SUPPLEMENTARY REPORT OF THE INDEPENDENT SCRUTINY PANEL ON PROPOSALS FOR HEALTH SERVICE CHANGES IN THE CLYDE AREA

Contents

Appendices

1. INTRODUCTION

The Clyde Independent Scrutiny Panel was established in September 2007, to consider and report on the options for public consultation put forward by NHS Greater Glasgow and Clyde, in relation to future health service provision in the Clyde area, including Unscheduled Medical Admissions (UMA) at the Vale of Leven Hospital. The Panel published its report on 4th December 2007.

NHS Greater Glasgow and Clyde considered the Panel's Report at its Board meeting on 18th December 2007. In relation to UMA, one of the Board's decisions was:

"That on the basis of safety and clinical governance, plans should be developed to transfer unscheduled medical admissions services in a planned and managed way from the Vale of Leven Hospital to the Royal Alexandra Hospital.[1]"

This conclusion, to proceed with one option without public consultation, was at odds with the Panel report, which had recommended that four options for that service should be "fully developed, appraised, and presented for public consultation".

Following the Board meeting, the Cabinet Secretary for Health and Wellbeing invited the Panel to reconvene, and to consider, in particular, whether there was any new and compelling evidence in relation to clinical safety, which would change the Panel's conclusions in relation to UMA. The Panel accepted this invitation, and this paper outlines its views in this regard. It also includes a brief response from the Panel to the Board's reaction to the other key issues covered in its report, relating to: mental health services; maternity services; older people's services and finance.

This paper should be considered as a supplement to the Panel's report, *Report by the Independent Scrutiny Panel on Proposals for Health Service Changes in the Clyde Area*, which is available at www.independentscrutinypanels.org.uk

2. PROCESS

The Panel Chair met with the Cabinet Secretary on 7th January 2008. The Cabinet Secretary confirmed her expectation that the reconvened Panel would seek and assess any new and compelling evidence on clinical risk around UMA at the Vale of Leven Hospital. She would also welcome a brief review of NHS Greater Glasgow and Clyde's response, thus far, to the Panel's Report.

The Panel met on 17th and 28th January and on 8th and 21st February 2008. Minutes of these meetings are available on the Panel's website.

In the early part of January, the Panel invited a paper on the safety issues arising from Lomond Integrated Care from Dr Hugh Carmichael, on behalf of the group of primary and secondary care physicians with interest in the pilot. The paper was submitted, accompanied by a Patient Clinical Incidents Report by the Clyde Acute Clinical Risk Co-ordinator, for the period 1st July to 30th September 2007 (Appendix 1). The Panel took careful account of these documents and held in reserve the possibility of meeting Dr Carmichael and his colleagues, should that seem necessary in light of the outcome of the anticipated clarification meeting with NHS Greater Glasgow and Clyde. Following that meeting the Panel felt it unnecessary to meet with the Vale clinicians.

[1] Minutes of a Meeting of the NHS Greater Glasgow and Clyde Board on Tuesday 18th December 2007, NHSGG&C(M)07/06, Item 139, Page 10

In order to review the availability and relevance of clinical outcome data for the Vale of Leven Hospital held on the National database, Professors Brunt and Mackay visited NHS Information Services at Cirrus House on 6th February 2008. However, in the absence of any such data being presented by the NHS Board, the Panel did not pursue that line of enquiry.

On 8th February, the Chief Executive and Medical Director of NHS Greater Glasgow and Clyde attended that part of the Panel meeting devoted to clarification of the safety issues around unscheduled medical admissions at the Vale of Leven Hospital.

This Supplementary Report was submitted to the NHS Board and the Cabinet Secretary on 25th February 2008.

3. UNSCHEDULED MEDICAL ADMISSIONS (UMA) AT THE VALE OF LEVEN HOSPITAL

Concern over NHS Greater Glasgow and Clyde's (NHS GG&C) reaction to the Panel's comments on this service was the reason the Cabinet Secretary invited the Panel to reconvene. In the expectation that any new and compelling evidence on clinical safety would be provided by NHS GG&C, the Panel Chair sent an e-mail to the Chief Executive on 8th January 2008 in which he requested a paper, suitable for the public eye, containing relevant information prior to a clarification meeting. An e-mail was received from the Chief Executive on 24th January which simply listed eight headings identifying the principal areas of concern. This fell far short of the Panel's requirement for a paper in which any safety issues were laid out in sufficient detail to form the basis for a clarification meeting, and to be understandable to an informed member of the public. The clarification meeting scheduled for 28th January was therefore postponed pending receipt of appropriate documentation from NHS GG&C.

On 5th February three papers were submitted to the Panel, ostensibly to inform the clarification meeting, which had been re-scheduled for 8th February. In fact, of the three papers, only one was of direct relevance to clinical safety (see Appendix 2). It dealt with a number of factors felt by NHS GG&C to impact on the current level of clinical risk around UMA, and the measures taken by them to manage these factors. The paper also included brief clinical summaries relating to ten cases, collected between January and October 2007, which were intended to illustrate the clinical risk about which concerns had been raised. A second paper described an outline option appraisal for UMA which included the Southern General Hospital, and the Western Infirmary, in addition to the Royal Alexandra Hospital (RAH) (Appendix 3). The third paper dealt with the resource requirements of the ambulance service for the provision of UMA at RAH (Appendix 4).

At the clarification meeting on 8th February the central question of why NHS GG&C had decided, at its December meeting, to proceed forthwith to implement the transfer of the service to RAH without public consultation, was explored in detail. It was clear that the ten case summaries presented as evidence of clinical risk were, without some form of statistical comparator, of little use to the Panel in forming a view about the safety of the service. In other words, it was impossible to conclude that these cases reflected a service that was necessarily different in safety terms from any similar hospital in Scotland. Indeed, the documentary information received from Dr Hugh Carmichael described a system in which there was frequent and detailed scrutiny by local clinicians, and implementation of any necessary corrective action.

The NHS GG&C representatives described a collection of longstanding issues which impacted on the clinical risk, all of which were acknowledged by the Panel, including inter-

hospital transfers, staffing and anaesthetic cover. The material points were that these factors were already present at the time of the NHS Board meeting in June 2007, when the Board was ready to proceed to work up its consultation documents and undertake a 12-week public consultation on its one preferred option, and that they actually related to sustainability rather than immediate safety. The Panel made particular note of the assurance, from the Board's Medical Director, that the service currently being provided was as safe as it could possibly be made in its present configuration. Taking all of these factors into account, the Panel could find nothing that had changed to increase clinical risk between June 2007 and the present time.

The explanation given for the December decisions of the Board appeared to the Panel to be based largely on principle rather than justified by any demonstrably new urgency related to clinical safety. The Panel was surprised to learn, from the Minute of the NHS Board meeting of 18th December 2007, that the Board had been persuaded that the Panel's Report of December 2007 served only to endorse a decision for immediate action to implement its preferred option. This appeared to the Panel to be associated with at least two misconceptions.

The first of these misconceptions was that the Panel's Report, in accepting that proceeding to the full integrated pilot would have been clinically unsatisfactory, meant that there was no point either in the evaluation of the integrated care model at the Vale of Leven Hospital under safe anaesthetic cover, or the full appraisal of alternative locations for UMA in Greater Glasgow. The Panel's Report clearly stated the case for consulting on a proper and safe evaluation of the first phase of the pilot, and for working up a Glasgow hospital option.

The second misconception was that the Panel's suggestion to include the status quo within the list of options for consultation was irreconcilable with the Board's conviction that it would be dishonest to consult on a manifestly unsustainable way forward. It should have been clear from the Report, and from subsequent communications with NHS GG&C, that the status quo was included in the Panel's list in order that a rigorous appraisal of the benefits and risks of the present service, alongside those associated with the other three options, might be presented to the public in such a way as to allow informed agreement, or disagreement, with the Board's preferred option.

It is worth emphasising the Panel's belief that the real value of transparent option appraisal is to identify, in detail, the many benefits and risks associated with a range of possible options and to weight and evaluate these through a process which genuinely involves all interested parties. NHS GG&C has thus far failed to do this for UMA.

Over the course of interactions with NHS GG&C it appears to the Panel that there has been broad agreement over the ways in which the present UMA service differs from any other in the Board area, and over the factors which render the service less than ideal. Where the views of the Panel and the Board have diverged, is on whether the decision to transfer the UMA service to Paisley should be tested in an open and transparent way by comparison with other options, including the status quo, within a conventional option appraisal that would naturally form the basis for public consultation.

The Panel notes that at its meeting on 22nd January 2008, the Board decided that its decision not to consult publicly on the transfer of the unscheduled medical care service from the Vale of Leven be reconsidered, and that a period of formal public consultation be initiated as soon as possible, although the Panel is not entirely clear about the number or nature of the options the Board would intend to present.

