NHS
Greater Glasgow and Clyde

Vision for the Vale of Leven Hospital

Consultation Document
October 2008 – January 2009

Foreword

The Vale of Leven Hospital plays an important role in the provision of health services to the West Dunbartonshire, Helensburgh and the Lochside communities. For the past 10 years the future of the hospital has been subject to much debate and considerable concern as services have had to change for a number of reasons. We are now able to describe a Vision for the Vale of Leven which we hope will end the uncertainty faced by our patients, by our staff and by the wider community.

Our Vision for the future of the Vale of Leven Hospital is that it will continue to be a vibrant and busy NHS site and that it will continue to play the central role in the provision of NHS care to the local communities.

One of our key principles in developing the Vision for the Vale has been to aim to provide high quality and safe services as locally as possible. This is the challenge that has been presented to us by the groups of independent experts that have considered the services offered at the Vale, by community groups in frequent discussions during the past two years, and by our staff who will strive to ensure that anything we do is safe and provides excellent care. We firmly believe that the Vision we describe in this document represents the best possible balance between providing local access to high quality services and a requirement to travel for more specialist or intensive care on the occasions when it is required.

Our Vision builds on the work undertaken during the Lomond Integrated Care pilot to ensure that unscheduled medical care can be offered in the hospital to the vast majority of patients who currently receive it. It also ensures that inpatient hospital beds for medical patients will continue to be provided in the Hospital. Rehabilitation inpatient services will also continue to be delivered at the Vale of Leven. There will be changes in each of these areas, which are explained in this document, but the key outcome of the detailed work that has been undertaken in relation to these areas is that we can offer and develop a service which will ensure that the majority of patients will continue to be cared for at the Vale safely.

Our Vision for planned care will see investment in the hospital to ensure that many thousands of patients who currently travel to Glasgow or Paisley for scheduled appointments to receive care will in future be able to be treated in the Vale of Leven Hospital.

Our Vision for the Community Maternity Unit is that it will be sustained and promoted to ensure that all women who are potentially able to give birth in the unit actively consider using it when making their choice about where to give birth.

Our Vision for mental health services is that elderly patients with acute mental health needs will continue to receive care at the Vale, alongside elderly mental health continuing care beds which will transfer from Dumbarton Joint Hospital. Our enhanced community services, which are being developed in West Dunbartonshire, will continue to treat the vast majority of mental health patients in a community setting and continue to reduce the number of adults and young people requiring Hospital admission. For adults aged between 18 and 65 who do require Hospital based mental health care we are consulting on two options, one which sees the retention of services on the Vale of Leven site and another which would see services transferred to Gartnavel Royal Hospital. Both options have advantages and disadvantages and we would like your views on them during this consultation period.

In addition to the provision and expansion of hospital care, our Vision for the Vale of Leven site (i.e. the wider hospital grounds) also includes the development of the new Alexandria Medical Centre and the development of a care home to serve the wider needs of the council and the local community.

We believe that by combining the Visions for each of these services into an overall Vision for the Hospital we can create a busy and vibrant acute hospital which will offer sustainable services. After detailed review of all the information at our disposal we believe that we can create a new model for unscheduled care which allows those patients who do not require higher dependency care to be safely treated locally and to receive a standard of care that is comparable to that provided in other hospitals. However, we are also clear that for this new model of care to be successful it needs to be supported by the community and by the staff.

This is why your feedback during this consultation period is extremely important. The Vision for the Hospital cannot be something held only by the Health Board. For it to be successful and sustainable it needs to become a Vision that is shared by patients, shared by NHS staff and shared by community groups. We believe that it can work, that it will be safe and that it will deliver high quality of care. Please take this opportunity to give us your views.

Tom Divers
Chief Executive

Executive Summary

1. This consultation document outlines a Vision for the Vale of Leven Hospital and the wider Hospital site. It describes the full range of services that we propose will be delivered from the Vale, explains how they will be delivered and highlights what this will mean for patients and staff. We believe that the Vision described in this document represents the best possible balance between providing local access to high quality services and a requirement to travel for more specialist or intensive care on the occasions when it is required. The Vision is closely informed by the work undertaken on the Lomond Integrated Care Model at the Hospital and also by the views expressed by the two groups of independent experts who have reviewed services at the Vale of Leven over the past 18 months.

2. The Vision outlines our proposals for a range of planned care services which will see approximately 18,350 patient appointments which are currently delivered in Glasgow or Paisley being delivered locally. This will significantly enhance the hospital and have real benefits for large numbers of local people. We believe that these are extremely positive developments which will be warmly welcomed by patients and by the community.

3. Similarly, the Vision proposes that the 99,000 episodes of care in diagnostic imaging, outpatient, daycase and planned treatments, the community maternity unit, the minor injuries unit, the day hospital for the elderly and the primary care emergency service which are currently delivered in the Vale of Leven will continue to be provided at the Hospital. We also think that providing assurance in relation to these services will be welcomed by staff and by the community.

4. For the past two and a half years we have been considering the issues relating to the provision of unscheduled medical care at the Vale of Leven. This area has also been subject to review by two different groups of independent experts. Currently, unscheduled medical care is provided to 6,300 patients each year at the Vale of Leven and is supported by access to anaesthetic cover. Including the two independent reviews there have been four reviews of anaesthetic services at the Vale of Leven, all of these have concluded that anaesthetic services are not sustainable 24-hours every day. This means that we need to change the way in which unscheduled medical care is provided at the Hospital.

5. The challenge for NHS Greater Glasgow and Clyde is to develop an unscheduled medical service which is clinically safe and which allows as many patients as possible to be treated at the Vale of Leven Hospital. The Independent Experts who reviewed services in August 2008 thought that a model of care could be developed which would allow between 36% and a maximum of 83% of unscheduled medical patient care to be retained at the Vale of Leven. We think that the model which we describe in this Vision will allow between 70% and 80% of patients to be cared for at the Vale of Leven. The other patients will either bypass the Vale after calling an ambulance, after being seen by their GP in the local surgery or be transferred after self presenting at the Vale Hospital. The decision on who will be suitable for care at the Vale will be based on the use of clinical protocols which assess how unwell the patient is and on an agreement that certain conditions will not be treated at the Vale.

6. The clinical safety of this model is a vital consideration. We have undertaken a detailed and comprehensive review of the clinical conditions and physical status of the patients who will either self-present at the hospital and require transfer or who will not be picked up by our scoring system and have concluded that the model would represent a safe system of care. We have undertaken a detailed assessment of individual patient records for patients who attend the Vale and would potentially require transfer to the Royal Alexandra Hospital (RAH). This thorough assessment reassures us that the model of care we propose does not expose patients to unacceptable levels of risk. No model of health care can ever claim to be

completely without risk but our detailed assessment of individual patient records allows us to propose this model as being clinically safe.

7. Maintaining between 70% and 80% of unscheduled medical activity will mean that we are able to maintain approximately 72% of the current acute beds that are provided in the hospital. This includes rehabilitation, medical and surgical beds. Overall, the bed complement for these areas will change from 122 beds to up to 88 beds. There will be changes to the way that the wards are configured as we respond to the changing activity and also as we make improvements to the ward environment to ensure that there is appropriate space between each bed. Between medicine and rehabilitation we will have up to 80 beds compared with a current complement of 108 beds. Surgery will reduce their inpatient bed requirement from 14 beds to eight beds with the space released being used to accommodate day patients. Approximately 42 beds will be developed at the RAH to accommodate the activity transferred from the Vale of Leven.

8. Although the level of service proposed in relation to unscheduled medical care and rehabilitation inpatient services is reduced when compared to that currently delivered we believe that the activity that we propose to retain at the site is the maximum amount that can be safely delivered. It ensures that patients only have to travel to access specialist or higher dependency care when this is potentially required. This solution allows more patients to be treated in the Vale than had previously been considered possible. During consultation we would like your views on whether you think that this model of care which sustains inpatient services is appropriate for the Vale of Leven hospital and the community it serves.

9. Our proposals for mental health take into account feedback received during the recent public consultation on modernising mental health services across Clyde. In addition to taking account of public feedback we have also been able to take advantage of the medical staffing arrangements arising from the wider Vision for the Hospital. For these reasons our Vision is to retain the elderly mental health acute admission beds on the Vale of Leven site and transfer the continuing care beds for elderly mental health patients from Dumbarton Joint Hospital to the Vale of Leven Hospital. Based on the feedback received during pre-consultation we believe that this proposal will be well received.

10. For inpatient mental health services for adult patients between the ages of 18 and 65 the community based crisis team which has been established is already ensuring that fewer patients require admission to hospital. We therefore project that the number of acute inpatient beds for adults will reduce from 18 down to 12. There are two possible options for where this service can be provided in the future: Gartnavel Royal Hospital and the Vale of Leven. This document describes both options and asks for your view on which option is preferable.

11. In addition to the increased hospital based care that will be delivered on the Vale of Leven site we also propose the development of a new Alexandria Medical Centre as part of our Vision. This will be an £18m investment in the site and one which will have benefits for patients and staff. The development of a care home on the Vale of Leven site is also included in our Vision.

12. The impact of these developments on the level of non-inpatient bed activity at the Hospital is shown in the table below.

Area	**Current Patient Episodes**	**Future Patient Episodes**
Outpatient Services	50,000	50,000
Daycase and short stay planned procedures	7,000	7,000
Planned diagnostic services	11,500	11,500
Community midwifery unit services	14,000	14,000

Day Hospital for Elderly Patients	7,500	7,500
Primary Care Emergency Services	10,000	10,000
Minor Injuries Unit	9,000	9,000
Medical Assessment Unit	6,300	4,410 – 5,292
New Planned Care Services: Diagnostic, Outpatient, Treatments and Daycase Procedures		18,350
Total	**115,300**	**131,760**

13. Between 31 October 2008 and 30 January 2009 there will be a range of public meetings, events and drop-in sessions scheduled to allow staff, patients and members of the community the opportunity to find out more about our proposals. A summary leaflet will also be available which will highlight the key proposals.

14. For the new model of unscheduled medical care to be successful it needs to be supported by the community and by the staff. We therefore want to encourage as many people as possible to give us their view on this model of care. In relation to mental health services for non-elderly patients your feedback will also be important in determining the conclusions reached by the Board of NHS Greater Glasgow and Clyde. We want the community to be as well informed as possible about our Vision for the Hospital when giving us feedback and for this reason we would also welcome your feedback on the overall Vision.

1. Introduction

The Vale of Leven Hospital plays an important role in the provision of health services to the West Dunbartonshire, Helensburgh and the Lochside communities. For the past 10 years the future of the hospital has been subject to much debate and considerable concern as services have had to change for a number of reasons. Although some further changes are required to the services provided at the Hospital we believe the Vale of Leven Hospital will continue to be a vibrant and busy NHS site and that it will continue to play the central role in the provision of NHS care to the local communities.

This document outlines the Vision for the Vale of Leven Hospital site and seeks to end the uncertainty surrounding the hospital's future. It describes the services that will continue to be delivered on the site and the additional new developments and services that we intend to introduce. Where we think that services need to change we explain why these conclusions have been reached by NHSGGC and by independent experts commissioned by the Scottish Government. We also begin to describe what the new models of care will mean for patients.

A key recent development has been the publication of an independent review report into the sustainability of anaesthetic services at the Vale. The conclusions and implications of this review are described in section 2 of this document which details our Vision for Unscheduled Medical Care.

We have also undertaken a thorough review of where patients from the Vale of Leven catchment area currently receive their planned care. We believe that by investing in the range of services that can be delivered on the Vale of Leven site we will enable more than 18,000 appointments which are currently scheduled in Glasgow or Paisley to be delivered locally. Our Vision for planned care services is described in section 3 of the document.

There are two important inpatient areas within the Vale which contribute significantly to the overall hospital. These are Rehabilitation services and Mental Health services for adults and older people. Section 4 of this document outlines our Vision for rehabilitation services and Section 5 describes the Vision for mental health services.

In addition to increased numbers of patient visits to access hospital services, our Vision for the Vale of Leven Hospital site also incorporates the development of a new Alexandria Medical Centre and the potential development of a new care home. These are described in Section 6 of the document.

From November until the end of January we will enter a period of formal public consultation. The feedback from this formal consultation will be discussed by the Board of NHSGGC in February 2009 who will decide whether to formally request that the Cabinet Secretary for Health and Wellbeing approves the vision for the hospital site. Section 8 of this document describes how you can find out more about our Vision and give us your feedback.

The areas covered in this Vision document are therefore:

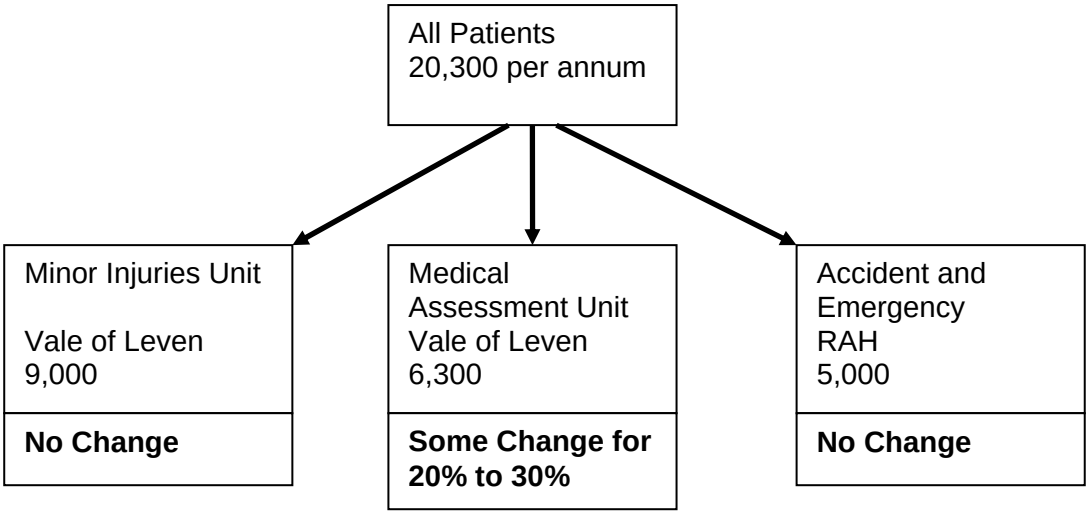
Section 2: Vision for Unscheduled Care
Section 3: Vision for Planned Care
Section 4: Vision for Rehabilitation and Older Peoples Services
Section 5: Vision for Mental Health Services
Section 6: Vision for the New Alexandria Medical Centre and Care Home
Section 7: Public Transport Provision
Section 8: Implications for Staff
Section 9: Bringing the Vision together
Section 10: Involving you – Consultation Arrangements

Appendix 1: Future Unscheduled Medical Model: Protocols and Assessment of Safety
Appendix 2: Future Unscheduled Medical Model: Clinical Governance
Appendix 3: Future Unscheduled Medical Model: Training Requirements
Appendix 4: Reviews of Anaesthetic Provision
Appendix 5: Frequently Asked Questions
Appendix 6: Glossary

2. The Vision: Unscheduled Care

2.1 Unscheduled Care Overview

Patients who live in the area served by the Vale of Leven and who require unscheduled hospital care today will broadly access it in one of three ways:



Our Vision for unscheduled care will mean that there will in future be a change in how the service is provided to the 6,300 patients who currently attend the Medical Assessment Unit (MAU). For 70% to 80% of these 6,300 patients there will be no change to where they access services. 20% to 30% of these 6,300 patients will in future require to bypass the Vale or transfer out of it following initial treatment. The work undertaken by the Independent Experts in August 2008 identified that between 36% and a maximum of 83% of medical assessment activity could remain at the Vale and our conclusions are therefore close to the upper end of the range they described. In overall terms our Vision therefore means no change for at least 18,400 of the 20,300 patients from the Vale of Leven area who currently require unscheduled hospital care.

2.2 Minor Injuries Unit

An important part of the future vision for the Vale of Leven Hospital is the continued provision of a facility for treating patients who have minor injuries. We are committed to continuing to provide a comprehensive minor injuries service at the Hospital. This will mean no change for the 9,000 unplanned patients who currently attend the Minor Injuries Unit at the Vale every year. The Minor Injuries Unit is able to treat a wide range of conditions including:

- Fractures of nose, shoulder, upper arm, elbow, forearm, wrist, hand (inc fingers), knee, lower leg, ankle, foot and toes
- Soft tissue injury including strains and sprains
- Dislocations
- Wounds
- Burns
- Minor head and neck injuries
- Eye injuries and conditions

As is currently the case, in the future only patients with the most severe types of these injuries would need to travel to the RAH to receive care. In terms of fractures this means that patients requiring further orthopaedic assessment with a view to surgical intervention (i.e. manipulation of fracture) would continue to go to the RAH.

2.3.1 Unscheduled Medical Care: Independent Expert Review

The provision of unscheduled medical care at the Vale of Leven, which affects the 6,300 patients who attend the Medical Assessment Unit each year, has been subject to much debate and discussion over the past three years. In June 2008 the Cabinet Secretary for Health and Wellbeing commissioned a group of expert clinicians, Chaired by Professor Chris Dodds, to undertake an independent review of service provision at the Vale of Leven. This review group published their report on the 15 August 2008. This was the second independent review that had been commissioned and followed the work that had been undertaken by the Independent Scrutiny Panel, Chaired by Professor Angus MacKay, from August 2007 to January 2008.

The work of both these Independent Reviews concluded that in the long term anaesthetic services cannot be sustained to support emergency care at the Vale of Leven Hospital. These conclusions and the detailed work undertaken by NHS Greater Glasgow and Clyde in relation to anaesthetics are included in appendix 4 to this document.

The Independent Scrutiny Panel chaired by Professor MacKay recommended that further work be undertaken to explore the implications and feasibility of learning from the work that had been undertaken as part of the Lomond Integrated Care Model. This was a model which had been developed from 2005 onwards to attempt to sustain unscheduled medical care when anaesthetics and junior medical cover were no longer sustainable.

