

Questions Posed at the Annual Review, 18th August 2008

The following questions from members of the public were posed directly to NHS Greater Glasgow and Clyde as part of the Annual Review.

Some received a verbal response in the course of the review event. However, all received a written response from NHSGGC's Chairman. The questions and written responses have provided here. We have anonymised the questions to protect the identities of the members of the public who posed them.

Health Visitors

There are plans to change the focus of the Health Visiting Service in Scotland. I would like to know if and when NHS Greater Glasgow and Clyde are going to implement these plans – given the fact that the health Visiting/District Nursing Service is seriously undermanned and has no direction at present ?

To ask if the Health Board will confirm the crucial role of practice-based Primary Care Teams in delivering a Universal Health Visitor Service? Recognise that it Health Visitor Review has lost the confidence of workers in Primary Care Teams? Halt local implementations of the old review? Work with GPs and Health Visitors to develop services for vulnerable children which are not at the expense of current services?

In response, I would firstly like to take the opportunity to reassure you that we absolutely recognise the importance of practice-based Primary Care teams and that there are no plans to remove health visiting services from NHS Primary Care. Health Visitors will remain employed by NHS Greater Glasgow and Clyde and will continue to provide a wide range of local health services to children and families. We see Health Visitors as a core and integral part of the primary healthcare team, centred around GP practices.

We are indeed, as you may be aware from media reports, currently undertaking a comprehensive review of the functions of Health Visitors in Greater Glasgow and Clyde. We see Health Visitors as a core and integral part of the primary healthcare team, centred around GP practices but, as you indicate in your question, there are key issues as to how these staff are used and deployed.

The purpose of our review of health visiting services is to consider:

- Making the best use of Health Visitors' skills, continuing to provide fully universal services but also to provide a stronger focus on meeting the needs of the most vulnerable families
- Achieving closer relationships between Health Visitors and Social Workers – *not* at the expense of their critical relationship with GPs but building on the development of integrated assessment. This in itself is a response to concerns from health staff about present ways of working and the 'compartmentalisation' of services. These closer relationships would provide a better link from Social Work into GP practices, with Health Visitors acting as a 'bridge'
- Ensuring that we provide properly comprehensive and integrated interventions to families with the most complex needs, using the distinct skills and roles of health and social work staff

- Ensuring that immunisation in Primary Care is delivered by nursing staff with the appropriate level of skill – but under the continued supervision of Health Visitors, in part overcoming some of the problems of coverage
- Achieving more robust cover arrangements by making use of geographic teams and ‘equitable case-holding’ to address the present large variations in workload between practices – however, the proposals would see that numbers of named Health Visitors would be maintained for each GP practice
- Providing better administrative support to Health Visitors, including improving the support they have to effect communication and improve dialogue within and across agencies about families’ needs
- Ensuring that teams have a range of professional support staff to deploy under the supervision of Health Visitors
- Re-affirming the integration of Health Visitors’ skills as a key asset in the Primary Care team to develop and extend services to prevent problems arising and effect early intervention where families do have problems

In August 2007, a document was issued to staff to encourage widespread discussion and debate. A wide range of local events and meetings were also organised to give Health Visitors, GPs and other frontline staff an opportunity to feedback their views and comments on the proposed changes.

Local implementation groups, which have representation from local GPs, school nurses and Health Visitors, were established across the Community Health (and Care) Partnerships in Greater Glasgow and Clyde to take forward the proposals. These groups were intended to produce detailed proposals that would have been strongly influenced by the input of local GPs. Originally, the proposals were to be subject to extensive local discussion, with the aim of reaching agreement with GPs and moving forward with implementation of the final proposals from October 2008.

We do accept that there may have been a lack of clarity about the purpose of local implementation groups, nor had there been sufficient clarity about the degree of local flexibility in the proposals and the importance of GPs to the final outcomes. In the light of this, Dr Linda De Caestecker, Director of Public Health, and Tom Divers, NHS Greater Glasgow and Clyde’s Chief Executive met with representatives of the Local Medical Committee a few weeks ago. We have now written to the chairs of the Committee confirming as agreed that we will suspend local implementation work to allow the review document to be re-visited.

A joint group comprising Community Health (and Care) Partnership and Local Medical Committee representation, chaired by Linda de Caestecker will seek to confirm where there is agreement in terms of existing review proposals, determine any points of misconception or confusion and make changes to the proposals where required. It is our expectation that we should be able to find ways to equitably overcome any areas of disagreement.

The group’s intended output will be a Statement of Principles on the way forward that will in turn inform the work of local implementation groups upon their resumption of activity. The statement will clarify working arrangements of Health Visitors with practices that take on board GPs’ concerns about relationships and the key principles of the review without compromising effective team working.

