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Stuart McMillan MSP

By email

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Dear Stuart

I am writing with regard to NHS Greater Glasgow & Clyde's recent changes to a specific clinical pathway; affecting some limited activity at the two Intensive Care Unit (ICU) beds at Inverclyde Royal Hospital (IRH) in Greenock. This had led to fears that the Board were closing the ICU and that this could, in turn, compromise the sustainable future of the hospital.

These concerns were raised during FMQs last week and you questioned whether the information provided by NHS Greater Glasgow & Clyde, which informed the First Minister's response and the Board's publicly stated position, was accurate; fearing that the unit was being kept open in name only. I can confirm that my officials have been in touch with NHS Greater Glasgow & Clyde to double-check the details and that I have personally received the following confirmation from the Chief Executive of NHS Greater Glasgow & Clyde. As the First Minister set out at in the Scottish Parliament last week and on which I have received further confirmation, NHS Greater Glasgow & Clyde has repeated their assurance that they are not closing the two ICU beds at the IRH. Indeed, the vast majority of local patients who require critical care will continue to be treated at the hospital.

Patients who need intensive care are typically the sickest and their care can include ventilation or multiple organ support. In light of the Board's experience during the early stages of the Covid-19 pandemic and from published evidence that 30% of COVID-19 patients who require ventilation also require renal support, a new pathway for patients in these circumstances was established which saw them transferred for continuing multidisciplinary ICU support to the Queen Elizabeth University Hospital (QEUH). This experience and the evidence has lead the Board to formalise that pathway.

However to be clear, the Level 3 ICU beds at IRH will remain open and patients from Inverclyde will continue to be admitted to the beds, assessed and stabilised. They will not bypass the hospital. Critical care services at the IRH (comprising the ICU, high dependency and coronary care units) will continue to stabilise and/or treat local patients with complications due to diabetes, sepsis, pneumonia, exacerbations of asthma or COPD, heart attacks, other cardiac conditions and trauma.

As we discussed, the changes in the clinical pathway reflect the best evidence about the quality of care and outcomes; such as the published evidence that shows around 30% of COVID-19 patients who require ventilation also require renal support. Renal support has not been provided to IRH ICU patients for a number of years now. Patients who therefore require such highly specialised care will be transferred following admission to IRH. As noted above, local ICU staff will manage and stabilise these patients and support their transfer to the QEUH; and once patients improve and no longer need Level 3 support, they will be assessed for transfer back to the IRH for their continued recovery and rehabilitation.

The Board has further confirmed that discussions with the local nursing staff have taken place and continue; and that the nursing staff will continue to provide care for all critical care patients including those admitted to the ICU beds, stabilised and transferred, as well as those who will not require to be transferred, or for whom transfer would not be appropriate.

For context, the IRH critical care services (comprising the ICU, high dependency and coronary care units) currently admit approximately 1,450 patients per year. The Board estimates that the number of most unwell local patients that they will need to stabilise and transfer under this pathway is approximately 100; some 7% of the total critical care admissions to the IRH.

The Board has also reiterated their assurance that all other IRH services, including emergency and elective surgery, and A&E services, will be unaffected by this change.

I would agree that these small but important changes to the patient pathway – which do not affect the bed numbers or staffing at the unit – should have been better communicated by the NHS Board; and that this would have helped to allay the level of local concern expressed in the last week. Please be assured that this has been raised with the Board and that they accept the criticism. I understand that local elected representatives have now been fully briefed and the Board has issued a media release to clarify the position. That position has now been further confirmed by the Board to inform this response.

I am clear that these changes are being made in response to the emerging clinical evidence about how best to treat the most ill patients with COVID-19. As a result of the pandemic, NHS Boards are currently operating under a state of emergency that currently runs until the end of March 2021. This is not business as usual: operational changes that are required to ensure that patients are safely and effectively treated during this time may not be subject to the levels of public engagement and formal consultation which are ordinarily required.

That said, please be assured that any proposals for the permanent change of services would have to be considered in the normal way, including those surrounding major service change and Ministerial approval, following the conclusion of the state of emergency.

Finally, I would reiterate that both the Government and NHS Greater Glasgow and Clyde have been consistently clear in our commitment to the continued provision of comprehensive hospital, community and primary care services across Inverclyde, including at the IRH.

I trust that this is helpful.

Kind regards

JEANE FREEMAN