

## INTEGRATED CARE AT THE VALE OF LEVEN

### 1. INTRODUCTION AND SUMMARY

- 1.1 In April 2006, when NHS Greater Glasgow and Clyde (NHSGGC) was established, the Lomond Integrated Care pilot project was running at the Vale of Leven Hospital but it had not been fully implemented. NHSGGC committed to developing plans to fully implement the pilot, which was intended to enable emergency medical care to continue to be provided at the hospital. In September 2006 it became clear that the integrated care pilot could not proceed to full implementation because of concerns about clinical safety. NHSGGC therefore established a substantial planning and community engagement process to consider the future arrangements for the provision of unscheduled medical care at the Vale of Leven.
- 1.2 This paper outlines the outcome of that planning process, covering in detail the provision of anaesthetics, unscheduled medicine and rehabilitation services at the Vale of Leven Hospital. The paper also describes the service changes that have taken place at the Vale of Leven over recent years.
- 1.3 The paper describes the community engagement process that has been undertaken, the impact that the proposed changes will have on patient access to services, and their impact on the staff who work at the Vale of Leven Hospital.
- 1.4 **The proposal for consultation is that the Integrated Care Pilot cannot be safely fully implemented and should be concluded, requiring the transfer of unscheduled medical care to the RAH.**
- 1.5 In our view, following appropriate consultation, if Ministerial approval is given, this transfer should take place as soon as possible. The detailed work on the partial model of Integrated Care currently in place at the Vale highlights significant clinical issues in relation to the protocol, intended to ensure the most seriously ill patients bypass the Vale and are taken to Paisley, and the arrangements to ensure rapid assessment and transfer of patients who become seriously ill while in the Vale.
- 1.6 In making this proposal, which will affect 6,000 patients, it is important to set the context of the services and activity which will remain at the hospital. These are described in the table below.

<b>Service</b>	<b>Patients per Annum</b>
Minor Injuries Unit	8,000
Daycase and short stay planned procedures	8,000
Day Hospital for elderly patients	9,000
Planned Diagnostic Imaging Services	11,500
Outpatient Services	50,000
Renal Day Patient Services	5,000
Haematology Day Patient Services	5,500
Rehabilitation Inpatients	1,400
<b>Total</b>	<b>98,400</b>

1.7 The rest of this paper is presented in the following sections:

**Section 2 : Overview of the Integrated Care Pilot, conclusions about its safety and the subsequent planning process.**

**Section 3 : Review of anaesthetic services.**

**Section 4 : Review of options for the provision of unscheduled medical care.**

**Section 5 : Review of rehabilitation services.**

**Section 6 : Preconsultation community engagement.**

**Section 7 : Access for patients and visitors.**

**Section 8 : Impact on staff**

**Section 9 : History of service change at the Vale of Leven**

**Section 10 : Proposed consultation process**

## 2. OVERVIEW OF THE INTEGRATED CARE PILOT

### 2.1 Background and Purpose

2.1.1 NHS Greater Glasgow took responsibility for services in the Clyde part of the former NHS Argyll and Clyde at 1<sup>st</sup> April 2006. The services for which the Greater Glasgow and Clyde Board became responsible included the Integrated Care project at the Vale of Leven. In taking on that responsibility we made a clear commitment to support the pilot to enable definitive conclusions to be reached on the safety and sustainability of the proposed model of care.

2.1.2 The Vale of Leven Integrated Care model was developed as a response to the challenge of sustaining medical emergency admission services at the Vale of Leven from the point,

initially expected to be in late 2006, when it is not possible to continue to provide on site, out of hours anaesthetic and medical junior cover. The model was developed by the Lomond Integrated Care Steering Group (LICSG), which emerged as a group of primary and secondary care physicians, AHPs, nurses and members of the public in the autumn of 2004. The LICSG took responsibility for identifying new models of care which could:

- safely and sustainably maintain services at the Vale of Leven;
- bring together disparate core services and professionals into a new, integrated team approach across primary and secondary care;
- develop new ways of working, with staff moving out of their traditional areas to provide care more responsive to patients;
- use new skills and methods to identify the needs of patients and their conditions with the aim of directing patients straight to the hospital that is best equipped to deal with their condition.

2.1.3 The Integrated Care model which was then developed through two years of detailed work had four key elements:

- (a) An assessment and scoring system enabling patients likely to require intensive or anaesthetic care to be identified and bypass the Vale for admissions to the RAH or be rapidly referred on from the Vale assessment unit into the RAH.
- (b) Out of hours a nurse practitioner “hospital at night” team which could safely and effectively provide cover with medical input from a primary care physician.
- (c) A retrieval service to ensure that patients requiring a more acute level of care than can be provided at the Vale could be safely transferred to the RAH.
- (d) The early transfer back of patients living in the Vale catchment area after they had completed an acute episode of care in another hospital for ongoing care and rehabilitation.

