

Greater Glasgow NHS Board



NHS Board Meeting
19th December 2006

Board Paper No. 06/71

Director of Acute Services Strategy Implementation and Planning

Clinical Strategy – South Clyde Acute Services

Recommendation:

The Board is asked to:

- Note the attached consultation documents relating to the delivery of acute hospital services at the Inverclyde Royal Hospital (IRH) and the Royal Alexandra Hospital (RAH)
- Note that the consultation period will run from 8th December 2006 to 2nd February 2007.

A. BACKGROUND AND PURPOSE

- 1.1 Attachment 1 to this paper is the full consultation document outlining the future strategy for acute services at the IRH and RAH.
- 1.2 Attachment 2 to this paper is the summary consultation leaflet which will be distributed widely in the IRH and RAH catchment areas.
- 1.3 The consultation period will run from 8th December 2006 to 2nd February 2007. This consultation period has been agreed with local people and patient representatives and also with the Scottish Health Council.
- 1.4 The formal strategy document will be discussed at the February board meeting before being sent to the Minister for Health for a decision.
- 1.5 Key messages contained in the consultation documents are that:
 - 1.5.1 Accident and Emergency Services will be retained on both sites
 - 1.5.2 Core emergency medicine, surgery and trauma and orthopaedic services will be retained on both sites.
 - 1.5.3 There will be some changes to sub-specialties on both sites
 - 1.5.4 We project that less than 500 inpatients from the IRH and less than 900 inpatients from the RAH will be affected by our proposed changes.
 - 1.5.5 This equates to less than 2% of total inpatient admissions
- 1.6 The document clearly highlights the areas on which we are not in a position to consult. These include:
 - 1.6.1 Acute services for the population North of the Clyde
 - 1.6.2 Maternity services
 - 1.6.3 Mental Health services
 - 1.6.4 Clinical and non-clinical support services

A Safe and Sustainable Future for Hospital Services in Inverclyde and Renfrewshire

This leaflet describes proposed changes to services delivered from Inverclyde Royal Hospital and the Royal Alexandra Hospital and lets you know how to put forward your views.



Foreword

NHS Greater Glasgow and Clyde took responsibility for Inverclyde Royal Hospital and the Royal Alexandra Hospital in April 2006.

At that time we made a commitment to review work done by our predecessor organisation, NHS Argyll and Clyde, and cast a fresh eye over the way services are provided at both hospitals.

This leaflet, and the consultation it supports, helps us keep our word that we would complete our review before the end of 2006. We have also kept our minds open about the way forward for the hospitals and we think the proposals set out here:

- ensure services are maintained locally where it is safe and sustainable to do so;
- take account of the needs of patients in accessing services;
- are built around the whole 'patient journey' from community-based services to hospital and back again.

Our proposals are very different from those put forward by the former NHS Argyll and Clyde and we hope that you will regard them as positive, constructive and realistic. We are also delighted – after seven years of debate – to offer the prospect of certainty about the future of the two hospitals.

We value your opinion and would welcome any comments you would wish to make. You can find out how to go about doing this on the last page of this leaflet.

I very much look forward to hearing what you think.

Dr Liz Jordan

Associate Medical Director for Clyde
NHS Greater Glasgow and Clyde
8th December 2006

Introduction



In 2004, after years of consultation and development, the former NHS Argyll and Clyde proposed a strategy for hospital services that would have brought a virtual end to inpatient care (for patients who need to stay overnight or longer in a hospital bed) at Inverclyde Royal Hospital (IRH). Between 27,000 and 37,000 patients would have to have travelled instead to the Royal Alexandra Hospital (RAH) in Paisley. The care remaining at IRH would have been concentrated on providing outpatient and daycase services (routine procedures or examinations that can be provided in a single or a series of single appointments) only.

NHS Argyll and Clyde was not able to confirm its strategy before it was split up by the Minister for Health and Community Care on 31st March 2006.

On taking responsibility for healthcare in Renfrewshire and Inverclyde, NHS Greater Glasgow and Clyde committed itself to reviewing the previous NHS Board's strategy and to seeking possible new alternatives. We also recognised that Inverclyde Royal Hospital provides services to the Argyll and Bute and North Ayrshire communities and that it was important that we considered these patients.



NHS Greater Glasgow and Clyde's review

Our review is based on trying to find ways of maintaining services locally wherever possible – both at the IRH and the RAH. We have spent a great deal of time checking how many patients access both hospitals and whether their 'patient pathway' is via referral from their family doctor or other community-services or on the basis of emergency and urgent care. We now have a better understanding of who our patients are and the types of services they need to use.

In doing this we have met with service planners, doctors and nurses, managers, medical staff and trade unions so we can better understand the pressures faced by the hospitals. We worked with them to find constructive solutions to some of the problems that we identified through the course of this work.

We have also taken the time to meet with local community and patient representatives to get their feedback before we launched this consultation.

Why there has to be change

Our first conclusion is that there are very good reasons why hospitals need to change – the question is what the change should be.

There are a number of important issues that make changes to some services unavoidable:

- Changes to the working hours (due to a European Directive) and contracts of consultants and junior doctors – this means both sets of staff have less time to spend with patients;
- New national training arrangements being introduced which mean that senior staff need to spend more time teaching and junior staff more time learning;
- Improving technology and medical knowledge mean that individual staff can't cover all the knowledge required – staff have to specialise in certain areas and the best way to ensure fair and efficient access to specialist services is to concentrate staff in fewer locations;
- Recruitment and staffing issues at the IRH in particular – we have to plan ahead for the retirement of certain key staff now. There is a lot of difficulty in recruiting qualified medical staff across Europe at the moment and we will have to find different options to keep certain services viable and safe;
- Inherited overspending from the former NHS Argyll and Clyde – services in Clyde cost £30 million a year more to run than we receive to provide them. The Scottish Executive has written off the historical debt and provided money up until March 2009 to give us time to get back into financial balance. But the clock is ticking and we need to find solutions quickly that don't compromise patient care if we are to get services onto a firm footing for future planning and development.

Our main conclusions

Even though many of these difficult problems are faced by every hospital in the country, we think we have found solutions that are radically different from NHS Argyll and Clyde's proposals.

