who looks after the interests of Helensburgh and Lochside has access to minutes of CHP Committee and the communication to GPs is through that conduit. Brian McLaughlin and Nick Dunn are very involved in particular with out of hours services.

Acumen
David Harrison advised that the minute and newsletter have been circulated to membership.

The Chairman thanked members for their feedback.

There was a discussion around the provision of microphones and Vivien Dance said that we did agree that we needed a different venue if microphones were unavailable. When we met in Helensburgh there were no microphones made available despite of the fact that there is a new speaker system.

Wherever the group next meets microphones should be a priority. LF

6. Acute Services Update

Grant Archibald presented the Acute Services Update paper. Consultant recruitment continues apace and while locums have been identified there is continued effort to seek to fill these posts on a permanent basis. It had been expected to appoint to all six GP Specialist Training posts, however only four of the six posts have been filled to date. Work continues around this recruitment process.

There was a discussion around consultant recruitment and communication between the Vale and the RAH. Grant meets regularly with clinicians and is encouraged that communication and understanding between the clinicians who share time between the two hospitals has improved. Grant also offered an assurance that patients would be referred to the most appropriate hospital and that patient choice imbues all we do.

Jackie Baillie expressed concern about medical secretaries being moved to RAH in August. There are real issues with case notes being available for the right clinics at the right time and concern that efficiencies will be lost.

Grant advised that arrangements had been made in the best interests of delivering good services. The situation will be monitored to ensure that intended outcomes are achieved. Arrangements will be kept under review

Jackie Baillie asked at the last meeting of the monitoring group whether any of the nursing posts would be cut. The minute records something quite different to what was said at the meeting. Grant and Jackie will continue discussion outside this forum. GA/JB

Jackie's third point was to express concern about the cost and quality of locum service and finally she expressed her regret at not recruiting to the two GP specialist posts.

Grant advised that the consultant model was designed to deliver the best service locally. Workforce planning is a priority in the health board and there is currently a national shortage of acute care physicians. The commitment is that the Board will continue

to exercise its commitment to employ permanent staff.

Grant also confirmed that the current locums are employed on a six month contract and he will provide costs direct to Jackie.

The GPST posts are continuing to be recruited to and work is ongoing.

After a discussion around the skill base of staff, when Vivien Dance expressed concern over any reduction in skill base, Grant advised that the Board has been careful not to denude the Vale of experienced staff. The commitment today is that there will be a suitably qualified level of staff to deliver services at the Vale of Leven hospital.

The development for the out of hours service has been clinically developed as an appropriate model and another paper will be produced for next meeting. GA

The assurance from the health board is that all posts at the Vale will be properly graded through agenda for change.

When recruiting, the consultant posts are described as being based at RAH with a commitment to the Vale Vision. The GPST posts are advertised as being based in the Vale with time spent in general practice.

7. Activity Monitoring Report

Grant presented the activity monitoring report. The paper provides activity analysis and post code analysis and provides a breakdown of activity by key specialties including general surgery, orthopaedics, urology, ophthalmology, ENT, gynaecology, geriatric medicine, dermatology, paediatrics, haematology, neurology, renal and general medicine.

8. Adult Mental Health

Linda Watt presented the Adult Mental Health paper. With both Anne Hawkins and Doug Adams on annual leave, the paper was prepared early and shows activity to the end of May. Linda highlighted several aspects of the report:

- The Katrine Ward is up and running and has been well received by both staff and patients.

- Confirmed that despite an indicative 2% savings target across the NHS Board system, that in West Dunbartonshire CHP, there had been no reduction in the budget for community adult mental health services.

- Historical boarding activity might not be 100% accurate.

- Boarding has reduced and is now close to zero.

An increasing number of people have access to the crisis team. There is a difficulty in monitoring primary care activity across Greater Glasgow and Clyde and Linda asked for a sub group to be formed from the monitoring group to look at the figures in more detail and to prepare a paper to come back to the monitoring group in October.

The Chairman thanked Linda for the report.

Margaret asked about the differences between the new Katrine Ward and Christie Ward. Linda went on to describe the general model for old age psychiatry which offers age specific services. Older adult services have two sorts of short term admissions - organic conditions such as dementia or others such as depression. There is now a single consultant who deals with all over 65 services.

A request was made for an executive summary to be prepared for Lily to present to the Vale of Leven Seniors Forum and Linda agreed to liaise with Lily on this point. LW/LK

Jackie Baillie asked if the group could be provided with a note of those savings which have an impact on the delivery of community services and inpatient services.

Linda confirmed that there is still a West Dunbartonshire Crisis Service – there has been no change and the detail is still being looked at. Linda agreed to provide an update on how the review is progressing for the next meeting. LW

Vivien advised that Table 5.7 is worrying in that it encourages us to look at an unsubstantiated correlation for growth in community services and leads us to assume, without evidence, that we are meeting need and that is as a result of not having acute admissions to the same level they were just three meetings ago.

She also stated that questions have been raised about Richmond Fellowship, with a suggestion that the RF contract is allowing non-NHS trained staff sit in overnight with patients. Keith confirmed that the Richmond Fellowship has been working in mental health services for many years and that they often recruit from the NHS. Linda added that the service was careful to ensure those requiring support by non NHS services were still supported by NHS community staff.

Vivien stated that the Crisis Team in Helensburgh and Lomond

out of hours doesn't exist. Linda explained that there are GP out of hours and duty psychiatrists availably out of hours to link into mental health services. There have been no changes to the out of hours services

Vivien sated a concern about the sudden changes to bed useage over a very short period of time. Linda accepted that those not familiar with mental health services might be alarmed at the speed of change of bed use . However, this change is related to the change in the community services which has been underway for sometime.

Ronnie McCall asked that the next paper should report on what proportion of any savings from the closure of Christie Ward will be put into community services. We are about to embark in a CHCP which will involve the current CHP and the Council. If we are going to be relying more on community services then the cost is going to fall in no small part to the council. Keith advised that it is important to point out that the investment has already been made to community services including additional social care services. In terms of the need for 12 beds, they are still going to be provided. The need for those beds is not being denied. Those are beds that are currently available in another part of the system. This is not about cost shunting from one organisation to another.

The Board's stated position is that the beds would be better provisioned from Gartnavel Royal.

PPF representatives asked that it be recorded that they would prefer services to be delivered locally.

9. Christie Ward Fire

Linda Watt presented the paper on the fire at Christie Ward and emphasised the fact that staff had been magnificent.

An incident review will take place and both local and external clinical staff have been put in place to complete this.

It was enormously timely that patients had moved to Katrine just two weeks before and had that not happened, the situation could have been much worse.

Linda advised that the Board was not pleased at the timing of this incident as we were not ready to move Christie beds at this stage. The possibility of reinstating the affected wards is being considered and the paper describes the five options that will be reviewed:

- Fully reinstating the ward back to a fully functioning

ward to accommodate 12 beds and bringing it up to current specifications.

- Reinstating two of the three wings (excluding the badly fire managed one). The fire alert systems came through the North wing and would need to be relocated.

- Relocating the ward in totality elsewhere on the Vale of Leven site.

- Relocating services partially elsewhere on the site.

- Continuing with the current situation with the beds at GRH.

So far there have been no overt untoward effects on patients who have been transferred and every attempt has been made to keep them with familiar staff.

It was confirmed that the NHSGGC operates on a self-insurance basis – the same basis as all other NHS systems and that any costs involved in reinstating the ward will have to come from the capital resources available to the Board.

It was requested that the Chairman should write personally to all staff on behalf of the Monitoring Group and to the Chairman of the NHS Board, an a letter to the Cabinet Secretary, stating the Monitoring Group's preference that the service be kept local and a location found within the Vale of Leven Hospital if possible.

A briefing has already been sent to the Cabinet Secretary

It was agreed that in view of the extraordinary circumstances, an additional meeting of the Vale of Leven Monitoring Group should be called for 30 August 2010 at 9.00am, venue to be advised. LF

10. Christie Ward – Vivien Dance

Vivien Dance presented the paper on Christie Ward. She expressed a view that community services were being used to prevent admission to Christie. Given that we've moved from modest to dramatic changes in numbers, her concern is that patient care may have been manipulated.

She expressed an objection to any smaller sub groups being formed and requested that all future discussions be held in public.

Linda agreed to share the report sent to Prof McKay which LW

describes the evidence base in terms of bed modelling. She refuted the accusation of any manipulation of care and advised that, as Medical Director, she has a process which looks at various factors and if there were any manipulations of clinical staff to decrease admissions, then that would be dealt with. There are regular meetings to review clinical work and there is absolutely no evidence that clinical staff are being manipulated to provide inappropriate referrals.

The Chairman advised that we need some further information about trends of use of Christie Ward and it is for the board to come back to the Monitoring Group with a paper which says this is where we are and this is how we got there.

The Chairman advised that there was no appetite for a sub group and that this work should continue within the Monitoring Group.

The Chairman will take these issues up with the cabinet secretary's office and with the Board and report back. The extraordinary meeting in August will focus on Christie Ward options and review the bed requirement trend.

It was agreed the letter to the cabinet secretary should have three elements:

- She and we recognise that in view of circumstances, all things have changed and former intentions should be set aside.
- It is the view of the non officers that whatever solution is found should keep the service local.
- Third thing is to say it is our intention to have an early meeting specifically on this subject which will express an opinion on options.

11. Communications

Sandra Bustillo presented the short paper on communications activity that has taken place. Work is ongoing on the User's Guide. David Bruce expressed disappointment that the guide had not yet been produced and stressed that it should be delivered to every household in the area at the earliest opportunity.

It was agreed that an updated plan would be available for the next full meeting.

12. Alexandria Health and Care Centre

The process of moving towards production of the full business case is underway as is the process to appoint the principal supply

chain partner. That partner will have been appointed by the October meeting and Keith will provide an update at that meeting. KR

There was further discussion around the request made by the Alexandria Regeneration Forum to locate the centre at Mitchell Way and it was agreed that the Chairman will write to the Chief Executive of Greater Glasgow and Clyde Health Board to confirm this group's support for the Board's position. BB

13. AOCB

There being no other competent business, the meeting closed at 1.10pm.

14. Date of Next Special Meeting: 9.00am, 30 August 2010, Dumbarton Burgh Hall, 17 Castle Street, Dumbarton

The Vale of Leven Monitoring Group

Mental Health Focussed Meeting

30 August 2010, 9.30am, Dumbarton Burgh Hall

DRAFT MINUTE

Present:		
	Bill Brackenridge	Chairman
	George Freeman	Argyll & Bute Council
	Jackie Baillie	Scottish Parliament
	Anne Hawkins	Mental Health Partnership
	Anne Hawkins	Argyll & Bute CHP
	Helstrip	
	Vivien Dance	Argyll & Bute Council
	Mairi Harvey	Argyll & Bute PPF
	Ronnie McColl	West Dunbartonshire Council
	Lily Kennedy	West Dunbartonshire PPF
	David Bruce	Helensburgh & Lomond Patient GP
	Jane Grant	NHSGGC
	Harry McCormack	West Dun Mental Health Forum
	David Harrison	Acumen
	Mike Hall	Argyll & Bute CHP
	Keith Redpath	West Dunbartonshire CHP
	Alison Wilding	West Dunbartonshire CHP
	Ally McLaws	NHSGGC
	Derek Leslie	Argyll & Bute CHP
	George Black	West Dunbartonshire Council
	Anne Hawkins	West Dunbartonshire PPF
	Ferguson	
Apologies	Jackie Pollock	United Campaigns Group
	David McBride	
	Alan Reay	
In attendance from the Mental Health Partnership:		
	Doug Adams	
	Gordon Anderson	
	Moira Connolly	
	John Russell	
	Gerry Kelly	
	Frances Paton	
	Mari Brannigan	
	Linda Watt	
In Attendance:		
	Garry Fraser	Scottish Ambulance Service
	Logan Taylor	Independent Media Adviser
	Lorna Fitzpatrick	Minute

1. **Correspondence between Chairman of the Monitoring Group and the Cabinet Secretary**

The Chairman welcomed the group to this special meeting and the representatives from the Mental Health Partnership were introduced.

The response from the Cabinet Secretary was noted. In that response, she indicated that the review period would be extended for a further 8 – 10 months and that interim repatriation of services would not be in the best interests of patients, or local people. Jackie Baillie commented that in her experience the Cabinet Secretary would normally request the Health Board to draft a letter of response. David Russell confirmed that practice to be consistent with his own experience. Anne Hawkins advised that after the last meeting of the monitoring group, Robert Calderwood and Anne Hawkins met with the Civil Servant who is the Performance Manager from the Scottish Government to provide an update. The Board was not asked to provide a draft response for the Cabinet Secretary.

2. **Mental Health Overview Report**

Doug Adams presented the overview paper which is available on the Vale Monitoring Group Web Site.

3. **Mental Health Detailed Individual Reports**

The second paper discussed the evidence base for the Board's approach to a more community oriented balance of care and its impact on outcomes for service users. It then went on to explore the options for the interim provision of inpatient services following the fire at Christie Ward.