2.1.4 The pilot was intended to test the safety and sustainability of this model. This section outlines the process through which we reviewed the potential development of the pilot and the conclusions of that process

## **2.2 Initial Appraisal of the Pilot**

2.2.1 During the transition to the new NHS Board arrangements we established a dialogue with key clinicians and managers from Argyll and Clyde involved in the Integrated Care pilot. Our stock take of progress highlighted the fact that the pilot, as established at that point, did not fully reflect the Integrated Care model. The original intention was that the pilot was to be implemented on a phased basis with the early months focused on testing elements (a) and (c) with full pilot implementation by June 2006. The position on elements (b) and (d) was as follows:

- An SHO was present on the Vale site overnight working with the primary care physician;
- The majority of anaesthetists on-call cover was provided by locums resident on the Vale site providing rapid response support;
- The retrieval service was not in place; its critical element of intervention was covered by the on-call and on site anaesthetic cover, which was able to ensure anaesthetic intervention within the 45-minute target, which would be established for the retrieval service.

2.2.2 These arrangements meant that the model was not being fully piloted and, therefore, the pilot process would not enable a comprehensive evaluation of the safety and sustainability of the Integrated Care service. We therefore proposed further development of the pilot to fully test the four elements of the model of care including:

- fully implement the hospital at night model with on site medical support provided by general practitioners;
- mimic the effect of the off site retrieval team.

2.2.3 This was to be achieved by a two-step process:

- from August 2006 the hospital at night practitioners will be in place. At that point we propose to withdraw the SHO cover to fully pilot the GP medical support;
- from October 2006 to withdraw the on site anaesthetic cover to mimic the target response time of 45 minutes which the model envisaged for the retrieval team.

2.2.4 These changes were designed to enable evaluation of the full Integrated Care model to inform decisions on whether or not the definitive implementation of the model was safe and sustainable and to test the critical clinical elements of the pilot which we identified as:

- the effectiveness of the medical assessment materials in achieving appropriate ambulance bypass and early identification of patients at risk in the medical assessment unit;
- cardiac arrest and other urgent interventions being delivered effectively;
- the effectiveness of the extended skills training for medical and nursing staff;
- the delivery and quality of the clinical guidelines and protocols which underpinned the pilot;
- the effectiveness of management of patients who deteriorate at the Vale.

2.2.5 We also implemented revised project management arrangements.

## **2.3 Clinical Discussion**

2.3.1 In order to discuss our appraisal of the pilot and proposals for its development we arranged an open meeting of clinical staff from the Vale and local GPs.

2.3.2 This meeting took place in June 2006. A range of views emerged among consultants on the safety of the withdrawal of the onsite anaesthetic cover, which was required to fully implement the pilot. It was clear from the discussion at the meeting that the critical issue, which would define whether or not the pilot could proceed, was the concern about clinical safety. The full pilot, with the withdrawal of on site anaesthetic cover, to reflect the proposed Integrated Care model, required explicit confirmation from the Vale Consultant Physicians and Clinical Directors that they were satisfied this would represent a safe system of work. While the GPs would provide the out of hours cover they could only do so with the on call consultant taking ultimate clinical responsibility for all patients. Without that cover an acute service could not be provided at the Vale. We concluded a more detailed discussion on the issue of safety was required with the responsible consultants.

## 2.4 The Issue of Clinical Safety

2.4.1 A further meeting with the Vale of Leven Consultant Physicians was held in July 2006. The meeting focused on the need to establish that the Consultant Physicians who would be providing clinical cover to the hospital, out of hours, with the GPs providing the immediate medical intervention, were satisfied the arrangement was a safe system of work. The context for the discussion was not an abstract evaluation of safety but rather the requirement to confirm that, from a clinical governance perspective, the Consultants providing clinical cover to the next phase of the pilot were confident it did not expose patients to avoidable and unnecessary risk, in the context of relatively proximate full acute general hospital facilities. The wide ranging discussion had a number of key conclusions which are outlined below:

- the experience of the pilot so far had raised concerns about the timing of medical interventions for a small number of patients;
- the bypassing expectations had not been fully met and while it was clear that this position could be improved it was agreed that this would not entirely exclude seriously unwell patients arriving at the Vale or those already inpatients becoming unpredictably seriously unwell;
- there was a clear expectation on the part of the Consultant Physicians at the Vale that after the pilot phase they would become part of a larger pool of Physicians with RAH colleagues providing cover to the Vale and ensuring their continuing exposure to the full range of acute care to maintain their skills and expertise;
- while there was an aspiration that the evolution of the primary care practitioner model would enable these clinicians to operate on their own account it was acknowledged this would not be for the foreseeable future;
- discussion touched on a number of arrangements elsewhere in the UK and the potential role of the Royal Colleges. However, it was agreed that these wider points of debate could not mitigate the need to reach a local judgment on the durability and safety of the pilot;
- it was clear there was a major challenge in terms of capacity and organisation if unscheduled care was not delivered at the Vale;
- there was clear and collective anaesthetic advice from the Clyde wide Directorate that, in the context of relatively proximal full acute hospitals, the pilot did not represent an acceptably safe model of care from an anaesthetic viewpoint.

2.4.2 In the light of this outcome it was clear that:

- there were significant issues about the clinical safety of moving to the next phase of the pilot, without on site anaesthetic cover;
- beyond the pilot phase the model was not sustainable without cover from the wider group of physicians at the RAH.

2.4.3 We agreed that a further discussion to include the RAH Consultants should be convened to enable conclusions to be reached on the future of the pilot. This further discussion was scheduled for August 2006. Vale and RAH Consultant Physicians and Geriatricians were invited.

2.4.4 The meeting focused on:

- enabling RAH Consultants to discuss and debate the model and proposed full pilot with Vale colleagues;
- testing the RAH Consultant views on the safety concerns which had been raised at the previous meeting and their views on their potential contribution to out of hours cover to the Vale site.