Conclusions On Unscheduled Medical Admissions

No new and compelling evidence on clinical safety has been presented to the Panel, nor has the Panel been provided with any other persuasive reason why the options for Unscheduled Medical Admissions at the Vale of Leven Hospital, suggested in its Report, cannot be properly presented for public consultation. If NHS Greater Glasgow and Clyde had decided upon this course of action last December, then the process could, by now, have been well under way. Further delay could have been avoided if documentary evidence of clinical risk had been provided promptly to the Panel. Given the Board's repeated desire to proceed as quickly as possible, the irony of this has not escaped the Panel, nor doubtless will it escape the members of the Board.

4. REMAINING TOPICS DEALT WITH IN THE PANEL REPORT OF DECEMBER 2007

What follows is a series of summarised assessments, by the Panel, of the early response by NHS GG&C to the other elements of the Panel's main Report, as stated in the Board papers and minutes associated with its meetings on 18th December 2007 and 22 January 2008. The Board's views, and the Panel's assessment of these views, are laid out under the headings of the main service changes and issues dealt with in the main Report.

4.1 MENTAL HEALTH

It appears that the Board has generally responded positively to the Panel's comments on the proposals, as follows:

- An independent facilitator has been appointed to manage the process of option appraisal in response to the Panel's comment on the lack of sufficient detail and quantification needed to conduct value for money comparison between options. A full option appraisal is being conducted on the future of Christie Ward;

- Measures of the capacity of in-patient sites to respond to peak demand, and of boarding-out levels, will be undertaken;

- Further clarification and refinement of the proposed mix of continuing care partnership beds and the range of community placements will be provided, based on individual needs assessment;

- Various steps will be taken to ensure that the public consultation material is explicit about the intended partnership arrangements, including handouts, photographs, and both one-to-one and group work with people likely to be affected.

4.2 MATERNITY

The December 2007 Board papers are largely dismissive of the Panel's comments, and, surprisingly, appear not to mention certain points felt by the Panel to be material to the Board's arguments in favour of centralisation.

The principal areas of concern to the Panel are as follows:

- Rejection of the Panel's suggestion of an option which would give the local birthing suites more time, accompanied by positive publicity, through which to establish their worth in the eyes of local mothers. Board papers fail to mention that, at the time of their inception, it was anticipated that the units would require a 5 to 10 year run-in period;

- The Board papers imply that the Panel was advocating a relaxation of the Expert Group on Acute Maternity Services (EGAMS) selection criteria. This is not the case. The Panel merely drew attention to the recommendation for a review of these criteria contained in the NHS Quality Improvement Scotland Report of February 2007. The Panel was surprised that no reference is made to this Report in Board papers;

- Other omissions in the relevant Board papers are the firm positive views of the Royal College of Midwives and the National Childbirth Trust concerning midwife led birthing suites, and the clear presumption of the Scottish Government against centralisation of services;

- Of particular concern to the Panel is the apparent failure of the Board to appreciate the extent to which involvement of all potentially affected parties in the development of options has fallen short of ideal, particularly with regard to the very limited attendance at public meetings, and the feeling of exclusion felt by some local midwives. It is difficult for the Panel to see how the Board can consider the option appraisal outcomes to have adequately informed its decision-making process under these circumstances.

4.3 OLDER PEOPLE'S SERVICE AT JOHNSTONE HOSPITAL

In its report, the Panel had accepted that the NHS Board's proposals for Johnstone Hospital were reasonable, in principle, however:

- The Board feels it is reasonable to extrapolate from its extensive experience in Greater Glasgow. However, the Panel felt that more detail on the intended partnership model, as applied to this service, was required for the public consultation.

- The Panel notes the acceptance by the Board that the reasons against a new-build on the RAH site should be made more explicit in the public consultation.

4.4 FINANCE

The general response of NHS GG&C, as recorded in Board paper 2007/56, took the form of a rebuttal of the approach taken by the Panel, and of its level of expectation, with regard to many aspects of the financial workings, specifically:

Board Response *(From Board paper 2007/56)*	**Panel Assessment**
We have operated within the normal parameters of an NHS financial planning process. The Panel has not given sufficient weight to the absolute obligation (*on the NHS Board)* to reduce costs by £30 million.	While the Panel recognised in its analyses that the savings arising from Mental Health, Maternity and Johnstone Hospital might contribute some £3.5 million per annum, the uncosted impact of closure and transfer of UMA effectively renders any comment on the overall impact on the inherited deficit less than helpful. The Panel found no reason to assume that honouring the obligation to the

Board Response *(From Board paper 2007/56)*	**Panel Assessment**
	Scottish Government through efficiency savings, associated with service improvements, lay beyond the capacity of a NHS Board with an annual revenue budget of £2.6 billion.
The report overstates the constructs of value for money and opportunity cost against the simple requirement of affordability.	For affordability to be demonstrated requires a detailed financial model incorporating all opportunity costs/savings, and risk assessment, as they relate to every option. The Panel does not believe that this has been demonstrated adequately.
All of our proposals are clearly costed.	The Panel's view is that none of the proposals had been fully costed.
Best Value methodology and (*HM Treasury)* Green Book guidance are not a central part of the planning system and norms for NHS service planning. We have used the option appraisal in a measured and proportionate way.	This view expressed by NHS GG&C prompts several questions; why do Scottish Ministers issue such Best Practice guidance to Public Bodies in accordance with the Scottish Public Finance Manual guidance; why did GG&C itself use this option appraisal structure in its analysis of options for CMUs; and why was it followed by NHS Lanarkshire and NHS Ayrshire and Arran in recent public consultation exercises? The Panel has serious concerns over NHS GG&C's position on option appraisal methodology.
The Panel rightly notes that we have not created zero based processes for significant elements of our planning – we believe that is appropriate. We have relied heavily on our planning experience from Greater Glasgow rather than creating entirely new planning processes and norms for service changes in Clyde.	The Panel is unconvinced that the process has demonstrated a full assessment of all local issues and factors in Clyde. The Board's view presupposes that the "Glasgow experience and approach" is robust in itself. On the evidence provided, this can only be treated as anecdotal.
The Report's conclusions about the inadequacy of the financial case contradicts its favourable comments on the Maternity and Mental Health proposals.	The Panel firmly rejects this. The financial model for Mental Health proposals appeared to the Panel to be thorough enough but the underlying cost assumptions on partnership working were lacking in detail and not tested in any sensitivity analysis. Likewise, while the CMU modelling appeared to be reasonable the impact of additional staffing costs from displacement/regrading was not apparent in

Board Response *(From Board paper 2007/56)*	**Panel Assessment**
	the workings. The Panel, in its Report, merely sought to give credit to some selected areas of good practice, but this has obviously been taken out of context.

5. CLOSING COMMENTS

Having listened carefully to the concerns of NHS GG&C, and having reviewed its comments on the full range of service changes proposed by the Board, the Panel stands by its Report of December 2007. Following the NHS Board's reaction to the Report, which prompted the Cabinet Secretary to invite the Panel to reconvene, no new and compelling evidence has been presented in relation to clinical safety which would change the Panel's conclusions in relation to UMA. Nor has the Panel been provided with any other persuasive reason why the options for UMA, suggested in its Report, cannot be properly presented for public consultation.

The Panel is also concerned, that the recent focus on the UMA service at the Vale of Leven Hospital, may have diverted attention away from the substantive comments by the Panel about other service changes contained in its Report.

The Panel's work is now concluded. It is for the Board and Cabinet Secretary to make any decisions regarding the future of the services to which it relates.

APPENDIX 1 –
PAPERS RECEIVED BY THE PANEL FROM DR HUGH CARMICHAEL, ON BEHALF OF A GROUP OF PRIMARY AND SECONDARY CARE PHYSICIANS

Clinical Governance safety issues arising from Lomond Integrated Care

Introduction

From the very inception of the concept of running acute medicine on the Vale of Leven site, without the usual back-up of A&E, acute surgery, ITU and (possibly) on-site anaesthetics, the central and foremost issue was that of the clinical safety of the patients entrusted to our care. This was the foundation on which the design and monitoring of the changes in clinical practice were built and it was this assurance that gained the backing for us to progress the project from Prof. David Kerr in his report to the Scottish Executive.

Basis of Model

A very demanding and ambitious research project involving a retrospective audit of over 2000 patients came up with what promised to be a highly successful tool (PREEMPT) that enabled the early identification of those medical admissions at risk of requiring ITU care backed up by a range of clinical triggers with the same object in mind and derived from a widespread cooperation between clinicians within the then NHS Argyll and Clyde.

