EMBARGOED UNTIL MEETING

NMG(M) 04/01

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, 23rd January 2004 in the Thomas J Thompson Centre, Stobhill Hospital, 133 Balornock Road, Glasgow, G21

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PRESENT:

Mr Ian Miller (in the Chair)

Dr Roger Hughes 
Mrs Elizabeth King 
Mr Paul Martin MSP 
Mr John McMeekin

Ms Mary Murray 
Dr J O’Neill 
Prof. Duncan Stewart-Tull 
Dr John Smith

Dr Jean Turner MSP

IN ATTENDANCE

Dr Brian Cowan .. Medical Director, NHS Board (to Minute 4)
Mr Tim Davison .. Chief Executive, North Glasgow Acute Trust (to Minute 5)
Ms Jane Grant .. General Manager – Division of Surgery, North Glasgow Acute Trust (to Minute 5)
Mr J C Hamilton .. Head of Board Administration – NHS Board

ACTION BY

1. APOLOGIES

Apologies for absence were intimated on behalf of Mr W Aitken MSP, Dr H Burns, Dr J Davis, Mr L Gaston and Mr D Sime.

2. MINUTES

The Minutes of the previous meeting held on 5 December 2003 were approved subject to the following change:-

Minute 4 – Minutes Page 4 – 1st line – insert “Davis” after Jo.

3. MATTERS ARISING FROM PREVIOUS MINUTES

i) Minute 6 – Recording Discussions in the Minutes and Distribution Arrangements for Approved Minutes

There was concern that specific points raised by specific individuals should be clearly attributed to these individuals in the Minutes of the North Monitoring Group. This concern was recognised, but felt by the Group to be the exception rather than the rule. This had been discussed at the last meeting and it was preferable only where an individual clearly required that their view be recorded under their name, and normally this would be where an individual wanted it recorded that they disagreed with a decision of the Group, would their name appear in the Minutes. The Minutes were collective and would reflect all contributions.
DECIDED:

That the recording of discussions in the Minutes cover the main areas raised, and other than by exception, did not record Group members by name.  

J C Hamilton

b) Minute 3 – Impact of Workforce Issues and Services

Clarity was sought on exactly what was a “rota” when described as Consultant and Junior Doctor rotas.

It was explained that a rota was a group of doctors (say, for example, about 7 junior doctors) on full shift rotas providing care seven days per week, 24 hours per day.

It was acknowledged that there would be benefit in producing a list of some of the NHS definitions in lay language explaining the various terms used.

D Stewart-Tull

4. EMERGING PRESSURES IN ACUTE SERVICES

There was submitted for members’ information a copy of the paper [Board Paper No. 03/73(a)] which was submitted to the NHS Board at its meeting on Tuesday, 16 December 2003 on the emerging pressures in acute services.

Questions and General Discussion

The Chairman referred to the 9 bullet points which had arisen at the last meeting which required clarification as well as the question submitted about patient transfers and opened up the debate on the possibility of moving to one rota for anaesthesia.

Anaesthesia was needed for intensive care, coronary care, emergency care, maternity on each hospital site providing these services and, therefore, it would not be practical to run anaesthesia on a single rota. Quite often, 3 or 4 Consultant Anaesthetists are on-call and the intensity of the work was increasing. There was pressure in covering the Western, Gartnavel General and Queen Mother’s. The rota at Stobhill was struggling to be compliant and obtaining accreditation for training purposes was a concern.

In light of recent medical manpower issues and, in particular, the recent European Court ruling about resting in hospitals being counted as at work, there were some difficult decisions to be made to ensure compliant rotas. This would also shortly affect the junior doctors’ rotas in general surgery.

There was appreciation of the problem, but concern for what the implications might mean for patients and delivering safe care and treatment. As discussed at the last meeting, it was important to look at available and alternative options and consider how best the optimal care could be provided for patients taking into account the restrictions on clinical staff and the need to provide safe services to patients.
It was felt that clinical staff had worked long hours for too many years and addressing the problem would ultimately raise the quality of care for patients and staff morale. The medical staff long hours culture had been known for years and, therefore, there must be plans to re-configure acute services which takes account of the Minister for Health’s commitment in September 2002 to maintain named services at Stobhill Hospital for 5 years. In reply, it was stated that every effort was being made to minimise disruption during the implementation of the Acute Services Strategy at Stobhill and to sustain safe services for as long as possible within an ever-changing environment. In addition to the junior doctors’ ‘new deal’ and Working Time Directives, the new and emerging issues which now had a significant impact on delivering services to patients were the requirements of the new Consultants Contract; the European Court ruling on rest in hospital being taken as counting towards work time and the forthcoming changes to the training of new doctors. These issues and the problems had been shared with the Monitoring Group on 5th December in an open way to engage in dialogue about how options and solutions could be developed to address the problems. There was no intention to change the number of beds available, just re-configure them in a way that satisfied the requirements of delivering safe clinical services taking account of the existing and new regulations/requirements on clinical staff.

