

GGNHSB(M)02/07
Minutes: 72 - 74

GREATER GLASGOW NHS BOARD

**Minutes of a Meeting of the
Greater Glasgow NHS Board
held in the Board Room, Dalian House,
350 St Vincent Street, Glasgow
on Thursday 27 June 2002 at 3.00 pm**

P R E S E N T

Professor G C A Dickson (in the Chair)

Mr J Best	Mr W Goudie
Ms M Boyle	Councillor J Gray
Dr H Burns	Councillor J Handibode
Mr R Calderwood	Dr R Hughes
Mr R Cleland	Mrs S Kuenssberg CBE
Councillor D Collins	Dr F Marshall
Mr T Davison	Councillor D McCafferty
Mr T A Divers OBE	Mr A O Robertson OBE
Councillor R Duncan	Mrs E Smith

I N A T T E N D A N C E

Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Ms C Renfrew	Director of Planning and Community Care

B Y I N V I T A T I O N

Ms C McCalman	Vice-Convener, Greater Glasgow Health Council
Ms L Love	Representative, Area Nursing and Midwifery Committee
Dr J Nugent	Chair, LHCC Professional Committee

ACTION BY

72. APOLOGIES

Apologies for absence were intimated on behalf of Professor M Farthing (Executive Dean, Faculty of Medicine, University of Glasgow), Professor D L Hamblen (Chairman), Mrs W Hull (Director of Finance), Mrs C Anderson (Chair, Area Pharmaceutical Committee), Dr F Angell (Chair, Area Dental Committee), Mrs E Borland (Acting Director of Health Promotion), Mr P Hamilton (Convener, Greater Glasgow Health Council), Mr E P McVey (Chair, Area Optometric Committee), Ms S Plummer (Nurse Adviser).

73. ACCIDENT, EMERGENCY AND ORTHOPAEDIC SERVICES

A report of the Chief Executive, Director of Planning and Community Care and Director of Public Health [Board Paper No. 02/48] was submitted asking the Board to consider further detailed work on the shape of Accident, Emergency and Orthopaedic Services. On the basis of that further work, the Board was asked to confirm the proposed shape of Accident, Emergency and Orthopaedic Services for submission to the Scottish Executive. This was outlined as follows:-

- Full Accident and Emergency (A&E) services would be provided on two sites, one north and one south.
- Minor Injuries Units would be provided on five sites at Gartnavel, Stobhill, Victoria, Glasgow Royal Infirmary and the Southern General.
- Acute receiving services would be provided on the three in-patient sites.
- Trauma and orthopaedic in-patient services would be provided on two sites – one north and one south, but retaining locally accessible out-patient and day case services.

Professor Dickson underlined the importance of the paper on Accident & Emergency and Orthopaedic Services, this being the final element of the Acute Services Strategy and the Board's recommendations would be submitted to the Minister for Health and Community Care to allow consideration to be given to the totality of the Strategy.

The key issues to be considered went beyond that of blue light emergency referrals - it included minor injuries, medical receiving, GP emergency referrals and Accident & Emergency for children and much of this would form the debate.

It was recognised that the overall strategy delivering this shape of services would take ten years to implement.

Professor Dickson suggested that the debate be structured with Mr Divers leading with an overview of the proposals and principles, followed by questions from Members and thereafter general discussion and debate – this format was agreed.

Mr Divers reminded the Board that in concluding its deliberations at the January 2002 meeting, it re-stated its working hypothesis that accident and emergency and trauma services should be provided from two, fully resourced A&E centres in north and south Glasgow working with a GP emergency receiving unit in west Glasgow. At that time, it was recognised, however, that further work should be undertaken on the following:-

- The model of acute receiving at Gartnavel General Hospital.
- Patient flows and numbers.
- Designing services at Glasgow Royal Infirmary to deal with large volumes of patients.

This further work had been undertaken to enable the Board to reach a final decision and it would also enable the Minister for Health and Community Care to consider and take decisions on the totality of the Board's Acute Services Strategy.