Organisation and Clinical Governance

Before and during the pilot period we established a hierarchy of responsibility and communication starting from the "front-line" in the Medical Assessment Unit and wards where the rules for the application, recording and implementation of these triaging tools were closely monitored by rigorous auditing overseen by a weekly meeting of the Issues Group comprising medical, nursing manager, ambulance and clinical audit input. This group looked at how well the triaging criteria were implemented, any perceived shortcomings in their application or reliability, the patient journeys of patients particularly those with high scores and requiring more specialist input including anaesthetic contact and ITU and finally the outcomes of patients including full recovery and discharge, cardiac arrest and death. This group in turn reported to the Airways and Protocol committee which was also responsible for the production of clinical, patient pathway, transfer and communication protocols and their monitoring and subsequent amendments in the light of experience. Monthly Interhospital Transfer Meetings with RAH were set up to discuss mainly clinical issues arising from transfer of patients to Paisley RAH under the pilot. In the earlier stages of the project other committees were set up for specific purposes e.g. to derive a modified version of the nationally established early warning tool MEWS that could be used in ambulances to identify patients at risk of respiratory arrest who should by-pass the Vale of Leven (PREAMBLE).

Overviewing these groups and committees was the Lomond Integrated Care (LIC) Implementation Group made up of primary and secondary care specialists, nurse managers and managers which ensured the coordination of the various issues brought to it from these other sources. Finally the LIC Steering Group brought together primary and secondary care, health board, community, local authority and patient interests.

Issues arising

The resulting scrutiny of our patients during their admission journey was far greater than we are aware of occurring elsewhere. During the time of the pilot the only problems or issues that were flagged up were identified by ourselves as a result of this intense "self examination". At the end of the first 6 months of the pilot (and in response to GG&C seeking evidence of safety) we produced an interim report on the pilot to that point including any issues that had arisen. The issues that arose during this time are shown below. There was an initial bedding-in period with medical and nursing staff getting used to the system and learning to react promptly and appropriately during which time some problems were experienced including non-implementation of the model, the model itself causing difficulties and needing modified and breakdown in communication.

However after a couple of months the incidence of these kind of problems steadily declined and during the latter few months we were left with concerns mainly around ambulance issues e.g. delays in transfer due to ambulance availability, failure to by-pass.

Lomond Integrated Care Issues Report August 2006

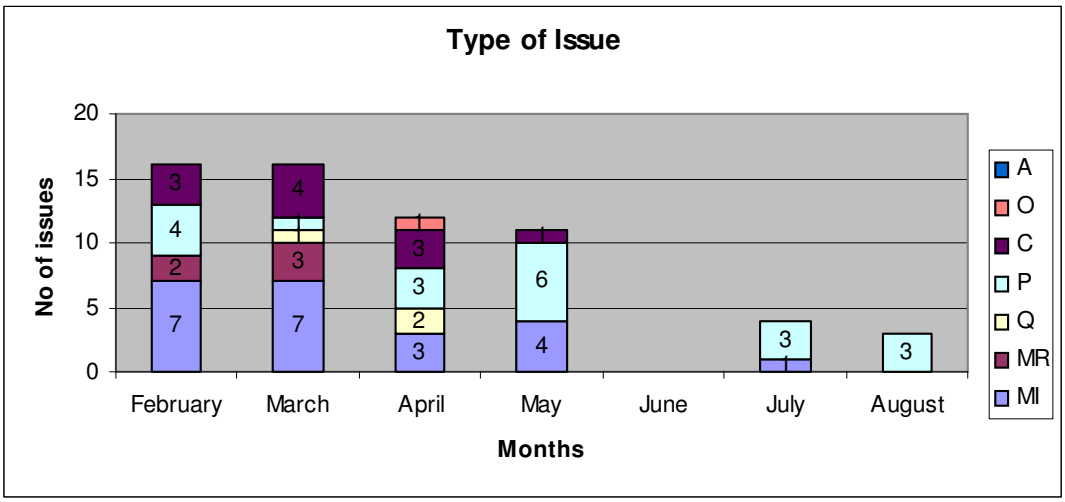
Total number of issues from 31st January to 7th August 2006 (n = 52)
Although there are 52 issues in total some of these were a combination of types.

Total of combinations:

Type	n	%
MI	15	29%
C	4	8%
MI, C	4	8%
MI, C, O	1	2%
MI, P, C	1	2%
MR	4	8%
MR, MI	1	2%
P	18	34%
P, C	1	2%
Q	3	5%
Total	52	100%

Type Codes:

A= Change required to audit form/ audit process	P = Concern/ Problem (In general)
MR = Problem with model	MI = Model not implemented/ followed
Q = Question/ Query	C = Lack of communication
O = Other	



From August 2006 onwards, till the removal of funding to support it functioning at the end of April 2007, the Issues Group continued to meet weekly and discuss a whole range of patient-related issues. The weekly agenda included (i) Transfers out (ii) Cardiac arrests (iii) Anaesthetic issues (iv) IR1 forms (Incident Reporting forms) (v) Previous issues (kept on agenda till resolved) (vi) Audit of transfers/by-passes. During this time there were really no issues that gave rise to sufficient concern to cause any of the clinicians involved – both physicians and anaesthetists - to suggest that what was being done posed a risk that was any greater than elsewhere. Indeed all found the degree of scrutiny very reassuring which, along with continued on-site anaesthetic cover, was felt to provide a safe environment. Virtually all of the issues that caused concern were again related to the ambulance services largely because they have been so stretched for so long and have found it sometimes difficult to adhere to the strict criteria for transfer we have asked for.

The main clinical concerns arose around the occasional case with high triaging scores that was kept on site for a bit longer than desirable in whom it was felt there was some risk. There were usually extenuating circumstances and the patient transferred out eventually when still safe to do so. To appreciate the extent of scrutiny involved during the pilot period I have attached the agenda and minutes of a typical meeting of the Issues Group before it ceased to be at the end of April 2007.

<u>Post-pilot period</u>

The end of the pilot period and the Issues Group brought a period of uncertainty and potential loss of stability in the process of triaging out at-risk patients because of the loss of our scrutiny of it. It is interesting that it was around this time that A&E staff at RAH were asked to specifically record any "problems" encountered in transfers from Vale of Leven Hospital. There was no discussion with ourselves and we are uncertain what influenced this to take place. It was this exercise that highlighted the notorious "eight cases" reported to Nicola Sturgeon. These cases were collected between 21st March and 6th July 2007 (with one from 13th January added in that we had heard off and investigated). It took till August for us to hear of this and get the chance to look into the concerns. We have already sent you our response to this but with your forbearance will briefly summarise.

One of these cases was in fact a direct GP referral from the Primary Care Emergency Centre based beside our MAU in the Vale and nothing to do with MAU or the hospital. One was a patient that should have by-passed to RAH but had to be told that by MAU staff (who could have and should have admitted and stabilised patient first but, in the absence of a Vale acute presence as proposed, would not in future be there to do so). The rest of the patients fell into three groups (i) those where we felt concerns were overstated and did not bear scrutiny (ii) those who left the Vale by ambulance in an appropriate state but deteriorated unexpectedly en route (iii) those who left probably in an unstable condition and who should have been better stabilised before transfer e.g. more I.V. fluids given. The dilemma in such patients can be to get them off site quickly to avoid the need to intubate and ventilate on the Vale site. The irony is of course that these are the very cases that stand to be more at risk when there is no longer the ability to stabilise them on the Vale of Leven site and they have to stand the journey to RAH without any initial input. (and when the Erskine bridge is shut?) However for these few patients we accepted that they would have been better served by being better stabilised at the Vale first. We discussed these cases with A&E and management at RAH first then with Clyde management and Brian Cowan later on and agreed on the issues arising from these cases and the solutions in the form of stricter implementation of a Sepsis Protocol (only now being rolled out in acute hospitals elsewhere) and training of medical staff in stabilising severe variceal bleeding (thankfully a fairly rare occurrence). At that meeting Brian Cowan spontaneously voiced that these experiences of the Vale were no different or worse than in any other hospital – it was just that the Vale was under the spotlight because of its unusual situation. That being the case, and given that we had dealt with the issues that had arisen from these cases, it seems indefensible for them to have been used as we are told they were to discredit the Vale of Leven Hospital and staff and cause inappropriate public concern. The Ombudsman case referred to in the newspapers seems to have been from 2004 before the start of the Lomond Integrated Care project and involved a patient being dealt with outside Clyde i.e. Urological services in Gartnavel General Hospital. As far as we can judge the issues were mainly failure of communication arising from GGH rather than at the Vale but we are aware the Ombudsman still has to deliver his opinion on this.

Following this it was agreed that we reinstitute a "watered down" Issues Group i.e. no funding to audit things. We had already made that decision in fact and had started up with the first meeting on 6th August with the aim of meeting regularly about once every 2 weeks. Again there have been very few issues arise during this time, mostly from our own awareness of them and with only 2 or 3 arising from A&E in RAH – all have been addressed and appropriate action taken. None have been seen as a cause for concern because of the different design of care on the Vale of Leven site.