We think that we can:

- maintain Accident and Emergency services at the IRH and RAH without change;
- maintain the vast bulk of inpatient services at the IRH and RAH without change;
- leave virtually all outpatient and daycase services untouched.

However, we do think we will have to make small changes to five specialist services – Ear, Nose and Throat (ENT), Dermatology (skin conditions and diseases), Ophthalmology (conditions and diseases of the eye), Vascular Surgery (conditions of blood vessels) and Urology (conditions of the "waterworks"). This mainly concerns the movement of inpatient services to new sites in order to provide safe and sustainable access to expert care – otherwise, there is no change to arrangements for routine outpatient and daycase appointments.

By our calculations our proposals would affect less than 900 patients each year at the RAH and less than 500 each year at the IRH. This compares to the many thousands of patients who would have been affected by NHS Argyll and Clyde's previous proposals and should be set against a total of just under 300,000 'patient episodes' at the RAH and 145,000 at the IRH.



Our proposals – The table below sets out what we are proposing and why, as well as comparing the original proposals made by the former NHS Argyll and Clyde

The old proposals made by NHS Argyll and Clyde in 2004		NHS Greater Glasgow and Clyde's new proposals, 8 December 2006			
Option 1	Option 2	What we are proposing	Why	Who would be affected	When the changes would take place
<p>IRH becomes an 'ambulatory care' facility. All A&E, inpatient and emergency care transfers to the RAH. Around 37,000 episodes of patient care would have to have been transferred to the RAH in Paisley.</p>	<p>IRH becomes an 'intermediate hospital' providing a mixture of planned and unplanned (i.e. urgent access) care. A & E services transfer to the RAH. Around 27,000 episodes of patient care would have to have been transferred from the IRH to the RAH in Paisley.</p>	No change to Accident and Emergency (A&E) at the IRH or the RAH.	We believe we can meet pressures around staff recruitment at Inverclyde by closer working between specialists at the IRH, RAH and Glasgow.	No change: – 60,000 patients would continue to be seen at the A&E at RAH – 30,000 patients would continue to be seen at the A&E at IRH.	No change.
		No change to most emergency and planned inpatient (overnight) care at the IRH and the RAH.	Most care can be sustained locally by taking the steps outlined above. There will be small changes in some subspecialties as described below.	Very small changes: – IRH: less than 500 patients affected. No change for 15,500. – RAH: less than 900 patients affected from over 38,500.	From August 2007.
		We will continue to offer planned daycase care and outpatient services at RAH and IRH. We will take steps to increase the number of patients we treat as daycases.	We believe it is important that patients are able to access planned daycase and outpatient services at their local hospital.	No immediate change: 13,500 daycases at the RAH, 185,000 outpatient episodes at the RAH, 9,000 daycases at the IRH and 90,000 outpatient episodes at the IRH.	No immediate change.
		IRH – Urology – We will create a team of four consultant urologists who will deliver outpatient and daycase care at both the IRH and RAH but provide 24 hours a day cover at only the RAH, where all inpatient activity will take place.	There is a requirement for patients who need to stay overnight for urological procedures to have access to specialist care. The relatively small number of patients treated, the impending retirement of one specialist urologist consultant and the future retirement of general surgeons with urology experience at Inverclyde make this change inevitable on clinical grounds.	Approximately 300 patients a year who currently receive inpatient care at the IRH will be cared for at the RAH. The average length of stay for this group of patients is three days. Another 3,200 episodes of patient care will continue to be delivered at the IRH as outpatient and daycases.	After October 2007.
		IRH – Vascular Surgery – emergency and overnight planned vascular surgery will be transferred to the Southern General in Glasgow. The vast majority of patients will continue to be treated locally at the IRH.	RAH patients already travel to Glasgow for care. Of two surgeons at the IRH, one is eligible to retire and we believe that in the long term the service cannot be sustained with only one consultant.	50 – 100 IRH patients will need to go to Glasgow for care. Daycase, diagnostic activity, nurse led care and outpatient and follow-up appointments will continue to be delivered locally.	In phases by 2012.
		IRH & RAH – Ophthalmology – if pressures on staff time from new training methods increase, we may have to take the option of creating an out of hours emergency service based in Glasgow.	The time demands from new national training requirements may make it impossible to sustain cover of out of hours (overnight) emergency staff rotas at the RAH and the IRH.	140 IRH and 80 RAH patients may have to travel to Glasgow each year for emergency care. 9,300 and 18,000 non-emergency patients would continue to be treated locally at the IRH and RAH.	After August 2007.
		IRH & RAH – Dermatology – To improve services to patients, our priority is to invest in daycase and outpatient facilities at the RAH (the IRH facilities are good). Inpatient activity for the RAH and IRH catchments is currently delivered from the RAH. We need to undertake further work with clinicians but it is possible that we will need to transfer inpatient activity to the Southern General Hospital.	There is increasing demand for dermatology services, especially for outpatient and daycase care. Despite investing in appropriate facilities to improve patient care, we may be unable to provide the space needed for inpatient care at the RAH. This may mean we need to transfer the relatively small numbers of inpatients to the Southern General Hospital.	Potentially, around 230 inpatients currently treated at the RAH would access care at the Southern General Hospital (of whom 80 are from the IRH catchment area).	Following further costing and examination, after August 2007.
		IRH & RAH – ENT (Ear, Nose and Throat) – Inpatient services are provided across the area from the RAH alone and outpatient and daycase services are provided at both the IRH and RAH. We may need to move a proportion of inpatient cases from the RAH to the Southern General Hospital in Glasgow.	Pressures from national training initiatives on staff time are challenging our ability to provide 24-hour cover. We suggest that it will be possible at the RAH to continue to deal with inpatients who need to stay in hospital less than five days – but, to ensure 'round the clock' cover, patients with a need for a longer period of care may need to go to hospital in Glasgow.	550 inpatients who currently attend the RAH would have to go to Glasgow in future. Around 240 of these patients come from the Inverclyde catchment area. 800 short-stay inpatients would continue to receive care at the RAH and 9,000 and 3,800 outpatients/daycases would continue to receive care at the RAH and the IRH respectively.	After August 2007.

