NHS GREATER GLASGOW

Minutes of the Meeting of the Greater Glasgow – Acute Services – North Glasgow Monitoring Group held at 9.30 a.m. on Friday, 16th July 2004 in Room F21, 1st Floor, North Glasgow Division HQ 300 Balgrayhill Road, Glasgow, G21 3UR

PRESENT:

Mr Ian Miller (in the Chair)
Dr Robert Cumming Mr Paul Martin MSP
Dr Jo Davis Ms Mary Murray
Dr Roger Hughes Mr Donald Sime
Mrs Elizabeth King Dr Jean Turner MSP

IN ATTENDANCE

Mr Tim Davison .. Chief Executive, North Glasgow Division (to Minute 17)
Mr W Tullett .. Clinical Director – Accident and Emergency – North Glasgow Division (to Minute 17)
Mr J C Hamilton .. Head of Board Administration – NHS Board

ACTION BY

14. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Mr W Aitken MSP, Dr H Burns, Mr L Gaston (represented by Dr R Cumming), Mr J McMeekin, Dr Paul Ryan and Professor D Stewart-Tull.

The Chairman welcomed Dr Robert Cumming, who was representing Mr Lex Gaston, and Mr Willie Tullett, Clinical Director – Accident and Emergency – North Division, who had been invited to attend to give a clinical perspective to the Monitoring Group on Accident and Emergency issues following discussions at the Joint Monitoring Groups meeting on 4th June 2004.

15. MINUTES

The Minutes of the Joint Meeting of the Monitoring Groups held on 4th June 2004 [N&SMG(M) 04/1] were submitted and contained the suggested amendments offered by Monitoring Group members following the circulation of the draft Minutes to members for comment.

The Minutes were approved on the motion of Dr J Turner and seconded by Dr R Hughes subject to the following changes:-

i) Minute 4 – (iii) – Page 4 – 3rd paragraph. Delete the penultimate sentence – “The information now given states that the Royal College had ruled that even if Consultants were appointed the Casualty Unit was to close on August 2005”.
ACTION BY

ii) Minute 4 – (iv) – Page 5 – 5th paragraph
- 4th line, last word – add – “additional”.
- 5th line – add new sentence – “The additional funds required amounted to £70M per annum after the completion of the building programme”.

16. MATTERS ARISING

a) North Monitoring Group Minutes – 5th March 2004 [NMG(M) 04/02]

In relation to Minute 10(b) – Update on Emerging Pressures on Acute Services – Casualty and Anaesthetics – Dr Hughes reported that out-of-hours anaesthetic provision continued at Stobhill and no patients had been transferred to Glasgow Royal Infirmary after 10.00 p.m.

b) Joint Monitoring Group Minutes – 4th June 2004 [N&SMG(M) 04/1]

There were no matters arising.

17. CASUALTY SERVICES – STOBHILL HOSPITAL

The Chairman advised that at the Joint Meeting, the North Monitoring Group members were keen to hold a special meeting to discuss the implications of the Royal College’s decision to withdraw training accreditation from the Casualty Service, Stobhill Hospital from August 2005. He appreciated the difficulties in finding a suitable date in the holiday period for all members but was delighted so many members had been able to attend. He invited Mr Davison to set out the background to this issue.

Mr Davison described the Casualty Service at Stobhill and its uniqueness when compared to the four Accident and Emergency Departments in other hospitals in NHS Greater Glasgow. The Casualty Service was originally operated by 5 Senior House Officers (SHOs) with no Consultant supervision or Senior Middle Grade doctors. The Royal College of General Practitioners and the Royal College of Surgeons indicated their unhappiness with these arrangements and stated in 2003 the intention to withdraw training accreditation. The then North Acute Trust negotiated changes to the medical cover for the Casualty Service – this resulted in disestablishing the five SHOs into a wider pool of SHOs across the North Division and arranging daily supervision from A&E Consultants. The Royal Colleges agreed extensions to the training accreditation, eventually until August 2005, after which the accreditation would be withdrawn, as the current arrangements could not be sustained.

In planning for a significant change to the current service provision, it was important to consider carefully the options from 1st August 2005.

Mr Davison described two possible options:–

i) Stobhill would receive all GP assessed patients only and all other referrals (self-referral and ambulance cases) would go to the Royal Infirmary and the Western Infirmary.

ii) Remove all acute admissions from Stobhill to the Royal Infirmary and the Western Infirmary and transfer the elective cases from the Royal Infirmary to Stobhill.
These options will be considered by the NHS Board at its meeting on 12th October 2004, after which there will be engagement and discussions with the relevant stakeholders to consider in a planned way the most acceptable option.