Finally to add weight to our own efforts to document safety we would draw your attention to the attached report just released from the Clyde Acute Directorate "Patient Clinical Incidents Result Report" – 1st July to 30th September 2007. On page 4 the table shows the low rate of incidents in Vale of Leven compared to other sites taking into account the relative population sizes (VoL 90,000; RAH 200,000; IRH 120,000 approximately). The breakdown of Vale of Leven incidents on pages 9-10 shows that there were only 2 "near miss" incidents – one was surgical and one involved a transfer from RAH to the Vale (<u>not</u> the other way round). Nothing is documented suggesting concerns about safety of acute medical patients in the Vale of Leven Hospital.

Summary

We hope this has made you aware of the trouble we went to to ensure that the level of risk on this site has been as low as possible. We have not been perfect by any means and there is always room for improvement. However, with the continued presence of on-site anaesthetic cover, we feel that what we provide on this site with regard the early identification of at-risk patients has improved safety, even with the loss of ITU. We cannot compare ourselves with other acute sites but very much doubt if this level of scrutiny goes on elsewhere and in fact it is a model that could and should be rolled out to other acute sites.

Although we continue to try and monitor what we do we realise it is far from ideal. Even during the pilot the only reason we achieved what we did was due the to selfless enthusiasm, commitment and professionalism of so many people from a wide variety of backgrounds. If the decision was to be that we should continue to investigate and refine this innovative approach to acute medicine it would have to be actively supported centrally with appropriate funding in terms of audit, I.T. and clerical input and major commitment and funding from NES to create the right educational and training ethos. As in other Clyde hospitals there are concerns about the impact of changes in medical training on the level of experience displayed by junior medical staff. The fabric of the hospital is in urgent need of upgrading. We are currently struggling to cope in temporary areas, e.g. MAU and our combined CCU/HDU, and specific changes in the layout are required for optimal and safe functioning. Most of all however is the opportunity to tap into the genuine commitment from those involved to provide a caring environment that we feel is at the very least as safe as would be possible elsewhere. And of course it is the nature of this "elsewhere" that causes great concern here from the point of view of distance, communication links and the likelihood that patient and GP pressures will see referral patterns being split between N.W. Glasgow and Paisley RAH thus adding to the potential for confusion and delays in patient management risking ever poorer levels of safety.

CLYDE ACUTE DIRECTORATE

Patient Clinical Incidents
Result Report

1st July 2007 to 30th September 2007

Sandi M C Cassidy,
Clinical Risk Co-ordinator, Clyde Acute, NHS GG&C

CONTENTS

1. INTRODUCTION

This is the second quarterly summary of the patient clinical incidents reported within the Clyde Directorate of NHS Greater Glasgow and Clyde. The period covered is 1st July to 30th September 2007.

The purpose of the report is to:

- Provide management and staff information on what is currently being reported
- To encourage appropriate recording
- To identify any external sources of incident and if required provide this information to the services
- To identify what lessons can be learned from the incidents that have been reported
- To note any trends or hot spots for incident types

It is expected that any immediate action required as a result of an incident will be implemented at the time by the staff and management of that area. These actions should not wait on a report of this type to be produced.

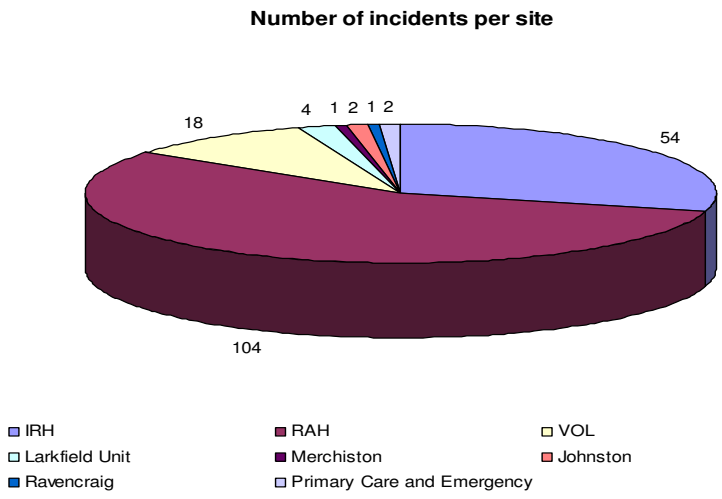
186 patient clinical incidents have been reported in this period. This is an increase of 50 incidents from the previous quarter.

It is important however, that we still recognise that any information gathered within this report is based solely on what has been recorded and we cannot therefore presume that this increase is due to a higher number of incidents being reported. There could be other underlying factors which may have caused there to be an increase in incidents occurring, for instance the change over of junior doctors.

2. REPORTING BY SITE

The pie chart below indicates the number of incidents reported by site.

Graph 1



The following table shows a comparison in the percentage reported at each site over the last two quarters.

Table 1

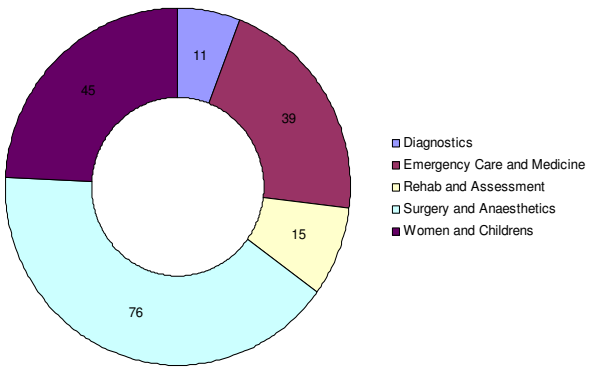
HOSPITAL SITE	PERCENTAGE REPORTED 1st quarter 2007	PERCENTAGE REPORTED 2nd quarter 2007	DIFFERENCE PERCENTAGE REPORTED
Inverclyde Royal	19%	29%	+10%
Larkfield Unit	6%	2%	- 4%
Merchiston Hospital	1%	1%	No change
Primary Care Emergency Services	1%	1%	No change
Royal Alexandra Hospital	53%	55%	+ 2%
Ravenscraig Hospital	5%	1%	- 4%
Vale of Leven District General Hospital	15%	10%	- 5 %
Johnstone Hospital	Nil	1%	+ 1%

Once again the data collected clearly shows a higher percentage of reporting at the Royal Alexandra Hospital, Paisley with 55% of the total incidents reported coming from this site. This is only marginally higher than the last quarter. However, Inverclyde Royal Hospital shows a marked increase in 10% of the total number of incidents reported in this period of time.

3. REPORTED INCIDENTS BY SERVICE AREA

The following chart shows the number of patient clinical incidents that have been reported in each speciality for the period of time analysed. It should be noted that there were no incidents reported directly from administration services or the pharmacy prescribing support unit

Graph 1



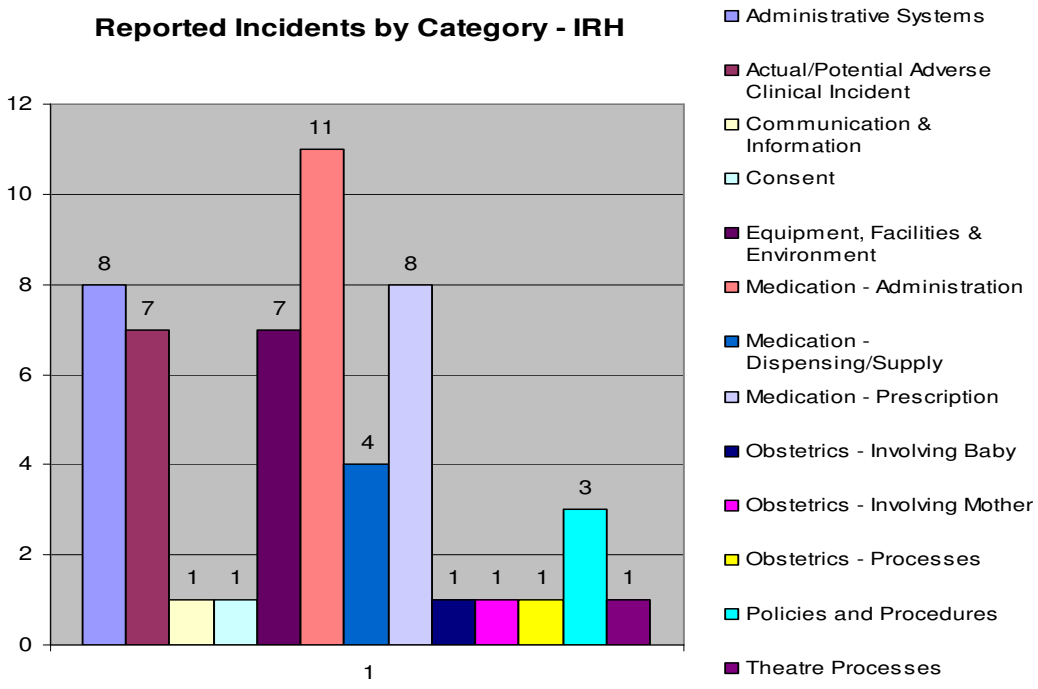
4. TYPE AND OUTCOME OF INCIDENTS REPORTED

Further breakdown of the 186 total incidents is as follows:

a. Inverclyde Royal Hospital

Inverclyde Royal Hospital reported 54 patient clinical incidents in this period of time. This equates to 29% of the total incidents reported throughout the Clyde Directorate. The following graph gives a breakdown of the type of incidents that were reported.