The paper included the activity monitoring report and went on to review community services, content, service developments and changes in expenditure.

The paper further described staff deployment following the fire, and reviewed the findings of the survey given to Christie staff.

In the final appendix, sustainability and risk issues were reviewed.

Jackie Baillie asked for a snapshot for all the patients from this catchment at the end of July when she believed there were 17 patients in Gartnavel.

Doug Adams distinguished between Vale catchment numbers relating to the function of Christie Ward, and wider use of

Gartnavel Royal Hospital for Vale catchment patients unrelated to the function of Christie Ward. He agreed to discuss and explore reconciliation of Jackie's information with the Boards understanding of the position, outside this forum.

Vivien Dance advised that she has some real difficulty with the information. Since May of this year, all that has been produced are figures which lead to a justification of 12 beds in Christie Ward.

Vivien asked that her discomfort be registered and advised that the number of officers in attendance from Greater Glasgow and Clyde Health Board made her very uncomfortable

The Chairman advised that it was important to reconcile these two different sets of figures and it was agreed that Linda Watt and Vivien Dance would meet outside this forum to discuss how to reconcile the figures quoted by the Mental Health Partnership, and those which had been given to Jackie Bailie and to Vivian Dance

The Chairman stated that the number of people who are here from the Health Board is an indication of how seriously the Board are treating this matter. Anne Hawkins advised that she brought along colleagues because she felt that they could contribute to the debate if required by the group.

The Chairman reminded the group of the role of the Monitoring Group – to oversee what Greater Glasgow and Clyde Health Board are doing and whether they are implementing the Vision. The job of this group is not to run the Vale of Leven Hospital.

Ronnie McColl expressed concern that there was any dubiety about numbers and asked that Vivien's figures be shared with him. Ronnie has recently been appointed to the Board and he would welcome clarity.

He would also appreciate having sight of Jackie and Vivien's figures. Given the fact that the Cabinet Secretary has asked for a longer monitoring period.

Ronnie McColl also advised that there would be no resource transfer from the closure of Christie Ward and he would need to see the evidence base from where community based services will be funded.

Anne Hawkins reported that in paper 3 and 4 she identified what resource has already been put into community services. Christie beds are acute admission beds and they are not closing they are moving to Gartnavel and therefore there would be no resource transfer.

David Bruce is less concerned about numbers but concerned at the

trajectory we are on as it is plain that the main aim is to close Christie Ward. He is disappointed that there is some doubt about the role of this group.

He is concerned at the political nature of the discussions taking place and suspects that the numbers do not have much relevance as there never was any question of finding alternatives on site. This raises fundamental questions about what function lay members are performing - he feels they have no influence which is disappointing and worrying.

The Chairman advised that it will be for members of this group to advise the Cabinet Secretary. If the requirement for adult acute admission beds remains above 12 then it is for this group to advise the Cabinet Secretary of this.

Bill reported that he had a discussion with the Cabinet Secretary in which she expressed her gratitude for the input of the lay members of this group.

Vivien advised that, from the Mental Health option appraisal, Christie Ward was highest in benefits and lowest in risk and she is unclear what she is being asked to monitor for the next eight months. There is no reference to patient need in these papers nor any reference to the health needs assessment which was pivotal during the options appraisal process.

Anne Hawkins responded that, in terms of what the group are being asked to monitor, the monitoring report is produced quarterly and she suggested that the group may wish this to be produced in another format.

Mairi Harvey asked if there had been conversations about preferences with patients and carers following their move to Gartnavel Royal Hospital.

It was explained there is a comprehensive patient survey designed by patients and carers which the Board uses throughout adult mental health admissions wards. This examines the quality of the patients stay and the discharge process. The outcome of a review of the questionnaire is that a shorter, sharper survey is required to enable the Board to get feedback from West Dunbartonshire patients.

There has been verbal feedback from patients that they are happy to be admitted to Gartnavel but there are still concerns around travelling for relatives. Anne Hawkins agreed that travel would be included in the reworked questionnaire.

David and Harry stated the location for acute inpatient care was a matter of personal choice but Harry advised that most people want a local choice.

Anne Hawkins Ferguson said that PPF are looking for information and she wanted to be able to take some decisions that have been made back to her group. The Chairman reminded the group that this is not a decision-making body – we do not run the Vale we just monitor.

Anne Hawkins wants it registered that her group want all our services maintained at the Vale of Leven. The Chairman said that there has been a huge debate about what services should be provided. The Vision has been endorsed and it is the job of this group to ensure that Greater Glasgow and Clyde Health Board are moving in that direction.

The Evidence Base

Throughout the UK there has been a shift in the balance of care which is described and explained fully in the paper. There has been a strong voice in the community for extra Crisis services in the community.

Linda Watt advised that to begin with the changes were driven by the views of users and carers who advised that they didn't want to go into hospital if alternatives were available. That drove the political machinery to deliver the policies which exist in Scotland. Staff working in mental health services have an aspiration to meet the needs of their patients and carers

Linda Watt agreed to make the write ups from the Clyde Consultation available to David Harrison as he was unaware of where the views had come from. LW

Doug spoke about deprivation being factored in with a needs weighting and agreed to provide Jackie with a full explanation of what "Greater Glasgow Adult Crisis adjusted" refers to. DA

George Freeman noted that Argyll & Bute and Helensburgh & Lomond are not included and the entire group needs to remember they are part of this process.

Exploration of Options

Anne Hawkins introduced the options paper which describes in detail the various options available for the replacement of the fire damaged Christie Ward. She asked the group to note that the figures provided at point 3.2 are not final figures as any work required would need to go out to tender.

Jackie Baillie asked that the draft report for the Board comes to the monitoring group for review.

Jackie Baillie was surprised to learn that the NHS doesn't carry insurance and she asked what contingencies are kept. It was confirmed that the Board does not have a contingency fund and that the capital budget was overcommitted this year - Anne Hawkins will provide Jackie with the detail. AH

NB – Missing George's views on what will happen AH

Anne Hawkins agreed to bring the Board paper to this group at the beginning of October for comment prior to its finalisation and submission to the Board. The paper will go to the Board at the end of October.

Activity Report

Anne Hawkins asked what other information the group wanted included in the report and requested feedback. Jackie Baillie asked for the Boarding figures for Gartnavel to determine whether it is coping with the totality of referrals from the whole area. She also asked for the total number of contacts with Crisis services - not just those that received treatment - as some clients are refused treatment if they have taken drugs or alcohol. She would welcome an assurance either that there will be no service cuts next year or details of service cuts which will be required. AH

In response to a question from Mairi Harvey, Anne Hawkins advised that the new building at Gartnavel started being planned in 1994 and was not designed to include the Vale inpatient activity. However, bed usage throughout Scotland has dropped steadily since 2004 and there is now capacity to absorb this additional inpatient activity.

Community Services Development

The report sets out service developments. The net new investment is circa £840,000. A more detailed report on total spend levels and changes in spending will be brought to the next meeting.

John Russell advised that there are no waiting lists in community mental health services except for those who require access to psychological services.

Staff Survey

Obviously there is continuing uncertainty and Jackie asked if in addition to the questionnaire was there an intention to carry out one to one interviews. Anne Hawkins responded that they did not propose one to ones which would normally only be provided on redeployment.

Sustainability and Risk

Doug Adams advised that the paper is a first response to Vivien's request to define sustainability.

Jackie Baillie welcomed the attempt to define sustainability. Jackie asked that the Mental Health Partnership uses the proposals and indicators set out in that report and produce a paper which sets out which indicators can be populated.

Appendix 1

THE ORGANISATION AND DELIVERY OF INPATIENT CARE

1. PURPOSE

1.1 This paper seeks to provide background information on the organisation of Inpatient Care to provide a context for the papers elsewhere on this agenda in relation to:

Reconciling inpatient activity at Gartnavel Royal

Changes in levels of bed use over time

2. ORGANISATION AND USE OF BEDS

2.1 Psychiatric Services across Greater Glasgow and Clyde operate a number of different services of which inpatients are an integral component.

2.2 Patients with different needs are cared for in a range of inpatient ward settings to ensure matching of inpatient ward functions to patient needs.

2.3 This development of specialist ward functions matched to distinct patient needs is broadly common to most mental health services throughout the UK, albeit there is some variation on models of rehabilitation and long stay care with some services merging these functions and others developing specialist sub functions.

2.4 In Scotland the Mental Health Act further supported the principle of functional specialty, requiring access to inpatient services which were age appropriate and specialty appropriate (in terms of the specialisms required to provide appropriate inpatient care particularly for more Highly Specialist services).

2.5 For Adults, defined as those between the ages of 18 and 65 years, NHS GG&C provides 5 distinct groups of inpatients beds as summarised in the table below. Normally wards are provided on an age or care group specific basis. The ticks in the table indicate the type of ward provided for a given age group or care group. In principle some types of beds such as IPCU and specialist beds might also be used by older people but such needs are very rare.

Organisation of bed types and use by age or care group

Bed type	Purpose	Care Group				
		Adults 18-65	Older people 65+ (Functional)	Older people 65+ (Organic)	Learning Disability	Addictions
Acute Admission Ward	short stay acute assessment function to stabilse illness and for most people prepare for discharge to community settings for ongoing care and support; lengths of stay for most adult patients are 1 month or less	✓	✓	✓	✓	✓
Intensive Psychiatric Ward	IPCU is for acute shorter stay assessment for a patient group requiring higher levels of security and observation due to suicide risks or risks of violence to others	✓				
Rehabilitation	for a challenging patient cohort who require extensive rehabilitation support prior to discharge to other inpatient or community settings, typically for a period of 1-5 years	✓			✓	
Continuing Care/long stay ward	typically rehabilitation and recovery to facilitate independent living in community settings or longer stay support for people whose behaviors are less predictable and more complex requiring a health response	✓	✓	✓	✓	
Specialist ward i.e eating disorders, perinatal, forensic	highly specialist services for mental health problems requiring complex specialist service responses normally provided on a regional basis given the low numbers of patients for such specialist services	✓				

2.6 All adults who require admission would normally be admitted through a local Acute Admission bed unless they were so unwell that they required to be admitted directly to an IPCU bed.

2.7 Each Community Mental Health Team is linked to a specific Acute admission ward and across the GG&C area each Acute admission ward relates to one of 4 IPCUs.

2.8 All other types of Adult bed Rehab, Eating Disorder or Long Stay are accessed following a period of time in an Acute Admission ward.

2.9 Women who have illnesses associated with pregnancy and for 1 year following the birth of their child would be under the care of the specialist Peri-natal Mental Health Team and would be admitted to the West of Scotland Regional Peri-natal unit at the Southern General Hospital.

3. CHRISTIE WARD

3.1 Christie ward, while part of Argyll & Clyde Health Board, admitted all adults 18-65 in addition to the over 65 population with functional illness, and from time to time had to admit people who had addictions problems, adolescents and patients with mild to moderate Learning Disability. There was access to IPCU, Rehabilitation and long stay wards at the Argyll & Bute Hospital.

3.2 Following the transfer of management to the GG&C NHS Board admission routes were gradually changed to the current pattern where:

- only those between the ages of 18-65 are admitted to Christie ward
- the ward functions as an adult acute admission ward
- Access to IPCU, Rehabilitation and long stay beds is at Gartnavel Royal Hospital

3.3 For all other categories of patients there are function specific wards e.g.

- Functional older adults > 65 – Fruin Ward, Vale of Leven
- Addictions Comorbidity – Kershaw Unit Gartnavel Royal
- Child & Adolescent Mental Health services – Skye House, Stobhill
- Learning Disability – Blythswood House
- Forensic services –Rowanbank Unit, Stobhill and low secure services at Leverndale

Appendix 1

RECONCILING INPATIENT ACTIVITY AT GARTNAVAL ROYAL

1. BACKGROUND

1.1. At the August meeting of the Vale monitoring Group there was discussion which suggested:

- diverse understandings of the inpatient activity at Gartnavel and the relevance of different types of inpatient beds in assessing levels of inpatient activity equivalent to the function of Christie ward prior to the fire and subsequent transfer of inpatient activity
- a commitment to produce daily bed state figures for the Vale catchment, including boarding
- a specific piece of work to reconcile the figures provided by Jackie Baillie/Vivienne Dance and those provided through the standard NHS GG&C monitoring procedures.

1.2 Subsequently, as agreed, Linda Watt and Vivienne Dance met to explore and clarify:

- the way in which NHS GG&C assembled its information and the working assumptions used
- Vivienne Dance's understanding of levels of inpatient activity on 27th August at Gartnavel Royal hospital, - which was stated as 16 patients in Henderson ward
- discussion of the changing role of Christie ward and the difference in functions between acute short stay, rehabilitation, IPCU and other specialist inpatient functions

1.3 This report should be read in conjunction with the separate report on the Mental Health section of the agenda "Organisation of Inpatient Beds" which sets out background information on the general organisation of inpatient beds and the evolving role of the Christie ward.