Consultation to follow

This consultation covers only the main acute hospital services at the IRH and the RAH. Separate process has been established with regard to services north of the River Clyde and at the Vale of Leven Hospital and consultation is also planned later in 2007 around Mental Health services and Older People's services.

What would the changes mean?

We think that these proposals offer the prospect of fair and equitable service delivery for local communities and staff alike.

They offer:

- Certainty about the future of the hospital for communities and staff after years of debate;
- A sustainable basis on which to plan and develop the hospitals and the services they provide;
- An ongoing commitment from the NHS Board to two excellent hospitals which will in turn give staff the confidence to stay and develop their careers or come and join from elsewhere;
- New and more flexible patterns of working that will benefit staff and patients;
- The retention of the vast majority of care at the two hospitals – less than 2% of the IRH's and the RAH's hospital admissions would be affected by our proposed changes. Admissions into hospital, whether planned or unplanned, account for less than 20% of total hospital activity and, if we include the activity that takes place at A&E and outpatients, then the changes affect only 0.3% of total patients at the RAH and the IRH.



What do you think?

We are keen to know what you think about our proposals and launched public consultation on 8th December 2006, which is due to finish on 2nd February 2007.

CONSULTATION BOOKLET

If you would like a copy of the detailed proposals and background information, please call 0141 201 4957 during office hours or download it from our website at www.nhsggc.org.uk/southclyde



ALTERNATIVE FORMATS AND LANGUAGES

If you would like the consultation documents in alternative formats such as audio tape, British Sign Language or Braille, or would like translations of the documents in languages other than English, please call 0141 201 4957.

COMMUNITY MEETINGS

We have set up two community meetings – one at the Tontine Hotel, Greenock between 6.30 – 8.00pm on 16th January 2007 and the other between 6.30 – 8.00pm at the Glynhill Hotel, Renfrew on 17th January 2007. The meetings are open to anyone to attend but it would help us to deal with venue arrangements and catering if you could pre-register by calling 0141 201 4957.

We have also arranged afternoon meetings with a range of stakeholder groups from Inverclyde and Renfrewshire. These take place between 1.00 – 2.30pm at the Tontine Hotel, Greenock on 16th January 2007 and between 1.00 – 2.30pm at the Glynhill Hotel, Renfrew on 17th January 2007. If you would prefer to attend a daytime meeting rather than an evening one, you are welcome to come to these afternoon sessions instead. Please call 0141 201 4957 if you would wish to register for the afternoon events.



8 Delivering better health

PATIENT FOCUS GROUPS

Focus group meetings with current and former patients of the five specialties affected by our proposals are being organised in the second and third weeks of January 2007. Please call 0141 201 4957 if you would like more information.

PUTTING FORWARD YOUR POINT OF VIEW

If you would like to put forward a formal response to the consultation, you can either:

Write to – John Hamilton
Head of Board Administration
NHS Greater Glasgow and Clyde
Dalian House
350 st Vincent Street
Glasgow G3 8YX

or email – southclyde@ggc.scot.nhs.uk

**The closing date is for comments is
Monday, 2nd February 2007 at 5pm.**





Delivering better health

www.nhsggc.org.uk

Acute Hospital Services

Royal Alexandra Hospital and Inverclyde Hospital

December 2006

Consultation Document



1. Introduction

1.1 This strategy describes the hospital services that will be delivered from the Royal Alexandra Hospital (RAH) in Paisley and the Inverclyde Royal Hospital (IRH) in Greenock in future. When NHS Argyll and Clyde was formally dissolved on 31st March 2006 responsibility for the provision of services within the Clyde geographical area passed to NHS Greater Glasgow. In April 2006, the renamed NHS Greater Glasgow and Clyde committed to revisiting the Clinical Strategy that had been developed by NHS Argyll and Clyde and to developing proposals which outlined the services that would be provided at the Inverclyde Royal Hospital and the Royal Alexandra Hospital in future. The aim was to formally present the public with these proposals by the end of December 2006. This strategy document outlines our proposals.

1.2 It proposes a very different approach from the previous strategy developed in 2004 by NHS Argyll and Clyde. In this strategy we outline that Accident & Emergency and core inpatient services such as emergency medical services, emergency surgical services and emergency trauma and orthopaedic services will be sustained at both the Inverclyde Royal Hospital and the Royal Alexandra Hospital.

1.3 Whereas the previous strategy would have resulted in between 27,000 and 37,000 patients transferring from Inverclyde to the Royal Alexandra each year, in this strategy less than 500 patients will need to transfer from IRH to the RAH or to Glasgow and less than 900 patients may need to transfer from the Royal Alexandra Hospital to Glasgow. However, just over 300 of these 900 patients currently travel from the Inverclyde catchment area to Paisley to access hospital services so we believe that the changes we propose will affect less than 600 patients from the RAH catchment area. This document clearly sets out why we believe that for these patients accessing services in Glasgow is the best option.

1.4 This strategy does not specifically outline the service developments that we propose in relation to cancer services but we believe that by developing services at the RAH we will enable many patients from the RAH catchment who currently travel to Glasgow for treatment, to be treated locally. Similarly, we aim to invest in the facilities at both the IRH and the RAH hospitals to increase the number of patients we are able to treat. This will enable some of the patients who are currently treated at the Golden Jubilee Hospital in Clydebank to be treated at their local hospital. We anticipate that the number of extra patients that we will be able to treat at their local hospital as a result of these developments will be greater than the number of patients that will experience change based on the proposals outlined in this strategy.

1.5 It is the aim of this strategy to be transparent with patients and the public. We will be clear on what areas we think need to change, why we think they need to change and the number of patients that we think will be affected by the changes. We will also be clear about those areas on which we currently are not ready to consult but which we will come back to during 2007.

1.6 There are several reasons why we feel it is important that we launch this strategy document now:

- Patients, staff and the public, particularly in Inverclyde, Cowal and Bute, have faced several years of uncertainty. This strategy commits to retaining the major hospital services at Inverclyde Royal Hospital and should resolve this uncertainty. When we met with members of the public as part of our pre-consultation engagement work

they emphasised that the sooner we were able to provide them with certainty the better.