Graph 2



The highest category of reporting is medication administration with 11 incidents being reported within this period of time. This equates to 20% of the total number of incidents reported at Inverclyde Royal Hospital. All of the 11 incidents were reported as having no adverse effect on the patients involved.

5 of these incidents were reported in G North, 2 in G South, 1 in H South, 1 in J North, 1 in K North and 1 in radiology.

The radiology incident reported that a patient claimed to have had an iodine allergy and that despite it being documented the patient was given contrast containing iodine at the time of the scan. Further investigation into this incident advised that if a patient has a reaction it is recorded on the radiology information system (RIS). This was checked at the time, as was the old Radwise system, which was in place prior to RIS. There were no recordings of this

patient having had a reaction in the past. When asked the patient described previous tests carried out with contrast and had experienced no reaction.

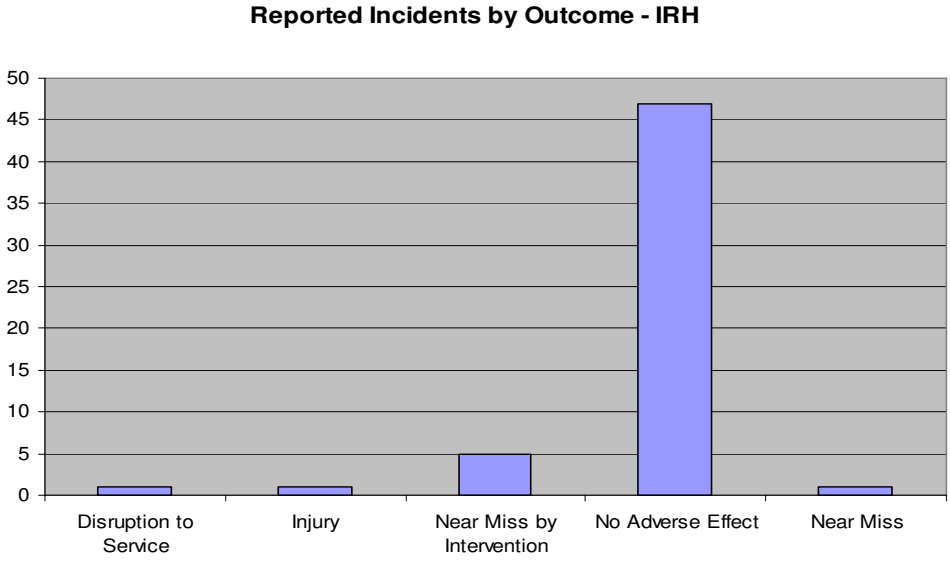
The next highest categories of incidents being recorded in this period of time are "Administrative Systems" and "Medication – Prescription". There were 8 of each type reported. Medication prescription incidents were the second most common category of reporting in the previous quarter at Inverclyde Royal Hospital. However this quarter it is the most recorded number of incidents of its type within Clyde Directorate, amounting to 66% of the total (12) reported.

Of the 8 Medication prescription incidents, 7 of these had no adverse effect on the patient whilst the outcome of one was noted as "near miss by intervention". On further investigation into this incident it would appear that a patient should have been prescribed oral Metolazone as per the case notes however, the kardex stated Methadone. The incident was averted and the patient was given the correct drugs as noted in the case notes and the patient's kardex was duly amended.

There were 7 incidents reported under the type "Equipment, Facilities and Environment". This is an area that crosses boundaries with health and safety. The outcome of 1 caused a "disruption to the service" due to TSSU not having a tin large enough to transport an instrument tray to Inverclyde Royal Hospital. The instrument tray was ready at 1215hrs but did not arrive until 14.30, unfortunately too late to assist the Surgeon. However, there were retractors on trial at Inverclyde Royal so the operation itself was not held up. A request for additional instruments has been added to the capital expenditure request list.

The outcome of another incident under the same category resulted in a "near miss by chance". A patient suffered a ruptured abdominal aortic aneurysm, class 3/4 haemorrhage shock, severe hypotension requiring resuscitation with IV fluid and blood prior to emergency laparotomy. The resuscitation was hampered by the lack of appropriate equipment in HDU: no 14G IV cannula stocked in J Centre; no wide bore IV administration sets stocked (only narrow bore). However, a 14G cannula was acquired from Theatres as it was believed appropriate to establish best possible IV access prior to laparotomy while patient still had BP fluid administration sets changed in theatre prior to induction of general anaesthetic. Critical care areas (ICU/HDU) should stock equipment appropriate for optimum resuscitation and management of haemodynamically unstable patients and therefore should maintain a stock of 14G cannula and wide bore administration sets. Since this incident occurred J Centre now has stocks of 14G cannula and wide bore administration sets.

The following graph shows the number of reported incidents by outcome at Inverclyde Royal Hospital.

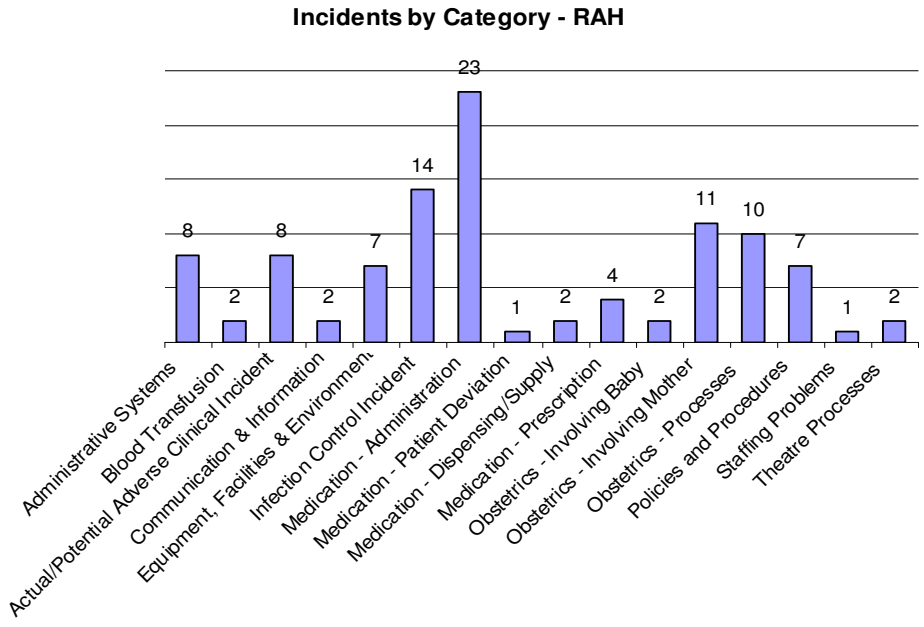


The incident noted in the above graph, which resulted in an injury, involved a nurse practitioner attending to a patient to re-site her cannula – previous cannula dressing insitu. On removal of the same, the patient's top layer of skin was removed resulting in a superficial skin flap. Nursing staff were unaware at the time that this particular patient had fragile skin due to steroid medication. A full apology was given to the patient.

b. Royal Alexandra Hospital

As previously noted, there were 104 incidents reported at the RAH this quarter. This is an increase of 31. The following graph details these incidents by category:

Graph 4



The highest area of reporting at the Royal Alexandra Hospital is medication administration with 23 incidents falling into this category, an increase of 5 more than in the last quarter. This amounts to 62% of the total medication administration incidents recorded within Clyde Directorate. 17 of these incidents had "no adverse effect" on the patients, it was "unable to assess the outcome" of 4, one resulted in a "temporary deterioration of condition" and one was recorded as a "near miss by intervention". Further investigation into the two later incidents noted, showed that:

"Temporary deterioration of condition" - a patient had been given 1.25mg of Ramipril instead of Simvastin in error. This resulted in the patient's systolic rate temporarily dropping.

"Near miss by intervention" – Transducer attached to arterial line, which had been removed prior to admission to HDU, contained 500ml bag of Hartmann's instead of N Saline. Accident and Emergency department notified immediately.

The next highest category of reporting is infection control. In total there were 14 incidents reported for this category. This was a decrease of 3 incidents in comparison with the last quarter. 5 of the incidents had "no adverse effect" to the patient whilst the remaining 9 were reported to have an outcome of "infection".