2.4.5 The discussion covered a similar range of issues as the session with the Vale Consultants. A range of significant concerns about the clinical quality and safety of the model were expressed. There were additional concerns raised:

- a model of two-site cover from a wider, joint pool of Physicians was possibly not tenable;
- there had not been detailed discussion about cover after the pilot;
- there was a shared recognition that the Vale Consultant posts are not tenable as a stand-alone group and there would be real challenges in recruiting to this model of Consultant working and cover.

2.4.6 The conclusion of the discussion was that there was a high, shared, level of concern across the extended group of Physicians and Anaesthetists who had the opportunity to consider the pilot so far and its extension. On the basis of that clear and consensus clinical opinion it was our conclusion that providing unscheduled care at the Vale without anaesthetic cover is not a safe system of work and could not proceed to the full pilot. This outcome inevitably meant that the model of Integrated Care could not proceed as conceived.

## **2.5 Conclusions**

2.5.1 This section has mapped out in detail the process NHS Greater Glasgow and Clyde established to take forward and strengthen the Integrated Care pilot to full implementation in a structured and robust way and how we concluded that it was not possible to move to the full pilot and therefore that providing unscheduled care on the basis set out in the Integrated Care model was not possible.

- 2.5.2 Given that conclusion and the fragility of the current arrangements, with on site cover provided by short-term locum Anaesthetists, and a substantial element of the Consultant cover also provided by locums, we needed to plan to implement change as soon as possible.
- 2.5.3 We also concluded that we should establish a comprehensive local briefing process for staff, and local GP's and for wider community interests. This was launched in September 2006.
- 2.5.4 Although the 2004 conclusion that anaesthetics could not be sustained at the Vale had been accepted and was the basis on which the Integrated Care model had been developed there was pressure to revisit that conclusion, given the outcome of the Integrated Care pilot.
- 2.5.5 The planning process which was established in the autumn of 2006 was organized as shown below, including a strand of work to review anaesthetics.

Vale of Leven Integrated Care	Reference Group	Review groups: - Anaesthetics - Rehabilitation - Emergency Medicine
		Community Engagement Group: - Anaesthetics. - Rehabilitation. - Emergency Medicine.

- 2.5.6 These reviews in relation to anaesthetics, unscheduled medicine and rehabilitation have now been concluded. These conclusions and their impacts on the future provision of services at the Vale of Leven are outlined in the following sections.

3. REVIEW OF ANAESTHETIC SERVICES

- 3.1 The anaesthetics review group included anaesthetists from across Greater Glasgow and Clyde (including the Clinical Directors from Glasgow and Clyde), Primary Care physicians, Acute Medicine physicians and acute services planning staff.
- 3.2 The terms of reference of the group were to:
  - review services across Greater Glasgow and Clyde to consider if the combined staffing of the services would allow different cover on the Vale site;
  - identify other models across the UK to see if other solutions could be transferred to the Vale.
- 3.3 A further key task was to answer issues raised by the Community Engagement Group in relation to anaesthetics.

3.4 A detailed report outlining the conclusions of the anaesthetics workstream has been completed. The key points from the workstream are outlined in the following sections.

### **3.5 Previous NHS Argyll and Clyde work on Anaesthetics**

In 2004 NHS Argyll and Clyde had undertaken a detailed assessment of the sustainability of anaesthetics at the Vale of Leven site. Following the changes to Emergency Surgery, Maternity Services and Accident and Emergency services that had been introduced at the Vale between October 2003 and January 2004 the Clinical Director for Anaesthetics had written to the Minister outlining that anaesthetics could only be sustained at the Vale of Leven in the very short term. The reason for this was that there was simply not the volume of work that would allow anaesthetists to maintain their skills base or provide adequate training workload to sustain training accreditation. In 2004, the Board of NHS Argyll and Clyde had recognised that anaesthetics could not be sustained at the Vale of Leven site and had therefore approved the development of the Lomond Integrated Care pilot as described in Section 4.

### **3.6 Anaesthetic Review Process**

In order to adequately review the 2004 findings of NHS Argyll and Clyde the review process established by NHSGGC in October 2006 identified several key questions that needed to be answered. These questions also summarise the issues raised by the community engagement group in the October meeting:

- Why are the current anaesthetics arrangements not sustainable?
- Can we develop the posts at the Vale to make them more attractive?
- Why can anaesthetists from elsewhere in Glasgow and Clyde not rotate to cover the Vale?
- Are there no other models of providing anaesthetics available?

To answer these questions a work programme was developed which involved:

- analysis of the activity at the Vale of Leven Hospital;
- analysis of the rota arrangements across Clyde;
- analysis of the rota arrangements across Greater Glasgow;
- discussions with a range of sites across Scotland and England to assess whether there are alternative models either for providing anaesthetic services or for providing unscheduled medical services without on-site anaesthetic provision.

The findings of each of these elements are outlined below.

### **3.7 Anaesthetics Activity at the Vale of Leven**

In the 15 months from February 2006 to April 2007 anaesthetics staff were called to deal with, on average, approximately one patient per week out of hours (between 6pm and 8am) and just over one patient a week within normal hours (between 8am and 6pm).

