EMBARGOED UNTIL MEETING

NHS Greater Glasgow

Greater Glasgow NHS Board

Board Meeting

Tuesday 20th July 2004 **Board Paper No. 2004/39**

Director of Planning and Community Care

Review of Assumptions Underpinning June 2002 Decisions on Accident and Emergency Services

Recommendation:

- **The Board:**
  - **consider for approval the proposed review process to retest the assumptions underpinning June 2002 decisions on Accident and Emergency Services.**

A. BACKGROUND AND PURPOSE

1.1 NHS Greater Glasgow's approved strategy for modernising acute hospital services includes reconfiguration of Accident and Emergency Services through the creation of two specialised 24-hour Accident and Emergency and Trauma Units at the Glasgow Royal Infirmary and the new South Glasgow Hospital, reorganisation of emergency acute receiving services, including a unit at Gartnavel General to receive GP referred emergencies and the establishment of five Minor Injuries Units around the city. The Board agreed this pattern of future provision at its meeting on 27th June 2002.

1.2 The strategy was ratified by the Minister for Health and Community Care on 10th August 2002, following which on 12th September 2002, in a debate within the Scottish Parliament, the Minister recognised "*the particular concern over the number of accident and emergency departments and supports a review of this in two years time that involves staff, patients and community groups, Greater Glasgow Health Council and the Scottish Royal Colleges"*.

1.3 In the course of the debate, the Minister said "*it is right that the assumptions that underpinned that decision should be looked at again, when we are a bit nearer any changes to accident and emergency services*".

1.4 The full June 2002 paper is attachment one. At very headline level the key factors which underpinned the Board's decision included:

- the need to deliver high quality care and ensure service sustainability in the longer term;

- the imperative of addressing the pressures of changes in the clinical workforce with a solution which will endure;
- the benefits of creating two high quality, viable trauma services, with accompanying improvements in the delivery of orthopaedic elective work;
- the importance of developing a model of acute medical receiving which would manage the volumes of admissions presenting at the two accident and emergency sites;
- the relevance of ongoing work during implementation with the Scottish Ambulance Service;
- the need to review the transport implications of these changes as part of the wider review of transport within the entire strategy.

1.5 The purpose of this paper is to set out proposals to undertake the agreed review of the key assumptions supporting our June 2002 decision.

B. PROPOSED PROCESS

2.1 Set out below is a proposed process to ensure that the review of the assumptions is undertaken in an open and inclusive way which will enable key stakeholders to re-interrogate the assumptions on which our decisions were based.

This paper will enable us to flag well in advance the timing of key stages of the process, proposed for September and October 2004, and the approach we are taking. This will enable a wide range of interests to participate if they wish to do so. Early notification also enables us to test with those stakeholders whether this process requires any modification and we can report back to the August Board if that is the case.

2.2 It is suggested that the review of assumptions should have three stages:

Stage one - a detailed paper restating the original analysis which underpinned our decisions and the programme of work which has taken place since June 2002. That programme of work includes:

- the development of detailed proposals about the organisation of emergency medical receiving services on the two major sites - a key output of the review of emergency admissions;
- other elements of that review which demonstrate how issues with the present arrangements of emergency services can be tackled;
- development and implementation work on minor injury services and the roles of extended nurse practitioners;
- detailed work on the organisation of Accident and Emergency services for children;
- further data which is now available;
- planning of bed numbers and service models for the new inpatient facilities.

This detailed paper would be circulated to all of the key interests for comment during September 2004 and also asking for feedback on any other relevant issues or perspectives which should be considered at stage two.

Stage two - a major workshop on Friday 15th October 2004 designed to feedback the outcome of the stage one process and to enable direct debate with key parties.

Stage three - the output of the September discussion phase and October event would be reported to the Board in November 2004.