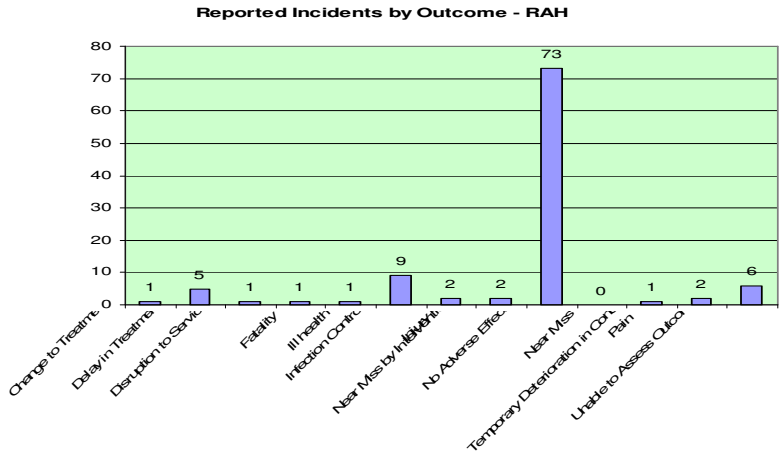
Further investigation of the incidents recorded with an outcome of "infection" showed 5 incidences of device-associated infections, and four incidents of gastric infection

There were 11 incidents reported under the category "Obstetrics – Involving Mother" 4 involved shoulder dystocia, 1 involved the baby being born prior to arrival at the hospital with the other incidents relating to post partum haemorrhage. None of these incidents are reported as having had an adverse effect on either the Mother or Baby and all are reported as being appropriately managed.

There were 10 incidents recorded under the category "Obstetrics – involving processes". Of these 10, eight incidents had no adverse effect to the patient, 1 was a stillbirth and one resulted in "Pain/Prolonged Pain" to the Mother. Further investigation of this incident showed a conflict over management. The patient had an irritable uterus and required pain relief. She was given only paracetamol in the ward before transferring to the Labour Ward. On review the consensus of opinion was that this patient should have been given stronger oral analgesia – all midwives concerned were debriefed at the time of the incident.

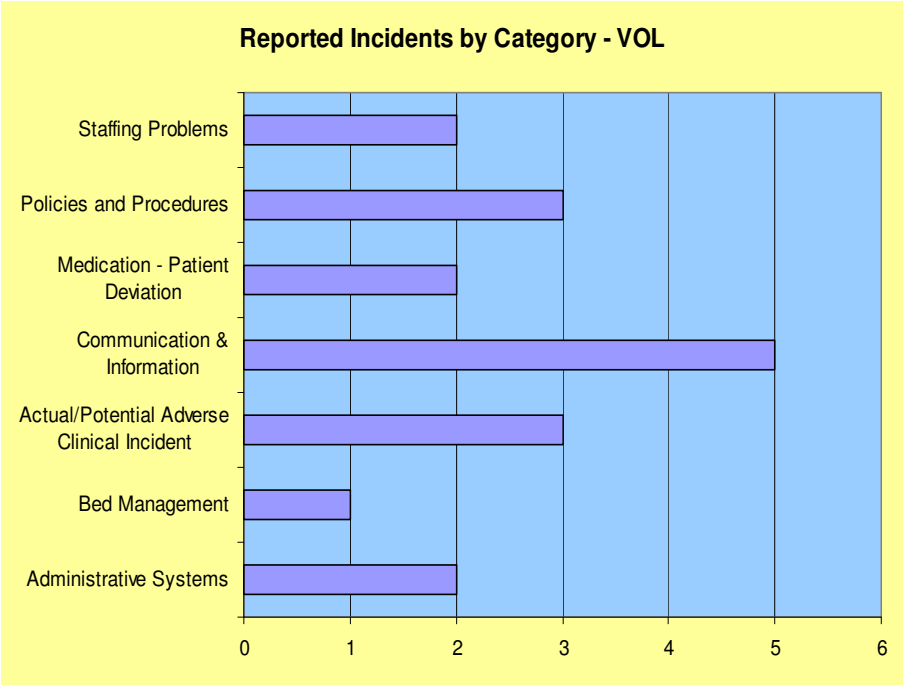
Graph 5

This graph shows the outcome of the reported incidents within RAH for this period of time.



c. Vale of Leven Hospital

Graph 6

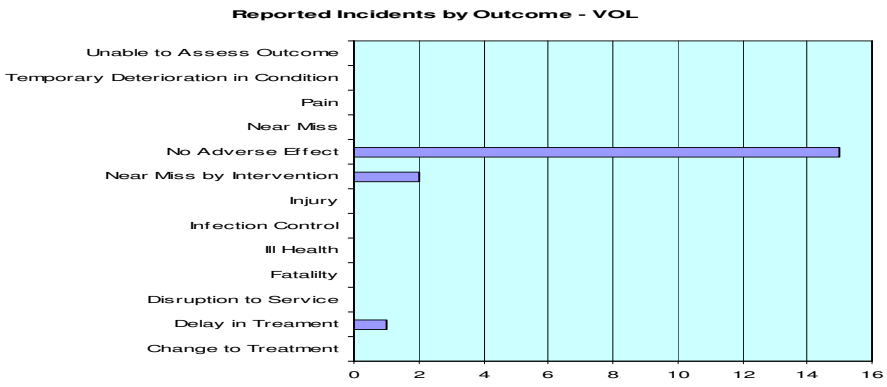


This graph highlights the reported incidents by category that were reported from the Vale of Leven Hospital for this second quarter. Reporting figures are low with only 18 incidents reported within this timescale.

Staffing issues are not normally noted under "clinical incidents". However; the two incidents reported at the time did have a direct effect on patient care. Both incidents reported a lack of clinical staff to sustain the services at the time. One resulted in a delay to the patient's treatment prior to the patient being transferred to another hospital.

There were 5 incidents reported under the category "Communication and Information" and there was no one particular commonality recorded.

Graph 7



Graph 8 indicates that the majority of incidents reported at the Vale of Leven Hospital had no adverse effect on the care of patients

2 incidents with an outcome of "near miss by intervention" are recorded. One was found to be regarding a theatre list and consent form stating the wrong site for surgery and the other is following the transfer of a patient from the RAH to the VOL with no appropriate medical information surrounding their care.

d. Larkfield Unit

In total 4 incidents were reported. The breakdown of this is as follows:

Medication Administration = 1
Infection Control = 1
Communication and Information = 1
Actual/Potential Adverse Clinical Incident = 1

The outcome of three of these incidents had no adverse effect on the patients whilst the final one caused a temporary deterioration in condition. This involved a patient who had a reaction to MST, which was not communicated when they were transferred to another ward resulting in the patient being given the drug again. The patient suffered a further reaction.

e. Merchiston Hospital

There was only one incident reported at Merchiston Hospital. This was an infection control issue surrounding the transfer of a patient to Merchiston with C.Diff infection.

f. Primary Care Emergency Services

There were two incidents reported in this service area.

1 of the incidents was reported under the category "Policies and Procedures" which occurred due to a lack of knowledge regarding the psychiatric referral process. This incident had no adverse effect on the patient.

The other related to a "communication and Information" incident. Two ambulances required for same site. No request in HUB log book for second ambulance. The carers called to see where ambulance was and it then became apparent that no second ambulance had been called. Incident rectified and emergency ambulance dispatched.

g. Ravenscraig Hospital

At Ravenscraig Hospital there has only been one incident reported. This came under the category "Medication – Administration" and resulted in no adverse event to the patient.

This is considerably lower than the last quarter when 7 incidents were reported at this particular site.

5. SUMMARY

As the second quarterly report of its type for Clyde Acute Directorate, it is hoped that the incidents identified will provide some feedback to staff and managers of what is currently being reported within the Directorate.

Once again it is noticeable that there is a lack of reporting at some sites with regards to infection control incidents. There were only 16 incidents throughout Clyde reported, 14 of which were at the Royal Alexandra Hospital in Paisley.

The highest category of reporting was medication incidents. There were 59 medication incidents recorded. This equates to 32% of the total incidents reported for Clyde in this period of time.

I appreciate that this report may seem out of date but unfortunately there are still pockets where incidents are coming through in large batches rather than as they happen or are investigated by the relevant Managers. This obviously has an effect on the information that we hold and the turn around for reports.

Any comments on the future layout and content of this report will be appreciated in an attempt to make this more useful to stakeholders needs.

Thanks to all staff for engaging with the clinical incident reporting system and I hope that together we can reduce the risk of further incidents.

Sandi M C Cassidy
Clinical Risk Co-ordinator, Clyde Acute

APPENDIX 2 – PAPER 1 RECEIVED BY THE PANEL FROM NHS GREATER GLASGOW AND CLYDE

BRIEFING PAPER FOR INDEPENDENT SCRUTINY PANEL ON VALE OF LEVEN HOSPITAL

1. INTRODUCTION

The purpose of this paper is to provide an overview and appraisal of case reviews from the Vale of Leven.

Incident reporting is a fundamental part of risk management in the NHS. It has limitations however, as the reporting of incidents is dependent on staff and therefore any statistical comparisons of different hospitals by number of reported incidents is not meaningful and will depend more on the reporting culture than on any real safety issues. Hospitals and individual specialties vary in their willingness to use the reporting mechanism. The cases used to develop this paper are reported and investigated.