How this could be presented to the public without them seeing the issue in an isolated way was going to be difficult. The issue of bed numbers remained a concern, especially when it appeared from the Health Board’s figures that bed numbers in the North Trust would decrease by 2005 and this would have an impact on waiting times. It was acknowledged that there would be centralisation in some specialties which would lead to better care and with an increasing number of day cases being performed, bed numbers would move in line with emerging clinical practice. The ultimate capacity required (number of beds in each specialty) was to be determined by a pan-Glasgow group which had been established to assess final bed requirements as part of the Acute Services Strategy. There was capacity in the North to configure services differently; this option was not so readily available to the South. Glasgow Royal Infirmary had space for approximately 100 beds and utilising the area available would clearly form part of the discussions and options.

Would this lead to longer waiting times for in-patient and out-patient services. It was explained that NHS Greater Glasgow had reached, for the first time, the national target of no in-patient waiting longer than 9 months as at 31st December 2004 and the next target was to reduce this to 6 months as at 31st December 2005. There were patients to whom this national target did not apply; these patients were not clinically available for their treatment for a variety of reasons and, therefore, on a national basis, the guarantee/targets did not apply to them. Examples were given of 18-month waits for treatment at the Royal Infirmary, patients lying on trolleys overnight and the need for NHS Greater Glasgow to be up-front and more honest about its services and failures.

It was agreed that the Monitoring Group receive the regular waiting times data produced by the NHS Board.

J C Hamilton

Has there been a planning failure that had led to the problems now being experienced? Commitments had been given about acute services at Stobhill and now the position seemed to be changing. Yet there was no pressure from medical staff at Stobhill saying they wanted to, or needed to, move to the Royal – this was significant.
Would it be possible to accelerate the complete Acute Services Strategy if additional funding was available? Elements of the current process would continue to follow the planned timetable – the ACADs development – however, there was a facility that if the remaining parts of the strategy were affordable more quickly then an acceleration programme could be achieved. Clearly, the NHS Board had a responsibility to balance its budget on an annual basis. The Monitoring Group was keen to let the Minister for Health know of the issues it had faced in its first year and, in particular, the need for early access to funding to allow the acceleration of the Acute Services Strategy. Members would be willing to approve, by e-mail, any letter to the Minister and the MSPs explained that they had also made approaches to Scottish Ministers for meeting on matters affecting NHS Greater Glasgow. In addition, the Minister should be sent a copy of the approved minutes of the Monitoring Group’s meetings.

On the question raised on the number of diversions, it was explained that over the last three months in the North Trust, of the 35,000 admissions, 42 patients were diverted between hospitals.

Dr B Cowan left the meeting.

In response to a question about waiting lists, it was explained that there was one waiting list with different categories. As explained earlier, there were patients who were not in a position to receive treatment and there were also instances of GPs requesting urgent referrals of patients because of their assessed clinical condition. Clinical judgements would, therefore, be a determination in a patient’s wait for treatment.

The next issue raised was access and transport to the Royal Infirmary and also navigation around the hospital (external and internal signage) when there is no clear front entrance.

The road access to the new Accident and Emergency Department was being widened and improved and a car park for 1,000 places was being developed. In addition, a Transport Group had been formed to liaise with Strathclyde Passenger Transport Executive over improved and better public transport links with hospitals and services, as part of the implementation of the Acute Services Strategy. Concern was expressed at charging staff and the public for using car parks servicing hospitals; public transport links from Twechar and Lennoxtown; the lack of public transport between Stobhill and the Royal and disabled access to car parking spaces. It was agreed that the Monitoring Group receive a copy of the Transport Group’s Report once it was available and be kept up to date with its progress.

5. PRESENTATION ON STOBHILL CASUALTY AND OTHER SIGNIFICANT ISSUES

Tim Davison and Jane Grant, General Manager, Division of Surgery, North Trust, gave presentations with regard to Stobhill Casualty and the main issues affecting Surgical Receiving, Orthopaedic Clinic and Ear, Nose and Throat and Gynaecology. The overheads used are attached to the Minutes of the meeting.

