

Greater Glasgow NHS Board

Board Meeting

Tuesday 18th May 2004

Board Paper No. 2004/29

Programme Director Acute Services Implementation

Emerging Pressures in Acute Services

Recommendation:

- **The Board:**
 - **endorse the proposed approach to the acceleration of the Acute Services Review with detailed proposals to be brought to a future Board meeting for approval prior to public engagement**
 - **note the requirement to close the casualty service at Stobhill by August 2005;**
 - **confirm its commitment to the major capital developments at the SGH and GRI approved as part of the ASR.**

A. BACKGROUND AND PURPOSE

- 1.1 The Board considered a paper “Emerging Pressures in Acute Services” 2003/73(a) at its December 2003 meeting. That paper set out the significant challenges to sustain our present pattern of services for the timescales envisaged in the Acute Services Review.
- 1.2 The purpose of this paper is to describe our progress in addressing those issues. It is important to restate the context in which the remainder of this paper has been put forward.
- 1.3 General acute services in Greater Glasgow are currently provided as follows:
 - six sites with general acute services at Gartnavel, the Western Infirmary, Stobhill, Glasgow Royal Infirmary, Southern General and Victoria;
 - four Accident and Emergency and one Casualty departments.
- 1.4 In March 2000 we set out proposals for significant service change. The key drivers for these proposals were:
 - **Outdated buildings**, unsuitable and unfit for modern healthcare - 21st century healthcare in 19th century buildings.

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- **Inpatient sites** which are unable to provide the one stop / rapid diagnosis and treatment models for the large volumes of patients treated in Glasgow hospitals.
- **Fragmentation of care** as patients are required to move around sites and different buildings, an inevitable loss of continuity and difficulties in transferring information e.g. laboratory results and x-rays between sites.
- **Unsuitable diagnostic and imaging facilities** which restrict capacity, create bottlenecks and inevitable delays in treatment.
- **Increasing sub-specialisation in medicine** – a move towards larger teams to ensure all patients can get access to the appropriate specialist .
- **Glasgow's role in teaching and research** and the links with the Universities, is critical for the service to attract and retain high calibre staff - critical in services where there are national shortages e.g. cancer, cardiac surgery, diagnostic imaging and pathology amongst others.
- **Too many inpatient sites requiring emergency on call rotas** on each site - with pressures growing on both consultants and junior staff.
- **Changes in doctors' training** – means consultants are being called in from home more often, or opting to do *resident on-call* to provide support to junior staff.
- **Restrictions on the hours doctors can work:** New Deal for Junior Doctors limits number of hours; European Working Time Directive restricts availability of consultants due to compensatory rest requirements.
- **The policy imperatives** outlined in the policy papers The Scottish Health Plan and The Cancer Plan which include waiting list guarantees, reductions in waiting times, improved access to rapid diagnosis and treatment, the provision of services designed around the needs of patients and improved integration with primary and social care.

1.5 In August 2002, after a prolonged process of planning, clinical and public debate the Minister approved proposals to reshape acute services, with a major programme of capital investment in the period to 2012. The pattern of acute services at that point would be:

- two major in-patient units with Accident and Emergency and Trauma services, at Glasgow Royal Infirmary and the Southern General;
- an in-patient hospital at Gartnavel providing local medical and surgical emergency services for General Practitioners colocated with the new West of Scotland Cancer Centre;
- ambulatory care hospitals at Stobhill and the Victoria, including minor injury services.

1.6 The most significant problems and pressures which are currently facing us are:

- New Deal for Junior Doctors

This agreement requires junior doctors to work no more than 56 hours in a full shift pattern or 64 hours on a partial shift pattern. We have not been able to achieve these targets on all rotas and a number of rotas which do comply do so on a fragile basis ie small additional demands will make them non compliant. Our most acute frontline rotas such as Accident and Emergency, Anaesthesia and Surgery slip into non-compliance if the intensity of work increases and doctors are unable to get the required amount of rest. The new deal also has a significant impact on consultants. Junior staff are available for less hours and have less experience. That means consultants are much busier

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when on call and, therefore, the frequency of on call is becoming a major issue.

- Consultant Contract

The consultant contract, currently being finalised for implementation, will have a number of effects. It will require us to recognise and pay for hours and activities above core sessions and, therefore, makes intensity and frequency of on call activity of greater significance. In December the impact of the contract was not yet clear. We now know that there are substantial numbers of Glasgow doctors with unsustainable patterns of working which are also not affordable.

- SIMAP

In August 2004, all time spent in work will be counted as working hours - requiring a maximum of 56 hours for all junior doctors. Currently many junior doctors are on partial shifts where they can work legally up to 64 hours if they are able to get guaranteed sleep during their time in hospital. This type of rota will have to disappear and will therefore reduce dramatically the number of hours juniors are available for work.

- Modernising Medical Careers

This UK wide policy radically changes the training of Senior House Officers (SHOs) from August 2006. It puts a much heavier emphasis on training rather than service input. Its effect will be to put major pressure on hours of work for SHO rotas in all specialties and reduce the number of SHOs available to be on-call, especially in Accident and Emergency and Anaesthesia.