There is no national database of incidents and the best most systematic national reviews of outcomes and deaths are based in specialties not provided in the Vale of Leven,eg, fractured neck of femur (Trauma), SICS (ITU), SASM (Surgery). There can be no meaningful comparison of hospitals made by looking at numbers of reported and investigated incidents in the Scottish NHS.

These incidents and their review have been used to draw lessons on systems of care, and to minimise any risks presented by the unique situation of the Vale Of Leven, notably, the lack of direct access to Intensive care and emergency surgery and the requirement to transfer acutely ill patients. The changes which have been made are detailed in section 3 below, our intention has been that this makes the Vale as safe as possible recognising the serious limitations in providing the unscheduled medical care service on this site.

2. ISSUES HIGHLIGHTED BY CASE REVIEWS AT THE VALE OF LEVEN

<u>Safety of Inter-Hospital Transfers</u>

Transfers are an important issue for the Vale of Leven as the hospital is dependent on transfer to deal with patients who require intensive care or surgery. These transfers may need to be performed on patients whose condition has suddenly deteriorated and in some instances the Shock Team can be used particularly if the patient is being transferred directly to ITU. However the team are very busy, they cover the whole of the West of Scotland, if they are not available within a reasonable clinical timeframe, the local team have to organise the transfer using only paramedic ambulances.

One further significant issue with transfer arrangements is insoluble in that the Vale of Leven cannot provide a medical escort if this is required due to the small number of medical staff available out of hours with the relevant skills. We aim to minimise this by using the Shock Team wherever possible in such situations but the points outlined above apply.

Recognition of the Severity of Illness

The cases examined pointed up issues around airway management, and the speed of decision-making and execution of transfers.

Seniority of Trainee Cover

With the small volume of activity passing through the hospital it cannot attract large numbers of trainee medical staff. It only has a single specialty (medicine). The hospital does not have out of hours of trainees in other specialties that can provide support to trainees in medicine. In addition though the junior rotas in the Vale of Leven comply with the requirements of the 'New Deal' contract they have staff who are at a more junior grade (FY2) on call on some nights than in other medical receiving units. They have the support of one of the GPs from the emergency service; this is also a unique arrangement. In the Vale of Level there will only be an FY2 doctor supported by a GP from the emergency service on call overnight on three nights per week.

Hospital at Night Team

The HAN team deals with relatively small numbers of acutely ill patients with a wide range of conditions. This limits their ability to gain experience in the way such teams do in busy, full-range receiving services. The HAN team has not always been appropriately used.

Use of Available Anaesthetic Cover

The workload in terms of emergency medical admissions is lighter in the Vale of Leven but the relatively junior nature and low number of trainees places more responsibility and pressure on consultants, nursing staff and locum anaesthetic staff. Because of the nature of the service and the volume of work it is inconceivable that the deanery will place more trainees in the hospital. The fragility of the locum anaesthetic cover is evidenced this week when none of the three locums is available owing to annual leave, sickness and compassionate leave.

In summary, using the case issues in section 4 of this paper we have highlighted how each relates to nine areas of concern, ie:

1. Safety of inter-hospital transfers
2. Seniority of trainee cover
3. Prioritisation of key clinical tasks
4. Recognition of the severity of illness
5. Use of the High Dependency Unit
6. Skill and experience level of the Hospital at Night team
7. Use of available anaesthetic cover
8. Knowledge of specialist areas of practice
9. Bypass protocol not consistently effective

3. ACTIONS TAKEN AS THE RESULT OF THE REVIEW OF THESE INCIDENTS

A series of actions has been taken following the individual case reviews which are summarised below:

Early direct involvement of locum anaesthetic staff if the MEWS score is 3 or above, or the patient is giving any cause for concern. Previously, some patients were not getting the benefit of the skills of the anaesthetic staff when their condition warranted it.

Make nursing staff aware of the need to inform consultants if their concerns about a patient are not being adequately addressed by junior staff, and to ensure senior staff are aware of their concerns and of the changing condition of the patient even when more junior staff have been informed.

Improve communication between members of the clinical team: to ensure that information about patients is transmitted accurately to allow timeous assessment and treatment if required.

Improve the HAN team handover, particularly to ensure the members of the team changeover at the same time and relevant and vital clinical information is accurately relayed.

Increase the appropriate use of HDU (High Dependency Unit) and combine it with CCU (Coronary Care Unit) .The HDU is a valuable resource for sicker or deteriorating patients but was occasionally full, its appropriate use needs to emphasised to ensure that the most appropriate patients benefit from the skills of the staff.

Staff education in certain specific areas of practice.

4. INDIVIDUAL CASE SUMMARIES

Case One

Summary:

- Patient admitted - treatment unsuccessful, patient died within 24 hours.

Issues:

- Failure to adjust treatment plan which was not working.
- High MEWS score tolerated without intervention.
- Patient should have been transferred to RAH.
- Lack of action on monitoring concerns.
- Communication between doctors.
- Confusion on clinical accountability.

Conclusions:

2. Seniority of trainee cover
4. Recognition of the severity of illness
5. Use of the High Dependency Unit
6. Skill and experience level of the Hospital at Night team

Case Two

Summary:

- Patient admitted deteriorates over a week, becomes seriously ill.

Issues:

- Absence of clear diagnosis and treatment plan.
- Incomplete records including MEWS assessment not recorded.

Conclusions:

2. Seniority of trainee cover
3. Prioritisation of key clinical tasks
4. Recognition of the severity of illness

Case Three

Summary:

- Patient MAU staff advised to bypass to RAH brought to Vale.

Issues:

- Patient would not have been brought to Vale if ambulance staff had followed the advice of MAU.

Conclusions:

9. Bypass protocol not consistently effective.

Case Four

Summary:

- Failure to review an unwell patient.

Issues:

- Breakdown of process, communication and lines of clinical accountability.

Conclusions:

2. Seniority of trainee cover
3. Prioritisation of key clinical tasks
6. Skill and experience level of the Hospital at Night team

Cases Five to Ten

Summary:

- A number of cases transferred from the Vale to the RAH.

Issues:

- Preparation for transfer - particularly intubation.
- Appropriateness of transfer decisions.
- Use of MEWS scoring prior to transfer.
- Absence of medical escorts.
- Anaesthetic review prior to transfer.

Conclusions:

1. Safety of inter-hospital transfers
2. Seniority of trainee cover
4. Recognition of the severity of illness
7. Use of available anaesthetic cover
8. Knowledge of specialist areas of practice

APPENDIX 3 – PAPER 2 RECEIVED BY THE PANEL FROM NHS GREATER GLASGOW AND CLYDE

A. VALE OF LEVEN UNSCHEDULED MEDICAL CARE: OPTION APPRAISAL

1.1 This short paper translates the planning, review and pre-engagement processes undertaken by the Board and the conclusions of the Independent Scrutiny Panel into an assessment of options for the provision of the service.

1.2 The process of option appraisal has a number of components:

- identification of a shortlist of options;
- development of criteria to evaluate and differentiate those options;
- weighting of those criteria to reflect their relative importance;
- the scoring of each option against the weighted criteria.

1.3 This process generates a score for each option which defines its non-financial benefits relative to other options. Financial appraisal can also be carried out to consider alongside the non-financial outcome. In the case of the unscheduled care at the Vale of Leven financial issues are not part of the decision-making criteria so the focus of this paper is solely on the non-financial option appraisal.

1.4 The rest of the paper sets out:

- the scores each option attracts;
- information on the shortlisting of options;
- an explanation of the basis of the criteria, their content and weighting;
- an explanation of the scores attracted for each option.

B. VALE OF LEVEN UNSCHEDULED MEDICAL CARE SCORED OPTIONS

2.1 This section summarises the scores for each option and the total weighted scores.

	Rates on each Criteria: Maximum 5; Minimum 0			
Shortlisted Options / **Criteria**	**Vale Status Quo**	**RAH**	**SGH**	**WIG**
Clinical quality and safety - 40	1	5	4	4
	40	**200**	**160**	**160**
Sustainability - 15	0	5	5	0
	0	**75**	**75**	**0**
Patient Access - 20	5	4	3	3
	100	**80**	**60**	**60**
Public Access - 10	5	2	2	4
	50	**20**	**20**	**40**
Availability/Timing - 15	5	4	0	0
	75	**60**	**0**	**0**
Total	**265**	**435**	**315**	**260**

2.2 This pattern of scoring suggests that the option to transfer this service to the RAH substantially out-performs the alternative options.

C. NOTES ON OPTIONS SHORTLIST

3.1 Only options which can already offer unscheduled medical care are shortlisted - excluding Golden Jubilee and Gartnavel Royal Hospital.

D. CRITERIA WEIGHTINGS

4.1 100 points are distributed across the five criteria depending on the importance of that criteria - the intention is that the criteria offer an opportunity to consider each option against the key issues which need to be reflected in arriving at decisions about the service.