- The work we have undertaken to date highlights that only small service changes will be required. We wanted to inform the public as quickly as possible of these.
- We committed to developing a strategy for hospital services by the end of 2006.
- Providing certainty for the services that will be delivered on the RAH and IRH sites allows us to begin to take forward the service redesign work that will be essential in allowing us to begin to tackle the significant financial pressures that exist.
- Providing certainty for the hospital services allows us to make progress on improving the way that our hospitals work with our community services.

2. Purpose of Consultation Document

2.1 NHS Greater Glasgow and Clyde has undertaken a comprehensive review of acute services delivered at the RAH and the IRH. The focus of the review has been on trying to find ways to ensure that the majority of services can be sustained locally within both the Inverclyde Royal Hospital and the Royal Alexandra Hospital catchment areas. This has involved service planners working with frontline clinical staff, managers, lead clinicians and staff side partners to understand the key pressures faced at both hospitals. We have also discussed the work undertaken to date with members of the public.

2.2 The purpose of this document is to outline the changes that we propose to a small number of acute hospital services and to describe what impact these will have on patients. It also outlines how people can provide feedback on our proposals. As part of the consultation process we will be holding a series of events where you can hear our proposed strategy and have the opportunity to ask questions and offer views. Details on how to contact us are provided on the back page of this document.

2.3 The work in reviewing the Strategy for Acute Services has been part of a broader programme of review which we have taken forward over the past eight months. That work has involved the development of other major service strategies and the crucial task of addressing and resolving the revenue deficit of £30.5m which we have inherited. Achieving a return to financial balance in three years will both cement our proposals for sustaining and improving clinical services and create a platform of financial stability from which we can look forward constantly to investing in further service enhancement in the years ahead. These include:

- Mental health services;
- Older peoples services;
- Maternity services;
- Support services – including laboratories, haematology and non-clinical support services such as laundry and catering services;
- Services for those patients served by the Vale of Leven hospital. Working with public health colleagues from NHS Highland we will be undertaking a detailed health needs assessment for the Vale of Leven patients. Based on this assessment we will explore all options for the delivery of health services to these patients and develop a service strategy.

2.4 We intend to develop proposals for the above areas by Summer 2007. If these propose significant service changes for patients we will consult with the public and patients.

3. Current Services at IRH and RAH

3.1 Both the Royal Alexandra Hospital and the Inverclyde Royal Hospital offer a wide range of services to large numbers of patients. These include Accident and Emergency (A&E) departments and emergency receiving services (which deal with those patients who require to be admitted into hospital in an emergency). In broad terms the types of patients who access hospital services can be separated into four main categories. Firstly we have patients who attend A&E. Secondly, we have patients who require to be admitted into hospital on an unplanned or emergency basis. Thirdly, we have patients who require treatment which has been planned. Finally, we have patients whose contact with hospital is on an outpatient basis. Obviously, one individual could have a contact with the hospital in each of these ways over the course of a year but the demands placed on services are quite distinct in each of these categories.

3.2 The number of patients who attended the RAH and the IRH in the 12 months from April 2004 to March 2005 in each of these categories is highlighted in the table below.

Table 1: 2004-05 Activity RAH and IRH

	Royal Alexandra	Inverclyde Royal
Accident and Emergency	60,000	30,000
Unplanned admissions	32,000	12,500
Planned admissions	20,350	12,500
Medical led outpatients	185,000	90,000

3.3 The catchment population for the Royal Alexandra Hospital is approximately 200,000. The catchment population for the Inverclyde Royal Hospital is approximately 120,000 of which around 90,000 live in the Inverclyde council area. There are significant numbers of patients from the North Ayrshire and Argyll and Bute communities for whom Inverclyde Royal is the local hospital.

3.4 The Royal Alexandra Hospital also provides accident and emergency and some planned and unplanned services to the Vale of Leven catchment area.

4. Drivers for change / key pressures

4.1 There are a number of pressures on hospital services in Scotland and across the UK. These pressures have been clearly outlined in a number of previous consultation documents circulated to patients and the public. The strategy we propose in this document is based on the belief that for the Royal Alexandra and Inverclyde Royal Hospitals we will be able to find ways to meet these pressures and that meeting them will allow us to sustain the overwhelming majority of services locally. For this reason, this document will not outline the pressures faced in great detail. However, it is important that we summarise these pressures as they are fundamentally important in understanding the context in which this strategy exists.

4.2 The general pressures include:

- **The changing population and changing healthcare needs.** It is projected that over the next decade the population served by the RAH and the IRH will, as a whole, grow older. This means that there will be greater numbers of older people who require ongoing health care. It is projected that this will place increased demands on health services. This situation is shared across Scotland and the rest of the UK.

- **Changing clinical practice.** There are constant developments in the way in which care is delivered. Some of these are dependent on new technologies which can improve both diagnosis and treatment of patients but which can be expensive. Others are dependent on the availability of limited numbers of specialist staff. As care becomes more expert in a whole range of areas then it is in the best interests of the patient to have access to the appropriate level of specialist care.
- **The impact of the European Working Time Directive.** By 2009 all staff employed by the NHS will, at most, be able to work an average of 48 hours each week. Currently, many of our staff, and particularly our doctors, work considerably more than this. We need to ensure that we design services that are compliant with new employment legislation.
- **New ways of training doctors.** Modernising Medical Careers (MMC) is the name given to the new way of training doctors. This will have two impacts on our ability to provide services. Firstly, it will mean that junior doctors will spend more time training and less time contributing to the service. Secondly, it will mean that our senior medical staff will spend more time training junior staff. This often affects the number of patients they are able to treat. In six years, however, MMC should mean that we have increased numbers of accredited doctors available.

4.3 In addition to these general pressures, Inverclyde Royal Hospital faces some specific pressures.

- **Forthcoming retirement of consultant surgical and medical staff.** Four of the five full time consultant surgeons will be eligible to retire within the next five years. Three of the eight consultant physicians are likely to retire within the next two years. There are concerns over our ability to recruit to these posts given the limited number of potential applicants and the way in which the jobs are currently structured.
- **Current difficulties in recruiting to consultant radiologist posts.** We currently have five vacancies out of seven posts at Inverclyde. The gap is filled by temporary staff and colleagues from Glasgow.