The independent report published in August 2008 by Professor Dodds gave a definitive recommendation for how services at the Vale of Leven Hospital should be delivered in the future. It described the optimal solution for the Vale of Leven as being as a hospital which was able to treat patients with medical conditions who had either been assessed by a GP as suitable for receiving care in the Vale or had presented at the hospital and been deemed appropriate to treat. The report recommended that the development of a receiving unit able to provide this type of “selected” unscheduled care would allow the benefits of a local hospital to continue to be felt by the residents of, and visitors to, the Vale and the surrounding area. This model was described by the review team as being “a supported GP acute unit” and they projected that it would allow between 36% and 83% of unscheduled medical care to continue to be provided at the Vale.

It was the clear view of Professor Dodds’ independent review group that it is possible to develop a model that allows a proportion of unscheduled care to be maintained at the Vale of Leven without the provision of anaesthetic services. The further study proposed by Professor MacKay has been enacted by an enhancement of the database of 4,300 cases which supported the work of the Lomond Integrated Care Pilot and by a ‘snapshot’ prospective audit of current attendances at the MAU and of patients receiving inpatient care. The challenge for NHS Greater Glasgow and Clyde has been to translate the views expressed by the independent experts into a model that will be clinically safe, that will deliver a high quality of care and that will be deliverable. Since August 2008 we have therefore been undertaking a comprehensive programme of work to develop a model for a consultant supported GP acute unit. The model and its impacts and requirements are described in the following sections.

2.3.2 Unscheduled Medical Care Future Model: Patient Perspective

There are currently protocols and clinical assessment scoring systems in place which ensure that the most acutely unwell medical patients bypass the Vale of Leven Hospital. By refining

these protocols, lowering their threshold and bypassing all patients with some types of medical complaints we can safely bring forward a model of care which will allow between 70% and 80% of the 6,300 patient episodes to continue to be provided at the Vale.

The introduction of a scoring system which identifies those patients that should not attend the Vale is important as it allows us to assess patients' physiological condition to determine those that may potentially require higher dependency or more specialist care. This scoring system will be used by GPs, the Scottish Ambulance Service and in the Medical Assessment Unit at the Vale to identify those patients who should go to the RAH regardless of their medical condition or symptom. The physiological criteria that will be included in the scoring system include heart rate, blood pressure and level of consciousness amongst other things. This will be a more refined version of the scoring system that is currently widely used in the Vale of Leven area. This scoring system will identify those patients most at risk of requiring higher dependency care.

In addition to the further development of the scoring system it has also been agreed that patients with the following conditions will not be treated at the Vale of Leven Hospital:

- Patients who have suffered from a stroke or a suspected stroke.
- Patients who have taken a drug overdose.
- Haematemesis patients requiring hospital care (patients with gastro-intestinal bleeding).
- Patients requiring inpatient haematology care.
- Patients with neutropenic sepsis.
- Patients requiring hospital care due to epileptic seizures.

Whilst many patients suffering from these conditions will bypass based on the scoring system it is considered that even patients in these groups who appear medically stable are either at risk of rapidly deteriorating or (in the case of stroke patients) would benefit from immediate bypass to the RAH.

In addition to these patients who will bypass the Vale of Leven or be transferred out immediately on arrival (if they self-present) there are other patients who will receive part of their care at the Vale of Leven and then transfer to another hospital if they require specialist care or are at risk of requiring higher dependency care. We think it is clinically appropriate that the majority of patients with chest pain who are not bypassed by the scoring system will initially present to the Vale of Leven Hospital. If tests subsequently show that they have experienced a heart attack and would benefit from specialist consultant input on an ongoing basis then they would be transferred to an appropriate unit. One exception to this is that from the 1 November patients from across the West of Scotland who experience a certain type of heart attack (STEMI) will be taken directly to the Golden Jubilee National Hospital by the ambulance service. We estimate that this will be the case for approximately 50 patients from the area served by the Vale of Leven.

From the patient perspective we have designed this model of care so that patients can continue to access care in the way that they currently do 24 hours each day. Our protocols will ensure that they are appropriately dealt with and taken to the most appropriate hospital. An overview of the draft clinical protocols that we will use and a detailed review of the clinical analysis that has informed our conclusion that this model of care is one that can be safely implemented is included in Appendix 1.

Included in Appendix 1 is a summary explanation of the detailed work we have undertaken to review patients who would potentially fall into the two categories that require greatest clinical consideration. These two groups are:

1. Patients that our scoring system and protocols would mean should not be cared for at the Vale of Leven but who self-present.

2. Patients who our scoring system and protocols would suggest can be cared for at the Vale but who subsequently require to transfer to the RAH.

We have used the comprehensive database of actual patient activity at the Vale of Leven that has been developed to predict and identify the individual patients that are likely to fall into these two groups. We have closely reviewed and analysed the individual records for these patients and conclude that it is very unlikely that patients in either category could not be safely managed at the Vale of Leven before being transferred to the RAH. This is why we believe the model is one which can justifiably be developed. However, regardless of the level of unscheduled medical activity that is maintained, there will always potentially be very rare occasions when a patient either self presents to the Vale or deteriorates extremely rapidly and whose complex needs cannot be optimally managed. Similarly, even if there was no unscheduled medical activity but a minor injuries unit on the site, this small risk would also still exist.

2.3.3 Unscheduled Medical Care Future Model: Activity and Bed Complement

By analysing the physiological status and conditions treated for the 6,300 episodes of care (4,300 unique patients) that are treated at the medical assessment unit at the Vale we can estimate how many patients will in future require instead to attend the RAH. We estimate that the application of our scoring system and protocols for the conditions outlined above will mean that approximately 1,200 patients will require to bypass the Vale of Leven. In addition to this there will be some patients who receive initial care at the Vale of Leven and are required to transfer at a later date. For this reason we think that between 70% and 80% of unscheduled medical patients who are currently cared for at the Vale of Leven will in future continue to be treated there. The work undertaken by Professor Dodds and his colleagues identified that between 1,000 and 4,000 patients would require to bypass the Vale of Leven meaning that between 36% and 83% of activity could be sustained. Our conclusions are therefore close to the upper end of the range they thought achievable.

We have undertaken detailed analysis of the lengths of stay for each of the patient groups that will bypass the Vale of Leven under the new model of care. The more unwell a patient is, the longer they generally stay in Hospital. The fact that the most unwell patients who currently are cared for at the Vale will in future attend the RAH should therefore mean that a greater proportion of beds than patients are transferred. This is verified by the detailed analysis that we have undertaken. However, given that many medical patients at the Vale of Leven are currently cared for in either the surgical beds or the rehabilitation beds we have factored this workload into the future medical bed complement at the Vale. We therefore anticipate that in future at the Vale of Leven there will be up to 39 medical beds (there are currently 45). In addition we will create up to 30 additional beds at the RAH.

2.3.4 Unscheduled Medical Care Future Model: Staffing and Governance

Our Vision for the provision of unscheduled medical care at the Vale of Leven Hospital is similar to that proposed by the group of independent experts – that it will be a consultant supported GP-led acute unit. This means that General Practitioner doctors, who are skilled and trained to deliver appropriate acute care to the types of patients who will be cared for in the Vale, will have responsibility for unscheduled medical patient care at the Vale of Leven Hospital. There will be doctors on-site 24 hours each day, 7 days each week in the Hospital and during busy times there will be more doctors available. There will be 24-hour hospital consultant support to provide telephone or telemedicine advice to the GPs when it is required. There will also be scheduled daily on-site hospital consultant support to provide the GPs with advice on patients when this is required. This arrangement will ensure that patients admitted to the Vale of Leven Hospital under the care of GPs have access to consultant advice and expert opinion if needed. The individual governance arrangements will be similar to those that exist within an outpatient context where the GP will retain overall responsibility for the patient but the consultant will provide advice.

In overall terms the Vale of Leven will remain a hospital managed by the Acute Division (not by the CHP) with governance responsibility being taken by a group of GPs led by a Clinical Director who are each responsible for their individual clinical practice.

In addition to the GP doctors we will also provide Nurse Practitioner cover 24/7 and explore the possibilities for role development for other clinical groups to determine what other support is required for doctors.

Appendix 2 of this Vision document describes the clinical governance arrangements in relation to the future model of care at the Vale of Leven Hospital. It also describes the training that GPs who develop skills in acute medical care will receive.

2.3.5 Unscheduled Care: Transporting Patients to the RAH

It is clear that between 20% and 30% of the 6,300 patients who currently attend the Vale Medical Assessment Unit will need to transfer to the RAH. A significant proportion of these patients are likely to require an ambulance to take them to the RAH. To ensure that these patients can be safely transported we will provide the necessary extra funding to the Scottish Ambulance Service to ensure that there will be extra paramedic staffed accident and emergency ambulance resource introduced to serve the Vale of Leven Catchment area.

We know from the broad range of discussions we have had at public meetings that one area of concern within the Vale area is the perceived risk associated with transferring patients to the RAH. As we described in section 2.1 of this document there are already 5,000 patients from the Vale of Leven area who attend Accident and Emergency services at the RAH each year and this includes those patients who are most seriously unwell. We think that experiences from transferring these patients to the RAH since 2003 should serve as reassurance to the public that although the concerns that are expressed in relation to transporting patients are understandable, assessment of the actual experience of transporting patients does not raise any significant clinical concerns.

When the A&E at the Vale of Leven was closed and services transferred to the RAH an audit was undertaken using the Scottish Trauma Audit Group (STAG) criteria to assess the morbidity and mortality of all trauma patients with moderate or severe injuries. Data was collected for a 12-month period following the establishment of the Minor Injuries Unit (MIU) at the Vale of Leven (Oct 2003 - Oct 2004) and this was compared with the STAG data collected up to December 2002 for Vale catchment patients treated at the Vale itself. This audit concluded, “there was no detrimental effect on patients from the Vale catchment area” following the establishment of the MIU.

Of the 5000 patients from the Vale catchment area who attended the A&E at the RAH during 2007, 2603 were transported by ambulance. The Scottish Ambulance Service report that there are no significant issues around transporting patients from the Vale of Leven to the RAH based on the experiences they have had since 2003. The Scottish Ambulance Service is confident that, “providing the resource base is sufficiently developed, then we would not have any significant challenges around coping with additional patient journeys to the RAH nor would the changes add to the complexities of the issues we face routinely in providing an emergency ambulance service in South West Scotland. Clinical governance indications have not highlighted any incidents of adverse clinical outcomes caused by either road conditions or bridge closure”.

The issue of transport of patients was also considered by the Independent Review Team who suggested, after reviewing the available evidence, that additional transport time is highly unlikely to affect clinical outcomes significantly.

2.4 Unscheduled Care: Primary Care Emergency Services

Another key area that we intend to retain at the Vale of Leven site and which plays a part in the Vision for the Hospital site is the provision of out of hours primary care emergency services. This service will continue to treat approximately 10,000 patients each year.

3. The Vision: Planned Care services

3.1 Planned Care: Overview

The vast majority of patients currently receiving care at the Vale of Leven Hospital attend on a planned basis. This means that they are given an appointment and receive either a new or follow up consultation, an operation or procedure, a diagnostic test or that they attend regularly for ongoing treatments for a specific condition. More than 90,000 episodes of care are delivered at the Vale of Leven on this basis every year.

We are committed to maintaining and enhancing planned care services at the Vale of Leven Hospital across as wide a range of specialties and to treat as many different conditions as is possible. In practical terms this means that we will continue to provide care in the areas (and to the approximate patient numbers) described in the table below.

Area	**Patient Episodes**
Outpatient services	50,000
Daycase and short stay planned procedures	7,000
Planned diagnostic services	11,500
Community maternity unit services	14,000
Day Hospital for elderly patients	7,500
Total	**90,000**

In addition to sustaining the existing care described in the table above we have undertaken a detailed assessment of where all patients from the Vale of Leven catchment area currently access planned care services and believe that we can expand the range of services that we deliver at the Vale or in alternative locations within the local communities. This means that patients receiving care in these areas will not have to travel to Glasgow or to Paisley to receive planned care. The services that we think we will be able to introduce or expand within the Vale are described in the following paragraphs. We anticipate that these positive developments will be welcomed by the community and would like to hear your views during consultation.

3.2 Planned Care: Dental Services

We have an ambitious vision for how dental services can be developed on the Vale of Leven Hospital site. We propose to build upon and expand existing services by creating a 20 surgery dental complex, which will be equipped to deliver Community, General and Secondary Dental Care. The focus will be on providing appropriate facilities for community dental services and general dental practice and also to create a suitable environment for dental ‘outreach’ teaching of undergraduate students in a primary care setting. The development of this service will require significant capital investment on the Vale site. We have bid for, and are confident of securing, £3.6m to support this development which can either be located within the new Alexandria Medical Centre or within the Hospital.

This centre will provide the opportunity for a replacement number of chairs to be offered to NHS independent general dental practitioners, who will have difficulty in meeting decontamination requirements. This will allow them to continue to deliver services to existing and new patients from improved facilities. Patients will be able to register with these dentists as they would in ‘High Street’ practice. Being based at the same site, there will be an opportunity for closer liaison with community and specialist dental services.

The replacement and consolidation of the four community units in Alexandria and Dumbarton onto one site will allow for improved and enhanced standards for community dental services. It will give the capacity to deliver over 5,500 patient appointments per year to groups who

would otherwise have difficulty in accessing general dental services, such as medically compromised, elderly and special needs patients.

It is intended that the centre will also support the development of a local oral health improvement service, including dental hygienist support and oral health education sessions.

The outreach teaching service will have the capacity for 3,600 adult patient appointments per year and patients will be referred for treatment.

As outreach requires specialist supervision this would give the centre the ability to provide secondary care dentistry with specialist consultant cover because of the scale and improved standard of facility. This means that considerable numbers of patients (4,700 appointments) who currently travel into Glasgow to access specialist services will be able to be seen locally. The specialist dental services will be provided by a team of visiting consultants and will include advice and treatment, such as oral surgery or crown and bridge work. Patients will be referred to this service by their own dentist in the same way they are currently referred to Glasgow Dental Hospital and School.

We are now in consultation with NHS independent general dental practitioners, community dentists and specialists to discuss and agree more detailed proposals for the mix of general, community and specialist services within these 20 chairs.

3.2 Planned Care: Surgical Services

For surgical specialties we will sustain the inpatient and day activity that is currently delivered at the Vale of Leven. In addition to this our Vision is that we will increase the day activity that takes place within general surgery, orthopaedics, ENT and endoscopy by approximately 360 procedures each year. We will also introduce new day services for urology and ophthalmology. These will provide local care for approximately 820 patients. These developments will therefore mean that approximately 1200 patients who currently travel to Glasgow or Paisley to receive operations or surgical procedures will in future be treated locally at the Vale of Leven. These developments will also require considerable investment of approximately £700k in our theatre equipment.

To deliver this activity effectively we will retain the current inpatient surgical ward which will be open 5.5 days each week (Monday morning – Saturday lunchtime).

As well as significantly increasing the number of operations that are undertaken at the Vale we will also be able to provide new and return outpatient care for more than 6000 appointments which are currently delivered from either Paisley or Glasgow. On the Vale of Leven site there will be new services developed for urology and ophthalmology and increased services for general surgery, ENT and orthopaedics. To deliver this activity we will require to increase the capacity of our outpatient accommodation at the Vale of Leven which will mean more investment in the site.

3.3 Planned Care: General Medical Services

The majority of outpatient and daypatient care within general medical services for the Vale catchment population that is non-tertiary specialist in nature is currently provided locally and this will continue to be the case. The one specialty area which we believe can be developed within the Vale site is a rheumatology service. Our Vision is that we will develop a local Rheumatology service at the Vale of Leven Hospital to be provided by visiting Consultants. This will enable care to be provided locally for a significant number of patients who currently travel to receive a new outpatient consultation and follow up care. We will establish up to two outpatient clinics per week to ensure that approximately 1,500 appointments can be provided on the Vale of Leven site each year.

We also believe there is the potential to develop a day service in rheumatology locally at the Vale of Leven Hospital for patients who currently travel to Glasgow for this service. Similarly, by working with local GPs to ensure that they are aware of the full range of medical specialties that are provided at the Vale we should be able to increase the number of patients referred to the Vale of Leven rather than to Glasgow hospitals.

3.4 Planned Care: Regional Specialist Services

The Regional specialist services which are currently provided at the Vale of Leven site are renal dialysis, two neurology clinics and two oncology clinics – of which one supports day chemotherapy for people with breast, urology or bladder cancers. There are no plans to reduce the services provided to the Vale of Leven; in fact, the neurology clinic hours have recently been extended to accommodate the ongoing growth in referrals. In addition to the retention of these services our vision for the Vale of Leven site is that we can expand the provision of renal dialysis and cancer services on the Vale of Leven site.

Expansion of these services would enable patients who currently travel to Glasgow for treatment to instead be treated at the Vale. For renal dialysis we envisage an additional six stations being required which would be able to treat 24 patients each week. This equates to approximately 3750 additional episodes of care each year. This is approximately a doubling of current capacity.

In relation to cancer care, there are elements of supportive care (e.g. delivery of non-chemotherapy IV infusions) which could be delivered within a nurse-led day service, provided there was appropriate clinical supervision on site. In addition to this, we believe that, in the medium to longer-term, by increasing the current level of oncologist cover from two sessions (one day) per week to four sessions (two days) and expanding the clinical nurse specialist numbers, there are a further 30 patients per annum receiving day chemotherapy who could be repatriated from the Beatson West of Scotland Cancer Centre, each receiving between three and 18 treatment cycles. This equates to 300 patient episodes per annum. It is envisioned that this development would be from 2010/11 at the earliest, within the context of enhancing the provision of local oncology services across the three Clyde hospital sites.

In relation to haematology day treatments, it is possible that we may in future need to undertake some treatments on a hospital site that has specialist high dependency cover. We anticipate that the number of patient episodes that this would affect would be similar to the number of additional cancer treatments that we intend to repatriate to the Vale and that therefore the overall impact in terms of patients having to travel for care will be broadly neutral.

3.5 Planned Care: Diagnostic Services

As well as playing an important role in supporting unscheduled and inpatient care at the Vale of Leven – which will continue – diagnostic imaging services also provide outpatient care for

patients. There are currently approximately 11,500 patient imaging events on the Vale of Leven site where the visit for imaging is the sole reason for the trip to Hospital. We have undertaken detailed analysis of the patients who live in the Vale catchment area and currently travel to either Glasgow or Paisley for outpatient imaging care. This shows that there are approximately 1200 patients from the Vale area who currently travel for CT, ultrasound, X-ray, mammography or fluoroscopy examinations that could be undertaken locally.