He described the term accident and emergency services which had traditionally covered a range of very different needs from patients with the most minor injuries and illnesses to those who were very seriously ill or injured. The essence of the proposals was to provide the appropriate level of services to meet the needs of different patient groups – moving away from the concept of an overloaded accident and emergency department providing the only immediate access to hospital services.

Mr Divers described the proposed shape of services and patient volumes and highlighted, in particular, the following:-

- For adult accident and emergency services – there would be two major units – one at the Southern General and one at Glasgow Royal Infirmary. Based on trends, it was expected that the total number of A&E attendees would remain relatively stable but the number of emergency admissions were rising. In geographic terms, he expected the service at Glasgow Royal Infirmary to serve the north and east of Glasgow as well as the Rutherglen/Cambuslang area. The Southern General would provide a service for patients in the south and west of Glasgow.
- For children's accident and emergency – the new arrangements meant that all children under the age of 13 years requiring A&E services would be seen at an enlarged facility at Yorkhill. This would ensure that all patients had access to dedicated paediatric facilities and staff and would ensure uniformity of management of paediatric emergencies.
- For orthopaedics – trauma and Orthopaedic inpatient services would be provided from two sites - one North and one South. Local provision would be through an out-patient and day case service at the Victoria and Stobhill Ambulatory Care Hospitals, Glasgow Royal Infirmary, Gartnavel and Southern General sites, each serving the populations of the current catchment areas. Based on trends, it was expected that trauma workload would remain static or decline and elective and out-patient activity would increase, marginally.
- Minor Injuries Units (MIU) – there would be five Minor Injuries Units, at the Victoria, Southern General, Gartnavel, Glasgow Royal Infirmary and Stobhill. These would be staffed by Nurse Practitioners probably open twelve hours per day and would provide locally accessible services to patients who referred themselves. Each MIU would be linked to a parent A&E department for training and clinical supervision. It was estimated, based on an analysis of Glasgow's data, that between 25% and 30% of current accident and emergency cases would access these facilities.

- Dealing with GP referrals – it was proposed that each of the three in-patient sites would have services designed to provide immediate access to specialist assessment and admission for GP referral. The Gartnavel service would deal with GP referrals for west Glasgow, the Glasgow Royal Infirmary for those from north, east Glasgow and Rutherglen/Cambuslang and the Southern for referrals from the rest of south Glasgow.

Mr Divers drew particular attention to two responses to the Board's proposals: one from the Area Medical Committee and the other from Greater Glasgow Health Council.

The Area Medical Committee submission set out the conditions it felt must be met for a two-site option for A&E and Orthopaedic services. Mr Divers described the conditions and was confident that the Area Medical Committee's caveats would be addressed as progress was made to implement the proposals.

In following up a point made earlier by Mr Robertson, Professor Dickson asked Dr Hughes, Chairman of the Area Medical Committee (AMC) if the second paper on the agenda on the review of the management of acute admissions addressed the issues raised by the AMC in its consideration of Accident & Emergency and Orthopaedic Services. Dr Hughes replied that the review was welcomed and did address the issues that had concerned the AMC.

Greater Glasgow Health Council was of the view that the NHS in Greater Glasgow would be best served by having the options and flexibility which three accident and emergency units would provide. They recognised that in five or ten years time, the pressures on hospitals would be such that a shift to the two centre option might be feasible and acceptable at that time.

Mr Divers summed up by describing that the working hypothesis of:-

- two full A&E services at Southern General Hospital and Glasgow Royal Infirmary;
- five Minor Injuries Units;
- two orthopaedic and trauma services;
- a GP-referred acute admissions service at Gartnavel

was a viable solution to achieve its primary objectives as follows:-

- a gold standard orthopaedic and A&E service with strong Consultant presence;
- local access for minor injuries and GP referrals;
- the most efficient service delivery.