4.4 Within Clyde we also face considerable financial pressures with current spend approximately 6% greater than allocated funding. As described in the introduction to this strategy, we need to take forward the clinical strategy alongside a robust financial recovery plan to address this deficit.

5. Previous NHS Argyll and Clyde strategy (2004)

5.1 In order to address the pressures described above, NHS Argyll and Clyde developed a clinical strategy in 2004. The strategy proposed that the Royal Alexandra Hospital would become the sole emergency and major inpatient site. As a result of this strategy large numbers of patients would have transferred from the IRH to the RAH.

5.2 The 2004 strategy proposed two possible options for the Inverclyde Royal Hospital. The first option saw the hospital becoming an ambulatory facility which provided all day treatment planned care at Inverclyde and which also hosted a nurse led minor injury unit to deal with less serious emergency cases. In this option there would have been no A&E or emergency receiving (where patients are admitted into a bed) services provided at Inverclyde. This option would have seen around 37,000 episodes of patient care transferring to Paisley.

5.3 The second option was for the Inverclyde Royal Hospital to become an Intermediate hospital. This would have seen a mixture of planned and unplanned care being undertaken

at Inverclyde with A&E services and more serious emergency care being transferred to the RAH. This option would have seen around 27,000 episodes of patient care transferring to Paisley.

5.4 The Royal Alexandra Hospital in Paisley currently operates very close to maximum capacity. In both these options significant development would have been required at the RAH to allow the additional patients to be accommodated.

6. The new strategy proposed by Greater Glasgow and Clyde

6.1 The new strategy proposed by NHS Greater Glasgow and Clyde would see the retention of the overwhelming majority of services currently delivered at the IRH and the RAH. There will be a full Accident & Emergency service at both hospitals and both hospitals will offer emergency receiving services (i.e. emergency hospital admissions) for medical patients, surgical patients and trauma and orthopaedic patients. This means that both hospitals will have intensive care units, coronary care units and high dependency units and will be able to treat patients who arrive by 'blue light' ambulance. Both hospitals will also offer planned inpatient and outpatient care for the full range of existing services.

6.2 These conclusions are the result of a comprehensive and robust programme of work that has been undertaken over the past nine months. A steering group, involving senior management and Clinical Directors (senior doctors) has led the work and overseen the proposals being developed by two groups. The first group was established to focus on the IRH and the second group to focus on the RAH. Both these groups have had involvement from clinicians from all service areas, staff side partners and managers.

6.3 A range of principles underpinned the review and these informed the work of each of the groups. These were that:

- Local services will be maintained locally where safe and sustainable;
- Deprivation and its effects will be considered as part of the strategy;
- Distance and time to access hospital services will be considered;
- A care pathway approach to the planning of services working across the acute and community settings will be considered.

6.4 The groups focussed on identifying the pressures faced within each of the hospitals and developing strategies that will allow us to address these pressures. This was done on a service by service basis and the key results are described below.

6.5 General Surgery, Radiology and General Medicine subspecialties

6.5.1 For General Surgery, General Medicine and Radiology we identified that we have difficulties either in currently recruiting senior medical staff to Inverclyde or we anticipate facing challenges in future. We believe that these challenges can be met through a combination of several actions:

- Firstly, by committing to a clear future for Inverclyde Royal Hospital we believe that clinical and other staff are more likely to want to work there.
- Secondly, for specialist areas where there is a potential for a doctor at the IRH or at the RAH being the only person at the hospital with their particular set of skills we will take steps to ensure that the doctors are able to work as a team across the two sites. In some cases this may potentially also involve working with colleagues in Glasgow. This will help them to maintain and develop their skills. This could also apply to

some of the specialist aspects of general medicine care such as the delivery of specialist diabetic services.

- These actions may result in more of our doctors providing daytime and planned care at both the RAH and IRH hospitals, or working with colleagues in Glasgow.
- By committing to a strong future for Inverclyde and by ensuring that doctors who are based mainly at the IRH are part of specialist teams across Glasgow and Clyde we believe we will be able to recruit high calibre consultant staff. By recruiting these senior medical staff we will be able to retain the emergency, 24 hour cover required to deliver the full range of hospital services.

6.5.2 By taking these steps we believe that this will mean that patients do not have to travel to a different hospital to access these services.

6.6 Accident and Emergency

6.6.1 This strategy proposes that there will be a full A&E service at both the IRH and RAH Hospitals. Accident and Emergency services can be sustained if we are able to provide appropriate 24 hour cover for General Surgery, Radiology, General Medicine and Trauma and Orthopaedic services at both hospitals. By implementing the proposals outlined above we believe we will be able to sustain these services which means we will be able to retain Accident and Emergency services at both sites. This means that the 60,000 people who attend A&E at the RAH and the 30,000 people who attend A&E at the IRH will continue to access these services in the same way as they do currently.

6.7 Services that will need to change

6.7.1 There are a number of specialty areas where we do think that changes to the way in which small numbers of the most complex inpatients are treated will require to be introduced over the coming years. These are Urology, Vascular Surgery, Ear Nose and Throat services, Dermatology and Ophthalmology. These are described in more detail over the following pages. For some of the areas we think that we will need to change the way in which services are delivered to respond to specific pressures around the way doctors are trained. The exact impact of this on services is still being finalised. However, we have highlighted these areas because it is likely that they will need to change in the next five years.

Table 2: Summary of patient numbers affected

	Patients Affected	Current Hospital	Future Hospital	Likely Timescale
Urology	300	IRH	RAH	After October 2007
Vascular	50-100	IRH	Southern General / Glasgow Site	Phased to 2012
Ophthalmology	120	IRH & RAH	Glasgow	After August 2007
Dermatology	230	RAH (includes IRH population)	Southern General	After August 2007
ENT	550	RAH (includes IRH population)	Southern General	After August 2007

6.7.2 In overall terms the impact of these changes is very small. They would mean less than 500 patients from the IRH requiring to access services in the RAH or in Glasgow and less than 900 patients who are currently treated at the RAH requiring to access services in Glasgow. At both hospitals this is less than 2% of the patients who are admitted to hospital and only 0.3% of the total patients treated in the hospital when A&E and outpatient attenders are included. The impact of this on each of the types of care that is currently delivered at both hospitals is shown in the following charts.