In relation to laboratory medicine services we will ensure that these continue to provide the required level of 24/7 support to the meet the current and future needs of the unscheduled medical care service.

3.6 Planned Care Summary: Additional New Developments

Combining the additional episodes of care that we intend to deliver on the Vale of Leven site on the basis of these proposed developments would see an additional 18,350 episodes of care being delivered locally.

Development	**Additional Patient Episodes**
Dental Services	4,700
Surgical Services	7,200
Medical Services	1,500
Regional Services	3,750
Imaging Services	1,200
Total	**18,350**

This additional activity is considerable. When this activity is combined with the large volume (90,000 episodes) of current planned hospital activity it is clear that the Vale of Leven will continue to be a busy hospital site.

4. The Vision: Rehabilitation and Older People's Services

4.1 Rehabilitation Services for Older People

Following an emergency admission to hospital older people often need the care of a multidisciplinary team that specialises in the care of older people to help them recover from their illness or injury. This team will include doctors, nurses and allied health professionals such as physiotherapists, occupational therapists and speech and language therapists. This service is described as rehabilitation.

The provision of a comprehensive Rehabilitation service on the Vale of Leven site is a key element in our Vision for the Hospital.

Older people who have been first admitted to either medicine, medicine for the elderly, surgery or orthopaedics may require a further period of time in hospital to allow them to be fit for discharge. This care should be delivered as close to people's homes and families as possible.

Rehabilitation will be delivered at the Vale of Leven by a consultant-led, multi-professional team and will include assessment, goal setting, intervention and evaluation. The key drivers behind the philosophy are:

- Having the right intervention, in the right place, at the right time
- Ensuring patients are discharged as soon as they are medically fit to do so
- Providing an integrated whole system approach to rehabilitation in patients' own homes and other community settings
- Providing fit for purpose environments for rehabilitation to take place

The point at which patients move into rehabilitation beds and between specialist and general rehabilitation will be agreed by all relevant clinicians and while guided by protocols will be driven by clinical decisions based on patient need. Some elements of care will be led by nursing and allied health professionals and opportunities will be taken to develop new roles and to provide a multi-professional and multi agency team.

Patients will transfer to the Vale of Leven rehabilitation beds from the RAH or from the medical beds at the Vale itself following an assessment by a Consultant in Medicine for the Elderly. The number of beds required on site is linked to the detailed work completed regarding unscheduled medical admissions which anticipates the shift of a number of admissions to the RAH. There are currently 59 rehabilitation beds at the Vale of Leven but a number of these are often occupied by general medical patients. It is therefore anticipated that up to 37 rehabilitation beds will be required at the Vale of Leven hospital and 12 beds will be required at the RAH. These numbers include beds for stroke patients of all ages (see section 4.2)

Whilst patients will continue to have a named Consultant responsible for their care, day to day medical cover will be provided from the medical workforce covering the hospital site.

In addition to inpatient services there will continue to be Consultant-led outpatient clinics for older people, and patients with movement disorders provided on the Vale of Leven site. Specialist nurses and Allied Health Professionals will also provide outpatient services on the site.

There will also be a Day Hospital for Older People to allow medical and functional problems in frail older people to be addressed without the necessity for admission to hospital. The

further development of links between services for Frail Older People and for Older People with Mental health problems will be discussed with the CHP (Community Health Partnership).

The development of an enhanced community rehabilitation model is currently being taken forward by the CHP and the Rehabilitation and Assessment Directorate and this will consider further development of care that can prevent older people being admitted to hospital. Care pathways will be developed to ensure that specialist staff can be accessed by patients whether they are in hospital or in the community and active discharge planning will minimise inpatient length of stay.

4.2 Stroke services

Patients eligible to be considered for thrombolysis (treatment with a clot busting drug) will be admitted to the Western Infirmary as is currently the case.

Patients of any age who are suspected as having suffered a stroke will be admitted to the stroke unit at the RAH. Stroke units have been proven to improve patient outcomes and it is a NHS QIS (Quality Improvement Scotland) standard that a consultant physician with a specialist interest in stroke is responsible for the management of stroke patients and that stroke patients are admitted to and remain in, specialist stroke care until their rehabilitation is complete.

Patients with complex discharge planning needs will transfer to the Vale of Leven for the final part of their inpatient admission. With a small number of stroke patients being cared for at the Vale of Leven a new workforce model will be developed to ensure that staff retain their specialist skills. A new stroke strategy for NHS Scotland will be published early in 2009 and this proposal will require to be reviewed in light of that, once it is available.

An outpatient clinic for patients who are suspected of having suffered a minor stroke or require ongoing support following discharge from hospital will also be provided at the hospital

4.3 End of Life care

There are four beds provided for NHS continuing care for older people at the Vale of Leven and these will remain. These beds are for older people, nearing the end of their lives, with complex clinical needs requiring specialist nursing and / or medical supervision. These beds will continue to be provided at the Vale of Leven Hospital and are therefore additional to the 37 rehabilitation beds.

Palliative Care is the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms and of psychological, social and spiritual problems is paramount. The goal of palliative care is to achieve the best possible quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness, in conjunction with other treatments. A further future development could see Palliative Care Consultants working at the hospital providing support to members of medical and nursing staff caring for patients with life limiting disease.

5. The Vision: Acute Mental Health Services

5.1 Introduction

NHS Greater Glasgow and Clyde, in partnership with local authorities, service users and staff, carried out a comprehensive review of mental health services throughout the Clyde area, with a view to developing a strategy to achieve service improvement and modernisation. The outcome of the review led to the production of a Clyde Modernising Mental Health Strategy, which sets out the guiding principles and supporting evidence behind our proposals to modernise and rebalance mental health services in Clyde.

Our proposals were then subject to review by an Independent Scrutiny Panel established by the Cabinet Secretary for Mental Health and Well Being. Steps were taken to address recommendations made by the panel, including the completion of formal option appraisals to help inform proposals for consultation, as well as the production of supporting information that set out the rationale and evidence for change.

Between April and July 2008 we undertook a comprehensive formal public consultation on key proposals within our Modernising Mental Health Strategy. For West Dunbartonshire this included the recommendation to transfer adult and elderly mental health acute admission beds from Vale of Leven Hospital to improved accommodation at Gartnavel Royal Hospital.

A copy of the previous consultation document 'Modernising and Improving Mental Health Services across Clyde, along with the full Clyde Modernising Mental Health Strategy and supporting papers can be obtained from our website:

http://www.nhsggc.org.uk/content/default.asp?page=s930_24

5.2 Feedback from Public Consultation

At its meeting on 19 August 2008, the Board of NHSGGC considered a report that summarised the feedback received during the consultation period. This report can be accessed by visiting our website at:

http://library.nhsggc.org.uk/mediaAssets/Board%20Papers/08-36-A.pdf

It was clear from the public consultation feedback that the elderly and adult acute mental health inpatient proposals for West Dunbartonshire commanded a low level of local public support and, in addition, that the public were keen to see any proposals for mental health articulated within an overall vision for the future of services at the Vale of Leven Hospital.

It is clear that the aspirations of the local population were:

- To retain access to inpatient services at the Vale of Leven site.
- That the Board sets out its vision for all services on the Vale of Leven site and that the individual proposals in relation to mental health (and other service proposals re unscheduled care etc) are then considered within that context.
- To deal with the issues of age appropriateness and the quality issues of the ward environments through access to capital improvements, if necessary through alternative capital procurement routes.
- To deal with issues of out of hours medical cover through exploration of extension of GP models for out of hours support.
- To ensure investment in community services is not dependent on the decisions concerning location of inpatient beds.

In light of the consultation feedback, together with the opportunity to re-evaluate them in the context of a vision for general acute services at the Vale, we have undertaken a further period of engagement with stakeholders to revisit our original proposals.

Summary of Outcome of Further Engagement

In essence the further work on the development of inpatient options has concluded that:

- Both adult and elderly acute mental services can be provided and sustained at the Vale of Leven through use of GP arrangements for out of hours medical cover, together with the benefits of synergies with other services at the Vale of Leven.
- The current ward environments require significant improvement to enable the provision of care in a setting which is above minimum standards. This is likely to only be achievable through relocation and significant capital development
- The revenue costs of providing adult and elderly services at the Vale, in accommodation of comparable standard to GRH, are higher than would be the case of providing those inpatient services at GRH
- Location at the Vale of Leven poses fewer challenges in terms of ease of access for patients and visitors.
- The mix of beds requires a reduction of around four adult acute beds and a corresponding increase in intensive rehabilitation//intensive community placements.
- Lengths of acute inpatient stays at the Vale of Leven are somewhat longer than in Glasgow and suggest discharges are not as timely as required to best meet the needs of individuals to achieve timely return to care in community settings. If “excess” lengths of stay are reduced, more patients can be cared for in fewer beds – this enables a reduction of three older people’s beds; for adults the combination of reduced lengths of stay, a reducing adult population and the impact of the development of community services enables a further reduction of two beds.
- It is easier to sustain elderly beds on the Vale as the beds and staffing can be flexibly deployed across a range of co-located elderly wards. Sustaining a small 12 bedded adult ward is less straightforward as optimum ward sizes are nearer 20 beds.

5.3 Summary of Proposals for Consultation

In view of the issues and alternative service models that emerged during the further period of engagement, we are now in a position to consult on the following proposals:

<u>Elderly Mental Health Services</u>

Single Option:

To retain elderly mental health acute services (dementia and functional services) in improved accommodation at the Vale of Leven Hospital, co-located adjacent to elderly mental health continuing care services, to be transferred from Dumbarton Joint Hospital. This model would be supported by resident senior and junior medical staff during daytime (Mon-Fri) and by GP resident medical cover out-of-hours (5pm – 9am Mon-Fri and all of Sat-Sun). A non-resident consultant psychiatrist will be on-call out-of-hours to provide additional back-up medical advice and support as necessary, normally by telephone.

<u>Adult Acute Mental Health Services</u>

While the synergies for elderly mental health services at the Vale of Leven site have led us to propose a single option for consultation, we consider that the issues facing adult mental health acute services are more complex. There are clear advantages and disadvantages associated with either the retention of services at Vale of Leven or with the transfer of services to Gartnavel Royal Hospital. We are therefore consulting on the following:

Option 1:
The retention of adult acute mental health services within improved accommodation at Vale of Leven, supported by resident senior and junior medical staff during daytime (Mon-Fri) and by GP resident medical cover out-of-hours (5pm – 9am Mon-Fri and all of Sat-Sun). A non-resident consultant psychiatrist will be on-call out-of-hours to provide additional back-up medical advice and support as necessary, normally by telephone.

Option 2:
The transfer of adult acute mental health services from Christie ward, Vale of Leven to the purpose-built accommodation at GRH, supported by resident senior and junior medical staff during daytime (Mon- Fri) and by resident junior medical staff cover out-of-hours (5pm – 9am Mon-Fri and all of Sat-Sun). A non-resident consultant psychiatrist will be on-call out-of-hours to provide additional back-up medical advice and support as necessary, normally by telephone.

A summary of the mental health bed changes associated with these proposals is set out below:

Service	Current Beds	Current Location	Proposed Beds	Proposed Location
Elderly Acute	12 (dementia)	Fruin, Vale of Leven	15 (dementia & functional)	Vale of Leven
Elderly Continuing Care	12	Glenarn, Dumbarton Joint Hospital	12	Vale of Leven
Adult Acute	24 (incl 6 elderly functional)	Christie, Vale of Leven	12 *	Vale of Leven or Gartnavel

- In addition to the 12 adult mental health beds, there will be access to four intensive rehab beds at Gartnavel Royal Hospital.

5.4 Current Service Profile – Elderly Mental Health Services

5.4.1 Community Services

We have already committed funding to commence the initial phases of community service development, in line with the aspirations set out in our Modernising Mental Health Strategy. The strengthening of community mental health services, in partnership with local authorities, should enable more people to be supported in the community and reduce the likelihood of people requiring hospital admission or reduce the period of time spent in hospital prior to return to care provided in the community.

5.4.2 Inpatient Services

Elderly Acute Mental Health Beds

Fruin ward within Vale of Leven Hospital is a 12 bedded organic (dementia) assessment ward. Patients admitted to this service will usually have advanced degrees of dementia.

Elderly patients with a functional mental illness are currently admitted to Christie ward, Vale of Leven Hospital. Patients with a functional illness have usually been in hospital previously or have otherwise been known to services for a number of years. They will have chronic or frequently relapsing mental illness. There may be some deterioration in social functioning

and cognitive impairment. Although social functioning may be compromised, they will not demonstrate the degree of lack of social judgement displayed by people who suffer from dementia with behavioural disturbance. Christie ward (24 beds) has approximately six to eight beds for elderly functional mental health admissions, mixed with admission beds for younger adults aged 18-65 years. This is an inappropriate mix that has been criticised by an external review body.

Elderly Mental Health Continuing Care

There are currently 12 NHS continuing care beds for elderly mentally ill provided within Glenarn ward, Dumbarton Joint Hospital. NHS inpatient continuing care provides inpatient healthcare arranged and fully funded by the NHS. It is for patients with complex needs and challenging behaviour in dementia. Patients' ages generally range from 40 years to 90 years +, with all having a diagnosis of dementia. Patients therefore require a high level of ongoing healthcare, usually for prolonged periods, but not necessarily for life.

To varying degrees, there are environmental constraints affecting the quality of our existing elderly mental health wards. Our dedicated staff continue to provide the best care possible within this environment. In addition, there is currently no resident 'specialist' out-of-hours medical cover for these mental health wards.

5.5 Proposal to Retain Elderly Mental Health Beds at Vale of Leven

In light of the emerging service models for both GP-led unscheduled medical care and older people's rehabilitation services at the Vale of Leven Hospital which are described in earlier sections of this consultation document, the opportunity has been taken to explore the potential implications for elderly mental health services. It is considered that there would now be a more sustainable critical mass of 'older people's services' at Vale of Leven Hospital, with which to support the retention of elderly mental health inpatient provision.

This critical mass of provision would be further strengthened by locating the beds for elderly acute mental health and elderly mental health continuing care patients in close proximity. This proposal would result in 15 elderly acute mental health beds (dementia and functional) retained at Vale of Leven, alongside 12 elderly mental health continuing care beds that would transfer from Dumbarton Joint Hospital.

Elderly mental health services would be supported by resident senior and junior medical staff during daytime (Mon-Fri) and by GP resident medical cover out-of-hours (5pm – 9am Mon-Fri and all of Sat-Sun). A non-resident consultant psychiatrist will be on-call out-of-hours to provide additional back-up medical advice and support as necessary, normally by telephone.

The medium-longer term location of these services at Vale of Leven Hospital will be considered as part of the production of a business case incorporating wider site development options. However, in the short term, we propose to relocate six elderly functional beds from Christie ward into an 'expanded' Fruin ward at Vale of Leven, which will address the inappropriate age-mix of patients within the former ward. In addition, we will continue to engage with West Dunbartonshire Council to explore the potential for elderly mental health services to be integrated within a care home development under consideration for the Vale of Leven Hospital site (please see section 6.2.)

5.6 Benefits of Proposed Service Model for Elderly Mental Health

The benefits of the proposal to retain Elderly Mental Health services at the Vale of Leven are:-

- Accessibility for patients and visitors coming from the Clyde catchment of West Dunbartonshire.

- Addresses the inappropriate age-mix of elderly functional patients currently cared for within the same ward as adult acute patients.
- Ensures the services have access as necessary to resident GP medical cover out-of-hours at the Vale of Leven Hospital, compared to the current arrangements where out-of-hours medical cover is provided from an off-site on-call arrangement.
- Provides a sufficient critical mass of provision to help manage staffing cover issues, as well as offering benefits to share clinical staff input and expertise, for example around occupational therapy, podiatry and speech & language therapy services.
- Provides continuity of clinical staffing at Vale of Leven Hospital.

5.7 Financial Implications

It anticipated that the model to retain elderly mental health acute and continuing care patients at the Vale of Leven Hospital will have additional revenue implications beyond the current budget and, for the acute bed component, beyond the cost of the recommendation set out in the previous consultation to transfer these services to the new accommodation at Gartnavel Royal Hospital. The net effect of this is likely to increase current revenue costs by circa £150,000 per annum to address the additional nurse staffing costs of managing elderly dementia and functional elderly patients as part of a single ‘unit’. The capital and revenue costs associated with an endpoint location for these services at Vale of Leven will be developed as part of a future business case for the wider cohort of services at the Vale or, alternatively, through the development of an accommodation solution as part of a care home development at the Vale.

5.8. Current Service Profile – Adult Mental Health Services

5.8.1 Community Services

We have already committed funding to commence the initial phases of service development, in line with the aspirations set out in out Modernising Mental Health Strategy. This includes introducing new Crisis Services to provide additional intensive community support for people with a serious mental illness during evenings and weekends; expanding existing Community Mental Health Teams to provide more support to people with serious and enduring mental illness; and expanding the range of local services available for people with mild to moderate mental illness.

5.8.2 Inpatient Services – Christie Ward, Vale of Leven Hospital

Adult acute mental health patients for the Clyde catchment of West Dunbartonshire are currently admitted to Christie ward (which has 24 beds in total) within the Vale of Leven Hospital. As previously described, 16-18 beds within this ward are for adult admissions and six to eight beds within the ward are for elderly functional mental health admissions.

Adult acute admissions (aged 18 to 65 years) are patients with serious mental illness who may have co-morbid personality disorders or addiction problems or learning disability. They may pose a risk to themselves and/or others, and who may require emergency admission and treatment either informally or under mental health act detention. Depending on the patient's mental and behavioural state, they may require to be cared for in either the acute mental health ward or in an Intensive Psychiatric Care Unit (IPCU), which is provided at Gartnavel Royal Hospital.

There are environmental constraints within Christie ward in comparison to the standard of accommodation and environment that can be offered in new-build facilities. Our dedicated staff continue to provide the best care possible within the current environment.

In addition, there is currently no resident 'specialist' out-of-hours medical cover for Christie ward. Given the complexity of adult acute mental health care, this has caused ongoing clinical safety concerns for NHSGGC. Both options for consultation would address those concerns.