Mr Davison introduced Mr Tullett, who talked about the unique arrangement at Stobhill and the view that sub-optimal care was being offered to patients. He also commented that the physical structure where the service was being provided had not been upgraded in many years. The recruitment drive to attract A&E Consultants to the North Division had not resulted in any applicants. There was a need to improve the service to a modern and acceptable standard in UK terms.

Questions

One member sought evidence about Stobhill Casualty’s record in its treatment of 50,000 cases per annum. Mr Tullett replied that he believed there was evidence of patients receiving sub-optimal care and there was a need to provide patients with a nationally acceptable standard which was equitable with the rest of the UK and a service which attracted the best calibre of staff possible.

It was pointed out that the Casualty Service over the years had access to Consultant cover – acute medical and surgical cover was available and only a phone call away. Mr Tullett replied that this cover was not in the Department and therefore not optimal.

There had indeed been no significant clinical incidents but it was important to keep pace with modern practice and provide a Consultant-led Accident and Emergency Service for patients who required this service.

The members wished to see evidence of the recruitment processes held by the former North Trust when trying to attract A&E Consultants – this should include copies of the adverts; where placed; the number of applicants and outcome of interviews.

The medical debate had been interesting and useful but clarification was sought on whether all patients admitted to hospital would be seen by a Consultant, now or in the future. Not all patients, now or in the future, would automatically be seen on admission by a Consultant. The service was evolving in a way that many clinical staff (including nurse practitioners) would quite appropriately see patients before a Consultant became involved in their care.

It was recognised that the extension granted by the Royal Colleges had allowed for discussions to be conducted to plan a new model and pattern of care, rather than reacting to a service which had collapsed.

A member felt that the medical staff were not to blame, but that the NHS Board had to take the blame for the situation Stobhill is in – for years the training at Stobhill was world-renowned and she thought people would now die if the Casualty Service at Stobhill was closed.

In response to a question, it was thought that the very rough figures for A&E attendance in NHS Greater Glasgow Hospitals was:-

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Infirmary</td>
<td>70,000 p.a.</td>
</tr>
<tr>
<td>Western Infirmary</td>
<td>55,000 p.a.</td>
</tr>
<tr>
<td>Victoria Infirmary</td>
<td>68,000 p.a.</td>
</tr>
<tr>
<td>Southern General</td>
<td>44,000 p.a.</td>
</tr>
<tr>
<td>Stobhill Hospital</td>
<td>47,000 p.a.</td>
</tr>
</tbody>
</table>
If the service was to transfer – the new service must be as good, if not better, than the current service – triaging of patients must be of the highest standard, good access to professions allied to medicine was essential and the hospitals must be capable of dealing with the extra capacity.

**Proposed Model of New Service**

Mr Tullett described the proposed new service – Stobhill would have a Minor Injuries Unit (pilot under way) for sprains and minor soft tissue injuries and this would account for about 20/25% of the 47,000 attendances per annum. The pilot was nurse-led and patient satisfaction was high with waiting times reduced.

The remaining patients would either go to the Royal or Western Infirmarys or GP referred patients would continue to be admitted to Stobhill. The capacity at A&E at the Royal Infirmary to see the additional patients was adequate; space would be tight at the Western Infirmary, so it was likely that a Minor Injuries Unit would be developed to deal with these types of patients. The ambulance service would deliver patients to the appropriate hospital and clinical staff would follow the service.

It was not felt that this new model of service would breach the Patient’s Charter and with the development of the multi-storey car park at the Royal Infirmary this would also see a widening and improvement to the entrance to A&E.

The initial reaction from GPs to GP referred patients going to Stobhill had been mixed and a preference might be that all emergency admissions went direct to the Royal and Western Infirmarys. Such an arrangement would necessitate identifying floor space at the Royal – this could be achieved with other possible forthcoming moves currently being considered. This would see the possibility of a Minor Injuries Unit at Stobhill, all acute admissions going to the Royal and Western Infirmarys and the need to identify floor space at the Royal. Whatever changes are eventually agreed – it would be best achieved by a gradual and incremental change/transfer of services up to the August 2005 date.

Mr Tullett indicated that it would be difficult to get the A&E Consultants to continue with the current arrangements after August 2005.

**Questions**

It was felt it would be useful to ask a representative from the Royal Colleges to attend a future meeting and explain the process and criteria they follow when accrediting facilities for training purposes. The Colleges would also be asked to explain the decision reached in connection with the Casualty Service at Stobhill.

There was also a concern about the capacity of the Royal Infirmary to take the additional patients from Stobhill – this might become an issue for the Auditor General.