- European Working Times Directive

The European Working Times Directive requires us to achieve a maximum of 58 hours for all junior doctors by 2004, reducing to 48 hours by 2009. The New Deal allows junior doctors to work up to 56 hours. Consultant medical staff currently work an average of 57 hours and should already be working 48 hours at present.

- Capacity

The new waiting times target of 6 months require us to step up efficiency, higher levels of productivity could be achieved by working on fewer sites.

These points put particular pressure on the following services:

Stobhill : Casualty, Anaesthesia and General Surgery.

South Glasgow : Surgery and Trauma, Accident and Emergency, Anaesthesia and Intensive Care.

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- 1.7 A further issue since our December report has been the worsening financial position. We need to reduce the costs of Glasgow's hospital services without compromising effectiveness or the safety of patients. That becomes a further driver for early change.
- 1.8 It is important to restate two key points:
- there is nothing in our proposed way forward which is at odds with the decisions we took at the end of the Acute Services Review in terms of the number and disposition of services;
 - while any accelerated proposals cannot be supported by upfront, significant, capital investment and will therefore require the reuse of existing facilities they do not undermine or dilute our absolute commitment to the full, agreed programme of capital investment to renew Glasgow's hospital facilities.
- 1.9 In terms of progress since the 2002 decision, there are a number of important points. We have delivered consolidation of gynaecology, ENT and orthopaedic services. the procurement of the ACADs is on track to see them open in 2007. A proposal which emerged from a clinical consensus about the early consolidation of cardiac surgery for the West of Scotland, at the Golden Jubilee National Hospital, is being developed for consultation.
- 1.10 Finally, the Ministerial Monitoring groups for Stobhill and the Victoria have been meeting regularly and we would intend to fully engage them in the programme of work outlined in the rest of this paper.

B. STOBHILL CASUALTY

- 2.1 We have previously highlighted that the most immediate issue of sustainability relates to Stobhill casualty. The December Board paper flagged this as a service where the pressures are particularly acute. The root of the problem is that we have a department staffed by five SHOs, without onsite Accident and Emergency consultant cover and therefore with inadequate clinical and training supervision. The accreditation bodies had previously indicated that they would withdraw recognition of the SHO posts for training purposes in August 2004. This would have meant that the service would have had to close, at that point. The clinicians and management team in North Glasgow have worked hard to put in place an interim solution, which we have just had confirmation will enable the Accreditation Committee to accredit the SHO posts until August 2005 to enable us to plan and manage the transfer of the service.
- 2.2 The interim solution has a number of components:
- rotation of SHOs through North Glasgow departments including Stobhill;
 - Accident and Emergency consultants within North Glasgow providing sessional cover at Stobhill;
 - improving middle grade support;
 - physical and equipment improvements to the department.

These solutions, which have impressed the Royal Colleges significantly enough to provide extended accreditation are viable only on the basis we commit to work towards a 2005 closure

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- 2.3 It is also important to note the Accident and Emergency Sub Committee have offered advice, on a number of occasions, that the casualty model at Stobhill is not a safe and sustainable service to deal with emergency patients.
- 2.4 In the light of the issue of accreditation, clinical safety, our commitment to early rationalisation of clinical services and our financial position it is imperative that we begin to plan now for the closure of the Stobhill casualty at that point. We have identified two potential options that we propose to develop for consultation.
- 2.5 The first would see Stobhill continue to provide acute medicine and surgery at Stobhill for cases referred by their GP, with a minor injuries unit - all other patients would attend Accident and Emergency departments.

The second would consolidate all emergency activity for the North and East at the GRI but fully utilise Stobhill to provide elective services and rehabilitation, for a larger catchment population than is presently the case. A minor injuries unit would also be provided.

It is important to highlight that this second option would not meet the minimum commitment to sustain named services at Stobhill until 2007, but we do not believe it should not be developed for consideration by the Board as it may offer a safer and more effective service than the first alternative.

C. ACCELERATION, KEY ISSUES AND PROPOSALS

- 3.1 Following the December discussion we established a pan Glasgow ASR Acceleration Group led by the Programme Director: Acute Services Implementation. The ASR Acceleration Group has been testing ideas about how the ASR can be accelerated. We have already identified a number of imperatives:
- only an early reduction in the number of emergency service sites we are trying to staff will enable us to address the pressures which section 1 of this paper described;
 - it is clear, as outlined in the previous section, that the casualty service at Stobhill cannot be sustained beyond August 2005;
 - we need to achieve the consolidation of a number of smaller specialties sooner rather than later because of the pressures outlined in the opening section of this paper;
 - the limited availability of beds on the GRI and SGH sites is a significant block to achieving early change.
- 3.2 Our conclusion is that our detailed proposals for early change should be developed with the following framework:
- we should aim to achieve single emergency and elective sites for each of the three sectors of the city, North and East, South and West and North West; This means that we will develop proposals to reorganise emergency and elective workload between:
 - the GRI and Stobhill;
 - Gartnavel and the Western;
 - Victoria and the Southern;