5.8.3 Inpatient Services – Gartnavel Royal Hospital (GRH)

The purpose-built mental health inpatient unit at GRH currently provides access to West Glasgow and the Clydebank catchment of West Dunbartonshire. The unit opened in 2007 and accommodates 60 adult acute mental health beds, 10 intensive psychiatric care unit beds (IPCU), and 45 elderly acute mental health beds. The unit provides an extremely high standard of environment for patients and staff.

5.9 Future Bed Numbers

As the impact of our investment in community services takes effect, it is likely that the level of adult acute mental health beds needed for the Clyde catchment of West Dunbartonshire will reduce to approximately 12 beds. Similarly, the impact of community mental heath service developments will enable a reduction of approximately six adult acute beds within GRH. In addition, routinely around six beds with GRH accommodate patients predominately requiring care and treatment for addiction related problems. These beds will transfer to the single inpatient unit approved for South/West Glasgow and South Clyde catchments. The net result of these changes will be to free up capacity within GRH.

5.10 Proposals for Consultation – Adult Mental Health Acute Services

An option appraisal exercise was carried out to inform the Health Board's previous Mental Health consultation. This concluded that, while options that sought to retain services at the Vale of Leven scored highest from a perceived benefits perspective, the option to transfer services to the new accommodation at Gartnavel Royal Hospital scored best when taking benefits and financial implications into account. In addition, the Health Board identified wider concerns over the sustainability of a single, relatively small adult acute mental health unit at the Vale of Leven. This led to the Board, during the previous consultation, to recommend the transfer of adult mental health services from Christie ward, Vale of Leven to the new accommodation at Gartnavel Royal Hospital.

In light of the feedback received during the consultation, the decision was taken to revisit the options to determine whether another service model could be achieved for retaining services at the Vale of Leven, beyond those already evaluated under the aforementioned option appraisal.

As part of the engagement work undertaken with GPs to explore the potential role that they may have in relation to a vision for all services at the Vale, a model has emerged that would support a sustainable resident out-of-hours medical cover solution for adult acute mental health services at Vale of Leven. We consider that there are advantages and disadvantages associated with this option, in comparison with the original proposal to transfer services to Gartnavel Royal Hospital. Accordingly, this consultation focuses on the following two options for adult acute mental health services:-

Option 1

The retention of adult acute mental health services within improved accommodation at Vale of Leven, supported by resident senior and junior medical staff during daytime (Mon-Fri) and by GP resident medical cover out-of-hours (5pm – 9am Mon-Fri and all of Sat-Sun). Under this model, additional mental health training will be provided for GPs to support the delivery of a specialist out-of-hours service. A non-resident consultant psychiatrist will be on-call out-of-hours to provide additional back-up medical advice and support as necessary, normally by telephone.

Option 2

The transfer of adult acute mental health services from Christie ward, Vale of Leven to the purpose-built mental health accommodation at GRH, supported by resident senior and junior medical staff during daytime (Mon- Fri) and by resident junior medical staff cover out-of-hours (5pm-9am Mon-Fri and all of Sat-Sun). A non-resident consultant psychiatrist will be on-call out-of-hours to provide additional back-up medical advice and support as necessary, normally by telephone.

5.11 Key Issues to Consider

5.11.1 Access for Patients and Visitors:

Vale of Leven Hospital is more accessible for the majority of people within the Clyde catchment of West Dunbartonshire, than GRH. From an 'access' perspective, option 1 is therefore a stronger option.

For patients requiring admission to adult acute mental health beds, NHS GGC will arrange as necessary for transport and nurse escort to take a patient to the ward, whether it be Christie ward or to GRH.

For friends and family wishing to visit patients in hospital, a transfer of services from Vale of Leven Hospital to GRH is likely to result in additional travelling time. We note that this was a significant area of concern in feedback from our previous public consultation.

Nevertheless, we do not consider that GRH represents an 'inaccessible' option. For example:-

- Hyndland railway station provides good access to Gartnavel Royal Hospital from West Dunbartonshire/ Helensburgh.
- Confirmation from First ScotRail that, in the event of a person with mobility problems being unable to use a station that is not fully DDA complaint (i.e. Hyndland station), they will arrange at no additional cost, with prior notice, alternative transport to take the person from the nearest accessible station to their destination.
- Concessionary fares are available, through the Strathclyde Concessionary Travel Scheme, for people over 60 years of age and people with a disability (who live permanently in the area covered by the Scheme).
- We will work with partner organisations, through Community Planning Transport Groups, to explore the potential to develop community and voluntary transport capacity to assist carers visiting relatives in hospital, an approach which underpins existing transport initiatives elsewhere in the Board's area, such as the Evening Visitor Transport Service and other 'door to door' initiatives

5.11.2 Managing Patient Admissions

In order to effectively manage the smaller cohort of 12 beds, it will be necessary for the member of medical staff assessing patients for admission to have sufficient training in psychiatry, with day-to-day experience and familiarity with the alternative community mental health supports available to service users.

We have confidence that both options would be able to manage this issue effectively, with option 2 potentially being stronger because of the continuity with psychiatric medical staff cover throughout the day and night.

5.11.3 Patient Complexity

It is likely that the threshold for admission to the 12 beds will increase compared with current practice. This will result in a ward environment where all patients will require a very high intensity of clinical input due to the complexity of their mental health needs and the risk they may present to themselves and others. Similarly, the ratio of patients in the ward who are admitted under mental health act detention is predicted to increase. Expertise around managing the care of patients is therefore needed throughout the day and evening. This includes specialist knowledge in the use of psychotropic medications, e.g. Rapid Tranquilization, possible rare adverse reactions, e.g. Neuroleptic Malignant Syndrome, and specialist knowledge of risk assessment and the mental health act.

Again, we have confidence that both options would be able to manage this issue effectively, with option 2 potentially being stronger because of the continuity with psychiatric medical staff cover throughout the day and night.

5.11.4 Nurse Staffing Cover

Despite being the only adult acute mental health services at Vale of Leven, Christie ward has coped effectively to date with managing issues associated with nurse staffing cover, whether it is to address unplanned absence or a need to increase nurse observation and support to particular patients. The predicted levels of patient complexity within the ward in future within a smaller cohort of beds are likely to place an additional strain on addressing such nurse staffing cover issues. Such constraints are more manageable where there is a larger critical mass of adult acute psychiatry services on site, as is the case at GRH.

5.11.5 Quality of Patient Environment

In relation to the option to retain these services at Vale of Leven, the future 'endpoint' location of these would be considered as part of the production of a business case incorporating wider site development options. However in the short term, the proposed relocation of six elderly functional beds from Christie ward into an 'expanded' Fruin ward will provide opportunities to improve the quality of environment within Christie ward for remaining patients.

The new-build facilities at GRH are widely acknowledged as offering an excellent environment to care for patients to assist them with their recovery, with immediate access to IPCU beds and other clinical supports as necessary.

5.12 Finance

The financial implications of retaining adult acute mental health beds at Vale of Leven (option 1) can be contained within existing resources in the short term. The capital and revenue costs associated with an endpoint location for these services at Vale of Leven would be developed as part of a business case for the wider cohort of services at the Vale. However, it is reasonable to assume that this would introduce additional revenue and capital cost implications.

The financial implications of transferring adult acute mental health beds to GRH (option 2), would be to reduce revenue costs by approximately £150,000 per annum, in comparison with a 12-bed Christie ward budget. This level of 'saving' is likely to increase further in comparison with the funding required to support an endpoint accommodation solution for the Vale of Leven, that would be progressed through a site business case. No additional capital funding would be required to support the transfer of services to GRH.

Accordingly, option 2 can be said to be more cost effective than option 1.

5.13 Conclusions

In setting out our proposals for elderly and adult acute mental health services, we have listened carefully to the feedback received during the previous consultation. In light of the proposed configuration of all services at the Vale of Leven set out in this consultation document, the opportunity has been taken, with the assistance of GP colleagues, to develop and recommend a service model that retains elderly acute mental health services at that hospital site, alongside elderly mental health continuing care services.

For adult acute mental health services, we have engaged further with GPs and other stakeholders and are confident both options proposed within this consultation document offer a sustainable choice. Both options have advantages and disadvantages. We will use the consultation period to listen again to people's views to inform our recommendation to the Cabinet Secretary for Health and Well Being.

Unlike the previous consultation, the mental health proposals within this paper have not been subject to a formal option appraisal exercise. Instead, they build on the work previously undertaken, and from our further engagement with key stakeholders.

As outlined in this paper, options to retain services at the Vale of Leven are more expensive than the options to transfer services to Gartnavel Royal Hospital. However, in setting out our proposals, we have demonstrated that the issue of finance, while extremely important, is not the over-riding factor that has shaped our thinking as we strive to find solutions that are in the best interests of service users and our wider communities.

Finally, while the mental health proposals for consultation relate to inpatient services, it is important to emphasise that 95% of care and support takes place in a community setting. Our commitment to develop community services will therefore significantly improve people's access to a wider range and quality of services.

6. The Vision: Alexandria Medical Centre and Care Home development

6.1 New Alexandria Medical Centre

The development of the New Alexandria Medical Centre on the Vale of Leven Hospital site is another substantial investment in services within the locality and one which we believe will deliver many benefits.

This long anticipated and much needed development is a key element for providing high quality primary care health and social care services within the local area.

Planning for the Centre and the range of services to be provided from it has been underpinned by the following objectives:

- To enable the CHP to provide an integrated service across primary care, community health and social services in the Alexandria area.
- To maximise clinical effectiveness.
- To provide accessible services for the population of Alexandria and its surrounding area.
- To provide flexibility for future developments to meet changing local needs.
- To provide a building that is acceptable to patients, staff and the public in terms of the quality of environment, functionality and provision of space.

Following a comprehensive assessment of a number of potential sites within Alexandria, the Vale of Leven Hospital site has been judged to be the best location for the new Centre. Key reasons for this include:

The large size of the site will enable the Centre to expand as community and primary care services develop over time.
The proximity to hospital services will strengthen the capability of both to better address the changing health and social care needs of the local community.

Developing the Centre as an integral part of this overall Vision provides enhanced opportunities for innovative patient care and seamless service delivery.

The new Centre would provide a base for a range of services and teams, including:

- General Practice
- Primary Care Mental Health
- Nutrition and Dietetics
- Physiotherapy
- Podiatry
- Audiology
- Children's Services
- Integrated Care Team
- Community Nursing Team
- Prescribing Support Team
- Joint Community Care Team – Social Work

It will also provide up-to-date education and training facilities for local staff.

The new Centre would provide the following benefits to the local community:

- Services designed from the start around the needs of patients and clients so that they work well and are convenient for them.

- Improved access to joined up services that meet both health and social care needs – a "one stop shop".
- Improved clinical effectiveness and service quality, including the ability to enhance scope and range of services on an on-going basis.
- Improved quality of physical environment that optimises the working conditions of staff, and enhances the experience of patients and clients.

Planning permission is already in place to develop this modern facility on the site, at an estimated cost of £18.2 million with building potentially commencing late 2009 / early 2010.

6.2 New Care Home

This £15 million facility is an important part of increasing the quantity and quality of care home provision within the local area. West Dunbartonshire Council is the lead agency for this work, and has been collaborating with West Dunbartonshire Community Health Partnership in developing the plans.

This would be a modern facility, with both the building and care provided within meeting the high quality of standards required by legislation and expected by the local community.

There would be the potential for a proportion of the beds developed in the Care Home to be allocated to the NHS for the on-going provision of care to elderly mental health patients.

Locating the Care Home on the Vale of Leven Hospital site would enable strong links with both the hospital and the new Health and Social Care Centre to the benefit of the patients resident within. This modern Care Home would be one that provides patients with privacy, comfort, support and dignity.

7. Access to Hospital: Public Transport Provision

Public transport, and access to hospitals, is an issue which is of concern to many people. Whilst rising car ownership has seen many people benefit from increased access to a range of life's opportunities, it has also had the effect of reducing the number of people using public transport. This has seen a reduction in services over the years. Also many people do not have access to a car and we know that car ownership decreases with age.

NHS Greater Glasgow and Clyde understands the importance of access to hospitals and the role public transport plays in ensuring good access for all. NHSGGC is not responsible for the provision of public transport – that lies with Local Authorities, Strathclyde Passenger Transport (SPT) and the Government, but we are a partner at all levels in seeking to improve it. For the last number of years we have worked in partnership with West Dunbartonshire Council and SPT. Our partners are committed to improving access to healthcare and hospitals.

Our Vision for the hospital will see approximately 18,350 cases of care which are currently provided in the RAH or in Glasgow Hospitals to residents of West Dunbartonshire or Argyll and Bute, being provided at the Vale of Leven in the future. This will make a major reduction in the amount of travel, travel time, mileage and costs spent by patients or carers in reaching hospital for their care.

However, there will still be those who require to use public transport to access hospitals and in relation to the up to 1900 unscheduled medical patients that will require to be admitted to the RAH there may also be a requirement for carers or visitors to use public transport to travel to the RAH.

Since February 2006 a bus service – the 340 - connecting the Vale of Leven Hospital to the Royal Alexandra Hospital has been funded, initially by NHS Argyll and Clyde, and since April 2006 by NHS Greater Glasgow and Clyde. The service, 340, runs six times a day in both directions.

The service provides a high quality, accessible service. However, we acknowledge it could be better used. To this end we will remarket the service and will work with partners to publicise it widely.

We also wish to see if the service can be made more useful to more people and have asked SPT to see if this service can be tied in with other bus services or if the route could be improved.

We also know that there are many people, especially some elderly people or people with disabilities, who find it difficult to use fixed bus services. This can often be due to the difficulties they experience in getting to the bus stop in the first instance. These people are often better served by a type of transport known as Demand Responsive Transport – DRT. DRT is a type of transport which collects people from their house and brings them to their destination. This type of service is often based around a telephone booking system where journeys are arranged in advance.

We have had discussions with SPT and West Dunbartonshire Council regarding the provision of DRT generally in the area. Since April 2008, SPT has received and managed the West Dunbartonshire allocation of DRT monies that had previously been distributed via other mechanisms. SPT and West Dunbartonshire Council are keen to work with NHSGGC to see how this allocation could be used to improve access to hospitals and healthcare.

We also wish to explore with SPT, West Dunbartonshire Council and the Voluntary Sector, opportunities to pool existing resources to improve access to healthcare and hospitals. For

example, Councils and Voluntary agencies often have vehicles, drivers or other transport related resources which are not used 24 hours a day, 7 days a week. Sometimes, one agency is not using a vehicle at the same time as another agency has a need for a vehicle. By sharing resources in this way the overall capacity to carry people can be increased.

We have also worked with First ScotRail to clarify the situation for people with a disability who potentially may need to use the train to get to Gartnavel. Within the First ScotRail network, a number of stations and trains are not fully accessible to disabled customers. In addition, not all stations are staffed and others are only staffed part time. However, First ScotRail are able to provide a comprehensive assistance service for customers who have a disability. To find out more about the assisted travel service telephone: 0800 912 2901.

8. Impact on Staff

Our Vision for the Vale of Leven Hospital describes the full range of services that we hope will in future be delivered from the site. This Vision is now subject to public consultation and will thereafter be considered by the Board of NHSGGC before they decide what recommendations to make to the Cabinet Secretary who will make any final decisions in relation to service change. Obviously any final impact on staff cannot be determined until a final decision is taken by the Cabinet Secretary.

There are several key elements of our Vision in terms of implications for staff. The additional developments in relation to planned care will have some requirement for additional staffing which will be worked through as these developments move to implementation.

In relation to mental health services there are two options being consulted on for the future provision of adult acute services. The option which sees the relocation of these beds to the Gartnavel Royal Hospital would obviously mean a reduced mental health inpatient staffing requirement on the Vale of Leven site. Any conclusions in relation to this area are dependent on the final outcome of the consultation and decision making process.

Similarly the proposal to retain between 70% and 80% of the unscheduled medical care activity and up to 72% of the acute inpatient beds in medicine, rehabilitation and surgery would require changes to the staffing required to deliver these services. As is described in section 2 and section 4 of this document there would be increases in the number of beds and staff required at the RAH hospital.

Following any final decision on the unscheduled medical service, the rehabilitation service and the mental health service at the Vale of Leven Hospital, meetings will be held with the trade unions and on a one-to-one basis with any member of staff who will be directly affected. NHS Greater Glasgow and Clyde has a successful track record in redeploying staff taking into account individual's skills and personal circumstances. Redeployment will be the first consideration with the aim of securing alternative employment for displaced staff as a result of service change. This redeployment would not solely be offered to the Royal Alexandra Hospital, we would work with any affected local staff to ensure that their professional and personal circumstances were taken into account when seeking appropriate redeployment opportunity. Based on this approach, detailed redeployment principles will be agreed and a process of vacancy management will be put in place to secure alternative employment in alternative departments and locations.

Regular briefing sessions would be held with staff throughout any period of implementation.

9. Bringing the Vision Together

This consultation document outlines a Vision for the Vale of Leven Hospital and the wider Hospital site. It describes the full range of services that we propose will be delivered from the Vale, explains how they will be delivered and highlights what this will mean for patients and staff. We believe that the Vision described in this document represents the best possible balance between providing local access to high quality services and a requirement to travel for more specialist or intensive care on the occasions when it is required. The Vision is closely informed by the work undertaken on the Lomond Integrated Care Model at the Hospital and also by the views expressed by the two groups of independent experts who have reviewed services at the Vale of Leven over the past 18 months.

The Vision sees the vast majority of activity that is currently delivered from the hospital being sustained. It also sees 18,350 planned episodes of care that are currently delivered in Glasgow or Paisley being repatriated to the Vale of Leven Hospital. These developments will significantly enhance the hospital and have real benefits for large numbers of local people.

In relation to unscheduled medical care the work that we have undertaken means that we think it is clinically appropriate to maintain between 70% and 80% of unscheduled medical activity. Taken together with the conclusions of our work on rehabilitation and inpatient surgery this will mean that we are able to maintain approximately 72% of the current acute beds that are provided in the hospital.

For inpatient mental health services for adult patients between the ages of 18 and 65 the community based crisis team which has been established is already ensuring that fewer patients require admission to hospital. We therefore project that the number of acute inpatient beds for adults will reduce from 18 down to 12. There are two possible options for where this service can be provided in the future: Gartnavel Royal Hospital and the Vale of Leven. This document describes both options and asks for your view on which option is preferable. For elderly patients with acute mental health needs we will continue to provide inpatient services on the Vale of Leven site.