Dr Burns referred to the work undertaken by the A&E Planning Group and, in particular, to its extensive data collection exercise which had formed an important element of its work. Data analysis illustrated streaming of patients currently defined as accident and emergency activity in the following ways:-

- acute receiving – a receiving point for medical and surgical emergency referrals from GPs, some of which would require resuscitation and emergency stabilisation;
- accident and emergency – patients with multiple injuries requiring a prompt trauma response;
- minor injuries – a minor injuries service which could be provided by Nurse Practitioners working to clinical protocols determined by A&E Consultants.

Dr Hughes referred to a typographical error on page five of the Board papers where it referred to 100 orthopaedic day cases at Stobhill. Ms Renfrew confirmed that this should, in fact, read 1,000 orthopaedic day cases at Stobhill.

In response to a question from Councillor Handibode, Mr Divers clarified that the catchment areas for the five Minor Injury Units and two ACADS would be the current catchment areas thus ensuring a consistent pattern of local access was maintained.

Councillor Duncan reiterated the tension and concern over local access and public transport links and encouraged the Board to ensure that the residents of Greater Glasgow had a better standard of public transport links to these proposed new services.

Councillor McCafferty referred to page seven of the Board paper and, in particular, the advice from the Area Medical Committee which stated that : *“A wide range of medical opinion had been sought on these proposals and some of this opinion had been supportive of the Board’s proposals whilst other opinion had not been supportive.”* Councillor McCafferty had reservations about the Board’s ability to address such complex issues particularly when opinion was so split – not only from a clinician viewpoint but also that from members of local communities.

Mr Goudie referred to the fact that, to date, the Health Council had not received the results of the Bed Modelling Steering Group and that this had left many of its members with concerns about Glasgow Royal Infirmary’s ability to cope, in the future, with the increased pressures it would face, particularly if the A&E department was closed in west Glasgow. Mr Divers confirmed that the Board awaited the publication of the next set of annual figures and that, at that time, this would be shared with Greater Glasgow Health Council. An annual review on bed modelling would be submitted to the NHS Board for consideration.

Mr Calderwood confirmed that the bed modelling figures for 2001/2002 would be available in September 2002 but that the bed requirement for Greater Glasgow had been “frozen” at 2,880 beds in the last calendar year – 2000. Following the release of the 2001/2002 bed figures, the physical positioning of these beds on the three in-patient sites would be further debated.

In response to a question from Dr Nugent, Mr Divers commented that there was recognition of the service currently being delivered by Glasgow Emergency Medical Service (GEMS) and how this would impact on the Board’s proposals. This interface was key and would form part of the work being developed particularly in relation to the Minor Injuries Units.

Dr Hughes, on behalf of the Area Medical Committee, strongly urged the Board to come to a decision as the status quo was no longer tenable and any further delay would not be in the best interests of patients or staff.

Mr Davison referred to the conflicting views already referred to and concluded that although a number of options could work, the complexity of various components within Greater Glasgow meant that it needed and could sustain the model of three acute medical receiving units and two trauma units – he concluded that this was the best fit decision.

Councillor McCafferty welcomed much of the paper but expressed concern that local communities wanted to see a full A & E Department at Gartnavel. He sought a compromise and was anxious that the Board did not make an irreversible decision particularly when opinion was split and there appeared to be doubts from clinicians on the Board's proposals. His preference would be to start with three A&E units with a view to possibly reducing this to two units following a review. He was concerned that the two A&E centres would be overloaded and referred, in particular, to the poor public access and transport infrastructure that currently existed. He regarded this as being outwith the control of the Board and referred, in particular, to the population of Clydebank who would attend the Southern General Hospital site via the Clyde Tunnel if the Board's proposals were approved.

His interpretation of the Area Medical Committee's response compounded this particularly in its caution, reluctance and seven conditions. Councillor McCafferty was of the view that the Board could not promise that these issues would be rectified prior to implementation. It was his understanding that Greater Glasgow Health Council, the A&E Subcommittee, the Orthopaedic profession and West Dunbartonshire Council all would prefer three A&E sites and the Board had to be seen to be open, transparent and listening to the views of the Communities and these key stakeholders.