1.4 This report sets out:

- the appropriate interpretation of inpatient activity in other inpatient settings, of equivalence to that of the Christie ward prior to the fire
- background information on the way in which NHS GG&C assembles the daily inpatient activity and the working assumptions used
- the daily inpatient activity for the month of August for the Vale catchment patients in terms of both inpatient activity at Gartnavel hospital and boarded placements
- a reconciliation of the numbers in the NHS GG&C daily inpatient activity and the numbers reported by Vivienne Dance/Jackie Baillie for 27th August 2010

2. INPATIENT ACTIVITY EQUIVALENT TO THE FUNCTION OF CHRISTIE WARD PRIOR TO THE FIRE

2.1 The separate report elsewhere on this agenda on the "Organisation of Beds" has summarised the range of specialist functions performed by different types of wards, and also the changing function of the Christie ward over time.

2.2 That report set out that:

- immediately prior to the fire in July 2010, Christie ward was functioning as an adult acute assessment short stay ward

- before and after the fire in July 2010 there was other inpatient adult mental health activity beyond the adult acute ward function of the Christie ward, which was being provided in a range of other inpatient locations including:

    - IPCU, rehabilitation and long stay beds provided at Gartnavel Royal Hospital

    - Addictions co-morbidity beds at Stobhill, and from mid August 2010 at Gartnavel Royal

    - Specialist eating disorder, perinatal and forensic beds provided in a range of inpatient settings within GG&C

2.3 Following the fire in July 2010 the adult acute assessment beds at Christie ward have been provided from similar adult acute wards in Gartnavel hospital, and in particular Henderson ward. In reporting inpatient activity following the transfer of Christie ward the relevant inpatient activity is for adult acute ward activity in Gartnavel or boarded elsewhere.

3. BED CAPACITY AT GARTNAVEL ROYAL HOSPITAL

3.1 The following types of mental health beds are provided at the Gartnavel Royal Hospital:

	Adult acute assessment short stay	**Intensive psychiatric unit**	**Rehabilitiation and recovery medium to longer stay**	**Addictions & mental health comorbidity**	**Comments**
Henderson Rutherford McNair	20 20 20				short stay acute assessment function to stabilse illness and for most people prepare for discharge to community settings for ongoing care and support; lengths of stay for most patients are 1 month or less
IPCU		12			IPCU is for acute shorter stay assessment for a patient group requiring higher levels of security and observation due to suicide risks or risks of violence to others
Kelvin Clyde			10 20		typically 1-5 yrs for highly challenging behavior group hence smaller ward size typically rehabilitation and recovery to facilitate independent living in community settings or longer stay support for people whose behaviors are less predictable and more complex requiring a health response
Kershaw				22	for complex addictions problems alongside mental health and physical problems whose management requires the containment and expertise of an inpatient setting
Total	**60**	**12**	**30**	**22**	

3.2 The major function of the Christie ward relates to adult acute short stay assessment.

3.3 Gartnavel has 60 adult acute assessment beds in 3 wards with the majority of Vale catchment activity concentrated in Henderson ward. The other ward functions of IPCU, rehabilitation and recovery and addictions comorbidity are not functions which Christie ward was providing prior to the fire and are therefore not counted as equivalent activity to the function of Christie ward.

4. DAILY INPATIENT ACTIVITY SUMMARY

4.1 The table attached as appendix 1 provides a daily summary for the month of August for all types of inpatient activity for adults from the Vale catchment area in terms of Vale catchment inpatient activity:

- located at Gartnavel Royal hospital
- boarded out to locations beyond Gartnavel hospital

4.2 Section 1 of the table covers all Vale catchment inpatient activity at Gartnavel hospital for all bed types, broken down by bed type.

4.3 Section 2 of the table sets out Vale catchment inpatient activity for adult acute beds only, setting out activity at Gartnavel and boarded out. This section is the relevant section for activity equivalent to the function of Christie ward prior to the fire.

4.4 Section 3 of the table sets out boarded adult acute bed use broken down by admissions and by bed days

Putting the daily bed schedule together

4.5 The daily bed schedule is based on daily records produced at 5pm each day by the Bed Manager which cover all ward related inpatient activity at Gartnavel, and additionally all Vale catchment related activity on other hospitals. The schedule is specifically focused on adult inpatient activity for the Vale catchment. Although a range of information systems exist for global reporting of inpatient activity it is challenging to use these information systems for the sub geography of the Vale catchment and an additional system has therefore been developed to provide this information.

4.6 Although apparently simple in concept, different information systems for different purposes tend to have different definitions and ways of counting inpatient activity. To ensure consistency of use of definitions and methodology specific work has been undertaken to review all information and check for consistency between different information sources. The assumptions used in the daily bed schedule are set out in appendix 2. (to follow). The table in appendix 1 is simply an edited summary of the information contained in the daily bed schedules.

Reconciling understandings of patients in beds on 27th August

4.7 The Table in appendix 1shows that on August 27th for adult mental health inpatient activity from the Vale catchment activity there were:

- 13 patients in adult acute beds equivalent to the Christie ward function
- 2 patients in a rehabilitation bed in the Clyde Rehabilitation ward at Gartnavel hospital
- 1 patient in a bed in the Gartnavel IPCU
- Nil patients boarded out

This gave a total of 16 patients at Gartnavel hospital of whom:

- o 13 patients related to acute assessment short stay functions equivalent to the Christie ward function prior to the fire
- o 3 patients related to non acute ward functions which were provided at the Gartnavel hospital both pre and post the fire

4.8 Based on the information provided by Vivienne Dance/Jackie Baillie their understanding, based on information they have received, was that 16 Vale catchments patients were in Henderson acute ward on the 27th August. Whereas the GG&C NHS Boards' figures showed 13 people in an acute ward function (of whom 10 were in the Henderson ward, 2 patients in McNair ward and 1 patient in Rutherford ward). It may be that the figures provided by Vivienne Dance relate to all patients at Gartnavel hospital (and not specifically the acute function of Henderson ward) in which case the figures would then reconcile. These issues are being further explored prior to the Vale Monitoring Group meeting on 1st October and a verbal update will be provided at that stage.

Key points from the daily bed schedule for August

4.9 The following points are of note from the daily bed schedule summary for August 2010 beyond the reconciliation issue summarised above:

In terms of *adult acute* short stay assessment beds equivalent to the Christie ward function prior to the fire:

- The average daily bed use for acute beds at Gartnavel was 11.6
- There were 3 instances of boarded admissions lasting a total of 8 bed days during the month – making the average daily boarded bed use 0.2 of a bed
- The above level of boarded activity is somewhat lower than the historic boarding levels for Christie (see 3 monthly Vale Monitoring Group report)
- Including boarding the average daily bed use for all acute activity at Gartnavel and boarded hospitals was 11.9 beds

4.10 Additionally *non acute* activity is provided through other ward functions at Gartnavel before and after the fire. This inpatient activity is not equivalent to the function of the Christie ward but is reported as the Monitoring Group had asked for all Vale catchment inpatient activity to be reported as part of the daily bed state reporting. Points to note are:

- 2 patients were in a bed in the rehabilitation ward at Gartnavel for the whole of the month

- 1 patient was in an IPCU ward for the majority of the month

- There was no boarded activity for adult mental health for the Vale catchment in relation to these functions.

Overall levels of boarding for the overall Gartnavel catchment

4.11 The Vale Monitoring Group were concerned to see the overall levels of Gartnavel hospital boarded activity to assess the degree to which the transfer of Christie inpatient beds was affecting overall patterns of boarded activity. Specifically the Monitoring Group wished to see this set out on a daily basis. This information is currently in preparation and it has not been possible to complete this work in time for the Oct 1st Monitoring Group and will be provided and circulated following that meeting.

4.12 Pending the availability of that data the following monthly information from the routinely available bed management data has compared levels of boarding for the Greater Glasgow catchment of Gartnavel for the period April to August with annual average levels.

Appendix 1

Gartnavel Greater Glasgow only catchment	May	Jun	Jul	Aug	monthly ave 12 mnths to Aug 2010
admissions	4	2	5	5	3.5
bed days	25	2	9	21	16.8

4.13 The table suggests that boarding can vary month to month and so single month comparisons need to be interpreted with caution. On the one hand levels of boarding for July and August might be seen as rising but on the other hand they are not significantly different to those of April.

4.14 Perhaps a truer reflection of trends is achieved by comparing monthly trends with the annual average. On this basis:

- July was higher than annual average for admissions but lower for bed use
- August was higher than annual average for both admissions and bed use
- But even for August the variation relates to an additional 1.5 admissions and 4 bed days compared to annual averages
- The above variations are comparatively small in the context of monthly admission levels of c50 admissions per month and bed use of 1800 acute bed days per month

4.15 It is likely that given the issues above, the truest measure of changes in Gartnavel boarding patterns will be the change in monthly average boarded admissions and bed days used for the 6-12 month period before and after the Christie interim transfer in July 2010. This information will be added to the monthly monitoring information provided to the Vale Monitoring Group.

5. SUMMARY

5.1 The report has:

- provided a daily bed state summary schedule for the month of August
- sought to set out the types of inpatient activity equivalent to the functions of the Christie ward prior to the fire
- sought to reconcile different understandings of daily bed use for the 27th August and may have achieved this subject to confirmation that the figure of 16 patients related to all Gartnavel hospital activity including 3 patients in non acute IPCU and rehabilitation wards, rather than 16 people specifically in Henderson ward.
- set out levels of acute bed use for the Vale catchment equivalent to the function of Christie prior to the fire (inclusive of boarded activity)
- shown average daily acute bed use in August of 11.9 beds (including boarding)
- shown boarded acute bed use for 3 admissions lasting 8 days in total
- has shown non acute activity of 1.7 beds in total for 2 patients

APPENDIX 1
DAILY BED SCHEDULE SUMMARY
VALE CATCHMENT ADULT MENTAL HEALTH INPATIENT ACTIVITY IN GARTNAVEL AND BOARDED CATCHMENT ACTIVITY IN OTHER LOCATIONS

	AUGUST 2010	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Daily average
All bed types	**1. Adult patients Vale catchment at Gartnavel Royal Hospital : all bed types**																																
	Patients in adult acute beds	12	11	11	10	9	10	10	10	10	9	10	10	11	11	11	11	12	12	12	14	14	14	14	14	13	13	13	13	13	12	12	11.6
	Patients in rehabilitation and recovery beds	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2.0
	Patients in IPCU beds	0	0	0	0	0	0	0	0	0	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0.7
	Total all patients GRH all bed types	**14**	**13**	**13**	**12**	**11**	**12**	**12**	**12**	**12**	**11**	**13**	**13**	**14**	**14**	**14**	**14**	**15**	**15**	**15**	**17**	**17**	**17**	**17**	**17**	**16**	**16**	**16**	**16**	**16**	**15**	**15**	**14.3**

	2. Adult patients Vale catchment at Gartnavel Royal Hospital : adult acute beds only																																**Daily average**
Acute beds	Patients in adult acute beds	12	11	11	10	9	10	10	10	10	9	10	10	11	11	11	11	12	12	12	14	14	14	14	14	13	13	13	13	13	12	12	11.6
	Boarded acute patients bed days used	0	0	0	0	0	0	0	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	**0.2**
	Total all patients adult acute beds only	**12**	**11**	**11**	**10**	**9**	**10**	**10**	**11**	**12**	**11**	**10**	**10**	**11**	**11**	**11**	**11**	**12**	**12**	**12**	**14**	**14**	**14**	**14**	**14**	**13**	**13**	**13**	**13**	**14**	**13**	**13**	**11.9**

	3. Boarded acute bed use																																**Total**
Boarded acute bed use	Boarded acute admissions								1	1																				1			3
	Boarded acute patients bed days used	0	0	0	0	0	0	0	1	2	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	8

CHANGES IN LEVELS OF BED USE OVER TIME

1. BACKGROUND

1.1 The Vale Monitoring Group asked for a report exploring the reasons for the reduction in average bed use from 18.2 beds for the 3 months to January 2010 - to 12.4 beds for the 3 months to May 2010.

1.2 This report provides further detail and analysis in response to that request.

1.3 The report should be read in conjunction with the separate report elsewhere on this agenda " Organisation of Inpatient Beds" which sets out the wider arrangements and functions of bed types within Greater Glasgow and Clyde and the evolving role of Christie over time.

1.4 In the context of the NHS GG&C Board arrangements post 2006, a range of inpatient options were now available which were able to provide care in both age appropriate environments and specialty appropriate environments which led to:

- Access to child and adolescent beds provided GG&C/Region wide at Stobhill
- Transfer of IPCU and rehabilitation and recovery inpatient beds from Argyll and Bute hospital to Gartnavel Royal
- Access to specialist addictions beds at Stobhill and from August 2010 at Gartnavel Royal
- The development of a separate ward environment for over 65 functionally ill people in Katrine ward

1.5 With these changes came the opportunity for a more focused role for Christie ward as an adult acute short stay ward. This role is consistent with practice elsewhere in GG&C, but also generally recognized good practice reflected in the development of distinctive roles for acute short stay wards throughout Scotland.