This piece of work will also describe how immunisation contacts can be maximised for health improvement, early intervention and advices for families and the Health Visitor role in overseeing immunisation.

The proposals will be subject to local discussion before they are finalised and implemented, with the aim of reaching agreement with GPs and Health Visitors. The discussion period required to achieve this will be to a timescale negotiated by the joint group. When agreement has been reached on the detailed plans, a further timetable will be set out for implementation and this will apply across all Community Health (and Care) Partnerships. In return, the joint group will be provide scrutiny and comment on subsequent local implementation proposals from Community Health (and Care) Partnerships.

The upshot of this is that our review will proceed and we are entirely confident it will introduce the improvements in the focus and effectiveness of services you point out is required.

Configuration of Hospital Wards and Infection Control

Placing hundreds of ill patients – even in small six-bedded wards – lends itself to the spread of infection among patients and staff and lack of fresh air in the wards. Any patient who contracts a contagious illness should be isolated immediately. Would the NHS Board please give serious consideration to the matter?

Currently we do have infection control policies in place which require, where possible, to either isolate patients in single rooms who may have contracted an infection, or, alternatively, isolate patients who themselves may be particularly vulnerable to infection.

However, given the hospital infrastructure we currently have available to us, we do have to work around existing ward accommodation. Single rooms and side rooms are limited in most of our older hospitals and so we will tend to manage infection by isolating groups of patients in ‘cohorts’ – in other words concentrating those patients suffering the same infection in the same wards. An example of where there has been done recently is in relation to outbreaks of Norovirus, or ‘winter vomiting bug’, which is airborne and highly infectious.

However, the majority of so-called healthcare acquired infections are not airborne and may be brought in by patients who may already have been colonised by the infection out in the community, or by their visitors. As you may be aware, there is a national initiative to screen patients before admission for planned care for infection and we enforce strict hand-washing procedures. We are also aware that over-use of antibiotics in some cases may affect destroy the ‘healthy bugs’ in the gut which keep in other types in check, such as *Clostridium difficile*, and allow them to multiply – consequently we are developing new policies on the use and monitoring of antibiotic prescribing.

In the longer term, we will certainly increasing the number of single bed wards in order to help combat infection. The new South Glasgow Hospital to be built on the site of the Southern General in Govan, for example, will offer single rooms to all adult patients

St Margaret's of Scotland

Could the NHS Board and Cabinet Secretary please clarify the plans for the redevelopment of Blawarthill Hospital with particular reference to the number of continuing care beds for terminally-ill persons that are planned?

If it is the case this means that the 30 beds at St Margaret's Hospice will no longer be needed, could you please explain why money should be spent to commission and build a new facility when there is already a good new facility, built with voluntary sector funding, available?

In April 2000, the then Greater Glasgow Health Board agreed to formal public consultation on the closure of both Blawarthill and Cowglen Hospitals. From the consultation it became clear that there was a strong case to rebuild and develop services for elderly people on the Blawarthill site, from a site that provided only stand-alone frail-elderly accommodation to one that could provide a range of social care services.

At its December 2000 meeting, the Board approved the retention and development of the Blawarthill site, with the initial phase to include 60 NHS beds and 60 care home beds. In doing this, the Board wanted to address the recognised shortfall in social care places and accessible housing in the west of Glasgow.

In January 2005, the Joint Community Care Committee approved a report describing a review of frail elderly continuing care in what was then the Greater Glasgow area. This report recommended a reduction of 30 beds in west Glasgow. Given the extant decision on NHS-provided beds at Blawarthill, the conclusion was that it would be no longer necessary to purchase 30 beds from St Margaret's of Scotland.

In January 2008, NHS Greater Glasgow and Clyde received an update of the foregoing review and agreed that there should be further work along with St Margaret's to consider future options for the continuing use of their frail elderly continuing care ward. Following a meeting between ourselves and representatives of St Margaret's in May, we need to explore potential options in greater detail. Our aim is to ensure, whatever the final profile of continuing care that is agreed, that transitional arrangements are put in place to avoid any financial turbulence that might affect other services at St Margaret's, including palliative care.

Vale of Leven Hospital: Mental Health Services

What is the future for mental health services in the Vale of Leven Hospital? The question regards the option appraisal/public consultation of the proposed moving of mental health services to Gartnavel Royal Hospital, Glasgow.

On 19th August, the NHS Board considered the outcomes of public consultations which were linked to provision of the Community Maternity Unit (CMU) and Mental Health services at the Vale of Leven. There was unanimous endorsement of a proposal to maintain the Vale's CMU for a further three years and to initiate a marketing plan aimed at increasing the number of births there during that period.

The Board also agreed to defer a decision on Mental Health services and to take the issues under consideration into a new consultation process.