Dr Burns referred to the two site option and its 24-hour service providing CT scanning, ultrasound and resuscitation for major accidents, head injuries, skull injuries and chest pains and commented that if this was diluted to three sites the level of expertise could not be kept at its peak. He referred to evidence that suggested following clear educational information, local patients did present at the right centre, either trauma or Minor Injuries Unit that best met their needs at that time. Given the rapidly changing technology, he was keen that the Board move to 21st Century working and it was not the case any longer that the only way a patient could get to a hospital was via an A&E door – many doors were now available to patients and this should be the way Greater Glasgow streamlined its services.

Dr Marshall reiterated the view that the proposals were for NHS Greater Glasgow and that a dispassionate objective view should be taken in relation to the needs of various parts of the city and how health care would be best provided in ten years time. Access was not merely geography – it was a case of getting patients to the right place at the right time and providing better and safer services in Glasgow.

Dr Nugent commented that it was to the benefit of patients to provide two gold star A&E centres which were well equipped and it should be emphasised that to go to one of the two centres would mean patients were seeing specialists in their field, particularly as the concentration of fewer sites meant that this could be provided.

ACTION BY

Mr Robertson referred to the timescale to make this decision and the importance to Greater Glasgow patients to provide a credible and realistic service – it was his view that two A&E services would do this.

Mr Goudie referred to the vast amount of patients who would continue to receive care and treatment at the three medical receiving units and two Minor Injury Units as well as the two proposed A & E units. He described the benefits to patient care which the proposals offered in that patients could have confidence that they were being treated in the right environment by a specialist in the field whether it be at one of the A & Es, MIUs or Medical Receiving Units.

DECIDED:

- That the report of further detailed work on the shape of Accident, Emergency and Orthopaedic Services be considered. **Chief Executive**

- On the basis of that further work, the proposed shape of Accident, Emergency and Orthopaedic Services for submission to the Scottish Executive as follows be confirmed:- **Chief Executive**
 - full Accident and Emergency services be provided on two sites, one north (Glasgow Royal Infirmary) and one south (Southern General);
 - Minor Injuries Units be provided on five sites at Gartnavel, Stobhill, Victoria, Glasgow Royal Infirmary and the Southern General;
 - Acute receiving services be provided on the three in-patient sites, Royal Infirmary, Southern General and Gartnavel General Hospital;
 - Trauma and Orthopaedic in-patient services be provided on the two sites – which house full A & E Services, but retaining locally accessible out-patient and day case services on all five adult acute sites.
 - Paediatric Accident and Emergency Services should be centralised at the Royal Hospital for Sick Children, Yorkhill.

Councillor McCafferty requested that his dissent be recorded against the decision not to have a full A & E Department at Gartnavel General Hospital. He supported all other proposals within the paper.

74. REVIEWING THE MANAGEMENT OF ACUTE ADMISSIONS

A report of the Director of Planning and Community Care and Director of Public Health [Board Paper No. 02/49] was submitted asking the Board to endorse the proposed review of acute admissions.

It was proposed to undertake a rapid review of acute receiving services across Greater Glasgow for approval and implementation in support of the implementation of decisions on the future shape of emergency care in Greater Glasgow.

ACTION BY

The review was in response to a number of factors and, in particular, widespread evidence that the current emergency care arrangements were operating under severe strain. It was the expectation that the outcome of the review would include:-

- proposals for change to:
 - clinical infrastructure including imaging, pharmacy etc.;
 - system changes – for example, to receiving arrangements;
 - investment to resolve capacity and organisational uses.
- These changes to deliver significant reduction to:
 - waiting times for admission in A&E;
 - patients boarded outside their specialty of admission.
- Building on the outline of the clinical strategy for accident and emergency services a clear plan:-
 - for migration to the final shape of services over the next eight to ten years;
 - based on a realistic appraisal of likely demand, the resources required to deliver the service required on each site.

DECIDED:

That the proposed review of acute admissions be endorsed.

Chief Executive

Meeting ended at 4.20 pm