1.6 As the focus of Christie has become clearer as an acute short stay admission ward, there has been a period of concerted management action to target the deployment of beds appropriately for this purpose and to ensure that individuals whose needs were best met in a non acute setting were moved to settings more consistent with their needs. In the majority of cases patients were discharged to tenancies with a range of community supports.

1.7 During the period from August 2007 to December 2009 there was an accumulation of patients cared for in Christie ward with lengths of stay of between 5 and 29 months (at discharge), whereas for the majority of patients the average length of stay for an inpatient episode in an acute care ward is likely to be for up to a month.

1.8 For the majority of patients in the longer lengths of stay cohort identified in para 1.7 above, care in an acute ward was no longer in the best interests of the individual patients but represented a "stop gap" pending more appropriate accommodation arrangements being put in place.

1.9 During the 6 month period December 2009 to May 2010 there was concerted management action to ensure discharge of these patients to more appropriate non acute settings with 6 patients being discharged in the period between December 2009 and May 2010. (A table summarizing brief anonymised details of the 6 patients is provided in appendix 1 of this report.). In short, whilst it took a period of 2 years to

accumulate this cohort of long staying patients who became inappropriately cared for in an acute ward, it took 6 months to ensure discharge to more appropriate settings in the best interests of individual patients.

1.10 The discharge of these 6 patients is the major factor which contributed to the reduced levels of bed use of 5.8 beds between the period of the first Vale Monitoring Report for the 3 months to January 2010 and the later report for the 3 months to May 2010 by which time bed use, including boarding, had reduced from 18.2 beds to 12.4 beds.

2. TRENDS OVER TIME

2.1 The monitoring framework reporting to the Vale monitoring group provided its first complete monitoring data for the 3 month period November 2009, to the end of January 2010.

2.2 At that stage occupied bed use (including boarding) over the 3 month period averaged 18.2 beds.

2.3 The report to the July monitoring group covered the 3 month period March to the end of May 2010.

2.4 At that stage occupied bed use (including boarding) over the 3 month period averaged 12.4 beds indicating that bed use over that period had reduced by 5.8 beds over a period of 4 months.

2.5 This report sets out:

- The changes between these 2 periods
- An exploration of the main drivers of the changes in bed use

2.6 The table below has summarized the trends over time against the indicators routinely reported to the Vale Monitoring Group comparing the May 2010 position with:

- the baseline 12 month period of the 12 months to Oct 2007
- the 3 month period Nov 2009 to January 2010

Monthly level for each Indicator	baseline 12 months to Oct 07	3 months to Jan-10	Mar-10	May-10	change to Oct 07 baseline		change to Jan 2010	
					no	%	no	%
occupied beds at Vale	18.3	16.1	14.0	12.3	-6.0	-33%	-3.8	-24%
Occupied beds inc boarding	20.1	18.2	14.7	12.4	-7.7	-38%	-5.8	-32%
Admsns	13.0	11.7	11.3	12.0	-1.0	-8%	0.3	3%
ave l.o.s	44	39	28	22	-22	-50%	-17	-44%
readmissions within 1 month	2.7	1.8	3.0	1.3	-1.4	-52%	-0.5	-28%
Delayed discharge	0.0	0.4	0.0	0.0	0.0	0%	-0.4	-100%
Boarded out admsns	4.3	5.6	3.7	0.7	-3.6	-84%	-4.9	-88%
Boarded out bed days	1.7	2.1	0.7	0.0	-1.7	-100%	-2.1	-100%
patients 6 months +	n/a	3.0	2.0	2.0	n/a	n/a	-1.0	-33%
readmissions as % of all admissions	21%	17%	25%	14%	-0.1	-33%	0.0	-18%

Comparing May 2010 with Jan 2010

2.7 Comparing the 3 month average position for March to May 2010 with that of the 3 month period Nov 2009 to Jan 2010 - bed use has reduced from 18.2 to 12.4 beds – a reduction of 5.8 beds

2.8 The drivers of this reduction in bed use appear to be:

- 44% reduction in lengths of stay from 39 days to 22 days
- 28% reduction in readmissions per month from 1.8 to 1.3 per month
- 33% reduction in patients with 6 months plus lengths of stay from 3 to 2 people

2.9 Admissions appear to have been broadly unchanged over the period and again boarded out admissions have reduced by 88% and readmissions reduced by 28% suggesting that the more efficient and targeted use of hospital beds has not been accompanied by a detrimental impact on readmissions or boarding out levels.

3. EXPLORING THE SIGNIFICANCE OF THE TRENDS

3.1 The papers to the August Vale Monitoring Group identified a range of factors which influenced bed use including:

- The availability of alternatives to admission
- The degree to which timely discharges from hospital to community settings are being achieved reflected in lengths of stay
- The robustness of the service system and clinical protocols to minimize relapse and readmission
- The degree to which inpatient bed use is used as a default option as a function of wider service gaps rather than the needs of the service user for care in that setting
- Active management of bed use and practice to ensure timely and robust
- discharge and follow up which minimizes relapse and readmission

3.2 Taking the position for the 3 month period to May 2010 and comparing this to the position for the 3 month period to Jan 2010 the table above has shown the most dramatic changes have been reflected in a 44% reduction in lengths of stay.

3.3 Reductions in length of stay are likely to occur where there is a clear focus on timely discharge from hospital to community services and additionally where the focus of acute bed use has shifted from a default option in the absence of a wider range of service options, to one more carefully targeted at the needs of service users for care in an acute setting only for the period in which care in an acute ward is appropriate.

3.4 During the period from August 2007 to December 2009 there appeared to be an accumulation of patients cared for in Christie ward with lengths of stay of between 5 and 29 months (at discharge), whereas for the majority of patients the average length of stay for an inpatient episode is likely to be for up to a month.

3.5 For the majority of patients in the longer lengths of stay cohort identified in para 2.4 above, care in an acute ward was no longer in the best interests of the individual patients but represented a “stop gap” pending more appropriate accommodation arrangements being put in place. During the period December 2009 to May 2010 there

was concerted management action to ensure discharge of these patients to more appropriate non acute settings with 6 patients being discharged in the period between December 2009 and May 2010. (A table summarizing brief anonymised details of the 6 patients is provided in appendix 1 of this report.)

3.6 The tables below para 1.6 has shown bed use during the same period reduced by 5.8 beds and lengths of stay from 39 days to 22 days.

3.7 It appears likely that the most significant factor contributing to the reduction in bed use of 5.8 beds is the concerted focus on discharging 6 patients in the above “longer stay” patient cohort to more appropriate settings, involving for the majority of patients community based placements, in their own tenancies with a range of supports.

3.8 Whilst the timely discharge of the above patient cohort is likely to be the dominant factor driving reduced lengths of stay and reduced bed use, it should also be noted that readmissions also reduced over the period which would have also contribute to reduced bed use, albeit modest in size compared to the discharge of the longer stay cohort above. Finally the more proactive approach to bed use and timely discharge to appropriate settings may also have applied to all discharges rather than just those of the longer stay cohort described above.

4. SUMMARY

4.1 In summary it appears the major factor in the reduction of bed use of 5.8 beds per month between the 3 month period ending 31st Jan 2010 and the 3 month period ending 31st May 2010 was the concerted focus on more timely discharge of a longer stay cohort of 6 patients, to more appropriate community based accommodation.

APPENDIX 1: DETAILS OF LONGER STAY PATIENTS DISCHARGED IN PERIOD DECEMBER 2009 TO MAY 2010 (ordered by discharge date)

Admission date	Discharge date	length of stay at discharge	Reason for length of stay	Discharge to where
23/08/2007	27/01/2010	27 months	awaiting suitable accommodation	own accommodation with support package
02/11/2008	16/12/2009	13 months	awaiting suitable accommodation	residential accommodation
15/11/2008	08/02/2010	15 months	Pending appropriate care home accommodation	Care home placement
25/11/2009	20/04/2010	5 months	CPA patient	new tenancy
09/12/2009	11/05/2010	6 months	ongoing treatment	home
06/04/2009	07/06/2010	14 months	relapse & awaiting own tenancy	own tenancy with support package

Appendix 1

EXPENDITURE AND SERVICE DEVELOPMENTS: MENTAL HEALTH SERVICES IN WEST DUNBARTONSHIRE

1. BACKGROUND

1.1 At its meeting on 30th August the Vale Monitoring Group received information on mental health service developments for the Dumbarton and Alexandria and Helensburgh Lochside area.

1.2 In response to information requests made at the Aug 30th Vale Monitoring Group meeting this report sets out:

- The total budgets for mental health services in West Dunbartonshire in 2006/07
- The total budgets for mental health services in West Dunbartonshire in 2010/11
- A summary of service developments and changes in expenditure over the period 2006/07 to 2010/2010.
- The planned expenditure at endpoint if the acute beds provided from the Christie ward are transferred to Gartnavel Royal on a permanent basis.

2. SUMMARY OF EXPENDITURE AND SERVICE CHANGES 2006/07 to 2010/2011

2.1 NHS Expenditure on services in West Dunbartonshire come from 2 sources:

- Community Services managed and funded through the West Dunbartonshire CHP
- Inpatient Services managed and funded through the GG&C Mental Health Partnership

2.2 Additionally services for the Helensburgh /Lomond population are funded via the Highland Health Board through it service agreements for inpatient services with the GG&C NHS Board and for community services with the West Dunbartonshire CHP

2.3 The table below summarises the overall expenditure positions in 2006/07 and in 2010/2011. (NB 2006/07 expenditure has been adjusted to a 2010/2011 price to facilitate clarity of changes in spend related to net increase beyond standard annual inflationary increases). The figures for Highland Health Board spend are subject to confirmation by Highland Health Board.

	NHS GG&C Spend WD area	NHS Highland spend H&L area
2006/07	7346	904
2010/2011	8223**	1044
Net change over the period	877**	140

**includes £160k of crisis service expenditure whose spend is reflected in CHP spend but whose source of funds is via WDC

Appendix 1

2.4 The table below summarises the major changes in revenue expenditure over the period which were resultant from the increased investment.

West Dunbartonshire - 2010/11 Mental Health Service Developments to Date

REVENUE			
Service	Description	New Investment Funding GG&CNHS HB £'000	Highland NHS HB
	ADULT MENTAL HEALTH		
Crisis Home Intervention Team (September 2007)	The Crisis team provides 24/7 support to people in serious mental health crisis by providing intensive community support, which enables community based alternatives to admission or early discharge from inpatient care to community based support. For the Helensburgh/ Lochside population the crisis team provides support as above from 8:00 am to 9:00 pm with access to crisis support outwith these times from the Duty Doctor covering the Christie Ward.	106	140
Crisis Home Intervention Team	£160k contribution to total costs of crisis teams reflecting role of crisis in providing social support function integrated within the service model	160(nb spend via CHP but source of funds via WDC)	
Primary Care Mental Health Team (PCMHT) (Alexandria End) (September 2009)	The Team in Alexandria was established in September 2009 Primary care supports are provided through individual GP practices supported by the PCMHT. A single PCMHT operates across West Dunbartonshire and Helensburgh/Lochside from two bases located at Goldenhill and Alexandria.	70	
Supported Accommodation Placements (April 2009)	Contribution to cost of placements of people who require supported accommodation placements in the community, this new investment underpins our rehabilitation strategy and facilitates timely discharge.	200	
Community Developments	Further development of Rehabilitation Care Pathway to facilitate timely discharge and recovery; dedicated psychology support provided via West CHP.	125	
	Uncommitted further developments (£70k 2010/11 and thereafter from 2011/12 £140k) : application between adult/OPMH to be determined	140	

TOTAL ADULT MENTAL HEALTH	731	140

REVENUE			
Service	Description	New Investment Funding GG&CNHS HB £'000	Highland NHS HB
OLDER PEOPLES MENTAL HEALTH			
Older Peoples Community	Two trained nursing posts	76	
TOTAL OLDER PEOPLES MENTAL HEALTH		76	

TOTAL ALL MENTAL HEALTH SERVICES DEVELOPMENTS	£717k NHS CHP/MHP & £160k WDC	£140k

In addition to the above there have been other service developments which are financially neutral overall or for which no charge has been made to local budgets as follows:	
Katrine Ward (Functional Over 65) (June 2010)	The Mental Welfare Commission has made comments over the years with regard to the inappropriate age mix within Christie Ward. One of the aims of the Clyde Mental Health Strategy was to address this by creating a dedicated facility. This has now been realised with the development of Katrine Ward which has been refurbished at a capital cost of £220k and an additional revenue investment of £130k. This £130k has been sourced from internal redirection of budgets so is shown as nil net increase in overall spending
Relocation of IPCU and Rehabilitation beds	Relocation of IPCU beds and rehabilitation beds from Lochgilphead to Gartnavel Royal (2 IPCU beds and 2 rehab beds)
West Area Autistic Service	To provide diagnostic support to Community Mental Health Teams in the care and well being of clients presenting with suspected autistic spectrum disorder
Eating Disorder Team	To provide expert Eating Disorders input to Community Mental Health Team and provide direct access to Mackinnon House Eating Disorder Inpatient unit

2.5 In addition to the revenue expenditure a range of capital commitments were also undertaken as summarized in the table below.