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- consolidation of orthopaedics from the present five sites to the two planned sites, with a reprofiling of emergency and elective activity to reflect an East West split and the distribution of clinical resources accordingly;
- we should endeavour to ensure that acceleration proposals do not require significant capital investment in facilities which are not part of the final shape of acute services and where interim service moves are required these should be made with absolute clarity on what the final disposition of the service will be;
- we need to examine specialty moves, which may deliver an objective of consolidation but will also create capacity for emergency care at GRI and SGH. In the case of GRI this may include an early move of cardiothoracic surgery to the Golden Jubilee National Hospital (GJNH) as a first stage in the proposals to consolidate all West of Scotland cardiac surgery there, which are presently under development. In this regard and in terms of other potential capacity - we will seek early agreement with the GJNH on a partnership approach to management and facilities;
- the work underway by the Services, Beds and Capacity Sub Group of the ASR Programme Board to finalise the disposition of smaller specialties should be reframed to make recommendations on potential interim service moves as soon as possible but alongside clear proposals on the final disposition of services; this work covers vascular and other surgical subspecialties, urology and renal services;
- we need to work through, with senior clinical staff, how to put in place arrangements to avoid concerns over patterns of work, status, clinical leadership and management arrangements becoming blocks to achieving change. At headline level, the assumption should be that in consolidating services we have a level playing field approach that does not disadvantage the clinical staff from the service which is transferring;
- the two options outlined in Section 2 for the future of Stobhill after July 2005 should be worked up for public engagement;
- early consolidation will require the use of existing physical facilities and restrictions on the short term availability of capital plus the need for rapid progress will restrict the opportunities for substantial upgrading. It is therefore imperative that the early consolidation includes systematic review of other ways of improving patient care through improved organisation of services;
- in the light of the above, it is critical that the confidence in and credibility of the whole programme that the work to deliver the business cases for the new inpatient facilities is completed by the autumn of 2004 and we will therefore be extending the resources available to the Programme Director: Acute Services Implementation to ensure that the necessary capacity is in place to deliver this challenging timetable.

3.3 Our objective should be to have achieved the changes outlined above, at the latest, by the end of 2007, alongside the opening of £265 million of brand new ambulatory hospital facilities.

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D. CONCLUSION

- 4.1 The work outlined in the paper will enable us to bring forward proposals for service change which progress the delivery of the shape of services agreed in the Acute Services Review but ensure that we can provide effective and safe services until the final, major capital investment is in place.
- 4.2 The Capital Investment Strategy which underpins the Board Clinical Strategy set out how we would remodel and modernise Glasgow's acute healthcare infrastructure over the period from 2007 to 2012 by means of a four phased approach to capital investment and clinical redesign.
- 4.3 The first phase which is actively underway with capital investment business plans approved by the Scottish Executive in the Spring of 2003, sees the building of the new West of Scotland Cancer Centre at Gartnavel General Hospital and the replacement of the majority of the clinical services at the Victoria Infirmary and Stobhill Hospital campuses with new built Ambulatory Care Hospitals. The cost of these developments is some £265.million and will see these new clinical facilities brought into use during the second half of 2007.
- 4.4 The second phase of this investment programme sees the creation of the new Southside hospital within the grounds of the Southern General Hospital and this scheme sees the construction of some 900 new beds with supporting theatre and other clinical work accommodation and will allow from the closure of the remaining in-patient beds at the Victoria Infirmary and Mansionhouse Unit in the south of the city and replacement of all old Victorian accommodation in the grounds of Southern General Hospital. This scheme has a capital cost of approximately £250.million and will see the new clinical facilities come on stream from late 2009 early 2010.
- 4.5 Phase three sees a similar development on the Glasgow Royal Infirmary campus where we will build 400 new beds which will allow the replacement of the remaining clinical facilities at Stobhill and replacement of the remaining Victorian buildings at the Glasgow Royal Infirmary campus. This scheme which is hoped will be completed late 2010 early 2011 has an indicative capital cost of approximately £120.million.
- 4.6 Phase four the final completion of modernisation of Glasgow's acute hospitals sees the building of new facilities and refurbishments substantially existing facilities on the Gartnavel General Hospital complex and they are also providing modern healthcare facilities for the West of the city allowing the full closure of the Western Infirmary facility. This scheme which should see patients admitted to the facilities in the second part of 2012 has an indicative capital cost of £120.million.
- 4.7 Alongside the proposals in this paper we are:
 - working with Argyll and Clyde to ensure their emerging clinical strategy is reflected in our final plans;
 - completing the bed modelling and capacity planning to size and design the new inpatient facilities;
 - developing proposals for the review of the assumptions which underpinned our decision to have two Accident and Emergency sites, by the autumn of 2004.

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- 4.8 Finally, we have referred throughout this paper to the need to engage the public and other interests in this programme of work. All of the propositions which are likely to emerge have been subject to public consultation and ministerial approval, and the process which we design to ensure there is proper and full engagement needs to reflect that fact.