40 - Clinical Quality and Safety

The most important criteria - differentials include:

- availability of key support services, particularly emergency surgery and ITU required in our appraisal and confirmed by the ISP as essential to provide clinical safety, high quality, unscheduled emergency care;
- relationship to other patient services, this is important because patients requiring unscheduled medical care may also be accessing a range of other hospital services.

15 - Sustainability

Tests whether each option has a medium term future. It is important the service is viable for a reasonable period. The key issues in appraising each option for the service are:

- anaesthetic cover;
- junior medical staffing;
- wider staffing issues;
- the known future of each site.

20 - Patient Access

Tests speed of access by blue light ambulance which will be mode of transport for vast majority of patients.

10 - Public Access

Tests access for relatives to each option.

15 - Availability/Timing

Appraises timing of option being available - with the absolute requirement to have early deliverability.

E. SCORES

5.1 This section provides explanatory notes for the score for each option.

Clinical Quality and Safety

Vale	-	Scores low because of unavailability of key support services.
RAH	-	Scores high, has all required services and existing clinical links to the Vale.
SGH	-	Scores reasonably, has all support services but lacks any clinical links to the Vale.
WI	-	Scores reasonably, has all support services but lacks any clinical links to the Vale.

Sustainability

Vale	-	Determined by our planning and review and endorsed by ISP, does not have a sustainable future in terms of anaesthetics and junior medical staffing.
RAH	-	Meets key sustainability factors.
SGH	-	Meets key sustainability factors
WI	-	Site due for closure under NHSGGC acute strategy. No long term future.

Patient Access

Vale	-	Scores highly, accessible to patients.
RAH	-	Scores well, accessibility by blue light ambulance good.
SGH	-	Scores reasonably - accessibility by blue light ambulance reasonable.
WI	-	Scores reasonably - accessibility by blue light ambulance reasonable.

Public Access

Vale	-	Scores highly accessible to the public.
RAH	-	Scores modestly, public transport challenges to access for the public.
SGH	-	Scores modestly, public transport challenges to access for the public.
WI	-	Scores well, good public transport access.

Availability/Timing

Vale	-	Scores highly, currently available, timing not an issue.
RAH	-	Scores well, available within a few months.
SGH	-	Scores badly, capacity not available in current configuration.
WI	-	Scores badly, capacity not available in current configuration.

NHS Greater Glasgow and Clyde
Acute Planning Team

5th February 2008

APPENDIX 4 – PAPER 3 RECEIVED BY THE PANEL FROM NHS GREATER GLASGOW AND CLYDE

NHS Greater Glasgow and Clyde
& Scottish Ambulance Service

Impact of potential changes to services at the Vale of Leven

1. Current Vale Patients Accessing Services at the RAH

1.1 There are currently 5000 emergency patients from the Vale catchment attend A&E at the RAH each year. These patients are the most acutely unwell patients from the Vale of Leven catchment area including A&E, Surgical, Orthopaedic and Trauma and the emergency medical patients who are considered too unwell to attend the Vale of Leven. As demonstrated in the table below large numbers of patients from the Vale catchment accessing emergency services at the RAH has been the situation since 2003.

Year	Vale Catchment A&E Attendances at RAH
2003 (part)	1928
2004	5234
2005	5153
2006	4830
2007	5017
Total	**22,162**

2. Analysis of Outcomes for these patients

2.1 An audit was undertaken using the Scottish Trauma Audit Group (STAG) criteria to assess the morbidity and mortality of all trauma patients with moderate or severe injuries from the Vale area who were treated at the RAH. Data was collected for a 12 month period following the downgrading of the trauma facilities at the Vale to a MIU (Oct 2003 – Oct 2004) and this was compared with the STAG data collected up to December 2002 for Vale catchment patients. This audit concluded, "There was no detrimental effect on patients from the Vale catchment area following the downgrading to MIU."

3. Patients from the Vale currently accessing the RAH by Ambulance

3.1 Of the 5000 patients from the Vale catchment area who attended the A&E at the RAH during 2007, 2603 were transported by ambulance.

3.2 The SAS report that there are no significant issues around transporting this cohort of patients to the RAH. Mr Sam Kennedy, General Manager for the South West Division, describes that The Scottish Ambulance Service is confident that, "providing the resource base is sufficiently developed, then we would not have any significant challenges around coping with these additional patient journeys to the RAH nor would the changes add to the complexities of the issues we face routinely in providing an emergency ambulance service in

South West Scotland. Clinical governance indications have not highlighted any incidents of adverse clinical outcomes caused by either road conditions or bridge closure".

4. Approach to analysis to ensure the SAS have enough staff and vehicles to meet increased demand

4.1 NHSGGC and the SAS have worked together closely to undertake detailed modelling to ensure that the SAS have the appropriate level of additional staff and vehicles to meet any increase in demand as a result of the transfer of activity from the Vale of Leven to the RAH. The financial consequences of providing the staff and vehicles can then be calculated but the fundamentally important point is that the financial requirements are derived from the staff and vehicle requirements **not** vice versa.

4.2 NHSGGC and the SAS estimate that of the approximately 6000 patients who currently attend the MAU at the Vale, 3778 will use an ambulance to travel to the RAH. This is based on taking the number of patients currently arriving at the MAU by ambulance (3300 each year), an 8% projected increase due to the fact that patient behaviour will change when the facility moves outwith the local area (i.e. people will be more likely to use an ambulance) and a buffer of 6% to factor in potential growth in demand.

	Annualised Patients
Estimated current annual patients (based on actual attendance in the first 4 months of 2007)	3300
Plus 8% increase due to behavioural change	264
Plus 6% growth rate buffer	214
Total projected to access RAH by ambulance	**3778**

4.3 The SAS capture detailed information in relation to the number of patients from specific postcode areas who are transferred to the Vale of Leven Hospital. These are the actual incidents picked up by each of the SAS stations affected by the service redesign in each of the postcode sectors; for example, up to February 2007 for the year 2006/07 there were 341 incidents in sector (G82 1) picked up by Vale of Leven station and 108 incidents in (G82 1) picked up by Helensburgh resources. SAS requires to establish a picture of demand on a station by station basis to ensure that adequate resources can be correctly located to meet the additional demand.

4.4 Based on historical patterns of attendance for any given time period the SAS are therefore able to apply detailed percentage figures to the 3778 patients who will require to be taken to an alternative site by ambulance. For example, approximately 8% of the patients taken to the Vale of Leven by ambulance in 2006-07 were picked up from the (G82 1) postcode area which is in Dumbarton. Approximately 8.5% were picked up from the G84 8 (Rhu / Shandon) area. The SAS are also able to calculate the average additional travel time for each station to access services at the RAH from each of the postcode sectors compared to accessing services at the Vale of Leven. For example, from the (G82 1) catchment area it takes an additional 6 minutes (one-way) to access the RAH compared to the Vale of Leven. From the (G84 8) area it takes an additional 25 minutes to access the RAH compared to the Vale. The total additional minutes required to access services (one-way) at the RAH can therefore be identified for each postcode sector based on actual demand from each sector. This is then averaged out across the spread of demand for each station to give an average additional service time.

5. Outcome of Analysis

5.1 Based on this detailed analysis (worked through in a previously circulated paper) the SAS anticipate that they will require an **additional 22 staff** to meet the projected increased workload. This is made up of 3 Team Leaders, 12 paramedics and 7 technicians. They will also require **3 additional A&E ambulances**. The Ambulance Service have 3 stations which cover the generic Vale of Leven area. The current establishment at the Vale of Leven ambulance station is **35** A&E staff utilising **5** vehicles over a 24 hour period. Arrochar station has **5** staff and **1** vehicle and Helensburgh station has **11** staff and **3** vehicles – the additional staff therefore represents a **43%** increase in A&E establishment. The additional ambulances would therefore represent an increase of **33%** in the A&E ambulances serving the Vale of Leven locality. The small numbers of patients who currently travel to the Vale of Leven from other parts of the Argyll area for emergency care will, under the new proposals, also have to travel to the RAH.

5.2 The analysis completed by the Scottish Ambulance Service also outlined that it is quicker and more resource effective to transfer patients from the Vale Catchment area to the RAH than it is to transfer them to the Western Infirmary.

6. Interhospital Transfer Service

6.1 In addition to the increased staff and vehicles required to provide the A&E element of the service there is also a requirement to introduce a process for transporting patients from the RAH to the Vale of Leven for the rehabilitation element of their stay.

6.2 The maximum number of patients who we anticipate will transfer back to the Vale of Leven from the RAH per annum in future is 1400. Currently we already transfer around 580 patients from the RAH to the Vale each year for local rehabilitation following initial treatment at the RAH. The additional new requirement for transferring patients will therefore be approximately 820 patients. Based on our current experience of transferring patients between the two sites we think that an appropriate service is one which which allows for transfers up to 8pm during the week and from 9am – 5pm on a Saturday. This will require one additional patient transport vehicle and 5 members of staff.