Table 3: Impact of proposed changes on Inverclyde Royal Hospital

	Current Patients	Patients Affected	No Change
Accident and Emergency	30,000	0	30,000
Unplanned (emergency) admissions	12,500	250	12,250
Planned admissions	12,500	250	12,250
Outpatients	90,000	0	90,000
Total	145,000	500	144,500

Table 4: Impact of proposed changes on the Royal Alexandra Hospital

	Current Patients	Patients Affected	No Change
Accident and Emergency	60,000	0	60,000
Unplanned (emergency) admissions	32,000	680	31,320
Planned admissions	20,000	180	19,820
Outpatients	145,000	0	145,000
Total	297,000	860	296,140

6.7.3 More detail on each of the specialty areas which where changes will need to be made, including why they need to change and what impact this will have on patients, is outlined on the following pages.

6.8 Urology

6.8.1 Urology is the specialty that focuses on the urinary tracts of males and females and on the reproductive systems of males. There are currently 5.5 whole time equivalent general surgeons at the IRH. (5 full time surgeons and 1 part time surgeon.) One of the 5 surgeons is accredited both as a urologist and as a general surgeon and this means that as well as undertaking general surgical duties he is able to lead the urological service at the IRH. There are three urologists at the RAH, in addition to the team of general surgeons, and these three urologists provide emergency urological cover 24 hours a day for the RAH population.

6.8.2 Why does the service need to change?

To ensure that patients receive the best possible care it is important that emergency urological inpatients, and also patients who are having planned major urological procedures

that will require a stay in hospital, have access to a dedicated urology service 24 hours a day. The urologist at the IRH will retire within the next three years. It will not be possible to recruit a urologist who is also able to take part in the general surgery rota as this type of clinician is no longer available. In addition, currently at the IRH the general surgeons are able to deal with the very small numbers of patients with urology problems out of hours. This is why 24 hour a day urological cover is not currently required at the IRH. As these general surgeons retire over the next five years they will be replaced by consultants who are extremely unlikely to have this urological experience. It will not be possible, or legal in relation to the EWTD, for us to attempt to recruit a urologist to the IRH to work single-handedly to provide 24 hour cover. This means that we need to provide a different model of urological service.

6.8.3 How do we intend to change it?

We intend to create a four person consultant urologist team to lead the urology service. This team will undertake daycase, outpatient and minor planned work at both the RAH and IRH hospitals. The emergency urological service and the major planned care will be undertaken from the RAH site.

6.8.4 What will this mean for patients?

This will mean that around 300 patients who are currently treated at Inverclyde each year will in future be treated at the RAH site. This is important for patients as it means they will have access to a dedicated urology service 24 hours a day. These patients generally stay for relatively short periods with the average length of stay being just over 3 days. We anticipate that of these 300 patients, 100 will be emergency admissions and 200 will be planned admissions. The vast majority of urology services for the Inverclyde catchment will still be delivered at Inverclyde and the 300 patients who will require to transfer should be seen in the context of the 3500 episodes of patient care that are undertaken by the urology service at IRH each year. In overall terms this therefore relates to less than 10% of the urology activity that takes place at the IRH requiring to transfer.

6.9 Vascular Surgery

6.9.1 Vascular surgery is a branch of surgery that deals with surgical interventions on arteries and veins. Vascular surgical services for patients in the RAH catchment are currently delivered from hospitals in Glasgow. For IRH patients the majority of vascular services are currently delivered locally. The majority of activity is daycase, outpatient, follow-up, investigations or minor planned procedures but there are small numbers of major planned cases and emergency admissions currently treated at the IRH. Two of the five surgeons who provide the emergency service at the IRH are specialised in vascular services. If these surgeons are available to provide the emergency service (an average of two nights out of every five) then patients admitted with emergency vascular needs are treated at the IRH. If these surgeons are not available then the patients are transferred to the Southern General. Currently, approximately 10 patients are transferred to the Southern General each year.

6.9.2 Why does the service need to change?

It is important that patients who require major vascular procedures have access to the appropriate level of specialist care. One of the two surgeons at the IRH who is trained in vascular work will be retiring within the next 9 months. This will mean that only one surgeon trained in vascular procedures will remain at IRH. Whilst this surgeon will work with

colleagues in Glasgow to ensure that he remains appropriately skilled we do not believe that it is sustainable in the long term to have only one vascular surgeon at the IRH. The forthcoming retirement will also mean that more patients need to transfer to the Southern General to access services.

6.9.3 How do we intend to change it?

Between 2007 and 2012 we will begin to transfer the emergency and major planned vascular service to one site across Greater Glasgow and Clyde. This will ensure that all patients are treated in an appropriate specialist environment.

6.9.4 What will this mean for patients?

This will mean that between 50 and 100 patients who currently access emergency and major planned vascular services at the IRH will need to be transferred to Glasgow. The vast majority of vascular activity undertaken at the IRH will continue to be undertaken locally and this will ensure that the vast majority of vascular care currently delivered within Inverclyde will be retained. This will include the outpatient service, the daycase service, nurse led services and the support services.

6.10 Ophthalmology

6.10.1 Ophthalmology is the specialty which deals with the diseases of, and surgery on, the eye. Currently the ophthalmology service operates one integrated out of hours rota across Clyde. This means that very small numbers of out-of-hours patients sometimes require to transfer both ways between the RAH and the IRH. Monday to Friday, 9 - 5 both the IRH and the RAH offer an emergency receiving service and there are also emergency clinics delivered locally on both a Saturday and Sunday – these are delivered by junior medical staff.

6.10.2 Why may the service need to change?

The main driver for change within ophthalmology is Modernising Medical Careers. Whilst the exact arrangements for Modernising Medical careers are still to be finalised we anticipate that changes to the way junior doctors are trained will have two impacts on the ophthalmology service. Firstly, it is likely that there will be less junior doctors to support the delivery of services. Secondly, it is likely that the junior doctors that are available will not be as experienced as the current cohort of junior staff. The loss of one junior medical post between the RAH and the IRH would mean a non-legal rota which would mean that out of hours cover could not be provided.