In addition to the increased hospital-based care that will be delivered on the Vale of Leven site we also propose the development of a New Alexandria Medical Centre as part of our Vision. This will be an £18m investment in the site and is one which will have benefits for patients and staff. The development of a Care Home on the Vale of Leven site is also included in our Vision.

The impact of these developments on the level of non-inpatient bed activity at the Hospital is shown in the table below.

Area	Current Patient Episodes	Future Patient Episodes
Outpatient Services	50,000	50,000
Daycase and short stay planned procedures	7,000	7,000
Planned diagnostic services	11,500	11,500
Community midwifery unit services	14,000	14,000
Day Hospital for Elderly Patients	7,500	7,500
Primary Care Emergency Services	10,000	10,000
Minor Injuries Unit	9,000	9,000
Medical Assessment Unit	6,300	4,410 – 5,292
New Planned Care Services: Diagnostic, Outpatient, Treatments and Daycase Procedures		18,350
Total	**115,300**	**131,760**

For the new model of unscheduled medical care to be successful it needs to be supported by the community and by the staff. We therefore want to encourage as many people as possible to give us their view on this model of care. In relation to mental health services for non-elderly patients your feedback will also be important in determining the conclusions reached by the Board of NHS Greater Glasgow and Clyde. We want the community to be as well informed as possible about our Vision for the Hospital when giving us feedback and for this reason we would also welcome your feedback on the overall Vision. The ways in which you can find out more about our proposals and give us your feedback are shown in the final section of this document.

Another important reason for seeking to describe the vision for the future of the Vale of Leven is to allow us to move to develop an appropriate capital investment plan. When we have clarity around the future configuration of services and the corresponding requirement for wards and other facilities then we can begin to develop the site to ensure that the facilities are appropriate to the needs of the patients that will be treated. We know that the existing infrastructure requires considerable investment to ensure it can provide an appropriate environment and a key decision moving forward will be to determine whether new build facilities for mental health, rehabilitation and unscheduled medical care services are a more effective solution than extensive refurbishment of the existing estate. The development of facilities to incorporate additional planned care activity, of the new Alexandria Medical Centre and potentially of a new Care Home will require significant new build projects to be undertaken on the site and we will explore whether there would be economies of scale and service advantages from also developing new build inpatient facilities.

10. Involving You – The Consultation Process

Consultation Arrangements

Public consultation on these proposals began on Friday, 31 October 2008 and will go on until **Friday, 30 January 2009**.

If we are to agree a vision for a successful and sustainable Vale of Leven Hospital, your feedback is absolutely vital. Please take this opportunity to let us know what you think.

Consultation Documents

If you would like more copies of this document, or a summary newsletter that has been produced, you can download them from our website at:

www.nhsggc.org.uk/valeofleven

Alternatively, you can call **0800 027 7246** to have copies posted out to you.

Arrangements have been made to have the summary newsletter *The Vale Vision* delivered to every household in the Vale of Leven Hospital's catchment area.

Both documents are also available in different formats and languages, including Braille, audio-tape, Cantonese, Urdu, Hindi and Polish (see the panel below for details). If you would like documents in any of these versions, please call **0141 201 4915**.

Public Meetings

Nine public meetings have been arranged as part of the consultation and you are welcome to attend to hear more about the proposals and to put forward questions and points of view. All meetings will be recorded and summarised so that the views expressed can be submitted as part of the consultation.

- **Thursday, 27 November 2008**, Commodore Hotel, Helensburgh - 2.30 to 4.30PM and 6.30 to 8.30PM

- **Monday, 1December 2008**, Dumbarton Burgh Hall – 2.30 to 4.30PM and 6.30 to 8.30PM

- **Wednesday, 14 January 2009**, Vale of Leven Academy, Bonhill, Alexandria – 6.30 to 8.30PM only

- **Monday, 19 January 2009**, Dumbarton Burgh Hall – 2.30 to 4.30PM and 6.30 to 8.30PM

- **Wednesday, 21 January 2009**, Commodore Hotel, Helensburgh – 2.30 to 4.30PM and 6.30 to 8.30PM

In all but one of the meetings (Alexandria) we have been able to arrange separate afternoon and evening sessions to ensure as many people as possible can attend.

If you would like to attend any of these meetings, please **call 0800 027 7246 to book a place in advance**. Places will be allocated on a first-come, first-served basis. Where there is a choice, please state if you are attending the afternoon or evening session.

Drop-In Sessions

We appreciate that the timings and format of public meetings will not suit everyone, especially those who to prefer to ask questions and make comments informally. For that reason, we are arranging a number of drop-in sessions around the area during the consultation period.

There is no need to book a place in advance, simply go to the venue at the time that suits you best. NHS staff will be on hand to chat through the proposals.

At the time of writing, the following session have been set up:

Dates to follow

We will advertise other sessions as we organise them in the local press and on screens at local health centres and the Vale of Leven Hospital. You can call **0800 027 7446** at any time to check forthcoming dates.

Group Meetings

We will be arranging for NHS staff to meet with local community and patient groups during the course of the consultation. If you belong to a group that you feel would benefit from one of these meetings, please call **0800 027 7446** to register your interest.

Staff Briefings

Two briefing sessions for NHS staff has been arranged at the Vale of Leven Hospital on Tuesday, 4 November and Wednesday, 5 November 2008. Further information about following arrangements will be provided by local managers, on *StaffNet* and in editions of *Core Brief*.

Putting Forward Your Views

Other than attending the public meetings and drop-in sessions, you can put forward your comments about the proposals in writing. You can do this in two ways:

By post to:

John Hamilton,
Head of Board Administration.
NHS Greater Glasgow and Clyde
FREEPOST SCO6902,
Glasgow,
G1 4BR
There is no need to affix a stamp to the envelope.
You can also put your views forward by e-mail:

valeofleven@nhsggc.org.uk

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

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

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

如果您需要该信息的其它语言版本，请联系：

اگر این اطلاعات را به زبانی دیگر میخواهید لطفا با این ادرس تماس بگیرید:

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

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

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

Eğer bu bilgiyi bir başka dilde istiyorsanız lütfen bağlantı kurunuz:

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

0141 201 4915

The consultation will end on Friday, 30 January 2009.

Appendix 1: Future Model for Unscheduled Medical Care

Draft Clinical Protocols and Assessment of Clinical Safety

This appendix outlines the clinical protocols and clinical scoring system that will be used to determine the patients that will in future be cared for at the Vale of Leven Hospital. It also describes the detailed work we have undertaken to review patients who would potentially fall in to the two categories that require greatest clinical consideration.

Clinical Protocols

There are currently protocols and clinical assessment scoring systems in place which ensure that the most acutely unwell medical patients bypass the Vale of Leven Hospital. The GPs, the Scottish Ambulance Service and Staff at the Vale of Leven therefore have experience in using protocols to inform the patient pathway. The new model of care is based on refining these protocols, lowering their threshold and bypassing all patients with some types of medical complaints.

There are three technical terms which are used in describing these protocols.

- PreAMBLE is an initial triage scoring system which can be used quickly and easily. It assigns points based on different physiological criteria.

- GCS is the Glasgow Coma Scale which is used internationally to determine the degree of consciousness and neurological (brain) functioning of a patient.

- PreEMPT is a scoring system which requires the results of tests that generally need to be undertaken in hospital before being applied.

Statistical Analysis being undertaken by the Public Health team within NHS Greater Glasgow and Clyde may augment and enhance the draft scoring system that is outlined in this document.

The protocols are based on two principles:

1. That all patients, regardless of their presenting complaint, whom our scoring system identifies as potentially requiring higher dependency care will bypass the Hospital or be transferred immediately on self presenting.

2. That all patients with certain complaints (regardless of their outcome based on our scoring system) should bypass the hospital.

The scoring system that will be used is an extension of the existing PreAMBLE system used within the Vale of Leven area. We have lowered the threshold and introduced additional physiological criteria. The draft system is described below.

New PreAMBLE

Score Parameter	3	2	1	0	1	2	3
Heart rate	≤ 30	31 - 40	41 - 50	51 -110	111 - 130	>130	
Respiratory rate	≤ 8		9 - 11	12 - 20	21 - 30	31 – 40	>40
AVPU				**A**lert	to **V**oice	to **P**ain	**U**nresponsive
Systolic BP	≤ 70	71 - 80	81 - 95	96 - 199	>199		
Oxygen Saturation (on air)			<95	>=95			

Patients would bypass or be immediately transferred should their **total score for all Parameters be greater than 2.**

In addition, if a patient scores 2 or less but:

- They have a **GCS of less than 14**
- They have a **PreEMPT score of >25**

they would bypass or immediately be transferred.

The PreAMBLE and GCS protocols will be used by the Scottish Ambulance Service, by GPs within surgeries and as an initial triage tool in the MAU at the Vale for patients who self present. The PreEMPT relies on the outcome of further tests and will therefore be used only in the Vale of Leven Hospital.

In addition to the use of this scoring system patients with certain conditions will not be treated at the Vale of Leven Hospital. These are:

- Patients who have suffered from a stroke or a suspected stroke
- Patients who have taken a drug overdose
- Haematemesis patients requiring hospital care (patients with gastro-intestinal bleeding)
- Patients requiring inpatient haematology care
- Patients with neutropenic sepsis
- Patients requiring hospital care due to epileptic seizures

We estimate that the application of these protocols will mean that approximately 1,200 patients who currently receive their care at the Vale of Leven will in future require to bypass the hospital or be transferred after presenting.

Clinical Assessment of Patient Groups

We have given detailed consideration to the clinical issues associated with the implementation of the revised scoring system and the protocols. There are two groups of patients which require greatest clinical consideration as a result of the development and potential implementation of this model.

These are:

1. Patients that our scoring system and protocols would mean should not be cared for at the Vale of Leven but who self-present.

2. Patients who our scoring system and protocols would suggest can be cared for at the Vale but who our existing information shows subsequently require Higher Dependency Care or to transfer to the RAH.

We have used the comprehensive database of actual patient activity at the Vale of Leven that has been developed to predict and identify the individual patients that are likely to fall into these two groups. We have closely reviewed and analysed the individual records for these patients. This has involved a detailed clinical review of individual case-notes where this has been considered appropriate.

The database that has been created to support the development of this model of unscheduled care is an extremely valuable resource that is based on 14 months worth of actual patient attendances at the
Vale of Leven Hospital. For the 4,300 patients who required admission during these 14 months we have captured all physiological presenting information, previous contacts with the wider NHS system, method of arrival at the Hospital, the initial facility to which the patient was admitted and the subsequent transfers to different specialties. As well as allowing us to assess the inpatient length of stay requirement for these groups of patients this database also allows us to identify the patients in the two groups which require detailed clinical consideration.

Group 1: Self Presenters

Based on actual physiological admission data, on presenting condition and on initial diagnosis we are able to identify the group of patients who actually self-presented to the Vale of Leven medical assessment unit but whom, in the future model, we would want to transfer from the Hospital to the RAH. It is important that we understand this group of patients to allow us to determine the urgency with which they would require to transfer.

We have reviewed the records for the 128 patients who fell into this category during 2006-07.

This analysis shows that:

- After attending MAU only 27 of this 128 required immediate admission to HDU at the Vale or transfer to the RAH.

- Of this 27:

- 18 had a PreAMBLE score of 3 or lower including the 1 point score for oxygen saturation. This suggests that they were clinically stable.
- 1 had no physiological data captured but the diagnosis was “alcohol withdrawal”. They were transferred to the RAH and stayed for 3 days in a general medical ward.
- 2 were recorded as being transferred to the RAH but no record was found of them requiring admission.
- The **remaining 6** are the ones which require closest consideration – the **case notes** for these patients have been reviewed.
- The outcome of this review shows that 5 of the 6 patients could have been safely transferred to the RAH on an urgent but non-emergency basis.
- The sixth case was a severe but unpredictable deterioration in a patient receiving a day treatment.

- The other 101 were initially dealt with in the Vale medical wards or by the chest pain service (CCU). I.e. these patients did not require HDU care on admission. 64 of these 101 patients had a total LOS of 3 days or less, 86 stayed for 7 days or less.

- None of the 101 patients were transferred to the RAH after being admitted to the Vale. 3 of the 101 patients required to be transferred to the Vale HDU after being admitted to a medical ward. 2 of these 3 required only 1 night stay in HDU before being discharged. The other stayed in HDU for 6 days before being admitted to a general medical ward for one day. The **case notes** for these **3 patients** have also been reviewed. This review showed that two of the three patients could have been transferred safely to the RAH on a non-emergency basis. The third patient was ultimately safely transferred to the Southern General for a neurological condition and therefore the outcome would have not been different under the proposed new model.

Group 2: Patients who our Protocols identify could be safely cared for at the Vale but who the information identifies required subsequent transfer to HDU or the RAH

This group of patients is one that we have given detailed consideration to and have undertaken comprehensive analysis of case notes. Our analysis suggests that there are approximately 150 patients who would fall into these criteria. Analysis has been completed for 90 of these patient notes which we believe represents an appropriate sample. For completeness, however, we will continue to work through the remaining records to ensure we have an absolute understanding of the clinical position.

The analysis completed to date shows that many of the patients were admitted to higher dependency care because this provided an immediately available bed en-route to a general medical ward and that they were therefore not truly higher dependency patients. Similarly, many of those transferred to the RAH were found to require surgical care and safely received a routine transfer.

16 of the patients we have reviewed require more detailed explanation as a result of being clinically at a higher risk. Of the 16 patients, our subsequent analysis has shown that 8 would be bypassed out by GPs, the SAS or immediately on presenting at the Hospital. All of these could be safely transferred on an urgent but non-emergency basis.

For the remaining 8 patients the review of case notes has shown that they could have been accepted for care at the Vale based on the application of our protocols. Our conclusion is that 3 of the 8 patients would have been transferred out from the MAU under the new arrangements and that the other 5 subsequently became of higher risk. We conclude that all 8 patients could have been safely and appropriately transferred to the RAH Hospital without requiring anaesthetic intervention.

Appendix 2: Future Model for Unscheduled Medical Care

Draft Clinical Governance Arrangements at the Vale of Leven Hospital

This draft document describes the proposed clinical governance arrangements for the provision of unscheduled medical care at the Vale of Leven Hospital. These will be subject to ongoing discussion and potentially to further review.

The document covers two areas:

1. Inter-professional relationships
2. Quality Assurance – General Practitioner with Special Interest (GPwSI)

1. Inter-professional relationships

Clinical responsibility for a patient's care will rest with the team of GPs involved in managing their care. Individual practitioners will be responsible for their own clinical decisions.

Formalised handover of care between members of the GP team will ensure continuity of care.

Corporate governance rests with the Emergency Care and Medical Services Directorate within the NHSGGC Acute Operating Division.

A Clinical Governance group, chaired by the GP CD (MD) will provide an overview of governance and ensure that robust systems are in place. This Group will report (potentially via the PEG) to the Emergency Care and Medical Services Directorate Senior Management team.

2. Quality Assurance

It is recognised that there are professionals from other backgrounds working on the hospital site, and they will all be expected to perform clinical duties to the highest standard as required by their professional regulatory bodies. All staff will be able to demonstrate on-going attention to their own training and personal development as described by their professional bodies such as GMC, NMC, RCGP, RCP. GPs working within the hospital acute medical service will have a recognised training providing the skills required of a GP.

The Clinical Governance Group in the Hospital should have representation from Nursing Staff, Consultants and GPs. This is anticipated to operate in a similar manner to the “Issues Group” which currently meets twice monthly, and feeds into the broader Clinical Governance structure as previously described. These would maintain a system of rapid clinical review, and identify issues which need to be looked at by the broader PEG.

<u>The relationship with RAH Consultant Physicians:</u>

This has two strands –

<u>A. Consultant visiting VOLH</u>

The role of the Consultant Physician in this model has to be clear. It is expected that the Consultant Physician attends on-site to provide protected time to allow joint review with a GP of selected patients. The Consultant would be expected to provide a specialist clinical

opinion and support, akin to the role which they have in a consultative capacity in Out-Patient Clinics or domicillary visits. These patients may include those admitted over the preceding 24 hrs, and patients who are posing particular management problems, but not clearly meeting the protocol criteria for transfer to RAH. They would have effectively been “referred” to the Consultant by the GP for a clinical opinion. These may be patients who do not appear to be making a recovery as expected for the underlying diagnosis, or even patients whose ceiling of care is below HDU level, but require additional clinical review. Clinical responsibility for the patient will remain with the GP unless, by mutual agreement, this is passed onto the Consultant. In this case the patient will be transferred to the RAH. The telephone on call commitment would be met at other times by the receiving consultant at RAH.

B. Receiving Consultant Physician at RAH

It is essential that there are clear lines of communication between doctors at the VOL and Receiving Team at the RAH. Patient management is based on a principle of transferring a small number of patients to RAH, either following initial triage and assessment, or due to on-going deterioration in the ward.

As a consequence, it will be necessary for the Receiving Consultant or deputy to be available for phone discussion and advice re patients over the 24 hr period. If good communication is maintained this may help minimise transfers to RAH, although decision to transfer still rests with the VOLH GP, and should be respected accordingly by RAH Consultant.

Appendix 3: Future Model for Unscheduled Medical Care

Draft Training Requirements

This draft document describes the proposed training and validation arrangements that the GPs leading on the provision of hospital care at the Vale of Leven would receive. These will be subject to ongoing discussion and potentially to further review.

1. Additional knowledge and skills

- As per that defined by RCGP for GP Principals
- ALS training
- LMA insertion
- CXR interpretation
- ECG interpretation
- Core Medical Topics as below

2. Training and Appraisal

- Training contract – "adult learning"
- Thorough and robust training requirements for GP ST1 trainees also
- Online modules – certificated as per doctors.net - to support monthly educational meetings * (See topics below)
- Monthly educational meetings – Mandatory attendance at annual residential and total 8/12 meetings
- Multi-source feedback 6 monthly
- Recorded online learning log
- SEA and clinical issues raised and addressed appropriately to identify learning needs
- PDP as appropriate in addition to above
- Annual appraisal by GP – trained GP Appraiser from same professional peer group – would require one weekly session through NES
- Linked with RCGP and RCP and NES

3. Monthly Meetings

To support and facilitate the ongoing training and development requirements it is proposed that a series of monthly meetings would be held. The proposed arrangements for these are outlined below.