The Regional Education Advisor has confirmed that this level of activity is not enough to meet training requirements for doctors in training or for consultants to maintain their specialist skills. 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.

### **3.8 Analysis of Anaesthetics Rota Options across Greater Glasgow and Clyde**

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. General anaesthetists specialise in maintaining the major part of anaesthetic services which is providing cover for theatres.

Bearing in mind the fact that what is required at the Vale of Leven to sustain unscheduled medical services is an Intensivist Anaesthetist, detailed analysis has been undertaken on the rota arrangements across NHS Greater Glasgow and Clyde.

One option which has been considered is providing consultant cover to the Vale of Leven by rotating anaesthetists who are predominantly based at 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 the anaesthetist was 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:

- The service required at the Vale of Leven is essentially critical care airway support for sick medical patients.
- 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.
- 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.
- Most anaesthetists who are not trained in intensive care medicine are therefore unwilling to deliver this type of care.
- 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.

- This body of consultants provides cover to 7 intensive care units across Glasgow and Clyde.
- Within their total available hours this group must ensure a number of different objectives are fulfilled:
  - deliver a demanding on-call service;
  - undertake adequate ongoing experience in an ICU to ensure that their intensive care skills are maintained;
  - provide sufficient anaesthetic input into theatres to enable the theatre work to continue;
  - undertake sufficient work in theatres to maintain their competence as theatre anaesthetists.
- 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.
- 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.
- 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.
- 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.
- 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.

- 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.
- 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.
- 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:
  - 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;
  - 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;
  - we are unlikely to be able to convince this cohort of staff to provide resident cover at the VoL.

### 3.9 Alternative Models

Having concluded that it is not possible to sustain anaesthetics at the Vale of Leven based on the current configuration of services either via a stand-alone rota or by rotating staff from other sites, the workstream has reviewed other models of care from across the country. The purpose of this was to assess whether there exists an alternative model either for providing anaesthetics to the Vale or for sustaining unscheduled medicine without on-site anaesthetic services.

A number of sites across the country were contacted to explore the feasibility of developing alternative models of care. These sites were selected on the basis that the services they provided might inform the search for a safe and sustainable future anaesthetic model on the VoL site. Sites included: Dr Gray's Hospital, Elgin; New Galloway Hospital, Dumfries; St John's, Livingstone; Falkirk Hospital; Kendal Hospital and Hexham Hospital.

In the appendix to the detailed paper on anaesthetics which will be available during the consultation there is a table which provides detailed information in relation to the sites contacted. 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 this site will become rehabilitation beds.

It was also anticipated that the interim report from the nationally established Remote and Rural Steering Group would inform the search for alternative models. 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 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.

### **3.10 Anaesthetic Workstream Conclusions**

For the reasons outlined in detail both in the above section and in Appendix 1 the anaesthetic workstream therefore conclude that:

- the workload at the Vale is not sufficient to meet the training needs of trainees or consultants, meaning a stand-alone rota cannot be developed at the hospital;
- there are no opportunities to rotate intensivists anaesthetists from other sites in Clyde to cover the Vale;
- there are no alternative models of care to allow unscheduled medicine to be sustained without anaesthetics.

These conclusions mean that, despite the additional work that has been undertaken, the position remains that anaesthetics cannot be sustained and, given the conclusion that the Integrated Care model cannot be safely implemented, this means that unscheduled medical admissions cannot be retained on the Vale of Leven site.

In addition to the powerful clinical arguments set out in this section it is also important to restate our obligation to provide economic and cost effective services for the small number of acute patients treated at the Vale of Leven Hospital - this test could not be met in providing an onsite anaesthetic service.

#### 4. REVIEW OF OPTIONS FOR THE PROVISION OF UNSCHEDULED MEDICAL CARE

- 4.1 Following the conclusion that the Lomond Integrated Care pilot would not proceed, this group was established to review the future options for the transfer of unscheduled medical care from the Vale of Leven Hospital. Participants in the group included: physicians from the Vale, the Royal Alexandra and Glasgow hospitals; GPs from West Dunbartonshire and Argyll and Bute CHPs; and NHSGGC operational and planning managers.
- 4.2 The review examined four options for patients requiring access to unscheduled medical care:
1. All medical patients from the Vale catchment would flow to the Western Infirmary in Glasgow
  2. All medical patients would flow to the Royal Alexandra in Paisley
  3. There could be a split geographical catchment allowing some patients to go to Glasgow and others to Paisley
  4. The choice of destination hospital could be left to patients themselves or their GP
- 4.3 Discussion with the Community Engagement Group suggested that option 3, which would have involved splitting the Vale of Leven catchment, would not be practical and we concluded that option 4 would not allow robust planning for high quality services to be available when patients needed them. Both these options were therefore ruled out. This meant that the Western Infirmary and the Royal Alexandra Hospital were the options which were focused on.
- 4.4 In considering both of these options a number of advantages were identified for the RAH proposition. These were:
- The RAH clinical team already deal with the most acutely unwell patients from the Vale catchment area.
  - The SAS are clear that the RAH is more accessible for emergency ambulances and will enable them to get patients to hospital more rapidly than a Glasgow option.
  - The RAH option enables the integration of unscheduled medical and surgical care.
  - Analysis shows that appropriate physical capacity can be developed at the RAH to accommodate the additional MAU patients.
  - In the example of obstetric services, where patient choice already exists as to whether to access services in Glasgow or at the RAH the majority of patients choose to access services in Paisley.