6.10.3 How would we intend to change it?

If it is not possible to maintain the current service arrangements as a result of the challenges posed by modernising medical careers then it is likely that out-of-hours emergency services would require to be integrated with a Glasgow site. This may also affect a very small number of planned inpatients who require access to dedicated 24 hour a day ophthalmology services.

6.10.4 What would this mean for patients?

If all emergency inpatients were to transfer from the IRH and the RAH to Glasgow this would equate to around 120 patients per year, around 40 patients from the IRH and 80 from the

RAH. If daytime emergency services were maintained locally then this number would be dramatically reduced and would result in very small numbers of patients requiring to be transferred. This would represent a change for a very small percentage of the overall ophthalmology service which currently handles approximately 9,300 episodes of patient care at the IRH and 18,000 episodes of patient care at the RAH.

6.10.5 Against this possible change it is anticipated that service redesign within ophthalmology will result in increased capacity being developed at the IRH and the RAH to treat some of the 450 patients who currently attend the Golden Jubilee Hospital in Clydebank for treatments at their local hospital.

6.10.6 This means that even if we centralise the emergency ophthalmology service at a Glasgow hospital, the net outcome of these changes is likely to mean that increased numbers of patients are treated locally in future.

6.11 Ear, Nose and Throat

6.11.1 ENT is the specialty that focuses on the diagnosis and treatment of ear, nose, throat and head and neck disorders. ENT services are currently provided by a single team of consultants who work across the two hospitals. Inpatient services are currently provided on the RAH site for both the RAH and IRH catchment populations. Outpatient and daycase services are provided locally at the IRH and the RAH.

6.11.2 Why may the service need to change?

The situation in relation to ENT is similar to that faced by ophthalmology. Modernising Medical Careers is likely to present a challenge to our ability to deliver 24 hour ENT services. Whilst the exact impact has not yet been finalised we need to be as open as possible with the public in identifying that over the next few years we may need to change the way in which ENT services are delivered. Similarly, there are clinical benefits for patients associated with the concentration of specialist staffing within one larger unit.

6.11.3 How would we intend to change it?

To allow us to meet the challenge posed by Modernising Medical Careers and to capitalise on the potential clinical benefits offered by moving to a larger specialist unit across Glasgow and Clyde it may mean that it is essential that some of the inpatient services are transferred from RAH to the Southern General Hospital in Glasgow.

6.11.4 What would this mean for patients?

If all inpatient activity was to transfer this would affect around 1350 patients. However, the majority of these patients are planned attendances who stay for less than 5 days. It is likely that there would be merit in maintaining a 5 day unit at the RAH to allow significant volumes of planned care activity to be treated locally. The development of such a facility would allow around 800 of these 1350 patients to continue to be treated at the RAH. This would mean around 550 patients requiring to transfer to Glasgow for treatment. These would be the unplanned inpatient attendances and a small number of longer stay planned patients. Of these 550 patients around 240 come from the Inverclyde catchment, North of the Clyde, and the Bishopton, Erskine, Renfrew corridor. For this cohort of patients accessing services at the Southern General Hospital as opposed to the RAH is unlikely to make a significant difference. This means that proposed changes would affect around 310 patients predominantly from the Paisley, Johnstone and Barrhead areas who would require to access

services at the Southern General Hospital. The creation of one single unit for emergency and major planned care ENT patients is likely to represent a sustainable solution which will provide a high level of clinical care for patients for the long term.

6.11.5 Daycase and outpatient activity will continue to be delivered locally at the RAH and the IRH. These account for approximately 9,000 episodes of care at the RAH and 3,800 episodes of care at the IRH every year.

6.12 Dermatology

6.12.1 Dermatology is the specialty that focuses on the treatment of skin conditions. Dermatology services between the RAH and the IRH are currently delivered by one team of consultants. Only outpatient and daycase services are available on the IRH site with inpatient services provided at the RAH.

6.12.2 Why may the service need to change?

Dermatology has faced steadily increasing demand over recent years. As an example, new outpatient attendances have increased by 27% at the RAH in the last three years. Complexity of case load is also increasing. It is recognised that the physical facilities available to the dermatology team within the RAH are severely limited. This relates to inpatient, outpatient and treatment facilities and as well as having an impact on patient throughput it means patients are not treated in an appropriate environment. There have been no changes to facilities in the past fifteen years despite the approach to care having changed considerably in this time with daycase treatment becoming the norm. Dermatology services are currently operating at maximum capacity within the current environment and MMC is likely to increase the training load and therefore reduce the number of patients that can be seen per session. This will exacerbate the challenges currently faced.

6.12.3 Inpatient care is predominantly required only for patients who are unable to manage their own care plans. Whilst new drugs and treatments may mean slightly fewer patients require to be treated on an inpatient basis it is not anticipated that this will dramatically reduce the inpatient requirement. In 2004-05 there were 230 inpatients admitted into dermatology and the average length of stay was 15 days.

6.12.4 How would we intend to change it?

To ensure that daycase and outpatient services remain sustainable, two actions need to be taken. Firstly, there needs to be improved outpatient, daycase and treatment facilities provided. Secondly, there needs to be further role redesign to ensure that the skills of all staff are used most effectively.

6.12.5 The improvements required to the physical environment within dermatology will need investment and potentially additional space. Further work is required on costing these developments, assessing the physical space they will require and considering the impact they will have on the number of patients we are able to treat on a daycase basis. Dependent on the outcomes of this work and on the impacts of Modernising Medical Careers it is possible that we will centralise inpatient services at the Southern General Hospital.

6.12.6 This may not be the final outcome for inpatient dermatology services, but in the interests of transparency to the public during the consultation process we need to identify this as a possible change.

6.12.7 What may this mean for patients?

This would involve 230 patients per annum receiving treatment at the Southern General Hospital instead of the RAH. These patients generally stay in hospital for two to three weeks. We anticipate that around 150 of these patients will come from Paisley, Barrhead, Johnstone and the surrounding area most closely served by the RAH. The other 80 will come from the IRH catchment and the Bishopton, Erskine, Renfrew corridor. For these 80 patients accessing services at the Southern General is not likely to be significantly different from accessing services at the RAH in terms of access.