C. CONCLUSIONS

3.1 This paper proposes an appropriately open and engaging process to meet the Minister's commitment to retest our key assumptions regarding Accident and Emergency services. It aims to do so in a way which offers a fair opportunity for dialogue and debate without revisiting the major public consultation exercise which underpins the Ministerially approved Acute Services Strategy.

Greater Glasgow NHS Board

Board Meeting

Thursday 27 June 2002 **Board Paper No. 2002/48**

CHIEF EXECUTIVE
DIRECTOR OF PLANNING AND COMMUNITY CARE
DIRECTOR OF PUBLIC HEALTH

ACCIDENT, EMERGENCY AND ORTHOPAEDIC SERVICES

Recommendation:

Members are asked to:

- **Consider this report of further detailed work on the shape of Accident and Emergency and Orthopaedic services.**
- **On the basis of that further work, confirm the proposed shape of Accident, Emergency and Orthopaedic services for submission to the Scottish Executive as outlined in paragraph 1.1 of this paper.**

1 BACKGROUND

1.1 The Acute Services Review consultation included proposals that:

- Full Accident and Emergency (A & E) services would be provided on 2 sites, one North and one South.
- Minor Injuries Units would be provided on 5 sites at Gartnavel, Stobhill, Victoria, Glasgow Royal Infirmary and the Southern General.
- Acute Receiving services would be provided on the 3 in-patient sites.
- Trauma and orthopaedic in-patient services would be provided on 2 sites – one North and one South, but retaining locally accessible out-patient and day case services.

1.2 These proposals were based on a number of key principles:

- That we should stream the different categories of patients who currently access emergency care through the single entry point of A&E into properly organised and resourced services which will focus on meeting the needs of the type of patient for which they are designed, ie separately staffed and accessed.
  - Minor Injuries Units providing care for less serious cases.
  - Assessment and admission services providing efficient, consultant based, access for patients referred to hospital for specialist opinion, investigation and admission by their General Practitioner.
  - Full Accident and Emergency services focussed on triaging large volumes of self referred attenders and treating the sickest and most seriously injured patients – providing the highest standard of care 24 hours a day.
  - A dedicated Children's Accident and Emergency service providing clinical expertise and on site specialist clinical infrastructure.
- That local access should be retained, where possible.

- That resources should be deployed to offer gold standard care, but also in a way which is efficient.

- That arrangements for orthopaedics needed to deliver:
  - The highest quality consultant led trauma services in support of A&E.
  - Large enough consultant teams to enable sub specialisation.
  - The requirements to reduce junior doctors' hours and intensity for consultants.
  - Maintaining and increasing elective activity levels.

2 PURPOSE

2.1 At its January 2002 meeting, the Board considered, within its overall review of decisions on the Acute Services Strategy, the shape of Accident, Emergency and Orthopaedic services.

That consideration was supported by detailed papers restating:

- The rationale for the proposed shape of services.
- Clinical advice received during the consultation process.
- Further work in progress.

and by the following presentations:

- North and South Clinical Directors of Accident and Emergency – supporting a 2 centre A&E model with acute receiving at Gartnavel.
- North and South Clinical Directors of Orthopaedics – supporting a 2 centre in-patient orthopaedic and trauma service.
- A GP and Consultant Orthopaedic surgeon from West Glasgow making the case for a third Accident and Emergency and Trauma service at Gartnavel General Hospital.

2.2 In concluding its deliberations the Board restated its working hypothesis that A&E and Trauma services should be provided from 2, fully resourced, A&E centres in North and South Glasgow working with an emergency receiving Unit in West Glasgow, but recognised the need for further work on:

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

2.3 **The purpose of this paper is to draw together the proposed shape of services with that further work to enable the Board to reach a final decision. Concluding discussions and decision on this issue will also enable the Minister for Health and Community Care to consider and take decisions on the totality of the Board's Acute Services Strategy.**

This paper is structured into further sections:

3 The proposed shape of service and patient volumes.

4 Issues of debate and clinical advice.

5 Conclusions.

In addition, Attachment 1 includes more detail on the outcomes of the further programme of work covering:

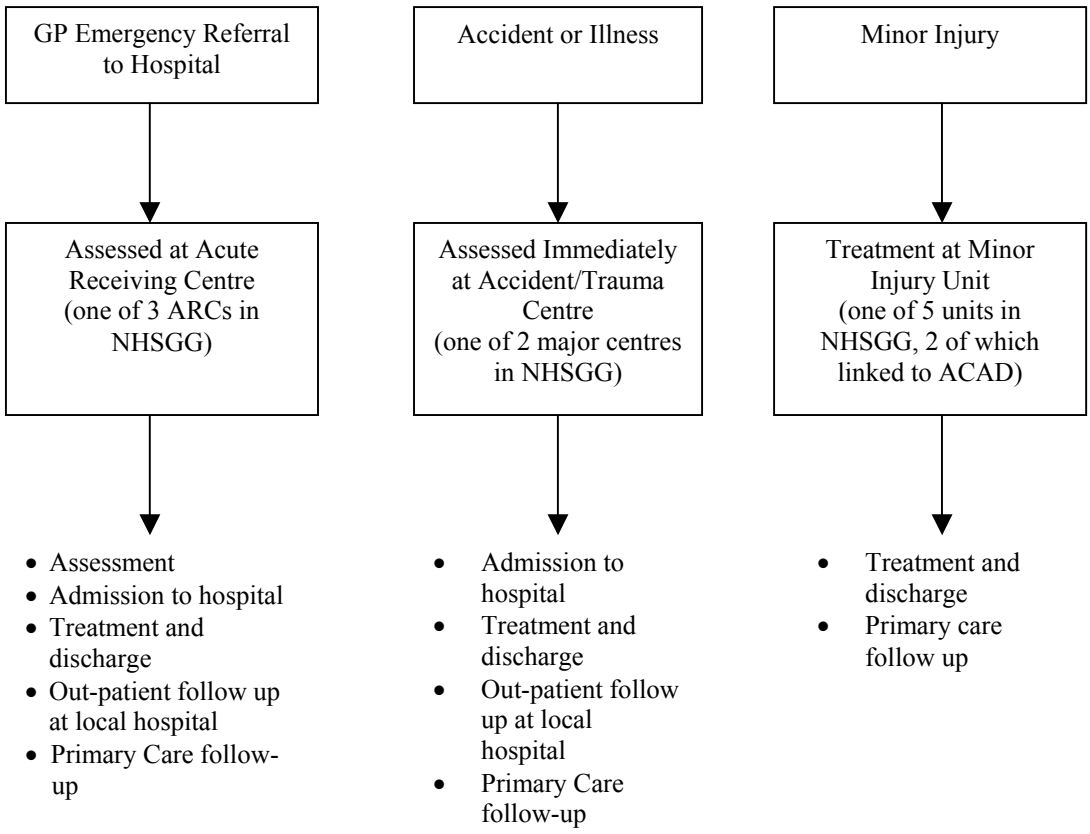
- Data collection and analysis.
- Managing high volume receiving services
- The Gartnavel Hospital Front Door
- Further analysis of orthopaedic services.

Attachment 2 summarises the further work undertaken by the A & E Planning Group.

3 THE PROPOSED SHAPE OF SERVICE AND PATIENT VOLUMES

3.1 The term Accident and Emergency services has traditionally covered a range of very different needs from patients with the most minor injuries and illnesses to those who are very seriously ill or injured. The essence of these proposals is 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. This section describes, in more detail, each component of the services we are planning, how they will serve each area of Greater Glasgow and the numbers of patients we estimate will be using each service. The flow chart below summarises how patients will be treated, streamed into services most able to meet their needs.