- there is a well developed and very substantial network of clinical relationships between the two hospitals, There are five key points which are important about this
  - the most acutely unwell patients from the Vale catchment currently access services in the RAH hospital.
  - there are approximately 6000 A&E attendees from this area at the RAH, of whom around 3800 are admitted.
  - there are around 1700 admissions into the RAH mainly for planned operations from the Vale area.
  - there are strong clinical links to facilitate the transfer of patients between the RAH and the Vale;
  - doctors based at the RAH provide very substantial clinical input to services at the Vale as part of their regular working patterns. Over 70 consultant half-day sessions each week are delivered at the Vale of Leven Hospital by clinicians based at the RAH. This is the equivalent to having 10 consultants dedicated to the Vale of Leven Hospital and its communities. It allows, however, access to a much wider range of specialties than could be provided by 10 clinicians. These sessions include 12 surgical and orthopaedic theatre sessions, 5 endoscopy sessions, 2 fracture clinics, 2 A&E follow up clinics, 22 radiological sessions, 21 Obstetrics and Paediatrics sessions, 3 Ophthalmology clinics and 10 clinics for surgical and orthopaedic patients. Changes to the links between the RAH and the Vale would potentially threaten the ability to maintain these services.

4.5 In addition to the advantages of transferring the medical activity to the RAH, a number of reasons have identified why it is not practical to transfer the activity from the Vale catchment to the WIG.

1. **A&E Capacity.** The Western Infirmary currently struggles to meet the 4 hour waiting time target within Accident and Emergency. It would not be practical to transfer the 6000 medical patients who currently attend the MAU at the Vale of Leven to the Western Infirmary A&E department. This department does not currently have the physical space to cope with these additional patients and to increase the physical capacity would required significant capital investment.
2. **Critical Care capacity.** As service changes at the Vale of Leven have been introduced over the past decade and the most acutely unwell patients have transferred to the RAH appropriate critical care resources at the RAH have been developed to cope with the increased demand. This includes the provision of HDU and ITU care and emergency theatre provision. Expanding these services at the Western would require significant capital investment.
3. **Future of the Western Infirmary.** The NHS Greater Glasgow Acute Services Strategy is clear that the Accident and Emergency services currently provided at the Western will in future be provided from the New Southern General Hospital.

This will be developed by 2012. After this time the Western Infirmary will not provide hospital services. This means that upgrading the Western to temporarily accommodate the emergency activity from the Vale of Leven catchment would provide a solution for only four years. This would not be an effective use of public resources.

- 4.6 For these reasons it is recommended that unscheduled medical services should be transferred to the RAH and that patients from the Vale catchment requiring access to unscheduled medicine should follow the A&E, Surgery and Trauma and Orthopaedic emergency patients to the RAH.**

## 5. REVIEW OF REHABILITATION SERVICES

- 5.1 The rehabilitation review group included physicians from the Vale and Royal Alexandra, West Dunbartonshire Community Health Partnership staff, GPs, the Associate Medical Director, the Lead Director of Rehabilitation and operational and planning managers.
- 5.2 Terms of reference were to explore potential models for rehabilitation services at the Vale of Leven if unscheduled medicine was not on site.
- 5.3 The review identified a number of options based on different staffing requirements. These options were:
- the status quo – no changes other than from ongoing joint service planning;
  - patients transfer at an early stage in their admission - circa one week;
  - patients transfer at a later stage - circa two weeks;
  - patients transfer near the end of their admission.
- 5.4 These options were discussed with the community engagement group in January 2007.
- 5.5 Based on detailed analysis of the number of patients admitted and the average length of stay across a range of conditions, the review has concluded that, whilst there will be some changes in the patients accessing rehabilitation, approximately the current numbers of beds could be maintained at the Vale. This would involve early transfer of patients back to the Vale of Leven from the RAH, and is therefore similar to the second option outlined above.
- 5.6 Rehabilitation will be provided for
- people of all ages who have suffered a stroke;
  - people of all ages who need rehabilitation after a broken leg;
  - older people who need rehabilitation after an emergency admission or a planned operation.
- 5.7 Patients will still be under the care of a hospital Consultant and will receive specialist medical, nursing and Allied Health Professional care.

- 5.8 Rehabilitation services will also be subject to further review as the long-term model of care develops across NHS Greater Glasgow and Clyde.

## 6. PRECONSULTATION COMMUNITY ENGAGEMENT

- 6.1 In addition to the initial programme of community engagement group in relation to the Integrated Care Pilot, each of the reviews described in the earlier section established have interacted with the community engagement group established by West Dunbartonshire CHP, at the beginning of the review process and throughout their work. Specific feedback from the community engagement group to each of the reviews was used to inform the work undertaken. This specific input is outlined in the previous sections.
- 6.2 In addition to the ongoing group, two widely attended public sessions were held in February 2007 at the Beardmore Hotel. At these sessions detailed analysis undertaken as part of the health needs assessment for West Dunbartonshire was discussed. In addition, there were presentations and discussions on the progress being made and the models being considered in relation to anaesthetics, unscheduled medicine and rehabilitation.
- 6.3 The Scottish Health Council (SHC) have also met regularly with NHSGGC to ensure that the pre-consultation engagement requirements have been met. Both the SHC and NHSGGC have found these regular meeting helpful in ensuring that pre-consultation process has been appropriately undertaken and that NHSGGC are now ready to move to full consultation.
- 6.4 Two further meetings of the community engagement group were held in May 2007 to plan for a further event at the Beardmore hotel and to ensure that the community engagement group were aware of the recommendations in relation to each of the workstreams. **The members of the community engagement group have expressed their disappointment in the conclusions of the review work and the proposed for the provision of unscheduled medical care to patients currently served by the Vale of Leven Hospital and do not support it.**
- 6.5 We have followed an appropriate pre-consultation community engagement process and this process has made a significant contribution to identifying the key issues which needed to be addressed in each review process and in shaping the work of the review groups.