This process will centre on developing a long-term, sustainable plan for the future of the Vale of Leven Hospital. We envisage this will comprise of the CMU and proposals recently put

forward by the recent Independent Review Panel for a new model of unscheduled medical care that would allow the majority of existing patients, those not dependent on emergency care underpinned by anaesthetic services, to continue receiving their care at the hospital.

We would also propose bringing new services to the hospital, such oral and dental health, additional renal services capacity and outpatient, diagnostic and day care provision for urology, rheumatology and gastroenterology. In addition, there is the opportunity to invest £17 million in a new Primary Care centre to be built on the Vale of Leven campus. In the course of the consultation we would also aim to determine the nature of Mental Health services that would be provided as part of the plan.

Around 100,000 patients currently receive care at the Vale of Leven Hospital each year and, under these proposals, we would foresee similar numbers being treated there well into the future.

These proposals will be brought together into a single, comprehensive vision for the future of the Vale of Leven site. We are currently working through the detail and our intention is to launch consultation in later this month for a period of not less than four months. Clearly, it is important that you take part in the consultation and make us aware of your views and suggestions.

Vale of Leven Hospital: Financial Investment

What is the projected financial investment for the next five years for the Vale of Leven Hospital? What is the absolute commitment within that financial investment during that period ?

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Following consultation, once the choices for a sustainable Vale of Leven Hospital become clear, and subject to approval by the Cabinet Secretary for Health and Wellbeing, we will be able to determine the investment required to achieve them and will commit ourselves to their delivery

Stobhill Hospital: 'Overnight Beds'

NHS Greater Glasgow and Clyde confirmed in 2005 that twelve overnight beds would be provided within the new Stobhill Hospital (opening in 2009). It later emerged that this would require a new build. This being so, why has the new build not been included in the building plan for the new Stobhill Hospital. Will the Board state where these beds will be located and at what cost?

In the original Outline Business Case for both the new Stobhill and Victoria Hospitals, neither had provision for short-stay beds. In the time since the Business Case was submitted, clinical developments in patient care have made short-stay recovery beds a feature in providing a greater range of clinical services and the provision of that care more locally. At the Victoria Hospital, it was possible to provide these beds within the existing design for the new building.

However, this was not possible within the new Stobhill design. It was originally planned to provide 'slow-stream rehabilitation' beds from the old hospital whilst it remained operational. However, the opportunity has presented to accelerate provision of both short-stay and the rehabilitation beds together in a new building. We have entered into a dialogue with Glasgow Healthcare Facilities Limited, the consortia undertaking the Stobhill and Victoria projects, to take this forward. We estimate that the new building will require a capital commitment of between £15 and £17 million.

This does mean that we are unable to have the final configuration of the New Hospital in place when the main building becomes operational in the summer of next year. We do think, however, that we will be able to conclude a deal that will allow the short-stay facilities to open in 2010.

Stobhill Hospital and Chemotherapy Services

If the Board's intention is to 'improve health and reduce inequalities', why is the new Stobhill Hospital not having an Oncology (Chemotherapy) Unit as is planned for the new Victoria Hospital? I believe that the Southern General will also have such a unit.

Public consultation was carried out between 2000 and 2002 on the future provision of Acute Hospital Services in Greater Glasgow. This was followed by the development of the West of Scotland Cancer Plan, which determines distribution of services in Greater Glasgow and Clyde, Lanarkshire, Forth Valley, Ayrshire and Dumfries and Galloway.

NHS Greater Glasgow and Clyde's chemotherapy services north of the River Clyde are based at the new Beatson West of Scotland Cancer Centre at Gartnavel, which also acts as the inpatient hub for the West of Scotland as whole. The plan was developed on the basis that centralising teams of specialists and cancer networks is

in line with aspirations of providing patients north of the river and elsewhere with a world-class centre of excellence.

The re-design of cancer services will enable two centres for day chemotherapy services. Patients north of the river will attend the new Beatson and patients south of the river will attend the new Victoria Hospital. Once the latter new hospital is operational, there will be no further chemotherapy provision at the Southern General.

Local Brain Injury Services

NHS Greater Glasgow and Clyde does have some good services for people with brain injury. However, Headway Glasgow works with people who travel in from other areas because there are no services there (like people from Kilcreggan, Motherwell, Dumbarton) – could we not see NHS Glasgow being used as a model to improve services in the rest of Scotland? What would be the next step in doing this?

Firstly, I have conveyed your positive comments about NHS Greater Glasgow and Clyde's services to our Acute Division and, on behalf of colleagues, wish to thank you for making them.

Before turning to national initiatives, I would like to say something about the local context to Brain Injury Services. We have an extant Acquired Brain Injury Strategy and action plan for Greater Glasgow. A planning sub-group of the Disability and Rehabilitation Planning and Implementation Group is also in place and, currently, there is a separate Acquired Brain Injury planning group in West Dumbartonshire whereas in other areas this function is covered by Physical Disability planning processes.