Description		Capital £'000
Riverview Resource Center 01/10/2007	Adult Community Mental Health Team covering the population of Dumbarton and Alexandria	750
Cairnmhor Resource Center 01/04/2009	Elderly Community Mental Health Team covering the population of Dumbarton, Alexandria and Helensburgh Lochside	280
Katrine Ward Mar 2010	Development of dedicated sub ward area for management of older peoples functional mental illness within Katrine ward in response to Mental Health Welfare Commission concerns	220
Total Capital Investment		1250

3. IMPACT OF TRANSFER OF CHRISTIE WARD TO GARTNAVEL ON SPENDING

3.1 The Vale Monitoring Group asked for information as to how any ultimate transfer of inpatient activity from Christie ward to Gartnavel might impact on spending on services to the Vale catchment / West Dunbartonshire population.

3.2 If there were a permanent transfer of acute inpatient activity from Christie ward to Gartnavel this would mean that the Vale catchment population was receiving a 12 bed acute inpatient service from a different location but there would be no net reduction in spend on the Vale Catchment /West Dunbartonshire population as it would still be receiving an inpatient service of 12 beds albeit from Gartnavel rather than Christie. In practice the costs of the GRH beds are actually slightly higher than those of Christie given the higher capital charge costs associated with more modern and higher quality accommodation

3.3 There would however be a saving to the total mental health service system as the 12 beds for the Vale catchment would be provided within existing capacity already available and funded at Gartnavel by the Mental Health Partnership releasing a net saving overall of £770k to NHS GG&C.

DEVELOPMENT AND REFINEMENT OF THE MONITORING FRAMEWORK

1. INTRODUCTION

1.1 At the Vale Monitoring Group meeting of Aug 30th there was support for the broad definition and indicators set out in the paper on Risk and Sustainability Issues and a request that officers take that framework and populate it setting out where information was or was not available to populate the indicators.

1.2 This report therefore sets out the indicators in the "definition of sustainable" and the availability of information sources which could be used to populate these indicators.

Definition of sustainable

It is perhaps easier to set out the characteristics of unsustainable services prior to consideration of the definition of sustainable services

Inpatient services might be considered to be unsustainable if they were characterized by:

- *high levels of boarding out to non local inpatient services suggesting insufficient capacity to meet demand,*
- *high levels of relapse & readmissions suggesting insufficiently effective stabilisation, treatment, discharge and follow up (i.e. poor health and quality of life outcomes)*
- *poor quality of patient experience reflected in high levels of violent or untoward incidents and feedback from patient surveys*

Community services might be considered to be unsustainable if they could not provide or ensure:

- *community alternatives to admission for some patients in a mental health crisis in accordance with user preferences*
- *timely discharge from inpatient to community settings*
- *low levels of relapse and inpatient readmission*
- *support which minimized the disabling impact of a persons mental illness on their quality of life*
- *access to early interventions and signposting to a range of community supports beyond specialist health supports (linked to reduced suicide risk and wider quality of life issues)*
- *low levels of use of inpatient beds as a default service response to wider service gaps rather than service user needs for care in that setting*

The service redesign to a more community oriented balance of care with reduced reliance on inpatient bed use might be considered to be sustainable if:

- *There is no significant detrimental impact on the health outcomes or quality of life for service users or the quality of service users experience of using services overall*
- *Patterns of acute bed activity are broadly stable in terms of bed use and the quality of service users experience of inpatient services is not adversely affected*

The report then went on to summarise a range of indicators that might be used to evidence the 2 points above. These indictors are summarized in the left hand column of the table below, whilst the right hand column has summarized the degree to which the indicators can be populated from existing data sources.

THEME	
The service redesign to a more community oriented balance of care with reduced reliance on inpatient bed use might be considered to be sustainable if: • *There is no significant detrimental impact on the health outcomes or quality of life for service users or the quality of service users experience of using services overall* • *Patterns of acute bed activity are broadly stable in terms of bed use and the quality of service users experience of inpatient services is not adversely affected overall. E.g.*	
INDICATOR	DATA SOURCE
Readmissions at or lower than baseline levels	reflected in Vale Monitoring Group standard report
Boarding out at or lower than baseline	reflected in Vale Monitoring Group standard report
Delayed discharges at or lower than baseline levels	reflected in Vale Monitoring Group standard report
Feedback from surveys of users experience of inpatient services	need to develop survey format specific to Christie/GRH interim transfer issues and supplement with stats re untoward and violent incidents on wards
THEME	
Community services are able to meet service user aspirations to provide/ensure:	
INDICATOR	DATA SOURCE
Alternatives to admission which enable a proportion of mental health crisis to be managed in community	reflected in Vale Monitoring Group standard report showing increased levels of crisis activity
Timely access to inpatient support when required	reflected in Vale Monitoring Group standard report on levels of boarding out
Timely discharge from inpatient services to support in community settings	reflected in Vale Monitoring Group standard report on levels of boarding out
Low levels of relapse and readmission	reflected in Vale Monitoring Group standard report on levels of readmission
Access to a range of early intervention and quality of life supports	partially reflected in Vale Monitoring Group standard report on levels of primary care signposting and access to one to one therapies
Access to a range of lower level supports which provide early intervention and support for less complex needs to minimize the impact on quality of life	partially reflected in Vale Monitoring Group standard report on levels of primary care signposting and access to one to one therapies

1.3 The Monitoring Group is asked to agree the themes and data sources identified.

Doug Adams
Head of Planning and Performance
Mental Health Partnership
NHS GG&C

Vale Monitoring Group Meeting
1st October 2010

Draft Board Paper on the Implications of the Fire in Christie Ward
Vale of Leven Hospital

1. **Purpose**
   This paper provides the Monitoring Group with an update on the content of the paper on the consequences of the fire in Christie Ward, Vale of Leven which will be presented to the NHS Board Meeting on 26th October 2010.

2. **Board Paper**
   The intention is that the Director of the Mental Health Partnership will present a paper on the implications of the fire, the paper will comprise the following:-

   a. Background to the fire.
   b. Information on patient decant.
   c. A copy of the report submitted to the Vale Monitoring Group on 30th August 2010 Copies of correspondence between Bill Brackenridge and the Cabinet Secretary following on from the July meeting of the Monitoring Group.
   d. The options identified as part of the above paper with indicative costs
   e. The views of the Monitoring Group on the options for Christie.
   f. A summary of staff views on the interim relocation to Gartnavel Royal Hospital.
   g. A summary of patient and carers views.
   h. A recommendation on the way forward.

3. **Staff views**
   As of 28th September 2010 only one member of staff has formally expressed views on the interim move of patients to Gartnavel Royal Hospital. The member of staff was of the view that West Dunbartonshire patient's deserve the highest standard of accommodation currently available in Greater Glasgow and Clyde and any less solution would be detrimental to their care. For most individuals in patient care is a rare though important occurrence.

   Should further views be expressed by staff between now and mid October these will be incorporated into the paper.

4. **Patient and Carers Views**
   An initial survey of patient and carers views was undertaken before the Monitoring Group meeting on 30th August 2010. Generally patients were comfortable with the care and facilities being provided at Gartnavel Royal Hospital. Some carers found the journey to Gartnavel Royal Hospital more difficult than to Vale of Leven, staff have been issued with guidance about how to support carers in their travel arrangements. A summary of the survey will be incorporated into the paper.

5. **Recommendation**
   The paper will recommend the NHS Board that patients from the entirety of West Dunbartonshire, Helensburgh and Lochside are accommodated at Gartnavel Royal Hospital for the time being. This will enable the Board to consider in 8 to 10 months the outcome of the further monitoring of the impact of Community

Services. At present there is no available capital funding to provide any upgrading of Christie Ward. The Board's Capital Plan has been circulated separately to the Monitoring Group. There is likely to be further pressure on the availability of capital in 2011/12 and it is possible that the Board will require to carefully review all capital allocations.

6. Views of the Monitoring Group

The Board paper will incorporate the views of the Monitoring Group on the options and intended recommendation. The Monitoring Group will wish to take account of the Cabinet Secretary's views in coming to a view. The Monitoring Group may wish to prepare a separate paper which can be provided as an appendix to the paper or alternatively agreed text for incorporation into the paper.

7. Recommendations

The Monitoring Group is asked to note the intended content of the Board paper and to agree how their views will be presented to accompany the paper.

Anne Hawkins
Director, Mental Health Partnership
NHS Greater Glasgow and Clyde
29th September 2010

Vale of Leven Monitoring Group **1st October 2010**

Implementation of the Vale of Leven Vision

Acute Services Division

1. Introduction

The Vale of Leven Vision document sets out the future reconfiguration of the service to be provided at the Vale of Leven Hospital. In approving the strategy for the Vale of Leven Services for implementation the Cabinet Secretary for Health and Well Being, Ms Nicola Sturgeon, set out two conditions:

- The establishment of this Monitoring Group
- NHS GGC to deliver a publicity campaign to promote current and new services at the Vale to local residents

To assist with the first of these two conditions, this paper sets out a summary of the recommendations agreed by the Cabinet Secretary as a framework by which the Monitoring Group can review the implementation of the Vision and the related activity.

2. Recommendations of the Vale of Leven Vision

The main recommendations of the Vale of Leven Vision, that are relevant to the Acute Services Division to be monitored through this group, are set out in the table below and it is proposed that they are used as a reporting template to note progress.

	Recommendations within the Vale of Leven Vision
1.	Introduction of a Consultant-led, GP supported model to deliver unscheduled medical care in order to maintain at least 70% of current activity
2.	Sustaining the Vale of Leven's Minor Injuries Unit
3.	Continued delivery of Rehabilitation Services
4.	Repatriation of Planned Care Services to the Vale

3. Detailed Position on Key Recommendations within the Vale of Leven Vision

This section seeks to provide an update on the key areas identified in the above table.

3.1 Introduction of a Consultant-led, GP supported model to deliver unscheduled medical care in order to maintain at least 70% of current activity

Progress to Date

Consultant Recruitment

As indicated previously NHS Greater Glasgow & Clyde have successfully recruited to four of the seven additional posts agreed to support an integrated medical model across the RAH and Vale of Leven Hospitals. Whilst recruitment will continue to secure permanent appointments to the three remaining vacancies, including the second Rheumatologist, we have secured two long term locums to the Acute Physician posts. This secures six of the seven appointments required. By integrating the locums with existing Consultants between the RAH and the Vale of Leven the Consultant position is sustainable to support the implementation of the Vale of Leven Vision model once the other service / staffing requirements are put in place.

GP Model

The GP model and out of hour's service has been agreed to support the Vale and is ready to be implemented at the commencement of the new model. Further detail on the GP model can be found in the paper on the Out of Hours and Integrated Care Clinical Staffing Model.

GP Specialist Training Posts

The six GP specialist training posts required to support the Vale Leven Hospital have been appointed to and took up post in August 2010.

This now sees the key components in place to support the introduction of the Consultant-led, GP supported model at the Vale of Leven Hospital. It is anticipated that the changes to the unscheduled medical care service can be implemented in early November.

3.2 Sustaining the Vale of Leven Minor Injuries Unit

As part of the Vale service model the Minor Injuries Unit will be sustained with no change to the service model. This unit continues to function strongly and effectively. The year end position in 2009/10 showed 9213 new patient attendances, (9874 including returns). The activity monitoring report to August 2010 shows that the new patient activity level for the first five months of 2010/11 is 4110. Based on the five months to date new patient activity the annualised position for the current year indicates an outturn of 9864 (10,670 including returns)

3.3 Continued Delivery of Rehabilitation Services

Progress to Date

Consultant Recruitment

The first of the two new Consultant Geriatricians took up post on the 19th July 2010. The second new Consultant commenced on the 6th September 2010. The establishment of these posts brings more stability to the service, which has been challenged by vacancies over the last few years.

Rehabilitation Pathways

The rehabilitation pathways with General Medicine and Orthopaedic Services have been completed and the stroke pathways and the model for stroke care have also now been finalised. As previously indicated the approach developed within the Rehabilitation and Assessment Services will support working across sites to ensure staff maintain their skills and expertise to support the long term rehabilitation of patients at the Vale of Leven Hospital.

3.4 Planned Care Repatriation of Activity to Vale of Leven

The Vale of Leven Vision indicates repatriation of planned care activity to the Vale of Leven Hospital which is summarised in the table below with the expected timescales.

Planned Care Changes Timeline

Timetable	**Repatriated Activity**
August 2009 (will continue during 2010)	General Surgery Orthopaedics ENT Surgery
April-May 2010	Urology OP Urology Theatre List
August 2010	Rheumatology OP Gastroenterology OP
September 2010 Roll out complete October 2010	Ophthalmology OP Ophthalmology Theatre List

Progress to Date

Medicine

As previously indicated the recruitment to one of the Rheumatology posts and to the Gastroenterology post has seen the establishment of the planned Rheumatology and the Gastroenterology clinics in August 2010.