- 12 meetings in total
  - One annual two-day residential in Stirling – based around Scottish Clinical Simulator Centre
  - All other meetings held locally for 2 hours
  - Two meetings led by SCSC clinical tutor
  - Nine remaining months – core topics:
    - Resuscitation and Anaphylaxis (including ARF- Management of hyperkalaemia) ; ABG interpretation
    - Cardiac - Chest pain and acute MI ; Arrhythmia
    - Chronic Heart Failure
    - Respiratory – Asthma ; Pneumonia; Pleural effusion
    - Surviving Sepsis
    - Acute Headache
    - Stroke and TIA
    - Infection - Acute confusion ; PUO ; HAI ; Acute swollen joint
    - Jaundice and alcoholic liver disease

4. Online Training Modules

A range of online training can be used in tandem with the monthly meetings. These can be accessed via doctors.net

The topics covered are:

1. Surviving sepsis 2. Acute Asthma 3. Acute chest pain 4. Pleural effusion 5. Pneumonia 2006/2007 6. Non-cardiac chest pain 7. Acute renal failure 8. Jaundice 9. Alcoholic liver disease 10. ABC of Hepatitis 11. Acute headache 12. Delirium in the Elderly 13. Headache in the Elderly 14. Management of Stroke and TIA 15. Intracerebral Haemmorhage 16. Suicide and Parasuicide 17. Management of Hyperkalaemia 18. Pyrexia of Unknown Origin (PUO) 19. Chronic heart Failure 20. Acute swollen joint	21. Advanced blood gas interpretation 22. Anaphylaxis 23. Bradycardia 24. Basic PLS 25. Clinical Blood Transfusion 26. Difficult airway management 27. HAI – C Difficile and Norovirus 28. Heart Failure in 2y care 29. Recognition of the Critically Ill 30. A Complicated Case of Acute MI 31. Acute MI 32. Anticoagulation 33. Atrial Fibrillation 34. ECG Interpretations 35. Tachycardia 36. Valvular Heart Disease 37. DVT and PE 38. Oncological emergencies

5. Appraisal

Appraisal will play an important part in delivering the ongoing training and development requirements. Key elements relating to appraisal are:

- Additional to GP Appraisal – assumes this is satisfactory but could dovetail
- Appraiser trained in appraisal and performing same job
- Online learning log bases record
- Annual appraisal by telephone – cf sign-off for nMRCGP SPTC
- Point of contact if concerns re unmet learning needs and could liaise with Clinical Governance lead
- Appraisers ensures updates of learning logs

Appendix 4:

Reviews of Anaesthetic Provision at the Vale of Leven Hospital

There have been four reviews undertaken which have assessed the sustainability of anaesthetic services at the Vale of Leven Hospital.

These have been:

1. Independent External Clinical Review of Anaesthetic Services at the Vale of Leven Hospital. August 2008, Chaired by Professor Dodds

2. Independent Scrutiny Panel. December 2007, Chaired by Professor MacKay

3. NHS Greater Glasgow and Clyde Review. June 2007

4. NHS Argyll and Clyde Review. August 2005

Overview

This paper highlights the key findings in relation to anaesthetics of the two independent reviews that have been undertaken. It also includes the full report of the review undertaken by NHS Greater Glasgow and Clyde which concluded that anaesthetics could not be sustained at the Vale of Leven Hospital.

We have not included the 60 page report developed by NHS Argyll and Clyde in 2005 which established arrangements for maintaining short term anaesthetic provision and recognised that the longer term future was to attempt to develop a model of unscheduled medical care that did not require anaesthetics cover. This report can be provided on request.

August 2008 Independent Review

This review group, Chaired by Professor Chris Dodds, was established by the Scottish Government and was tasked with assessing the sustainability of anaesthetic services on the Vale of Leven site. The full report of the group can be found at:

http://www.scotland.gov.uk/Resource/Doc/924/0064627.pdf

In relation to anaesthetics provision the report has the following conclusion:

"**It is the unanimous view of the review team that the continued provision of anaesthetic services at the VoL is not sustainable in the short, medium or long term.** We have reviewed all possible steps to secure anaesthetic services at the Vale of Leven and, as indicated in the options appraisal, we were not able to identify a feasible and sustainable model of delivery for the VoL."

December 2007 Independent Scrutiny Panel

The Independent Scrutiny Panel, Chaired by Professor MacKay, was established by the Scottish Government in July 2007 and reported in December 2007. It reviewed the conclusions of the anaesthetics work that had been undertaken by NHS Greater Glasgow and Clyde and which is described in the remainder of this appendix.

The full report of the Independent Scrutiny Panel can be found at:

http://www.independentscrutinypanels.org.uk/resources/FINAL+REPORT+12.12.07.pdf

The following extract from the Independent Scrutiny Panel report outlines the outcome of their review of anaesthetics.

"The Panel has examined the case made by the Glasgow anaesthetists for their inability to cover the Vale of Leven. They made the following points to us:

- The European Working Time Directive and new contract arrangements (which have to be adhered to) place new limitations on working hours.
- Critical care involves more than core anaesthetic skills (intubation) but also clinical judgement and whole care of critically ill patients (as practised by intensivists who are relatively few in number).
- It would not be possible to supervise junior or incompletely trained staff safely from a distance.
- The frequency of critical episodes requiring skilled anaesthetic involvement is low which would lead to deskilling and 'clinical boredom' - wholly unattractive to permanent consultant staff.
- Rotation of consultant intensivists into short periods at VoL was simply not a practicable option.

The Panel notes the inability of the Glasgow anaesthetic service to provide a sustainable service to cover out-of-hour requirements for UMA at VoL. These views were substantiated by expert opinion outwith the West of Scotland."

The review of anaesthetics provision at the Vale of Leven Hospital undertaken by NHS Greater Glasgow and Clyde is described in the remainder of this appendix.

NHS GREATER GLASGOW AND CLYDE

REVIEW OF ANAESTHETIC SERVICES
Vale of Leven Hospital: June 2007

1. Purpose of Paper

1.1 In September 2006 at the time of considering services within Clyde by the Greater Glasgow and Clyde Health Board, the then Health Minister requested further work be undertaken to review the anaesthetic position at the Vale of Leven Hospital in light of being part of a larger organisation and the opportunities that this might offer. This paper has been prepared to report on the findings of the review of Anaesthetic Services across NHS Greater Glasgow and Clyde.

2. Background

2.1 Between 2002-2004 significant service reconfiguration was undertaken at the Vale of Leven Hospital (VOL) in order to address the challenges of delivering and sustaining safe specialist acute clinical services for the local population. Reconfigurations of obstetrics, paediatrics, gynaecology, urology, general surgery and accident and emergency services gave rise to a reduced volume, variety and complexity of work for the Anaesthetic Department at the VOL. These services are now provided at the Royal Alexandra Hospital (RAH).

2.2 Accident and Emergency services transferred to the RAH Hospital in January 2004. The anasethetic community had made it clear at that stage that, due to the low levels of activity remaining at the VOL, anaesthetics would not be sustainable there beyond the short term. In order to sustain unscheduled medical admissions at the VOL, anaesthetics cover continued to be provided locally but this continued on the understanding that “Shaping the Future”, the Argyll and Clyde Clinical Strategy, which was published in June 2004 would inform the way forward and that the provision of anaesthetics would only be an interim position.

2.3 Dr Douglas, Clinical Director (VOL) wrote to the Chief Operating Officer, Neil Campbell and the then Health Minister, Malcolm Chisholm, in June 2004 highlighting that anaesthetics could be sustained only in the short term. His letter outlined the profound consequences of the actions taken to stabilise obstetrics, general surgery, urology, gynaecology and A&E services on the anaesthetic department. He reiterated to the Minister that it had been made clear, during the process of planning for the reconfiguration of surgical services, that the interim measures in place for the VOL could be sustained for only a limited period due to a number of clinical and professional reasons. The reduction in range, diversity and volume of work at the VOL had been considerable and had major consequences. These risks and consequences to anaesthetic services and the knock on impacts on remaining services at VOL were discussed with the members of NHS Argyll and Clyde Board prior to the November 2004 meeting of the Board.

2.4 It was clear to the Anaesthetic Service, since the letter to the Minister in 2004 that it would not be possible to sustain a 2 tier rota (resident middle grade and consultant on-call) at the VOL beyond the short term. In addition, there were immediate difficulties in sustaining a 2 tier anaesthetic rota at the VOL, where volume and complexity of work did not justify the existing level of resource.

2.5 This was compounded by the need to sustain rotas at the RAH to provide safe cover for the increased surgical, obstetric and level 3 critical care workload that had transferred as the services had been reconfigured.

2.6 Recognising the fragility of the anaesthetics service and its potential for sudden collapse it was clear that there was a major risk around the sustainability of unscheduled medical care. If unscheduled medical care was to be retained on the Vale of Leven site it would have to be done so via the development of a new model of care which did not require on-site anaesthetics support. Steps were therefore taken to develop a new model of care for unscheduled medical patients which would not require on-site anaesthetics. This model was called Lomond Integrated Care.

2.7 Lomond Integrated Care Model

2.7.1 The Lomond Integrated Care pilot project was an innovative solution which proposed breaking down the boundary between Primary and Secondary Care. It involved upskilling nurses and producing a new type of Generalist Doctor, who would be involved in managing the majority of the in-patient medical care on the Vale of Leven site out of hours. In the shorter term, general medical input would be available from some upskilled local GPs interested in supporting the development of the model. In the longer term it was envisaged that primary care physicians who were specifically trained for this purpose would provide this care. In this model of care the most acutely unwell patients would bypass the VOL and be treated in the RAH.

2.7.2 The proposed model of care at the VOL would allow 85-88% of medical admissions to continue at the VOL under the management of medical consultants. Based on the audit data available it was anticipated that 12-15% of medical assessment patients would be transferred to the RAH

2.7.3 Scoring systems were established to support the identification of critically ill patients who would need to be by-passed or transferred in the absence of an on-site anaesthetist / ITU facilities.

2.7.4 The model proposed that medical staff / GPs and nursing staff would support the service, including airway management, without on-site anaesthetic cover. A rapid retrieval service would support the transfer out of patients requiring care with anaesthetic input. The pilot was to be phased so that initially there would be onsite anaesthetic cover, which would move to off site on-call anaesthetic cover. The off-site on call cover would act as a proxy for the retrieval service until the pilot was completed and conclusions formed on the way forward.

2.7.5 In April 2006, when NHS Greater Glasgow and Clyde was established, the Lomond Integrated Pilot had been launched. At this stage anaesthetic support was still available on-site. The planned next stage of the pilot would have seen the withdrawal of the on-site out of hours anaesthetic cover from the VOL, leaving GPs to run the service. However, by July this had still not occurred – both Anaesthetists and physicians had indicated concerns about clinical safety. Consequently a series of meetings with clinicians led NHSGGC to conclude in September 2006 that Lomond Integrated Care Pilot could not be taken to the next stage and was ultimately unsustainable. This was followed by a number of meetings with staff and culminated on 21st September 2006 with a public meeting when NHS GGC stated that the pilot could not be fully implemented based on clinical concerns.

3. Review Process

3.1 Following the meeting on 21st September 2006 NHS GGC established a substantial planning and community engagement process to identify what alternative arrangements were required. At the end of October 2006 the process was further widened at the behest of the then Minister for Health to incorporate a further review of the work undertaken by Argyll and Clyde in relation to the sustainability of the anaesthetics cover at the VOL Hospital. Therefore it was agreed that a small group would be established to undertake a review of the sustainability of Anaesthetic Services.

3.2 Membership and terms of reference Anaesthetic working group

3.2.1 The anaesthetic group was made up of Anaesthetic representatives from Glasgow, Paisley and the Vale of Leven hospitals including the clinical directors for both areas. Representatives from both general practice and acute medicine were invited to participate in the group.

3.2.2 The terms of reference for the group were to:

- Review anaesthetic services across GGC to consider if the combined workforce of the services would allow any different cover of the VOL site, considering the anaesthetic demands of the VOL Hospital.

- Identify other models across the country to see if other sites solutions for anaesthetics would be transferable to the service at the VOL Hospital.

3.2.3 It was subsequently agreed, following the meeting with the community engagement group that a key task for the group was to:

- Consider the questions raised by the community engagement group. In November 2006 a community engagement meeting was organised to consider the previous report on Anaesthetic Services by NHS Argyll and Clyde. At this meeting a number of questions in relation to anaesthetics were identified that the group felt needed further answers.

3.3 To meet the terms of reference 4 key actions were identified:

- A review of the anaesthetic activity at the VOL
- Review the anaesthetic rota requirements across Glasgow and Clyde
- Identify other models across the country to see if other sites had found solutions for anaesthetics that would be transferable to the service at the VOL.
- Answer the questions identified by the Community Engagement group that they felt needed further consideration. These questions are listed below:

    - *Why was this situation not foreseen?*
    - *Was Anaesthetics being reviewed in isolation?*
    - *Due to the large numbers of Anaesthetists in post across both Glasgow and Clyde, can cross-site cover/ working be pursued?*
    - *Can another rota be developed?*
    - *Can we develop the posts to make them more appealing?*
    - *Can the pilot be extended beyond June?*
    - *Why did the pilot not move to stage 2?*
    - *Why can't we use the rapid retrieval team?*

4. Findings

In undertaking the review the group and individuals from the group were required to consider the different strands outlined above. This section documents the findings of the group in relation to each of these components.

4.1 Review of Anaesthetic Services across Glasgow and Clyde

4.1.1 Level of demand on the current anaesthetic provision at the VOL

There are 2 components to the anaesthetic requirements at the VOL

1) Elective requirements in relation to inpatient short stay and day case surgery, which is covered by the Consultant grade staff and would continue with the support as currently with the support of pre-assessment and out of hours support from the hospital at night team where required.

2) Anaesthetic On-call Requirements.

It was anticipated following the removal of on site ITU support that approximately 12- 15 % (10%) of patients would bypass or be transferred off the site. Provisions were therefore put in place at Paisley to accommodate this cohort of patients. To enable this transfer to take place tools were put in place to identify inappropriate patients by both the hospital and the ambulance service, in order to avoid delays in recognition of the acutely unwell patients.

The anaesthetic workload following the change for ITU to support the patients requiring transfer off site is shown in table 1 below.

Table 1. Lomond Integrated care information from February 2006 - April 2007

Number of patients that have bypassed	41
Number of patients who have been transferred off site by the shock team	28
Number of anaesthetic incidents or calls	144
Number of cardiac arrests	72

Of the anaesthetic calls received 55% of the calls occurred between the hours of 8am and 6pm, the remaining 45% occurred out of hours between 8pm and 8am.

Table 2. Breakdown of Anaesthetic Calls from *May 2006 – April 2007

Code	Code Definition	Total Number
1	Pt requires to move off site	29
2	Cardiac arrest	40
3	Clinical issue e.g. venflon/ chest drain	28
4	Opinion re ventilation/ airway management	39

* This information has only been collected since May 2006.

The information within the tables indicates that the number of patients being transferred or bypassed is less than anticipated. The demand on Anaesthetics in relation to the work remaining was 144 calls within a 15-month period. This equates to an average of slightly more than 2 calls each week. 0f the 144 calls 28 calls were for clinical reasons that could have been undertaken by non-anaesthetic staff. Taking these calls into account means that there were 116 calls which required anaesthetics input. 55% of calls are within day time hours, where cover remains for theatre sessions, there is therefore daytime activity requiring anaesthetic on-call input of just over 1 patient per week. The remaining 45% of these calls are out of hours. Therefore approximately 1 patient per week out of hours requires anaesthetics input.

4.1.2 Review of Anaesthetic Staffing across Glasgow and Clyde

4.1.2.1 Training Grade Staffing

1.1 In terms of trainees there are not sufficient doctors to cover the current number of rotas required both in Glasgow and Clyde. This position is expected to worsen over 2007-9 as Modernising Medical Careers (MMC) is implemented fully and the rotas are organised to comply with the European Working Time Directive (EWTD) by 2009. Although the full implications of MMC are yet to be understood in terms of impact on service delivery it is expected that these changes will result in a shortfall increasing the gaps in the service.

1.2 In terms of Clyde there are insufficient staff to support the rotas currently with problems at the RAH in achieving a compliant rota within the RAH Maternity Service which is an additional pressure to the problems of providing a rota at the VOL Hospital. It is also likely that the rotas at IRH will require to change in light of MMC and the EWTD.

1.3 If it is assumed that 6 - 8 people minimum are required to provide a rota there would be a requirement for 24 - 32 middle grade/trainees to run these rotas. There are currently 17.

1.4 In terms of Glasgow rotas work had previously been undertaken by the Clinical Director to consider if there was any slack or duplication within the existing rotas which could allow for reconfiguration. This work had been driven in part due to the service demands within Glasgow. The outcome of this piece of work highlighted that there was no slack within the current service; in fact it highlighted gaps in the service within Glasgow. This position is expected to worsen with MMC and the requirement to meet the EWTD.

1.5 Even if sufficient number of training grade staff were available across NHSGGC the volume of workload at the Vale of Leven would not allow training accreditation to be granted. This has been confirmed by the Regional Education Advisor. Indeed, even prior to the service reconfigurations between 2002 and 2004, which considerably reduced the anaesthetics workload, a trainee rota did not exist at the VOL.

1.6 An anaesthetics training grade rota solution is therefore not feasible at the Vale of Leven Hospital.

4.1.2.2 Non-Training Grade Staffing

2.1 Clyde does not have enough experienced middle grade anaesthetists to provide resident cover to all necessary areas out of hours where they are essential, i.e. RAH ITU, PMH and the VOL Hospital. This is the major limiting factor on rotational cover.

2.2 Within the IRH it is also difficult to meet the rota requirements with the numbers available particularly with the same loss of time due to the training requirements there is a need for non-training grade staff to support the rotas. There is no capacity to aid the other hospitals.

2.3 To create a staff grade / non-training grade rota we would require 6 posts. This was the situation previously at the VOL although there were only 5 people on the rota before the changes were implemented and locum posts were required to support the service. The use of locums is not a viable way to provide a sustainable service. Even if sufficient non-training grade staff could be found there would still exist a requirement to have a named consultant taking overall clinical responsibility for the service.