Patient Journeys for Accident, Emergency and Orthopaedic Services



3.2 **For Accident and Emergency** there will be 2 major units – one at the Southern General and one at Glasgow Royal Infirmary. This flows from the decisions taken by the Board at its January and March meetings. These units will meet the needs of patients who refer themselves for treatment or are brought in by ambulance services. The focus of the A&E services will be to make rapid assessments of these 'unselected' patients of whom there are large volumes but relatively few are seriously ill or injured. Following that rapid assessment the delivery of rapid and effective care, including resuscitation to the most seriously ill and injured patients, is the critical priority. For the relatively small numbers of patients who are seriously injured, a trauma team approach – rapidly bringing together A&E, orthopaedic and anaesthetic specialists - will deliver the best outcomes for patients.

In geographic terms, we expect the service at the Glasgow Royal Infirmary to serve the North and East of Glasgow as well as the Rutherglen/Cambuslang area. The Southern General will provide a service for patients in the South and West of Glasgow.

3.2.1 **Accident and Emergency - Adults**

South Glasgow	Glasgow Royal Infirmary
84,000 attenders 28,000 admitted	70,000 attenders 23,000 admitted

Based on trend we expect the total number of A&E attenders to remain relatively stable, but the number of emergency admissions are rising.

3.2.2 **Accident and Emergency – Children**

Yorkhill	
60,000 attenders	17,500 admissions (including to short stay)

Currently there are around 60,000 attendances at A&E departments of children under the age of 13 years. Of these, around 35,000 are already attending Yorkhill Hospital. The new arrangements mean that all children under the age of 13 years requiring A&E services will be seen at an enlarged facility at Yorkhill. This arrangement will ensure that all patients have access to dedicated paediatric facilities and staff, and will ensure uniformity of management of paediatric emergencies. As all children requiring admission to hospital following an A&E visit are already admitted to Yorkhill, there will be no change to admission levels, but the new arrangements will avoid onward transfer and delay for children. This arrangement will also assist efficient use of specialist paediatric staff and will lead to clarity of referral for GPs, the ambulance service and families. This new arrangement will be accompanied by the development of an enhanced paediatric A&E service, including consultant led services and improved training opportunities.

3.3 **For Orthopaedics** there will be out-patient and day case services 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. In-patient services will be concentrated at the Southern General and Glasgow Royal Infirmary sites, providing elective surgery, including hip and knee replacements and emergency, trauma surgery. Properly organised and resourced trauma services are critical to ensure that seriously injured patients, arriving at A&E are properly treated – this requires rapid access to orthopaedic expertise and dedicated theatre capacity to ensure that trauma surgery can be dealt with. As well as the serious injury cases, a large number of older people suffer fracture of the neck of femur and require surgical treatment. Such patients are then likely to require longer periods of rehabilitation in hospital than the generality of orthopaedic cases. Due to this and the concentration of in-patient services, with the Southern General serving the South West and West of the City and the Glasgow Royal Infirmary serving the North, East and South East – we intend to transfer older people, from West Glasgow, who have had their fractured neck of femur repaired, back to Gartnavel to improve access for relatives during longer hospital stays. These patients would be looked after by Care of the Elderly physicians with support from orthopaedic advice, if required, through the presence of consultants undertaking out-patient and day case work on the Gartnavel General Hospital site.

Orthopaedics

Southern	Glasgow Royal Infirmary	Stobhill	Victoria	Gartnavel
In-patients 5,000 Day cases 300 Out-patients 7,000	In-patients : 5,000 Day cases: 400 Out-patients 8,500	Day cases 100 Out-patients 3,500	Day cases 500 Out-patients 9,000	Day cases 1,000 Out-patients 9,000

Based on trends we expect trauma workload to remain static or decline and elective and out-patient activity to increase, marginally.