Surgery

Repatriation

The work to actively repatriate patients with a Vale of Leven catchment postcode to clinics and theatre lists at the Vale of Leven continues in relation to Orthopaedics, General Surgery and ENT Surgery. As advised previously exceptions to this will be patients where the complexity or specialist nature of the surgery, the health of the patient, or patient choice precludes patients from attending this location for investigation or treatment.

Urology

The new enhanced Urology service is now established at the Vale of Leven Hospital. This has seen the establishment of 2 clinics per week and 1.5 day surgery sessions per week. Increased activity at the Vale of Leven Hospital can clearly be seen in the August 2010 activity report. Work continues to ensure that patients are repatriated from across Glasgow and Clyde to these clinics.

Ophthalmology

Outpatient care and day surgery for this service, such as cataract removal, for example, is now being undertaken at the Vale of Leven Hospital and combines sessions being relocated from Dumbarton Health Centre alongside an overall increase in the numbers of patients treated locally through the increased day surgery services now offered. This sees the establishment of 3 clinics at the Vale of Leven Hospital and 1.5 day surgery sessions per week.

4. Workforce

There is an overall increase in the posts associated with the service changes with the Vale of Leven Vision, 27 WTE/ 24.2 of which are nursing staff.

The exercise to ensure all employees are secured in a post has been undertaken and continues to be progressed with further HR engagement and processes in place to support staff to secure a post suitable to their circumstances.

To facilitate this process and ensure a conclusion before the go live date, all Directorates are working together to hold relevant vacancies for the small group of staff who remain displaced. The exercise has also highlighted staff now wishing to retire under our normal age retirement process.

Communications / Engagement

Managers continue to communicate updated information with staff on a Directorate basis. A further set of HR meetings has taken place. The Workforce Engagement Group continues to meet ensuring consistency of approach across the hospital.

5. Capital Plan Update

Additional Accommodation at RAH

The capital schemes to create the additional 42 beds at the RAH and the medical assessment unit for GP referred medical patients have been completed.

Redesign of Ward 4 to an Outpatient Department

Phase 1 of this work is now complete. Phase 2 of this work is currently in the planning phase.

Changes to Fruin Ward to accommodate older people with mental health problems previously cared for in Christie Ward

Both phases of this project have now been completed.

Haemato-oncology to Ward 5

The design has been signed off by the users and work is expected to commence in September 2010 once the ward has been vacated.

Relocate Laboratories into Ward 2

The work in relation to the laboratories will commence after the completion of ward 5.

Jane Grant
Chief Operating Officer
Acute Services Division

September 2010

Vale of Leven Hospital Monitoring Group **1st October 2010**

ACTIVITY MONITORING REPORT

1. Introduction

This report provides information on the first five months of 2010/11 for new outpatient, day case and inpatient activity (see appendix A). It also includes activity information on Minor Injuries and Medical Assessment patients, as well as information on the activity at the Community Midwifery Unit. It demonstrates that outpatient activity is showing an overall increase on last year's position with day cases remaining fairly static and inpatient activity showing a slight decrease.

2. New Outpatient Activity

New Outpatient activity has increased by 3.9% in comparison with the previous financial year. Within the medical specialties, General Medicine continues to see an increase (18%) on last year with new Rheumatology clinics now in place. Dermatology has seen a small decrease of 8.7% on 2009/10, although a new consultant appointment has now been made which should increase the activity. Orthopaedics and Urology have seen significant rises in activity, while there has also been a small rise in ENT and Gynaecology. General Surgery, Haematology, Renal and Oral surgery have seen slight reductions and this will be monitored carefully to ensure all suitable patients are treated locally. The Neurology new outpatient service returned to the Vale of Leven for the latter part of August following the return of a consultant from sickness absence. Ophthalmology activity has been reduced in this month owing to consultant compassionate leave.

3. Day Case Activity

Day case activity shows the same level of activity overall as in the same period in 2009/10. Day cases in General Surgery, Orthopaedics and Urology have all increased on last year. ENT is down by 9 patients on this 5 month period in 2009/10. General Medicine day case procedures have risen to 36 from 26 for the same period last year. Endoscopy for General Surgery and General Medicine are shown as a combined total to allow the overall position to be more clearly identified. The Dental service is showing a small reduction of 13 patients, which reflects the decreasing demand for general anaesthesia in this area.

4. Inpatient Activity

Inpatient activity is showing a 9.2% reduction on the year 2009/10. General Medicine shows a slight decrease in admissions, while Geriatric Medicine continues to show an increase in activity compared to the same period last year. The transfer of activity to day case continues to show in General Surgery and Orthopaedics, while there are small variations in Gynaecology and ENT Surgery.

5. Minor Injuries / Medical Assessment Unit

The number of patients presenting at Minor Injuries and Medical Assessment both show a slight decrease in the first five months of 2010/11 compared to the same period in 2009/10. This is primarily in relation to below average activity in April and July 2010. The other months position look to be in line with the activity pattern seen in 2009/10.

6. Obstetrics

Within the Community Midwifery Unit, August was a quiet month with 4 births in the Unit, although the overall Obstetrics daycase activity has increased by 25%. Work continues to promote the Community Midwifery Unit at the Vale of Leven Hospital.

Appendix A

1. New Outpatient Activity

Vale Of Leven Hospital	Year to Date Apr 10-Aug10	Year to Date Apr 09–Aug 09	Difference (%)
Specialty			
General Medicine (inc. Respiratory / Endocrine / Gastro/Diabetes)	1039	880	+18.0
Rheumatology	20	NA	∞
Dermatology	737	808	-8.7
Geriatric Medicine	101	80	+26.3
General Surgery	905	955	-5.2
Orthopaedics	872	735	+18.6
Urology	248	86	+188.3
ENT	641	623	+2.8
Ophthalmology	619	658	-5.9
Haematology	90	121	-25.6
Renal	37	54	-31.4
Neurology	33	117	-71.7
Gynaecology	789	777	+1.5
Paediatrics	192	182	+5.4
Oral	35	39	-10.2
Total	**6358**	**6115**	**+3.9**

2. Day Case Activity

Vale Of Leven Hospital	Year to Date Apr 10-Aug10	Year to Date Apr 09–Aug 09	Difference (%)
Specialty			
General Medicine	36	26	+38.4
General Surgery	248	215	+15.3
Endoscopy incl. GS and GM Endoscopy	823	897	-8.2
Orthopaedics	351	283	+24.0
Urology	50	31	+61.2
ENT	28	37	-24.3
Gynaecology	166	207	-19.8
Community Dental	49	62	-20.9
Haematology	1299	1297	0
Total	**3050**	**3055**	**0**

Appendix A

3. Inpatient Activity

Vale Of Leven Hospital	Year to Date Apr 10-Aug10	Year to Date Apr 09–Aug 09	Difference (%)
Specialty			
General Medicine (incl. CCU/ GM Endoscopy)	1613	1814	-11.0
Ger Medicine	299	291	+2.7
General Surgery (inc. GS Endoscopy)	88	96	-8.3
ENT	24	28	-14.2
Orthopaedics	124	147	-15.6
Gynaecology	65	63	+3.1
Total	**2213**	**2439**	**-9.2**

4. New Minor Injuries Unit / Medical Assessment Unit

Vale Of Leven Hospital	Year to Date Apr 10-Aug10	Year to Date Apr 09–Aug 09	Difference (%)
Minor Injuries Unit	4110	4214	-2.4
Medical Assessment Unit	2710	2789	-2.8

5. Obstetrics

Vale Of Leven Hospital	Year to Date Apr 10-Aug10	Year to Date Apr 09–Aug 09	Difference (%)
Ob Inpatients (excl. births)	3	11	-72.7
Births	34	48	-29.1
Total CMU IP activity	**37**	**59**	-37.2
Obstetric Day Cases	**290**	**232**	+25.0

Appendix 1

Vale of Leven Hospital Monitoring Group
1st October 2010

Marketing and Promoting Services at the Vale of Leven Hospital: Update

1. Introduction

This short paper reports on recent activity to ensure residents served by the Vale of Leven Hospital are being kept informed over progress towards delivery of the 'Vision for the Vale.'

It also describes progress towards delivering the essential guide on the hospital for every household in the Vale's catchment area.

2. Recent activity

2.1 Web

The following figures confirm the 'hit-rates' on vale-associated web-pages since the end of January until 29th September 2010:

Vision for the Vale	9,261 (up 2,874 on 26th July)
Vale of Leven Hospital	28,242 (up 6, 963)
Vale of Leven Community Maternity Unit	3,563 (up 1,117)
Vale of Leven Monitoring Group	2,123 (up 915)

2.2 Media Coverage

Relevant media releases relating to NHS services in the Vale catchment area have been issued in the period since the last meeting of the Vale Monitoring Group include:

- Announcement of appointment of contractor for Alexandria Medical Centre
- Introduction of a new eating disorder service in West Dunbartonshire
- Happy 2 Chat – joint collaboration between the CHP and the Council's education services
- Waiting times success for hospitals across NHSGGC
- Launch of pilot employer scheme, REALISE, in West Dunbartonshire
- NHSGGC success in training Cleanliness Champions

Other media coverage in the period focussed primarily on the future of Christie Ward. A sample of all media coverage for the period is attached.

2.3 GP web pages

To ensure local GPs are well informed about services available locally at the Vale, including the latest services to return or be introduced, dedicated web pages for GPs have been created within the Vision for the Vale microsite.

Launched on 1 October, these pages provide information on the full range of outpatient services available locally and remind GPs of the referral processes for these services.

A feedback mechanism has been built in to enable GPs to provide suggestions about further information they would like to be included on the bespoke website.

The web pages are currently being publicised by the Clinical Directors of West Dunbartonshire CHCP and Argyll and Bute CHP.

2.4 Public meeting

NHSGGC officials were invited to participate in a well-attended public meeting on Wednesday 22nd September 2010 in Alexandria. Representatives from NHSGGC's acute services and mental health services attended the meeting to answer questions from the audience on progress in delivering the Vision for the Vale.

3. Publicity Campaign

Production of the Essential Guide to the Vale is underway and a design concept will be shared with the Monitoring Group at the meeting on 1st October and a proof of the guide will also be shared with members before going to print. It will also be shared once again with patient representatives for 'road testing' via our Community Engagement Team.

The guide will be delivered to Royal Mail by 25th October with an onward delivery to every household in Vale of Leven Hospital's catchment within a two to three week period.

An electronic version of the guide will also be posted on the Vision for the Vale microsite.

Ally McLaws,
Director of Corporate Communications,
NHS Greater Glasgow and Clyde

1st October 2010

Vale of Leven Outpatient Redesign

Introduction

Due to a redesign of services at the Vale of Leven Hospital, the Patient Transport Service (PTS) has carried out an analysis of the patient journeys to ensure the resources will meet the demands of the redesign.

Outpatient clinics covering, Orthopaedics, Opthamology, Rheumatology, Urology, Day Surgery and General Surgery will be the main additional services provided. This will mean that more patients will be able to access these services locally.

To measure the impact this will have on the Scottish Ambulance Service Patient Transport Service (PTS) analysis was carried out by the performance and planning department of the SAS along with GG&C planning department.

The purpose of this report is to recognise the operational impact on the PTS.

Vale of Leven PTS Establishment

Staff – 18.7 WTE
Vehicles – 15

The PTS staff at the Vale of Leven cover shifts from 06.00 – 20.00 six days a week to provide a service to renal patients, day hospital, clinics and discharges. The method of transport ranges from double crew ambulances with a stretcher facility to a car to best meet the needs of the patient.
There is no patient transport resources based at Helensburgh or Arrochar therefore Vale of Leven resources also serve these areas.

Demand

The PTS service is experiencing fluctuations in demand year by year. It is the strategy of the SAS to ensure that transport is provided for those who need it most on *a medical need only* and to engage with our NHS Partners to enforce the eligibility criteria and reduce any abuse of the service.
The main out of area clinics by demand which will be unaffected by redesign are Beatson, Neuro at SGH, West marc Limb Fitting, Plastic Surgery and MRI Scanning.

The demand for the Vale of Leven catchments area for 2009/10 can be summarised in table 1 and 2.

C = means can travel by car with no assistance
C1 = can walk but needs assistance from a single ambulance attendant but does not require any assistance on route
C2 = cannot walk unaided and requires the assistance from ambulance crew and carrying equipment. May also need assistance on route
St = Stretcher. Needs carried and assistance throughout.