2.4 It is not acceptable that an anaesthetic consultant provides cover to the Vale of Leven at the same time as they are on call for another busy site across Glasgow or Clyde. They are not able to be in 2 places at one time and the risk associated with this model is therefore not one that we would be prepared to accept.

2.5 Therefore, even if a non-training grade rota was developed to support the Vale there would also need to be an additional consultant on-call rota developed for the Vale. This would have significant cost implications without the workload required to sustain this level of staff input. With the limited workload it would be extremely difficult to retain the level of skills required on an ongoing basis.

4.1.2.3 Consultant Provided Model

3.1 This model would see the Consultant being first on call without resident middle grade support. This is not an attractive option for recruitment. There would need to be 6 wte posts at the VOL to provide this rota. Currently at the VOL there is a reliance on 3 locum Consultants to provide this type of cover to support the site. The basis on which this is provided cannot be considered to be a long-term solution in part because it relies on the use of locum Consultants. To date, the department has been fortunate to keep the same group of locums allowing continuity of service. This cannot, however, be relied upon for the longer term. It is not acceptable to the NHS in Scotland to attempt to maintain a service with a workforce who could leave at short notice and leave the service uncovered. It is also an expensive option for the level of input required.

3.2 As with the middle grade rota one of the key challenges is in relation to the limited workload which would make it difficult to retain the level of skills required on an ongoing basis. The type of anaesthetist required to support the provision of unscheduled medical services is one who has skills in airway management in emergency situations. This skillset is more aligned to the Intensivist Anaesthetist or the emergency care doctor and is not within the average competencies of a general anaesthetist, which is what is required to maintain the major part of the service i.e. the need for cover for theatres. To maintain these intensivist skills requires exposure to considerably more patients than 2 per week during on-call periods. This means that a stand-alone consultant anaesthetics rota is not sustainable at the Vale of Leven site due to the volume of activity being seen.

3.3 The other option for providing consultant cover to the Vale of Leven is to rotate anaesthetists who are predominantly based on other sites through the Vale for specific time periods. In theory spending only short times at the Vale (say a one week period every six months) would mean that they are able to maintain their skills when based at other, busier, sites. This option is one that has been widely regarded by community groups within the Vale catchment as being straightforward to implement. The practicalities of this model, however, mean that it is not one that is possible to deliver. The reasons for this conclusion are outlined in the following points:

1. The service required at the Vale of Leven is essentially critical care airway support for sick medical patients.

2. The vast majority of anaesthetists across Glasgow and Clyde have not had recent training, or more importantly ongoing experience, in intensive care medicine, which is the type of care this group of patients requires.

3. Consequently, the provision of the type of care required at the VOL involves a degree of responsibility which is potentially outwith the competence of the majority of anaesthetists.

4. Most anaesthetists who are not trained in intensive care medicine are therefore unwilling to deliver this type of care.

5. There are currently 33 consultant anaesthetists across Glasgow and Clyde who are trained in intensive care medicine. In addition, within Clyde there are several anaesthetists who provide care critical care coverage who were trained under the older system and who have maintained their skills in order to sustain critical care services at the RAH and the IRH.

6. This body of consultants provides cover to 7 intensive care units across Glasgow and Clyde.

7. Within their total available hours this group must ensure a number of different objectives are fulfilled:
    i. Deliver a demanding on-call service
    ii. Undertake adequate ongoing experience in an ICU to ensure that their intensive care skills are maintained
    iii. Provide sufficient anaesthetic input into theatres to enable the theatre work to continue
    iv. Undertake sufficient work in theatres to maintain their competence as theatre anaesthetists.

8. In order to balance these objectives and maintain their skills in both theatre anaesthetics and intensive care it is not appropriate for this group of staff to spend time undertaking duties which do not maintain or enhance their skills.

9. Maintaining services at the Vale of Leven would require each of these consultants to deliver approximately 2 weeks of resident on-call cover at the Vale each year. Resident on call would represent a very significant departure from current work patterns for the overwhelming majority of consultants in Glasgow and Clyde, including intensive care specialists. We would expect very few intensive care consultants to be willing to take up such a radical change to their job plan.

10. Maintaining the same level of rota frequency as currently provided (around 8 weeks per year) would mean this group of consultants being exposed to 6 weeks on-call intensive care workload in a busier acute site and 2 weeks resident each year at the Vale of Leven. Given the low levels of activity at the Vale of Leven any time spent in the Vale would result in this group having less exposure to patients who require the use of their specialist skills.

11. These circumstances would potentially result in the de-skilling of this group of staff and in the interests of clinical standards this is not a situation that we are prepared to attempt to impose on these highly trained, senior doctors.

12. More importantly, however, the requirement to have anaesthetic consultants providing resident on-call cover would have a profound impact on the ability of

NHS Greater Glasgow and Clyde to sustain services across all sites. The reason for this is that providing resident cover for one night from 5pm to 9am is equivalent to providing 5 sessions of work. Providing one 24 hour period of resident cover on a Saturday or Sunday is equivalent to 8 sessions. A consultant providing resident cover at the Vale of Leven for one week would therefore be "working" for the equivalent of 41 sessions. This is 25 sessions for the weekday overnight cover (5 sessions x 5 days) and 16 sessions for the weekend cover (8 sessions x 2 days). This is the equivalent to 6 weeks of direct clinical workload for an anaesthetic consultant and effectively means that providing one week of resident on call cover at the Vale would mean that the consultant was not able to work for the next six weeks.

13. This would result in NHSGGC being unable to provide intensive care services at other sites. It would also result in the de-skilling of anaesthetists.

14. We can not simply pay consultants extra to have them provide cover at the Vale over and above their normal working patterns. Even if anaesthetists were prepared to do this it would not be compliant with the EWTD requirements.

15. Simply recruiting more consultants to this cohort of staff across Glasgow and Clyde and then rotating these staff to cover increased numbers of sites is not a practical solution because:

    a. The contact time that the consultants have with the type of patients who maintain or enhance their skills would be considerably reduced when they were based at the VOL.
    b. The requirement to provide resident cover at the Vale would mean each consultant requiring approximately six weeks away from patient care for every one week spent at the VOL. This would reduce their skillset and be cost prohibitive.
    c. We are unlikely to be able to convince this cohort of staff to provide resident cover at the VOL.

4.1.2.4 Review of anaesthetics staffing conclusion

4.1 It is the view of the Anaesthetic workstream that they have explored the potential solutions based on the current model of service provision, including the rotation of staff across Glasgow and Clyde, and have found no answers.

4.2 Due to the level of activity requiring on-call anaesthetics provision at the Vale of Leven, training accreditation will not be received to provide a rota made up of doctors in training.

4.3 Due to the level of activity at the Vale it is not appropriate to deliver services based on non-training grade anaesthetists providing services. Even if a non-training grade rota could be developed it would require oversight from a consultant anaesthetist. This consultant cover could not be provided by the same consultant who was on-call at another site due to the risk of the consultant requiring to be called to two places at once.

4.4 A stand-alone consultant rota could not be developed at the Vale of Leven due to the level of activity requiring anaesthetic input. This would not be conducive to maintaining consultant skill level.

4.5 The potential for recruiting additional anaesthetists across Glasgow and Clyde and then rotating them out to the Vale was also explored. Analysis of the working practices of anaesthetists with specialist training in intensive care across NHS Greater Glasgow and

Clyde shows that there are a number of different objectives that must be met by this group of staff. These objectives are currently met by balancing a number of different priorities one of which is having access to enough critically unwell patients to maintain their skills. Introducing greater number of intensive care anaesthetists and then having them cover a greater number of sites will reduce the number of patients that each anaesthetist sees and therefore reduce the opportunity that they have to maintain their skills. This would not be appropriate to the continued delivery of high quality care.

4.1.3 Other Anaesthetic Models of Care

4.1.3.1 Having concluded that it is not possible to sustain anaesthetics at the Vale of Leven based on the current configuration of services the workstream has also reviewed other models of care for either providing anaesthetics to the Vale or for sustaining unscheduled medicine without anaesthetics on-site.

4.1.3.2 A number of sites in Scotland and England have been contacted to determine whether there are alternative models available.

4.1.3.4 The attached table in appendix 1 provides detailed information in relation to the sites contacted for alternative anaesthetic models across the country. These sites were selected as it was assumed that due to the similarity of their function they might inform the search for a safe and sustainable future anaesthetic model on the VOL site. None of the sites, however, offered a viable alternative model or a direct comparison in terms of the population served, or the services delivered. Previous comparison had been made between the Vale of Leven Hospital and Kendal Hospital who had attempted to develop a model of care which provided unscheduled medical admissions without anaesthetic support out-of-hours. Kendal has, however, faced the same challenges as anticipated at the Vale of Leven and has subsequently required to have its services downgraded to a nurse led unit due to staff recruitment issues and clinical governance concerns. The inpatient beds at Kendal will become rehabilitation beds.

4.1.3.5 It was also anticipated that the interim report from the nationally established Remote and Rural Steering Group would inform the search for alternative models following its publication on the 16th of April 2007. The main aim of the steering group is to deliver a strategy for sustainable health care in remote and rural Scotland. The definition of remote and rural is informed by the clinical peripheral index. This takes into account population density, practice size and the time to reach secondary care. Given its proximity to hospitals which provide the full range of acute services the Remote and Rural Steering Group have not identified the Vale of Leven as being either a remote or a rural hospital. It was hoped, however, that the interim report would highlight new ways of working within smaller sites that could be adopted by the VOL. One of the issues being considered by the group was the anaesthetic support required on a remote and rural site. The interim report suggests the there will be no change in the model of anaesthetics cover required in the rural general hospital in future and that the current “consultant protected model of anaesthesia” will apply. It would appear, therefore, that there are no new models of care available.

4.1.4 Response to Questions from the Community Engagement Group

4. 1 Whilst the general points raised by the community engagment group are answered in detail in previous sections of this report this section will summarise

4.2 The following responses were provided by the Anaesthetic Working group in relation to the specific questions raised by the community engagement group in terms of anaesthetics.

4.3 Why was the situation not foreseen?

- As early as 2004 it had been identified formally that there would be issues around the provision of anaesthetics at the VOL. This was primarily due to the reconfiguration of obstetrics, paediatrics, gynaecology, urology and general surgery to create sustainable services for the population. These services changes would ultimately lead to the reduction in the volume, variety and complexity of the work that was required within the VOL site.

- A paper presented to the board of NHS Argyll and Clyde outlined the concerns and the action required. The key issues were:

    - A heavy reliance on locum cover to meet the service needs.
    - Challenging on call commitments for local staff
    - Concerns re the staffs ability to cover level 3 critical care patients
    - Inappropriate use of the consultant staff at paisley resulting in a reduction in emergency workload.

- Lomond Integrated Care, as described above, was developed as a direct response to the understanding that anaesthetics was not sustainable at the Vale of Leven site.

4.4 Is Anaesthetics being reviewed in isolation?

- Anaesthetics is not being reviewed in isolation. It is being reviewed along with Acute Medicine and Rehabilitation to determine the future model of acute services at the Vale of Leven. At a board level a Health Needs Assessment is being undertaken to identify the specific health needs of the West Dunbartonshire population. A review of Glasgow wide midwifery and mental health services across Clyde are also being undertaken.

4.5 With the large group of Anaesthetists across GGC - can cross-site cover be pursued?

Both Dr Cameron Howie Clinical Director for anaesthetics within Glasgow, and Dr John Dickson Clinical Director for Clyde were asked to identify through looking at the current rotas within Clyde and Glasgow, whether any cross cover is possible within the existing workforce.

From a Glasgow perspective Dr Howie explained that the recent changes in medical training arrangements (Modernising Medical Careers) has highlighted the fact that Anaesthetic services in Glasgow have relied on large numbers of SHOs. This grade is disappearing and services are being sustained by the appointment of a relatively large number of Fixed Term Training Posts (FTSTA). This is not unique to Anaesthetic services and derives from a failure, to date, to rationalise acute services within Glasgow. While there will be rationalisation of Maternity services in the city, substantial rationalisation will be difficult to achieve prior to completion of the new South Glasgow Hospital. Employing large numbers of doctors in FTSTA posts is not seen as a long-term solution so the Glasgow service will require to identify ways of reducing dependence on trainee doctors over the next two years.

The situation has been further aggravated by the new training arrangements for doctors embarking on a career in Emergency Medicine, which now involves an obligatory one-year of training in Anaesthetics and Intensive Care. These doctors now substitute for Anaesthetic trainees. This means each Anaesthetic department will have a greater proportion of trainees who are in the first year of training. New trainees in Anaesthesia cannot contribute anything

to on call services in their first three months and must be very closely supervised in their second 3 months. Consequently while overall numbers have been maintained in the short term, the change in the profile of seniority will put pressure on current rotas. From a Glasgow perspective Dr Howie work had previously been undertaken looking at existing rotas to see whether there was any duplication or slack within the current staffing configuration. This work had been driven in part due to the service demands within Glasgow. The outcome of this piece of work highlighted that there was no slack within the current service; in fact it highlighted gaps in service.

In light of these findings, and with enhanced pressures due to the European working time directive along with the reduction in trainee numbers due to Modernising medical careers then the service gaps in Glasgow were going to expand rather than contract. This in essence means that Glasgow services will be looking at ways of resolving its own service gaps within the near future.

With the reduction in the hours which each junior doctor can work, there is ever increasing need to guarantee that where trainees are required to be at work in the hospital, they work intensively in settings which provide regular use of core skills. A trainee anaesthetist working in a low work intensity setting, providing a service with limited reliance on their core skills is providing a service, which is to the detriment of their overall training. It is for this reason that those in charge of training critically evaluate all the settings in which trainee anaesthetists provide a service.

Compliance with the European Working Time Directive will put even greater emphasis on guaranteeing quality of training opportunities offered by each post and put further pressure on the number of sustainable rotas.

Anaesthetic services must adapt to these pressures in the same way surgical specialties in Clyde have been required to adapt, by centralisation of services.

Within Paisley Dr John Dickson outlined similar issues to Glasgow, however there gap was slightly more acute as they are currently unable to cover there existing Maternity rota, and are in fact doing so through the current consultant team working excess hours in order to back fill the gaps within the service.

Both Clinical Directors identified the lack of training opportunities at the VOL as an absolute impediment to utilising anaesthetic trainee staff for out of hours work. Advice was sought from Dr Paul Wilson, Regional Education Advisor, in relation to the potential to create additional training posts to service the VOL. He confirmed that the posts would not fulfil the training requirements.

A detailed analysis is provided in section 3.3, which highlights why it is not possible to simply recruit more anaesthetists across Glasgow and Clyde and then rotate intensive care specialists to the Vale.

4.6 C*an we develop the posts to make them more appealing?*

- The current profile of out of hours work precludes use of a trainee anaesthetist.

- A trained anaesthetist, whether staff grade or consultant, who had a substantial proportion of their total hours devoted to covering infrequent clinical events overnight, would see a progressive deterioration in their clinical skills.

- An anaesthetist whose main interest is theatre work would be unlikely to be attracted to provide a service to a hospital where there was no emergency surgery and would be of limited use in contributing to the overall care of patients out with dealing with clinical scenarios involving airway problems.

- An anaesthetist with a particular interest in Intensive Care would have a broader range of skills appropriate to contributing to overall care of the sickest patients but would be unlikely to work in a setting in which there was no Intensive Care Unit

- None of these concerns preclude appointment of an anaesthetist to provide these services, but there would be a real concern about the quality of applicants who would be attracted to such a post and their ability to sustain their current level of competence in such a low intensity clinical setting.

4.7 Can another rota be developed?

- Anaesthetists provide out of hours services for emergency surgery, maternity services and intensive care. In the absence of such services being provided there is no need for on-site anaesthetic services. The only exception would be where a major elective surgical service and or acute medicine service was being provided which generated sufficient critical care activity to provide an adequate workload. The current service arrangments where an average of two episodes per week require anaesthetics input does not provide an adequate workload. Prior to rationalisation of surgical services the VOL was able to sustain a only a very small critical care unit.

4.8 Can the pilot be extended beyond June?

- The current model of care delivery could possibly be extended beyond June and it would remain in place until an outcome has been reached.

4.9 Why did the pilot not move to stage two?

- The pilot did not progress to the next stage as there were clinical concerns about the ability to provide unscheduled medical care without anaesthetic input.

4.10 Why can't we use the rapid retrieval team*?*

- It was agreed that the offsite anaesthetic provision would act as a proxy for the retrieval team rather than commit funding to this until pilot had been concluded. The concerns over clinical safety without anaesthetic cover on site resulted in the stopping of the pilot has meant that this has not been further explored.

5. Conclusions

5.1 It is the view of the Anaesthetic workstream that they have explored the potential solutions based on the current model of service provision, including the rotation of staff across Glasgow and Clyde, and have found no answers.

5.2 Due to the level of activity requiring on-call anaesthetics provision at the Vale of Leven, training accreditation will not be received to provide a rota made up of doctors in training.

5.3 Due to the level of activity at the Vale it is not appropriate to deliver services based on non-training grade anaesthetists providing services. Even if a staff grade rota could be developed it would require oversight from a consultant anaesthetist. This consultant cover could not be provided by the same consultant who was on-call at another site due to the risk of the consultant requiring to be called to two places at once.

5.4 A stand-alone consultant rota could not be developed at the Vale of Leven due to the level of activity requiring anaesthetic input. This would not be conducive to maintaining the skill level of consultant staff.

5.5 The skills of an intensive care specialist are more relevant to the needs of the VOL. No anaesthetist who has undergone training in intensive care medicine would be willing to provide such a limited service on a stand-alone basis. The potential for recruiting additional anaesthetists across Glasgow and Clyde and then rotating them out to the Vale was also explored. Analysis of the working practices of anaesthetists with specialist training in intensive care across NHS Greater Glasgow and Clyde shows that there are a number of different objectives that must be met by this group of staff. These objectives are currently met by balancing a number of different priorities one of which is having access to enough critically unwell patients to maintain their skills. Introducing greater number of intensive care anaesthetists and then having them cover a greater number of sites will reduce the number of patients that each anaesthetist sees and therefore reduce the opportunity that they have to maintain their skills. This would not be appropriate to the continued delivery of high quality care.