## 7. PATIENT AND VISITOR ACCESS

- 7.1 We are very aware of concerns about the capacity of the SAS to respond to these proposed changes to patient flows and the implications for visitors.

7.2 There are three elements which have been carefully considered in relation to the increased numbers of patients who will require to access services at the RAH. These are:

- the requirement for increased numbers of patients to access the RAH by ambulance;
- the requirement for increased numbers of patients to transfer back from the RAH to the Vale by ambulance;
- the requirement for patients and visitors to use public transport to access the RAH and travel home.

These three elements are covered in more detail in the rest of this section.

7.3 Detailed work has been undertaken by NHS Greater Glasgow and Clyde and the Scottish Ambulance Service (SAS) to identify the additional ambulance service resource that is required to make sure that all patients affected by the changes can be taken to the RAH.

7.4 This work has involved a number of steps:

- identifying the current number of patients from the West Dunbartonshire and Lochside communities who travel to the Vale and the RAH hospitals by ambulance;
- calculating the additional time it will take for the ambulance to travel from each of the points where patients are picked up to the RAH instead of to the Vale;
- factoring the time required for the return journey (taking account of the ambulance services ability to provide a “dynamic” service by repositioning ambulances);
- projecting how peoples reliance on ambulance services will change because they will access services at the RAH rather than at the Vale;
- factoring in the overall growth in demand for ambulance services that is projected across the Clyde area.

7.5 A detailed paper outlining how these stages have been worked through is being prepared jointly by the SAS and NHSGGC. The outcome will be that the SAS will require additional staff and ambulances available 24 hours a day to ensure that an appropriate service can be delivered to the West Dunbartonshire and Lochside communities. The SAS are still to finalise the exact costs of associated with implementing the required changes. Similarly, the location where ambulances are to be based is still to be determined. This additional ambulance capacity will obviously increase the ability of the SAS to deliver a “dynamic” service which will ensure that when an ambulance from one area is taking a patient to Paisley vehicles from another area will be able to cover if required.

7.6 The second area considered has been the requirement to transfer increased numbers of patients from the RAH to the Vale of Leven to undertake the rehabilitation stage of their treatment. We project that at most, approximately 1400 patients will require to be transferred each year. A process has been worked through by NHSGGC and the SAS to

identify the level of resource required to meet this demand and it is projected that one additional patient transport vehicle working on an extended day basis and on a Saturday will be enough to allow us to meet this demand.

- 7.7 The third area of consideration has been the provision of public transport between the Vale of Leven and the RAH. Since February 2006 a bus service 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. Approximately 10,000 passenger trips were reported by the bus operator to have been made between 1<sup>st</sup> April 2006 and end March 2007, equating to approximately 4 passengers per bus trip. How many of these trips were made by people wishing to visit either hospital is unclear – it has been noted at the RAH that some passengers alighting the bus walk away from the hospital. It has also been noted by patient's groups, that the provision of a bus service from either hospital does not address the needs of those elderly patients who may have some distance to travel to get to the Vale in the first instance.
- 7.8 One option we will explore is to use the monies which currently fund the VoL/ RAH bus to fund a different type of service. Demand responsive transport (DRT) is a type of transport which collects people from their homes and brings them to their destinations at an agreed time. It may be possible to have a number of minibuses operating across the area bringing patients or visitors from their own home to hospital.
- 7.9 Another option may be to see if the route of the current bus service can be modified to provide a service to more people. Discussions have already begun with the major transport providers around the options for ensuring that services are available to the maximum possible number of people. These options will be discussed as part of the consultation process.

## 8. IMPACT ON STAFF

- 8.1 It is anticipated that approximately 150 staff currently based in the Medical Assessment Unit, The Coronary Care Unit, The High Dependency Unit and in wards 3 and 6, along with some staff who provide support services will be affected by the proposals.
- 8.2 Throughout the implementation of the changes proposed, work will continue with staff and their representatives to manage the impact of change. This will be done within the context of the national and local organisational change policies, which are based on the principle of "no detriment".
- 8.3 Once staff directly affected by the changes proposed are identified, in addition to meetings with the trade unions, one to one meetings/individual redeployment interviews will be held. NHS Greater Glasgow and Clyde has a successful track record in redeploying staff taking into account individual's skills and personal circumstances. Redeployment will be the first consideration with the aim of securing alternative employment for displaced staff as a result of service change. Based on this detailed

redeployment principles will be agreed and a process of vacancy management will be put in place to secure alternative employment in alternative departments and locations.

8.4 Deployment may be to a post at a lower grade and in these circumstances protection of earnings will apply. Redeployment will also be supported by a training and development plan, which will include induction and orientation programmes, and retraining/skills updating where necessary.