It was explained that the casualty service at Stobhill was unique in that it was not run by consultants but by junior doctors. This meant that there was no consultant cover or training supervision and, therefore, the Royal Colleges were intending to withdraw accreditation from 1st February 2004, but on the basis of the plans in place, allowed the situation to continue until August 2004.
To address this problem from 1st February to 1st August 2004 the 5 Senior House Officer posts at Stobhill would join a single pool of North Glasgow Senior House Officers. All 27 posts would rotate through the Western, Royal and Stobhill (therefore, would be gaining consultant supervision at the Western and Royal and being better trained); negotiations would be undertaken with existing consultants to see if they would carry out additional sessions to provide cover for Stobhill. In addition, steps would be continued in order to attract two Accident and Emergency Consultants by the autumn. There was the need to satisfy the Royal Colleges on the new arrangements at their follow-up visit in Easter 2004.

As the current plans were dependent upon a number of factors, there was a need to develop a contingency plan for the potential of a new model of care for the 47,000 attendees at the Casualty Unit, Stobhill Hospital.

Jane Grant summarised the work of the North/East Steering Group and the Surgical Sub-Group and Casualty Sub-Group.

There were pressures on anaesthetics and theatres and they impacted on surgical receiving at Stobhill. Out-of-hours anaesthetic cover could only be maintained if consultant anaesthetists covered first on-call and 6 new Senior House Officers were appointed to the North Trust Junior Doctor rota. The practical possibility of securing these additional posts, and the extra funding which would be required to support a very small number of operations out-of-hours, meant that limiting out-of-hours surgery was highly likely to be required in the short term. The various options/models for running surgical receiving, depending on the outcome of negotiations, was explained together with the plans for Ear, Nose and Throat and Gynaecology.

Ear, Nose and Throat, would be transferred to Ward 2C, Gartnavel General in June 2004 to allow demolition as part of the plan to build the ACAD. 6 in-patient theatre sessions would be transferred to the Royal Infirmary and the Day Surgery theatre sessions would remain at Stobhill.

For gynaecology, transfer to Wards 23/24 at the Royal Infirmary by August 2004 prior to an eventual move to the Princess Royal Maternity Hospital to allow demolition as part of the plan to build the ACAD, 12 theatre sessions would transfer to the Royal.

The Chairman thanked Mr Davison and Ms Grant for their clear and transparent presentations and invited comments/questions on both. The following were raised:-

- The position with casualty was heartening, although surprising that nationally so few Accident and Emergency Consultants were available for recruitment.

- All steps must be taken to recruit the 2 Accident and Emergency Consultants to the North Trust.

- With the Royal College’s accreditation depending upon a number of factors, there was a fine line between achieving accreditation and not and, therefore, contingency plans should be developed. There were no guarantees that the current well developed plan would ensure appropriate accreditation.

- The transfer of the gynaecology services was, in the first instance, in an interim move until the purpose built accommodation was available. The clinicians had been fully involved in planning the move and accommodation. The gynaecology oncology beds were proposed to transfer to the Beatson Oncology Centre.
On anaesthetic cover, there would be insufficient junior doctors to cover rotas by mid-March 2004 and discussions and negotiations were ongoing with anaesthetic staff on consultant staff being first on call. The issue was around determining an acceptable level of payment to undertake the first on-call duties. There was an understanding that the negotiations had to be seen in the context of achieving value for money in utilising scarce public funds. The impact of no agreement being reached was Surgical Receiving being maintained until 10.00 p.m. but the one operation on average per week overnight would need to be carried out at the Royal Infirmary.

Other specialties will, under the Acute Services Strategy, see a centralisation and all children’s services being carried out from the Royal Hospital for Sick Children.

The Chairman thanked Mr Davison and Ms Grant for their presentations and for discussing the points raised by members.

6. ACCIDENT AND EMERGENCY

The Monitoring Group asked that it receive the quarterly attendance figures at Accident and Emergency and Casualty in North Glasgow. There was concern at the Accident and Emergency Department at the Royal Infirmary having the capacity to cope with additional referrals. There was concern that the police were not aware of any possible move of Casualty Services from Stobhill.

H Burns

7. DATE AND TIME OF NEXT MEETING

Friday, 5 March 2004 in the Library, North Glasgow University Hospital’s NHS Trust HQ, 300 Balgrayhill Road, Glasgow, G21

This would be a regular meeting of the North Monitoring Group and members wished to receive an update on the ACAD, Casualty and Anaesthetics.

It was agreed to approach the South Monitoring Group to see if the 4th June meeting could be arranged as the annual joint meeting of the Monitoring Groups.

J C Hamilton

The meeting ended at 11.55 pm