5.6 A number of sites across Scotland and England were contacted to determine whether alternative models of care either for providing anaesthetics or for delivering unscheduled medical services without on-site anaesthetics provision. None of the sites, however, offered a viable alternative model or a direct comparison in terms of the population served, or the services delivered. Previous comparison had been made between the Vale of Leven Hospital and Kendal Hospital where a model was being developed which would have seen unscheduled medical patients admitted without out of hours anaesthetics cover. Due to staffing and clnical governance concerns this model is being downgraded and the inpatient beds at this site will become rehabilitation beds.

5.7 The compromises, which sustain anaesthetic services in remote and rural areas, are not readily applied to the geographic setting of the VOL given its proximity to urban centres. The remote and rural group have taken a view that the Vale of Leven is not a remote and rural hospital.

Sites Contacted for Alternative Anaesthetic Model

Sites Contacted for Alternative Anaesthetic Model

	Dr Grays, Elgin	New Galloway, Dumfries	Falkirk, Stirling	St Johns, Livingston	Westmoreland, Kendal	Hexham
Hospital function	DGH, with 190 beds. HDU facilities on site, no ITU.	Small rural site, with 20 inpatient acute beds, plus 24 inpatient GP assessment beds. No ITU beds on site.	Community hospital providing Intermediate care and day care. No unplanned emergency activity on site.	This is a large University teaching Hospital, with on site ITU beds.	Small community hospital with emergency unit and day surgery unit, with 100 beds.	Small DGH with 98 in patient beds. No ITU beds on site, however there are HDU and CCU beds.
Conditions treated on site	Emergency Surgical, Medical, Ophthalmology, Orthopaedics, ENT, gynaecology and Obstetrics patients.	Emergency surgical and medical patients, however ambulances will bypass the acutely unwell and trauma patients.	Day surgery patients who have been fully screened at surgical preassessment clinics, and patients that are suitable for rehabilitation.	Full accident and emergency department, which treats all presenting conditions i.e. burns, emergency surgery and medicine.	Currently medical emergencies are seen on site, however bypass protocols are used by the ambulance service as the site has no ITU beds	Emergency medical and surgical patients are treated on site, with trauma patients being moved off site.
Staffing	8 Consultant anaesthetists in post. No problem with recruitment and retention currently. 24-hour consultant cover provided, with 2 on at any one time.	Anaesthetics covered by 1 x anaesthetist and 1 x GP, plus a locum- delivering a 1:2 rota	Anaesthetic provision is only available during 9 –5 i.e. theatre activity. No out of hours anaesthetic Cover.	Full anaesthetic rota 24/ 7, covered by both consultants and middle grade staff.	Consultant anaesthetist during 9-5, for day surgery, no cover out with these hours. Patients are transferred off site.	Full 24 hour anaesthetic provision on site provided by consultants

	Dr Grays	New Galloway	Falkirk	St Johns	Westmoreland	Hexham
Nearest blue light centre	Closest centre 40miles away (Inverness) however patients are transferred 60 miles to Aberdeen.	75 miles to the nearest blue light centre at Dumfries	Stirling Royal Infirmary 10 miles away.	Not required	Patients requiring ITU support would travel 23 miles to the nearest blue light centre in Lancaster.	Patients requiring ITU support would travel 26 miles to the nearest blue light centre.
Is this model transferable to the VOL	Busy small DGH, seeing a cross section of emergencies thus ensuring the skill base of the staff group. Due to this cross section of both surgical and medical emergencies this is not a model that is transferable.	This is not a model that could be applied to the VOL, as it is not a sustainable model in terms of workforce planning and on call demands on the staff.	This model has no emergency activity and therefore is not comparable to the VOL site.	Not a transferable model as it is a fully functioning acute site.	Similar to the VOL in terms of emergency medicine. However the model is being down graded to a nurse led facility due to clinical governance issue and medical staff recruitment problems. The inpatient beds will become rehabilitation beds.	Not similar as it has full anaesthetic provision.

Vision for the Vale of Leven Hospital

Appendix 5

Frequently Asked Questions

What is 'unscheduled' medical care?

This is assessment, observation and treatment of patients who have taken ill and need swift attention but do not need emergency or intensive care. Although not the most seriously ill, the patients' conditions are serious enough that they are unable to wait for a scheduled GP or hospital appointment.

What is 'planned' care?

'Planned' care is by far the most commonly used type of service at the Vale of Leven or any other hospital – this means that the treatment is organised in advance following referral from a GP or as a follow-up to previous hospital care.

Why is anaesthetics cover at the Vale of Leven unsustainable?

For the past two and a half years we have been considering the issues related to the provision of unscheduled medical care at the Vale of Leven. This area has also been subject to review by two different groups of independent experts. Currently, unscheduled medical care is provided to 6,300 patients each year at the Vale of Leven and is supported by access to anaesthetic cover. Including the two independent reviews, there have been four reviews of anaesthetic services at the Vale of Leven, all of these have concluded that anaesthetic services are not sustainable 24 hours every day. This means that we need to change the way in which unscheduled medical care is provided at the Hospital.

The reviewers have confirmed that it is not possible to continue with current 'out of hours' (evening, overnight and weekend) anaesthetics cover. Arrangements put in place by the former NHS Argyll in Clyde depend on locum (temporary contract) consultants – efforts to recruit full-time consultants have been unsuccessful, mainly because the numbers of patients requiring anaesthetic care are low and the posts would not be able to meet their training and accreditation requirements. It is also not possible to rotate anaesthetists from other hospitals to provide cover, as this could not be justified by the low patient numbers at the Vale, and as this would also adversely impact services at those sites.

How were these proposals developed?

NHS Greater Glasgow and Clyde took responsibility for the Vale of Leven Hospital in April 2006. At that point we committed ourselves to a full review of all services provided at the hospital.

Reviews and engagement with staff, patient and community representatives were carried out over 2007, leading to public consultation on Mental Health Services and Maternity Services across the whole of Clyde in 2008.
The Cabinet Secretary for Health and wellbeing sought an independent viewpoint about the potential future of services at the Vale of Leven Hospital. She initiated an Independent Scrutiny Panel, chaired by Professor Angus MacKay, with a remit to review NHS Greater Glasgow and Clyde's findings on the main service strands and to confirm proposed options for the future or suggest alternatives. The panel reported its findings in December 2007 having reviewed proposals for unscheduled medical care, Rehabilitation Services, Mental Health Services and Maternity Services at the Vale in 2007.

A further review of services at the Vale of Leven Hospital was commissioned by the Cabinet Secretary. This concentrated directly on the issue of the sustainability of anaesthetic cover at the hospital and was chaired by Professor Chris Dodds. The review was commissioned on 12th June 2008 and findings reported on 15th August.

The Board of NHS Greater Glasgow and Clyde considered the cumulative outcomes of the Mental Health and Maternity Consultations in addition to the findings of the Independent Scrutiny Panel and Independent External Clinical Review at its August 2008 meeting.

The Board agreed to develop a long-term, sustainable plan for the future of the Vale of Leven Hospital and instructed officers to begin engagement with stakeholders in order to work up proposals to be brought together into a single, comprehensive vision for the future of the Vale of Leven site.

Over the past two months NHS staff have met with a wide range of patient, voluntary and community interests in West Dunbartonshire, Argyll and the Lochside. The proposals now out to consultation have been influenced by the feedback received.

Who will manage critical risk patients under the proposed arrangements?

Since 2004, all patients from the area requiring Accident and Emergency Care have been taken to the Royal Alexandra Hospital in Paisley. Well-established protocols are in place to ensure that ambulance crews and GPs are able to assess each patient and ensure that those who are most ill are stabilised and moved to the care of the most appropriate professionals.

This means that no-one who needs emergency care, or has a high chance of needing emergency care, should be admitted to the Vale of Leven Hospital in the first place.

Under the proposed new service arrangements at the Vale, the basic principles of this arrangement are not going to change.

Currently, those 'unscheduled' patients not found to need attention at an A & E unit or intensive care, but still needing swift assessment and possible admission, are taken to the Medical Assessment Unit at the Vale of Leven Hospital. Currently the unit receives cover from anaesthetists because of a proportion of existing patients who may present a higher risk of becoming more unwell.

As the 2008 independent review found, it is not possible to maintain the arrangements left in place at the Vale by NHS Argyll and Clyde to ensure anaesthetists are available 'out of hours' overnight and at weekends.

The proposed new model for unscheduled care at the Vale will not have on-site anaesthetic cover for this service, so there will need to be changes to the categories of patients who will be accepted, to ensure the chances of anyone being inappropriately brought to the Vale or suffering complications whilst there are reduced even further.

By doing this we can confidently say that the numbers of patients becoming critically ill whilst at the Vale will be very low indeed. But where a patient does deteriorate in future, as now, our staff are prepared to take action. There are long-established arrangements in place to stabilise patients and use ambulances to take them to the A & E or to the most appropriate specialist service at another site.

What model of care can be offered at the Vale's Medical Assessment Unit without anaesthetic cover?

Initial assessment of patients will be carried out by ambulance crews or GPs and by staff at the Vale using a clinical scoring system and protocols. Those patients who are most seriously injured or ill, or at high risk of their condition worsening, and perhaps needing anaesthetics care, will be taken to the Royal Alexandra Hospital and not the Vale of Leven.

Those patients who are taken to the Vale will placed under the care of a consultant supported GP-led acute unit. This means that General Practitioner doctors, who are skilled and trained to deliver appropriate acute care to the types of patients who will be cared for in the Vale, will have responsibility for unscheduled medical patient care at the Vale of Leven Hospital.

There will be Doctors on-site 24 hours each day, 7 days each week in the Hospital and during busy times there will be more Doctors available. There will be 24 hour hospital consultant support to provide telephone or telemedicine advice to the GPs when it is required. There will also be scheduled daily on-site hospital consultant support to provide the GPs with advice on patients when this is required. This arrangement will ensure that patients admitted to the Vale of Leven Hospital under the care of GPs have access to consultant advice and expert opinion if needed.

What education and training will be given to staff providing the new model of unscheduled medical care?

GPs and the nursing team supporting them, will undergo an intensive training course which ensure they have the sills to deal with the types of patients who will be using unscheduled medical care services.

How will staff decide which patients are taken to the Royal Alexandra Hospital or to the Vale?

There are currently protocols and clinical assessment scoring systems in place which ensure that the most acutely unwell medical patients bypass the Vale of Leven Hospital. By refining these protocols, lowering their threshold and bypassing all patients with some types of medical complaints we can safely bring forward a model of care which will allow between 70% and 80% of the 6,300 patient episodes to continue to be provided at the Vale.

The introduction of a scoring system which identifies those patients that should not attend the Vale is important as it allows us to assess patients' physiological condition to determine those that may potentially require higher dependency or more specialist care.

This scoring system will be used by GPs, the Scottish Ambulance Service and in the Medical Assessment Unit at the Vale to identify those patients who should go to the RAH regardless of their medical condition or symptom. The physiological criteria that will be included in the scoring system include heart rate, blood pressure and level of consciousness amongst other things. This will be a more refined version of the scoring system that is currently widely used in the Vale of Leven area. This scoring system will identify those patients most at risk of requiring higher dependency care.

In addition to the further development of the scoring system it has also been agreed that patients with the following conditions will not be treated at the Vale of Leven Hospital:

- Patients who have suffered from a stroke or a suspected stroke
- Patients who have taken a drug overdose

- Haematemesis patients requiring hospital care (patients with gastro-intestinal bleeding)
- Patients requiring inpatient haematology (blood-related conditions) care
- Patients with neutropenic sepsis (fever and infection due to low white blood cell counts, which can occur with patient undergoing chemotherapy)
- Patients requiring hospital care due to epileptic seizures

From 1st November 2008, patients from across the West of Scotland who experience a certain type of heart attack (STEMI – blocked arteries) will be taken directly to the Golden Jubilee National Hospital by the ambulance service. We estimate that this will be the case for approximately 50 patients from the area served by the Vale of Leven.

How many more people will be taken to the Royal Alexandra Hospital in Paisley as a result of the new model of unscheduled care?

The changes that we propose for unscheduled medical care would mean that between 1,000 and 1,900 additional patients would have to travel to the Royal Alexandra Hospital each year. Significant numbers of these will travel by ambulance.

Is it proposed to increase the number of ambulances and crews available to cope with the increased numbers of patients who would be taken direct to the Royal Alexandra Hospital (RAH) in Paisley rather than the Vale of Leven Hospital?

The Scottish Ambulance Service has made it clear that the RAH is accessible for emergency ambulances and do not anticipate any significant problems in being able to move patients there rapidly. All patients requiring access to A & E services from the Vale catchment are already taken to the RAH – about 5,000 each year - and the Scottish Ambulance has been experienced in achieving this since 2004.

The Scottish Ambulance Service has not identified any adverse clinical outcomes as a result of transferring these patients. Similarly, an audit that was undertaken after A & E services transferred to the RAH revealed that there was no detrimental clinical impact on patients from the Vale of Leven area as a result of this change.

Our proposals are designed to ensure that as many people as possible should continue to use the Vale of Leven as their local hospital. Based on a very detailed, thorough review of the numbers and types of patients requiring 'unscheduled' care at the Vale, we estimate that between 70 and 80% of them would still use Vale services, with the remainder - between 1,000 and 1,900 patients - being taken to Paisley or other sites. Significant numbers of these will travel by ambulance.

The NHS Board are committed to working with the Scottish Ambulance Service to provide the extra funding needed to ensure an increased level of paramedic services including vehicles to enable the rapid transfer of patients around the clock.

A small number of patients taken to the Vale may, following further assessment and observation by the GP-supported unit, be indentified as needing transfer to the RAH. Existing arrangements to allow transfer to other sites are well-established and quite routine in virtually all hospitals. The Scottish Ambulance Service is also clear that these small numbers of transfers can also be organised without difficulty.

Will ambulances only be assigned to cover the Vale of Leven catchment?

One of the issues that will be agreed between NHSGGC and the Ambulance Service before any changes are made is the location where ambulances will be based. In practice, vehicles cannot be assigned to remain in one particular area only – ambulance crews have to take their patients to the most appropriate sites for the

treatment they need and this can mean, on occasion, travel to sites outwith the area when specialist care is required. However, the ambulance service operates a 'dynamic' service , which means when ambulances from one area are taking patients to Paisley or elsewhere, vehicles from other areas will be able to provide cover if required

What will happen to patients who make their own way to the Vale of Leven Hospital?

In short, the same as at any other hospital. Under the proposals the patient will be assessed by the onsite team – in this case the GP-supported unit responsible for 'unplanned' care at the vale of Leven Hospital. If it is clinically safe and appropriate for the patient to receive care at the Vale of Leven, that is what will happen. If the patient needs emergency or specialised care, the team at the Vale will stabilise him or her, make the person comfortable and arrange rapid transfer to the appropriate site by ambulance. This is a standard arrangement at all hospitals and nothing we are proposing will change this.

How much money will be allocated to the Vale of Leven Hospital to make these changes?

We have indicated where we can our estimates of the investment that will be required to take forward elements of the proposals. We have already committed over £1 million to improving the fabric of buildings at the Vale of Leven Hospital. When public consultation is complete, the NHS Board will submit the resulting recommendations to the Cabinet Secretary. If the Cabinet Secretary agrees to the proposals, we will be then able to develop a full business plan and so provide an accurate cost for delivering the 'Vale Vision'.

What happens if there is an accident of traffic jams, or closure of the Erskine Bridge, preventing access to Paisley?

Accident and Emergency patients have been taken from Helensburgh, the Lochside and West Dunbartonshire to the RAH in Paisley safely since 2004. Blockages on the A814 and A82 would also potentially restrict access to the Vale of Leven Hospital and the Ambulance Service is practised in finding and using alternative routes in these situations.

The Erskine Bridge has been closed to all vehicles twice since October 2007, although it was closed to high-side vehicles more often. Emergency ambulances are not classed as high sided vehicles and so are not affected by these latter restrictions.

Since January 2008, Transport Scotland, and their operating company Amey, have introduced a new system which comprises signs on all approach roads to the Erskine Bridge to warn drivers of wind speeds and restrictions. This means drivers of vehicles, including ambulances, have earlier warning of the need to use alternative routes and, by following the guidance, this helps alleviate congestion that previous bridge closures caused on the local road network.

Appendix 6: Glossary

Cognitive Impairment Loss of the ability to process, learn, and remember information

Critical Mass A certain amount of something (for example, patients, staff, resources) must be available before an activity or organisation can function. If the critical mass is not reached, the activity or organisation will not function properly

Diagnostic Testing Testing carried out to identify the nature of a medical condition. This helps with learning whether an illness or injury is present (e.g. Ultrasound, CT scans)

Elderly Mental Health Continuing Care
This refers to the care of older people with mental health problems who require long
term treatment following a stay in hospital or because of the long term nature of their mental health problem

Functional Elderly Mental Health
This refers to older people who have mental health problems such as depression and schizophrenia

General Medical Council (GMC)
The organisation that registers doctors to practice medicine in the UK

Haematemesis The vomiting of blood

Lomond Integrated Care Pilot
The pilot service at the Vale of Leven where local GPs, who after receiving additional training, substituted for the overnight cover provided by anaesthetists and junior doctors. In this pilot the most seriously ill patients were taken to the Royal Alexandra Hospital

MAU Medical Assessment Unit

Neutropenic A blood disorder where a patient has an abnormally low number of
a type of white blood cells (Neutrophil granulocytes)

Patient Episode A period of care (for example, a visit to a clinic) to see a health professional (for example, a doctor or nurse)

Physiological Condition	The condition or state of the body
Planned Care	Planned care means all care that is organised or booked in advance rather than emergency or urgent care
Protocol	A detailed plan, or set of steps, to be followed in the management of a specific medical or surgical condition
RAH	Royal Alexandra Hospital in Paisley
Rehabilitation	To help somebody return to good health or a normal life by providing treatment, training or therapy
Scottish Trauma Audit Group (STAG)	The Scottish Trauma Audit Group (STAG) was set up in 1991 to audit the management of seriously injured patients in Scotland
Social Functioning	The ability of the individual to interact in the 'normal' or 'usual' way in society
Telemedicine	The use of electronic medical information and communication to provide and support health care when distance separates the participants
Unscheduled Medical Care	The care given to patients that have taken ill and need swift assessment and treatment