8.5 Regular briefing sessions will be held with staff throughout the period of implementation.

## 9. THE HISTORY OF SERVICES CHANGE AT THE VALE OF LEVEN

### 9.1 **Service Changes Prior to mid-2004**

In the mid-1990s major trauma and orthopaedic services for the Vale of Leven catchment were provided from the WIG. Most patients requiring access to these services in an emergency situation were initially taken to the Vale of Leven for assessment at A&E before being transferred onwards. For a number of reasons there were concerns within the local community about the service. A tendering process for the provision of these services was therefore undertaken and the RAH hospital was the successful bidder. At this stage, therefore, trauma and orthopaedics and some paediatric services for the Vale of Leven catchment were provided from the RAH hospital.

Attempts have been made for a number of years to develop a sustainable strategy for the Vale of Leven. From 1999 to 2001 work was undertaken on the "Vale of Leven project" which considered how best to develop the Vale of Leven Hospital and its clinical services. The project identified the key issues in relation to each of the specialties provided at the hospital. It concluded that:

- an inpatient general surgical service at the Vale of Leven could not be maintained in its current form primarily due to medical manpower and clinical governance concerns;
- the obstetric and gynaecology services at the Vale of Leven were not viable in their current form because of medical manpower and clinical governance concerns arising from activity levels;
- the A&E service relied on the back up of surgical and anaesthetics teams. Obstetric and gynaecology services affect anaesthetics and therefore affect A&E. Changes to these services required a new service model in A&E.

Although outlining the need for change, the "Vale of Leven project" did not generate any agreed specific plan for the future of the hospital.

In December 2002 surgical services at the Vale of Leven came close to total collapse. This was because of surgeons leaving to take up positions elsewhere or retiring and there being an inability to recruit replacements. In December 2002 the two remaining surgeons both applied for positions elsewhere. These surgeons agreed not to take-up

the alternative posts and to stay on until service integration could be managed effectively between the RAH and the Vale. Therefore during 2003 plans were made and enacted to transfer surgery and urology services to the RAH.

Also in 2003 a major review of maternity services across NHS Argyll and Clyde was undertaken. The conclusions of this review dovetailed with the findings of the national Expert Group on Acute Maternity Services (EGAMS) and led to the development of community midwifery services at the Vale of Leven and Inverclyde Hospitals. Consultant led obstetric and gynaecology services for the Vale catchment were therefore transferred to the RAH. In January 2004 Accident and Emergency services also transferred to the RAH. During January 2004 short-term arrangements were established to sustain anaesthetics at the Vale to allow unscheduled medical admissions to be maintained. It was clear at that stage that these arrangements were absolutely short term and it was anticipated that “Shaping the Future”, the 2004 NHS Argyll and Clyde Clinical Strategy which was then being developed would result in a clear direction for the Vale of Leven hospital. “Shaping the Future” is described in more detail in later in this section.

Whilst the emergency and complex inpatient element of these services were transferred to the RAH arrangements were made to sustain planned care, day services, and rehabilitation at the Vale of Leven.

Since January 2004, the medical assessment unit at the Vale of Leven has treated 6000 each year admitting 3000, the most acutely unwell patients from the Vale of Leven catchment area have bypassed the Vale and been treated in the RAH. In addition, approximately 6000 patients from the West Dunbartonshire and Lochside area attend A&E in the RAH each year. The Scottish Ambulance Service indicate that it is quicker for patients from West Dunbartonshire and the Lochside to access emergency services at the RAH, Paisley than at the Western Infirmary Glasgow. Around 1700 patients are admitted into the RAH for planned care each year.

## **9.2 “Shaping the Future” 2004: NHS Argyll and Clyde Strategy**

In summer 2004 NHS Argyll and Clyde undertook a consultation period on its strategy for the future of health services across the Argyll and Clyde area. Overwhelming service pressures faced at the Vale of Leven had already seen the reconfiguration of trauma and orthopaedic, surgery, urology, maternity, gynaecology and accident and emergency services.

“Shaping the Future” attempted to bring certainty about the future for the Vale of Leven Hospital. It described the reasons why services in Argyll and Clyde needed to change and proposed two options for the Vale of Leven Hospital. The drivers for change and the options proposed are summarised in the following sections.

“Shaping the Future” outlined that Hospital Services across Argyll and Clyde needed to change for a number of reasons.

Changes in the population in Argyll and Clyde:

- the strategy projected that there will be fewer children and young people;
- it also projected that there will be more older people;
- it stated that overall the population of Argyll and Clyde is reducing (by 5% over 15 years);
- it outlined that services need to develop to meet the specific requirements of the changing population.

Addressing health needs:

- the strategy described that whilst the health of the people of Argyll & Clyde is improving in many ways it is still poor compared to most other Western European countries. Within Scotland, Argyll and Clyde is one of the areas where people are likely to die younger and suffer poor health at a young age. The health services that we provide must meet the changing health needs of the people of Argyll and Clyde.