Although we do have good services in Greater Glasgow, as you point out, there are gaps and issues we need to address. In particular, we need to develop provision in relation to the first 48 hours after injury, when patients are admitted to a variety of wards on each acute receiving site. Similarly, we need also to do more in slow-stream rehabilitation where we purchase placements with private providers outwith the NHS Board area.

Part of our response is to appoint a second Head Injury Nurse within Glasgow to provide specialist support to acute wards where brain injured patients are cared for – appointment of the nurse is imminent as interviews were on 13th August 2008. Additionally, the Brain Injury Rehabilitation trust is to build its new national centre in Springburn and this will allow us to place patients needing slower-stream rehabilitation closer to home.

We are also beginning further integration of social and healthcare services in the Community Treatment Centre and working with Glasgow City Council to commission care home beds for patients with a brain injury and to provide specialist health support to those beds.

Clearly, we are doing our best to continuously improve our existing services and we are very happy indeed to work with colleagues from other NHS Boards to share our experience. One practical step towards this is our invitation to the Scottish Government's Joint Improvement Team to review our services and to suggest areas that require further development or integration. This will be beneficial to us in terms of better services but, I am sure, will also build the 'knowledge bank' that can be shared nationally.

At national level, as you may be aware, there are further opportunities for closing working between NHS Boards. A national Managed Clinical Network for Acquired Brain Injury has been established and this has issued draft standards for Traumatic Brain Injury in Adults for consultation. The network has asked for comments on this to be made by 31st October 2008. Once agreed, these would represent national standards for services, although planning and delivery would remain local and mainly planned jointly with local authorities.

The network's wider aims are to map out services for people with an Acquired Brain Injury, promote recognised standards of care and identify consistent information needed by patients, families and carers.

The work on standards is particularly important in ensuring that people will receive the care they need wherever they live in Scotland. The Scottish Intercollegiate Guidelines Network (SIGN) is currently revising its guidelines on early management of head injuries. This is due for publication next year and will contain recommendations on management of head injuries based on the most recent international evidence. Each NHS Board, including Greater Glasgow and Clyde, will be obliged to ensure local services meet these standards.

Early in 2007, the national Delivery Framework for Adult Rehabilitation in Scotland was published. This is to lead to the setting up of a Rehabilitation Framework Implementation Group that will be tasked with ensuring the framework is taken forward.

A further national initiative is a Managed Knowledge Network for self-management and rehabilitation, which was launched last April. This includes information for patients and carers about Acquired Brain Injury. The purpose of the network is to enable patients, carers and health and social care practitioners to share and assess advice, information and evidence around adult rehabilitation and the management of long-term conditions. You can be assured that we are playing a full part in the network.

Diabetes

The Scottish Public Health Observatory estimated that there could be as many as 10,000 people with undiagnosed diabetes in Greater Glasgow and Clyde. What is the Health Board doing to identify these people, before the complications of diabetes become evident?

As you will be well aware, there are a range of risk factors linked to lifestyle which can signal a higher potential to develop Type II diabetes in particular. In general terms, NHS Greater Glasgow and Clyde's health improvement policies are aimed at prevention of ill-health as much as they are about alleviating and managing conditions once they have developed. Consequently, much of the action we have in place to tackle the growing problem of diabetes is not necessarily badged as specifically addressing that condition.

Examples of this include the major smoking cessation programme we have available to everyone in Greater Glasgow and Clyde, either on a walk-in basis or via GP referral. We also have in place joint initiatives with local authorities and health professionals, again accessed via GPs, to encourage individuals to become more active and there is also our very successful Glasgow Weight Management Service, which shortly is to be joined by a parallel programme in Clyde. Thus we have a fairly comprehensive approach to the main behavioural factors that may lead to diabetes.

However, we do not feel that a systematic programme to screen all individuals for undiagnosed diabetes would be cost effective. Rather, our aim is to target particular communities which have greater prevalence of 'high risk' behaviours and health trends. In such communities, in partnership with GPs, we are screening people at risk – patients with a family history of diabetes, or who are overweight or have concomitant problems with hypertension. As you will know from your previous background, NHS Greater Glasgow and Clyde has participated in the first and second 'waves' of the Keep Well national initiative.

In addition to the above, there are educational programmes in place in relation to both Type I and Type II diabetes. These are DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) and DAFNE (Dose Adjustment for Normal Eating) and also an independent programme tailored for patients of Asian origin.

DAFNE has been piloted at the Victoria Infirmary and this has proven to be highly successful. However we do have problems in recruiting appropriately trained staff and this is hindering our ability to roll the programme to every area. Other programmes, including DESMOND, have been rolled out widely.

Lastly, our Managed Clinical Network for diabetes is instrumental in developing policy and clinical practice.