The North Division was confident of recruiting 2 new A&E Consultants in the next recruitment phase, however, there were currently more Consultant vacancies than available candidates and A&E was not an international specialty where candidates from abroad could be attracted.
In response to a question, Mr Davison described the impact on other specialties if all acute admissions were transferred from Stobhill. Medical and surgical beds would need to be re-provided, as would the remaining acute specialties. Under this option the spare capacity created could be used for elective admissions from the Stobhill and Royal Infirmary catchment areas; there would be a Minor Injuries Unit, Day Surgery, Out-patients and Rehabilitation beds. This would have a knock-on effect on clinical support services, like haematology and biochemistry. Some services would transfer to interim accommodation before moving to the accommodation planned under the approved Acute Services Strategy.

There was recognition from a member that the Acute Services Strategy saw the closure of the Casualty Service at Stobhill and it was only with the Royal Colleges’ visit that this closure will now be earlier than planned. The closure of Casualty would have a significant knock-on effect on other acute services and planning and energies should now be directed towards obtaining the best pattern and model of services for patients at the Royal and Western Infirmaries. The plans for the Royal will see older facilities opened up, services split (ITU was an example given) and being less efficient and welcoming. The timescales did not appear to be achievable and there are capacity issues – management had to address these critical issues urgently.

It was further commented that the Royal Infirmary has many problems – size, layout, records management. The recent transfer of the 30 beds (Gyn-Cancer and Gynaecology) from Stobhill had caused stress to staff by lack of information and delayed decisions. Access to high dependency beds had been questioned by some of the service users in the GRI – access was one of the guarantees made when the transfer was agreed.

The Community Councils felt that Royal Infirmary would not be able to cope with the additional patients, there were already unacceptable lengthy delays in A&E and the ACAD proposals should have included step-down beds for acute emergencies.

**Conclusion**

i) An audit trail of the recruitment process for A&E Consultants would be presented to the next meeting.  

   **TP Davison**

ii) The capacity issue at the Royal was a serious concern – this would need further discussion at future Monitoring Groups – this may also require an external review from the Auditor General.  

   **All Members**

iii) The Royal Colleges should be invited to a future meeting to discuss the criteria for training and supervision of doctors in training and a copy of the Executive Summary of the visits to Stobhill would be requested.  

   **H Burns**

iv) It needed to be highlighted in the Minutes that Mr Tullett had stated that the North Division A&E Consultants would not continue to work within the current arrangements beyond August 2005.  

   **North Division**

vi) Early sight of the paper going to the October 2004 NHS Board on accelerating the Acute Services Strategy would be requested and the September meeting would consider whether there was a need for a further special meeting in October to discuss the implications in the paper for Stobhill.  

   **All Members**

vii) Any concerns about the proposals would be communicated to the NHS Board and the Minister for Health and Community Care.  

   **All Members**
18. COMMUNITY COUNCIL REPRESENTATIVES’ LETTER – 3rd JULY 2004

There was submitted a copy of a letter dated 3rd July 2004 from the four Community Council representatives on the North and South Monitoring Groups about the lack of progress on monitoring the continuity of services and progress towards solutions, as well as setting out some proposals for future meetings.

The Community Council representative talked about the issues in the letter, the need for a combined Monitoring Group or more joint meetings, the poor content of information presented to the Groups and the fact that she felt patients would die if the proposals were implemented.

In the discussion that followed the following points were made:-

- The Monitoring Group was satisfied that all information consistent with its remit which had been requested had been provided by NHS Greater Glasgow.

- It was recognised that many Monitoring Group members were required to report to their constituent bodies and explain the work of the Monitoring Groups. They also had the facility of raising issues direct with NHS Greater Glasgow.

- The Monitoring Groups were created to monitor the named services and participate in discussions about proposed changes, not implement the Acute Services Strategy.

- The Community Council representatives should continue to meet as they see fit and liaise with the NHS Board on the issues important to them, however, the Monitoring Group would determine its own issues and means of working. The early Monitoring Group meetings had determined the modus operandi and the Group felt these principles were still relevant.

- Meetings were held as often as the Group required; occasional Joint meetings had benefit and voting was not necessary as consensus had been previously agreed with any disagreements being minuted.

- A forward work programme would be developed for consideration at the next meeting, to be consistent with the Monitoring Group’s remit. **Chair**

- Any evidence that the 5-year commitment would not be met should be submitted to the Minister for Health and Community Care. **All Members**

- The Chairs of the Monitoring Groups would meet with the Chief Executive of the NHS Board, Tom Divers, about the proposed change and impact on the 5-year Ministerial guarantee. If necessary, a request would be made to Tom Divers to attend a future meeting of the Group. If a meeting with the Minister was still necessary, a request would be made for such a meeting. An official from the Minister’s Office should be invited to attend a future meeting of the Group. **Chair**

19. DATE OF NEXT MEETING

The next meeting would be held at 9.30 a.m. on Friday, 3rd September 2004 in the former Library, North Glasgow Acute Offices, 300 Balgrayhill Road, Glasgow, G21. **J C Hamilton**

The meeting ended at 12.30 p.m.