Changing clinical practice:

- clinical practice is how healthcare professionals treat patients. The consultation document described that what might have been best clinical practice in the past is unlikely to be best today. Improved understanding of illnesses, better ways of finding out what is wrong with a patient and a greater range of treatments allow for the provision of higher quality care today than ever before. The strategy explained that services must change to allow these advances to be capitalised upon;
- it identified that there are many more opportunities in Argyll and Clyde for treatment and care to be given in people's homes or in local communities rather than being admitted for long term care to an institutional setting like a hospital;
- the strategy explained that fewer hospital doctors are now trained to deal with a wide range of problems. Instead, they specialise in treating a smaller number of conditions. Such specialisation produces more skilled and experienced staff with improved results for patients. However, this often requires services to be brought together in one place to enable essential skills to be shared and maintained.

A changing workforce:

- "Shaping the Future" described that in 2004 Scotland, along with the rest of the UK, faced overall shortages of clinical staff and serious shortages in some areas including radiology, pathology and psychiatry. It highlighted how unfilled posts disrupt services and increase waiting times. Changes in medical training and practice can lead to difficulties in attracting and keeping staff to provide certain services. Retaining good local access to services and maintaining quality may involve local clinicians working more closely with specialists from other hospitals to continue to provide services, but in a different way.

The impact of employment legislation:

- the strategy explained that the European Working Time Directive places an obligation on employers to reduce the number of hours staff are allowed to work. Historically, the NHS has relied on doctors working very long hours – sometimes as much as 100 hours per week. This is no longer allowed and therefore services need to be redesigned.

Pay modernisation:

- in 2004, NHS Argyll and Clyde described the impact that pay modernisation would have. It explained that there are new, UK-wide, employment contracts for all staff. It suggested that these changes would improve patient care and make careers in health more attractive, thereby improving the recruitment and retention of staff. These contracts would require radical redesign of how NHS staff work and will, in turn, allow major improvements to services for patients.

Ongoing training and development:

- the strategy document described how the skills of NHS staff depend on on-going experience, professional training and development and having access to appropriate supervision. Services must be designed so that staff are able to maintain and develop their skills to provide the best possible standards of care and to meet accreditation requirements.

Resources:

- the strategy explained that NHS Argyll & Clyde spent about £40 million each year more than its allocated Scottish Executive funding. It stated that health services have to be managed within budget and that money needed to be released to develop the health services required for the future.

Geography:

- the strategy described that the geography of Argyll and Clyde is one of the most diverse in Scotland. Making sure that health services are safe and sustainable across Argyll and Clyde presented particular challenges. It emphasised that social deprivation and transport issues are important factors in accessing healthcare services.

### **9.3 NHS Argyll and Clyde Strategy Proposals**

In response to these drivers NHS Argyll and Clyde had proposed that specialist inpatient care be concentrated on the RAH site. This meant two options for the Lomond area.

“In Lomond we are proposing, at the Vale of Leven site or an appropriate alternative local site:

- Option A - An ambulatory care hospital providing out-patient and minor injury services (which make up the majority of current services). Emergency and acute in-patient services will be provided in Greater Glasgow as a long term plan, with a commitment to explore the possibility of providing intermediate care locally.
- Option B - An intermediate hospital providing out-patient and minor injury services (which make up the majority of current services) together with intermediate in-patient beds. Emergency and acute in-patient services will be provided in Paisley.”

#### 9.4 Strategy Outcomes

Whilst the 2004 NHS Argyll and Clyde strategy was published and consulted upon it was not taken to formal conclusion. This means that it did not receive a formal response from the Minister for Health before it was announced, on the 19<sup>th</sup> May 2005, that the process of dissolving NHS Argyll and Clyde was to begin.

Although no formal Ministerial response had been provided in relation to “Shaping the Future” the drivers for change outlined in the document still existed. It was clear in January 2004 when Accident and Emergency Services transferred to the RAH that the solutions in relation to anaesthetics and unscheduled medicine were short term. There was a need to develop sustainable solutions to the challenges faced at the Vale of Leven. In particular, during 2004, the Board of NHS Argyll and Clyde definitively concluded that 24/7 anaesthetic provision to support unscheduled medicine was not sustainable at the Vale of Leven Hospital.

In an attempt to avoid the requirement to transfer all unscheduled medical care to the Royal Alexandra Hospital it was proposed that a new model of care would be developed at the Vale of Leven Hospital. This new model of care was called the Lomond Integrated Care Pilot.

An earlier section of this paper describes the Lomond Integrated Care pilot project.

## 10. THE PROPOSED CONSULTATION PROCESS

- 10.1 This section describes our proposed approach to formal consultation - building on the extensive programmes of public and community engagement which have already been at the heart of our review and planning processes.
- 10.2 During the consultation process public events will be organised to discuss the proposals outlined in this document. These will be structured around presentations and workshops and avoid holiday dates.
- 10.3 Adverts providing summarised headline proposals and contact points for additional information will be used to launch the consultation period and draw attention to public

meeting dates. These will appear in the local newspapers - Dumbarton and Vale of Leven Reporter Helensburgh Advertiser and Lennox Herald.

- 10.4 All relevant material will be made available on the NHSGGC website on specific consultation pages.
- 10.5 Local media releases will be published tailored to suit local requirements and interests.
- 10.6 One to one meetings and briefings will be held for local stakeholders and groups as required.

## 11. CONCLUSION

- 11.1 The extensive programme of work over the last 18 months has established that:
  - the Integrated Care model cannot be fully implemented and therefore the Vale of Leven Hospital cannot continue to provide unscheduled medical care;
  - the RAH is the best option to provide this service to the Vale of Leven population.