7. Impact on patients

7.1 This strategy proposes that the majority of services will continue to be delivered at the RAH and at the IRH. It proposes that the majority of patients will continue to be treated in their local hospital. For the catchment area of Inverclyde Hospital this represents a very different proposal from the previous clinical strategy. The impact on each of the hospital sites is outlined in the charts below.

7.2 These charts show that in relation to the overall number of patients who receive medical led care the impact on each of the hospitals (0.3%) is less than a half of one percent of total activity. This does not include the large numbers of patients seen by physiotherapists, Dieticians, Speech and Language Therapists, Radiographers and other Allied Health Professionals which we do not anticipate changing as a result of the proposals we are outlining.

Figure 1: Inverclyde Royal Hospital: overall activity comparison

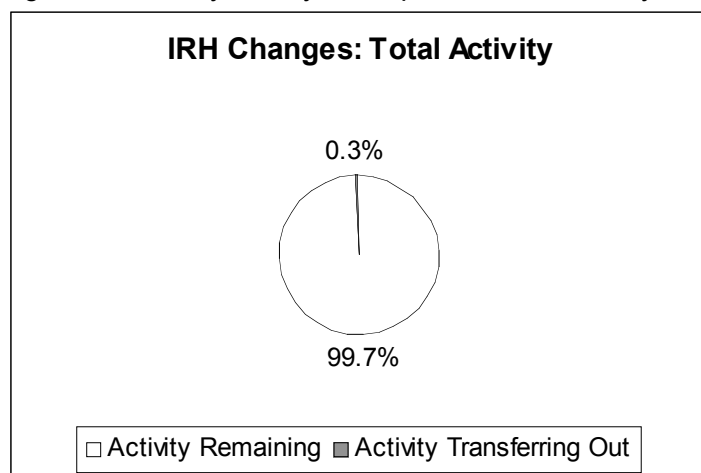
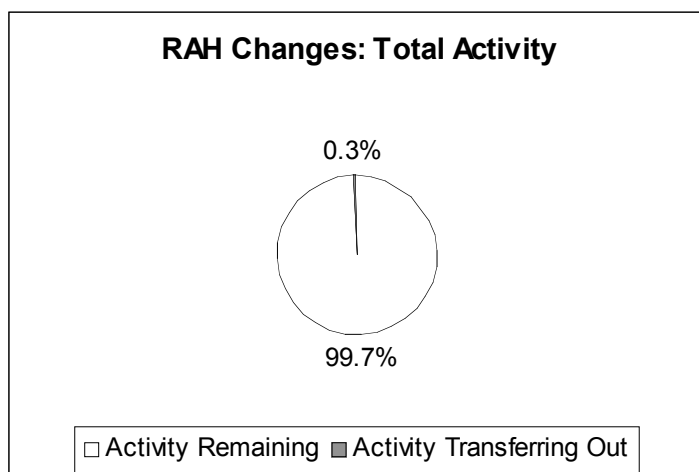


Figure 2: Royal Alexandra Hospital: Overall activity comparison



7.3 If we were to factor in the increased numbers of patients that we will treat at the RAH due to the local provision of cancer services and the increased numbers of patients we will treat at both the IRH and the RAH by delivering some of the services currently provided at the Golden Jubilee Hospital in Clydebank then we would anticipate that the overall numbers of patients treated locally is likely to increase.

7.4 For the Inverclyde Royal Hospital, the difference from this strategy to the 2004 strategy developed by Argyll and Clyde is highlighted in the table below.

Table 5: Comparison of impact on Inverclyde Royal Hospital

	2004/05 Patients	Previous Argyll and Clyde Strategy		New Greater Glasgow and Clyde Strategy
		Option 1: ACAD	Option 2: Intermediate Care	
A&E	30,000	25% - 30%	50%	100%
Emergency Inpatients	12,500	0%	20% - 25%	98.5%
Planned Inpatients	3,500	0%	20%- 25%	93%
Planned Daycase	9,000	100%+	100%+	100%*
Outpatients	90,000	100%	100%	100%
Total Patient Episodes	145,000	108,000	118,000	144,500

* Potentially increasing in due course.

8. Next Steps

8.1 What Next - Public Consultation

Public consultation was launched about our proposals was launched on 8th December 2006. It is due to finish on 2nd February 2007.

Additional information and details of consultation events can be obtained by calling 0141 201 4957 or from our website www.nhsggc.org.uk/southclyde

8.2 SUMMARY LEAFLET - a leaflet summarising our proposals has been widely distributed. Copies can be obtained by contacting the number above or as a download from our website.

8.3 ALTERNATIVE FORMATS AND LANGUAGES - if you would like copies of this document or the summary leaflet in alternative formats such as audio tape, British Sign Language or Braille, or would like translations of the documents into languages other than English, please call 0141 201 4957 or e-mail us at southclyde@ggc.scot.nhs.uk

8.4 PUBLIC EVENTS - Two open public events have been organised on 16th January 2007 at the Tontine Hotel, Greenock and on 17th January 2007 at the Glynhill Hotel Renfrew.

Additionally, afternoon meetings have been organised on the same days at the same venues for local stakeholder organisations. If you would prefer to attend a daytime event, you are welcome to join the afternoon sessions.

Please call 0141 201 4957 if you would like to attend any of the events.

8.5 PATIENT FOCUS GROUPS - We will be organising group meetings of current and former patients of the five specialist services affected by our proposals in the third and fourth weeks of January 2007. Please call the number above if you would like more information about these arrangements.

8.6 PUTTING FORWARD YOUR POINT OF VIEW

We will formally record points made to us at public meetings but you can also send a written submission as part of the consultation to:

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

Or by e-mail to: southclyde@ggc.scot.nhs.uk

The closing date for comments is Monday, 2nd February 2007 at 5.00 PM.

9. What Next - After Consultation

9.1 Once we have received comments from stakeholders, we will take stock of what we have been told. Our aim would be to take a final set of proposals to the Greater Glasgow and Clyde NHS Board during February for approval. If approval is given, our proposals would then go to the Minister for Health and Community Care for a final decision. If this is granted, we would aim to begin implementation in line with the timescales outlined in this document.