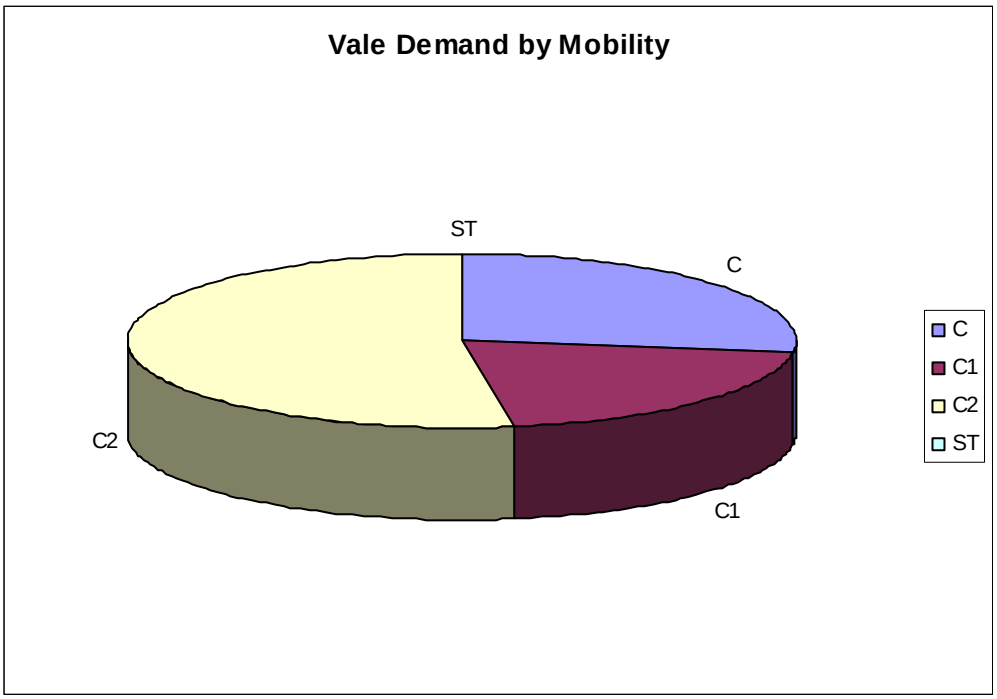


Table 1

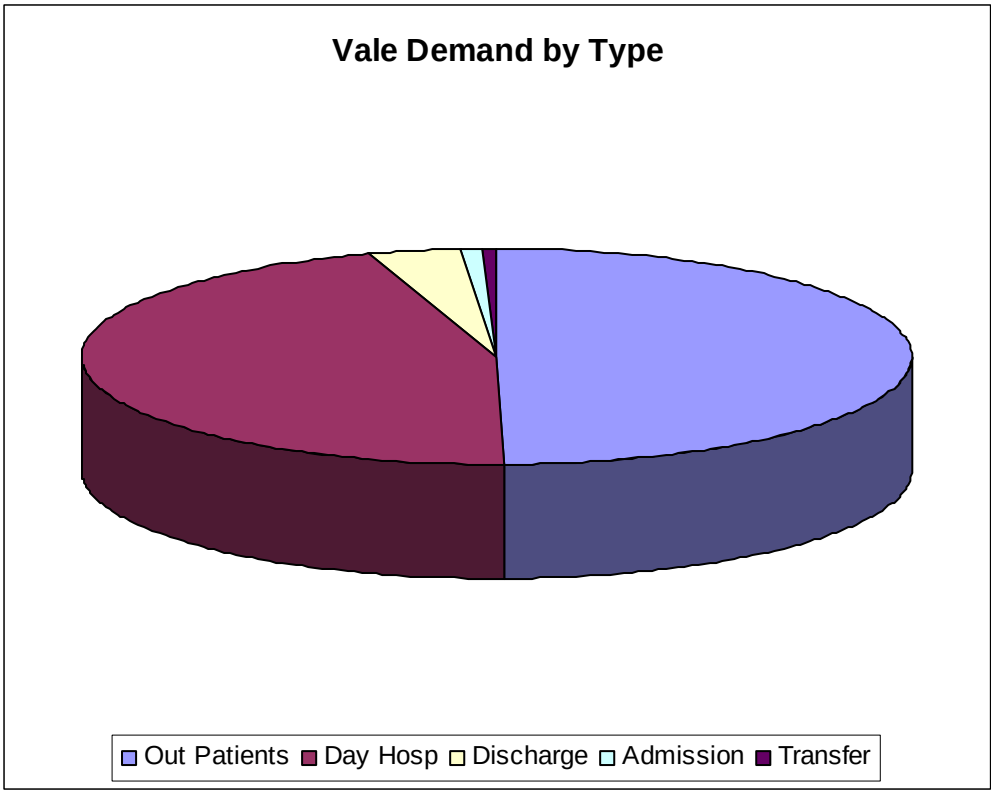


Table 2

Current activity for 2010 for Vale of Leven PTS is displayed table 3.

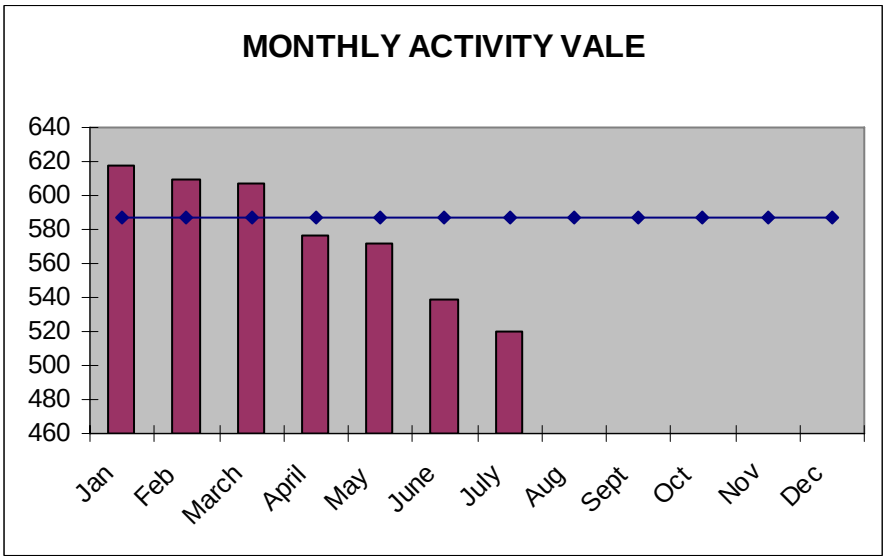


Table 3

Operational impact

To measure the impact that the redesign will have on the Scottish Ambulance Service Patient Transport Service (PTS) analysis was carried out by the performance and planning department of the SAS along with GG&C planning department.

The result of this is that there was expectation that 80% of patients who travel to Glasgow or other out of area hospitals would now only require local transport to Vale of Leven. In terms of transport time, it was calculated that the current PTS resources would free up 77minutes per day to be available for additional journeys to and from the RAH. It must also be stated that the remaining 20% would still need transport to out of area hospitals for specialist treatments associated with the identified clinics above.
Therefore there will be no extra PTS resources required for the Vale of Leven redesign. The additional time gained from using resources locally will be used to provide a more efficient service to patients and allow any extra transfers to and from the RAH to be facilitated.

Vale of Leven catchments area A&E demand

The Vale of Leven hospital surrounding area is serviced in the main by three ambulance stations. The Vale of Leven ambulance station based at the Vale of Leven Hospital. Helensburgh ambulance station based in the grounds of the Jeanie Deans unit, Helensburgh and Arrochar ambulance station based in Arrochar town.
The overall ambulance callout demand by post code for the areas responded to by these station locations is displayed in tables 1&2 below.

When a call comes into the Emergency Medical Dispatch Centre (EMDC) the call is triaged by a call taker who questions the caller and takes them through an algorithm to ascertain the severity of the patient requiring the ambulance. Calls are then categorised into emergency, urgent or planned. If a member of the public calls 999 their call will be triaged into category A, B or C. Health care professional's calls will be categorised into emergency, urgent or planned.
There are different descriptions of each category which are described below.

Cat A - Life threatening emergency call for example cardiac arrest

Cat B - Non life threatening emergency call for example broken limbs

Cat C - Non life threatening emergency call for example a swollen foot

Urgent - An A&E ambulance called by another health care professional to attend within a specified time scale. For example abdominal pain to be uplifted within 2 hours.

Routine/Planned - An A&E ambulance called by another health care professional to attend within a specified time scale usually AM/PM. For example admission to a nursing home facility.

Category A life threatening calls are measured by the response time from the second the call is answered with the aim to have an ambulance at the patient as quickly as possible and under 8 minutes 75% of the time. This is a challenging target to meet in some of the rural locations of Scotland.

The Category A performance of each station is listed in table 3. The emergency count is the total emergency calls A, B &C. The category A calls are then filtered out to provide the percentage of category A calls within 8 minutes.

Total calls, emergency, urgent and planned per post code area April 2009-March 2010

Table 1

Vol

Postcode Sector	Count of Calls
G63 0	391
G82 1	720
G82 2	731
G82 3	503
G82 4	922
G82 5	662
G83 0	2066
G83 8	818
G83 9	640
Sum:	7453

Arrochar

Postcode Sector	Count of Calls
FK20 8	93
G83 7	201
G83 8	818
G84 0	410
Sum:	1522

Helensburgh

Postcode Sector	Count of Calls
G82 5	662
G84 7	750
G84 8	835
G84 9	293
Sum:	2540

Total calls, emergency, urgent and planned per post code area April 2010 – August 2010

Table 2

Vol

Postcode Sector	Count of Calls
G63 0	175
G82 1	279
G82 2	290
G82 3	170
G82 4	326
G82 5	299
G83 0	811
G83 8	342
G83 9	270
Sum:	2962

Arrochar

Postcode Sector	Count of Calls
FK20 8	52
G83 7	89
G83 8	342
G84 0	168
Sum:	651

Helensburgh

Postcode Sector	Count of Calls
G82 5	299
G84 7	314
G84 8	326
G84 9	114
Sum:	1053

Category A response form 1st April 2010 to 31st August 2010

Table 3

VALE OF LEVEN

	April	May	June	July	August	Total
Emergency Count	310	442	416	414	394	1976
Cat A Incidents	91	153	135	113	118	610
Cat A In Performance	75	132	105	100	86	498
Cat A Performance	82.42%	86.27%	77.78%	88.50%	72.88%	81.64%

ARROCHAR

	April	May	June	July	August	Total
Emergency Count	90	171	59	35	33	388
Cat A Incidents	27	51	21	4	7	110
Cat A In Performance	17	37	10	4	4	72
Cat A Performance	62.96%	72.55%	47.62%	100.00%	57.14%	65.45%

HELENSBURGH

	April	May	June	July	August	Total
Emergency Count	191	182	214	271	138	996
Cat A Incidents	56	62	55	77	27	277
Cat A In Performance	43	47	38	58	15	201
Cat A Performance	76.79%	75.81%	69.09%	75.32%	55.56%	72.56%

Greater Glasgow & Clyde NHS Board

Board Meeting
22nd June 2010

Paper No. 10/24

Proposed Capital Plan 2010/11 – 2012/13

RECOMMENDATION

Members are asked to:

- Note the total allocations of Capital Funds for 2010/11 approved by the Performance Review Group on 18th May 2010;
- Note the current indicative allocations for 2011/12 and 2012/13;
- Delegate, to the Capital Planning Group, the authority to allocate any additional available funds against the 2010/11 capital plan throughout the year.

1 INTRODUCTION

1.1 The Performance Review Group (PRG), considered and approved the Board's Capital Plan 2010/11, and noted indicative allocations for funding in 2011/12 and 2012/13, at a meeting on 18th May 2010. This paper provides Board members with a high level overview of the approved capital plan.

1.2 During 2009/10, the Board has worked with SGHD colleagues to confirm the level of capital funding which is likely to be available for the period 2010/11 and beyond. These discussions have enabled the Board to agree with SGHD a firm capital funding allocation against which it can plan for 2010/11 and indicative allocations which it is reasonable to anticipate for 2011/12 and 2012/13. It should be noted that these capital funding allocations are considerably lower than those that had been forecast in presenting the previous year's Capital Plan. These are shown in Table 1, in Section 2 of this paper.

While general funding allocations are reduced, SGHD has confirmed its commitment to fund the £841.7m new South Glasgow Hospitals and Laboratory development.

1.3 In tandem with these discussions, a series of detailed reviews of the Board's existing capital programme have been undertaken to identify how this could be

reprioritised and rephased where appropriate to manage expenditure within likely capital funding availability.

1.4 The purpose of this paper is to set out outline plans of how the Board would seek to deploy its prospective allocation of capital funds in 2010/11 and also to set out indicative plans on how the Board plans to deploy its prospective allocations of capital funds in 2011/12 and 2012/13. The levels of available capital funding assumed for 2011/12 and 2012/13 have been discussed with SGHD and agreed to be realistic estimates which can be used for planning purposes. Firm allocations for 2011/12 and 2012/13 will not be confirmed until the outcome of the next Spending Review is known, which is anticipated to be in late Autumn 2010.

1.5 Subject to final audit review, net capital expenditure in 2009/10 amounted to £329.044m against a Capital Resource Limit (CRL) of £329.047m. As a result of this modest underspend of £3,000, the Board has met the requirement to operate within its Capital Resource Limit as set by SGHD for 2009/10.

Note:
In a previous paper which was presented to PRG in May 2009, (i.e. the paper which sought approval for the Board's 2009/10 Capital Plan), it was explained that with effect from 1st April 2009 all NHS Bodies were required to adhere to the requirements of International Financial Reporting Standards (IFRS). One of the effects of conversion to IFRS is that expenditure on a number of capital schemes, i.e. those funded by the Government's Private Finance Initiative (PFI), is no longer classified as revenue but reported as capital expenditure against the Board's Capital Resource Limit. The impact of this change is included within the reported outturn for 2009/10, also in the Board's CRL, which has been adjusted by SGHD by an equivalent amount to take account of the conversion to IFRS.

2 AVAILABLE CAPITAL RESOURCES

2.1 The table below summarises the level of capital funding which SGHD has confirmed for 2010/11 together with indicative capital funding for 2011/12 and 2012/13.

Table 1 – Anticipated Capital Resources	**Firm 2010/11 £'000**	**Indicative 2011/12 £'000**	**Indicative 2012/13 £'000**
National Formula Capital Allocation	£83,887	£73,038	£66,202
Medical Equipment Allocation	£7,874	£7,874	£7,874
Primary care Modernisation Programme (PCCPMP)	£16,000	£5,040	£5,494
IT Patient Management System (PMS)	£4,700	-	-
Other specific IT Schemes	£3,988	-	-
Radiotherapy Equipment Replacement	£3,608	-	-
New South Glasgow Hospitals development	£61,100	£161,700	£257,900
Balance of funding carried forward from 2009/10, agreed with SGHD	£10,951	-	-
Other Capital Funding Sources	£808		
Total Capital Resources	**£192,916**	**£247,652**	**£337,470**

2.2 The National Formula Capital and Medical Equipment allocations for 2010/11 reflect the figures contained within the funding confirmation letter received from SGHD, dated 22nd March 2010. The remaining anticipated allocations for 2010/11 have been confirmed with SGHD's Deputy Director, Capital Planning and Asset Management. Some of these have been formally confirmed as noted in paragraphs 2.4 – 2.6 below.

2.3 The anticipated levels of capital funding in 2011/12 and 2012/13 are based on discussions with SGHD colleagues, as explained in paragraph 1.2 above, and can be regarded as indicative at this stage, pending the outcome of the forthcoming Spending Review.

2.4 The anticipated funding allocation for the Primary & Community Care Premises Modernisation Programme (PCCPMP) in 2010/11 reflects the bid submitted by the Board in December 2008, which was confirmed by SGHD in a letter of 9th February 2009. PCCPMP funding noted for 2011/12 and 2012/13 is included only as an indicative allocation at this stage and is matched by a corresponding expenditure provision.

2.5 The funding allocation for IT PMS in 2010/11 of £4.7m relates to the purchase of licences for NHSGGC as part of a national scheme.

2.6 The remaining allocations for specific IT schemes have been confirmed by SGHD in letters of 16 April and 5 May 2010.

3 PROPOSED CAPITAL PLAN

3.1 The Board's Capital Planning Group has reviewed its capital programme and updated this to reflect anticipated capital funding levels for 2010/11 to 2012/13.

Table 2, below, summarises the outcome of this review, setting out an updated capital expenditure plan, incorporating proposed Capital Schemes across Acute Services, Acute Services Strategy, New South Glasgow Hospitals, ICT, Board and Partnerships including Mental Health.

Table 2 – Summary of Proposed Capital Schemes	**2010/11 £'000**	**Indicative 2011/12 £'000**	**Indicative 2012/13 £'000**
Acute Schemes – Directorates	£39,097	£24,367	£13,885
Acute Schemes – Other (Local Formula and Medical Equipment Allocation)	£17,849	£19,874	£19,874
Acute Strategy – Acceleration Schemes	£26,172	£2,000	-
Acute Strategy – Main Schemes and Enabling Works	£14,780	-	£1,500
New South Glasgow Hospitals	£61,225	£161,700	£257,900
ICT Schemes	£16,923	£6,620	£2,000
Board Schemes	£9,639	£4,049	£3,849
Partnerships and Mental Health Schemes	£25,165	£42,995	£25,004
TOTAL	**£210,850**	**£261,605**	**£324,012**

3.2 An amount of £8.862m is included within "Acute Schemes – Other" in respect of the Acute Division's local formula allocation. Similarly, an amount of £1.951m is included within "Partnerships and Mental Health Schemes" in respect of local formula allocations. These allocations take account of slippage and acceleration of spend in 2009/10. Local formula allocations allow for expenditure on minor works, normally of an estates/building nature. These works are normally of a value less than £500k, such as minor building upgrades/refurbishments. Bids for funding in excess of £500k would be considered by the Capital Planning Group before receiving specific approval. Other priorities that this allocation would cover are "Invest to Save" schemes, Infection Control, Fire Precautions, Health & Safety, Road Improvements, Flooring Upgrades and the requirements of the Disability Discrimination Act. Local formula capital allocations for 2010/11 have been scaled back by approximately one third relative to 2009/10, reflecting the reduced availability of capital funding in 2010/11 compared to previous years.

New South Glasgow Hospitals and Laboratory Funding (NSGH)

3.3 As noted in paragraph 1.2, SGHD has confirmed that the full budget of £841.7m for the New South Glasgow Hospitals and Laboratory development remains available.

3.4 NSGH funding and expenditure is currently forecast at £61m for 2010/11. This will be closely monitored during the course of the year, to confirm that the phasing of capital expenditure and funding availability is synchronised.

Financial Summary

3.5 The table below summarises the financial position of the Capital Plan for the three years 2010/11 to 2012/13:

Table 3: Summary Consolidated Three Year Capital Plan – 2010/11 to 2012/13	2010/11 £'000	Indicative 2011/12 £'000	Indicative 2012/13 £'000
Estimated Available Resources (Table 1)	£192,916	£247,652	£337,470
Forecast Capital Expenditure (Table 2)	£(210,850)	£(261,605)	£(324,012)
Anticipated Slippage – 2010/11	£17,934	£(17,934)	-
Anticipated Slippage – 2011/12	-	£31,887	£(31,887)
Surplus/(Deficit) on Capital Programme	**£0**	**£0**	**£(18,429)**

3.6 As explained above, a series of reviews of the Board's capital programme have been carried out during the past twelve months, including detailed reviews of the forecast expenditure profiles for all capital schemes.

The output of this process is summarised in Table 3 above, and forecasts a level of over-commitment rising to £32m in 2011/12, reducing to £18.4m by 2012/13.

Notwithstanding the detailed review process which has been carried out and the reduced scale of the Board's general capital programme, it remains reasonable to anticipate that there will still be capacity for some slippage to occur on an annual basis. For this reason, as noted in Table 3, a provision for slippage has been incorporated into the Board's Capital Plan. In the context of the Board's overall capital programme it is felt that a cumulative anticipated slippage figure of £32m, by the end of 2011/12, split broadly evenly over the next two years, should be manageable by phasing expenditure during March/April.

Monitoring Arrangements

3.7 Expenditure on all capital schemes will be monitored throughout the year and reported to the Capital Planning Group to allow for the required decisions to be made to ensure that a balanced capital position is achieved. In addition, it should be noted that the figures contained within the plan for 2011/12 and 2012/13 remain indicative at this stage and will also be reviewed by the Capital Planning Group on an ongoing basis.

4 CAPITAL PLANNING PROCESS

4.1 The Capital Planning Group continues to meet at least every quarter, with additional extraordinary meetings as required, in order to monitor progress with the plan ensuring sufficient connections are made with the work of joint planning groups

established with Local Authority partners. The CPG also continues to ensure that required actions under the Design Action Plan are progressed.

5. RECOMMENDATION

Members are asked to:

- Note the total allocations of Capital Funds for 2010/11 approved by the Performance Review Group on 18th May 2010;
- Note the current indicative allocations for 2011/12 and 2012/13;
- Delegate, to the Capital Planning Group, the authority to allocate any additional available funds against the 2010/11 capital plan throughout the year.

Appendix 2

NHS Highland

Argyll & Bute CHP
c/o Hartfield Clinic
Latta Street
Dumbarton
G82 2DS

Nicola Sturgeon MSP
The Scottish Parliament
Edinburgh
EH99 1SP

Date 6 August 2010
Your Ref
Our Ref WB/LF

Enquiries to Lorna Fitzpatrick
Direct Line 01389 812334
Email lorna.fitzpatrick@ggc.scot.nhs.uk

Dear Cabinet Secretary

The Vale Monitoring Group met last week. It received a detailed report on the fire at the Christie Ward earlier in the month. No doubt you will also have been fully briefed.

The Group gave considerable consideration to the future provision of in-patient mental health beds at The Vale of Leven Hospital.

Importantly, it believes that it must have all the options for re-provision set out for it, that it must be afforded the opportunity to propose further options (and have them rigorously explored), to be allowed to comment on all the options and to have its views fully taken into account by the Board of Greater Glasgow and Clyde Health Board when it takes any decision on the subject. It follows that The Group takes no decision before the Group is able to express its comments upon all the options.

It would be very helpful if you would encourage The Greater Glasgow and Clyde Health Board to take this approach.

However, through discussion The Group came to the conclusion that the fire, having effectively destroyed the current Christie Ward, the whole issue of the provision of in-patient mental health beds for people in the Vale's catchment area needs to be re-visited. The lay members of The Group therefore believe that the issue should be approached from a new beginning, that the elements of *The Vision,* relating to mental health in-patient provision be set aside and that your qualified approval for the closure of the Christie Ward be set aside.

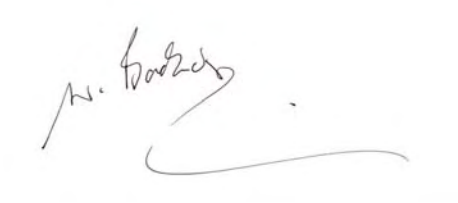
The lay members believed that this fresh approach would allow for the identification of a safe, sustainable and affordable way forward for the provision locally of in-patient mental health services.

Headquarters: Assynt House, Beechwood Park, INVERNESS IV2 3BW

Chair: Garry Coutts
Chief Executive: Dr Roger Gibbins BA MBA PhD
Highland NHS Board is the common name of Highland Health Board

The Group asks that I invite you to agree that this “fresh approach” is the best way forward and to ask Greater Glasgow and Clyde to take this approach. In this way, it is very possible that some good will come out of a very unfortunate incident.

Yours sincerely



W Brackenridge
Chairman
Vale Monitoring Group

Deputy First Minister & Cabinet Secretary for Health and Wellbeing
Nicola Sturgeon MSP

T: 0845 774 1741
E: scottish.ministers@scotland.gsi.gov.uk

Appendix 3

The Scottish Government

Mr Bill Brackenridge
Chairman
Vale of Leven Monitoring Group
Argyll & Bute CHP
c/o Hartfield Clinic
Latta Street
Dumbarton
G82 2DS

Your ref: WB/LF
16 August 2010

Dear Bill

Thank you for your letter of 6 August on behalf of the Vale of Leven Monitoring Group concerning the next steps in relation to the future of local inpatient mental health services, in light of the recent fire at the Christie Ward. I remain grateful to the members of the Monitoring Group for their continuing efforts to represent local stakeholders during the implementation of the important *Vision for the Vale*.

I was, of course, shocked and deeply saddened to learn of the fire at the Christie Ward on 11 July. I wrote to the ward staff shortly afterwards to pay tribute to their calm but rapid actions which I understand were instrumental in avoiding potentially very serious consequences; and ensured the safety of local patients.

The fact that the ward is no longer operational will clearly affect the way both the Greater Glasgow & Clyde NHS Board and Monitoring Group take forward their roles in relation to providing me with a further report on local demand for inpatient mental health services. I can therefore fully understand why the Group has asked you to write to me on their behalf. I would certainly agree that the Board should be prepared to discuss all reasonable options with the Monitoring Group in the first instance.

I am aware that the Board has been sharing data on the local demand for inpatient mental health services with the Monitoring Group since its inception; and that, in recent months, this has been at or around the level of 12 beds that I had previously acknowledged as being clinically unsustainable in the longer term. I should be clear that I remain of this view and am not minded to instruct NHS Greater Glasgow & Clyde to fully revisit their mental health strategy. I do, however, think it is reasonable for the Group to expect that the local demand for inpatient beds continues to be monitored over a longer period in order to establish a meaningful trend. I also think such an extended period, of around 8-10 months, would allow the Group to monitor the efficacy of the enhanced community-based services put in place by the Board.

I acknowledge that this extension in monitoring timeline will result in some calls locally for inpatient mental health services to be re-established at the Vale in the interim. The Board will be presenting further information on what this would involve to the Monitoring Group at the meeting on 30 August. NHS Greater Glasgow & Clyde has already shared the results of its initial feasibility studies with the Health Directorates and, having carefully considered the clinical, financial and logistical impediments involved, I am of the view that there are compelling arguments to support the view that the interim repatriation of the service is not in patients or local people's interests. The Monitoring Group will, however, wish to talk all of this through with the Board at the 30 August meeting.

I am happy to reiterate my expectation that the NHS Board fully involve the Monitoring Group as this work is taken forward and would like to once again thank the Group for their continuing efforts.

NICOLA STURGEON