3.4 **Minor Injuries Units (MIU)** – there will be 5 Minor Injuries Units, at the Victoria, the Southern General, Gartnavel, the Glasgow Royal Infirmary and Stobhill. These units will be staffed by nurse practitioners, open 12 hours per day, and will provide locally accessible services to patients who refer themselves. The proposed hours of opening are based on the pattern of attendances observed during the detailed two-week study of A & E Departments undertaken in Autumn, 2001. These units will be able to deal with soft tissue injuries to hands and feet, minor head injuries and wounds, superficial burns and scalds, strains and sprains. Nurses will be able to stitch wounds, apply plaster casts, order and interpret x-rays and arrange onward referral. As well as maintaining local access for large numbers of patients, these units will offer a significantly improved service to the patients who currently wait the longest in A&E Departments continually displaced in the queue by patients with greater levels of clinical need.

Each MIU will be linked to a parent A&E Department for training and clinical supervision. Our estimate, based on analysis of Glasgow data, is that between 25% and 30% of current Accident and Emergency cases would access these facilities.

Minor Injuries

Southern	GRI	Stobhill	Victoria	Gartnavel
11,000	14,000	10,000	18,000	9,000

Experience from other quarters of the country suggests that these activities estimates may be conservative and that we might expect these services to deal with larger volumes of attendances.

3.5 **Dealing with GP Referrals** – at present patients whose GP has decided they require assessment by a hospital specialist, or admission, are sent to Accident and Emergency Departments to access hospital services. Our proposal is that each of the 3 in-patient sites should have services designed to provide immediate access to specialist assessment and admission for GP referral. These would deal with a whole range of patients assessing, investigating and discharging some – for example those whose chest pain turns out to be non cardiac, and rapidly treating and admitting others. The key factor is that these patients have already had an initial medical assessment by their GP, either at home or in a practice, before they are sent to hospital. This service, focussed on the needs of those patients, will be able to offer more rapid access to specialist assessment and treatment and quicker admission, if required.

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.

GP Receiving

Southern	**Glasgow Royal Infirmary**	**Gartnavel**
15,000 referred 13,500 admitted	16,000 referred 14,000 admitted	11,500 referred 10,000 admitted

We expect admissions to rise, and have included this projection in our estimate of future years' workloads.

4 ISSUES OF DEBATE AND CLINICAL ADVICE

4.1 The outcome of the programme of further work is included as Attachment 1 with the advice of the A& E Planning Group as attachment 2. This section summarises the key areas of debate covering:

- **Acute medical receiving**
- **A&E services**
- **Trauma services**
- **Gartnavel 'Front Door'**

It includes the clinical advice which we have received since January 2002 and sets out proposed conclusions to the main areas of debate.

4.2 The Advice from the Area Medical Committee

At its meeting held on 21st June, 2002 the Area Medical Committee received for consideration a series of papers submitted by Greater Glasgow NHS Board on the future provision of A & E and Orthopaedic Services in Greater Glasgow. Particular attention was focused on the Board's discussion paper which set out its proposals for a two site option for A & E and Orthopaedic Services at Glasgow Royal Infirmary and the Southern General Hospital with Gartnavel General Hospital providing a GP referral service for West Glasgow.

A wide range of medical opinion has been sought on these proposals and some of this opinion has been supportive of the Board's proposals whilst other opinion has not been supportive. However, the Area Medical Committee has identified a consensus around some key issues and it recognises the Board's need to come to a decision on A & E and Orthopaedic Services at its special meeting on 27th June, 2002. The Area Medical Committee strongly urges the Board to come to a decision as the status quo is no longer tenable and any further delay would not be in the best interests of patients or staff.

After careful consideration of all the complex issues involved the Area Medical Committee could only support a two site option for A & E and Orthopaedic Services if the following conditions and assurances were met:

1. The Area Medical Committee understands that the Board has established an urgent review of acute medical receiving arrangements across Greater Glasgow NHS Board to report by October, 2002 with firm proposals for change. That being the case, the Area Medical Committee trusts that this review will be adequately funded to allow appropriate clinicians time to serve on it; that it will look at bed occupancy; that it will look at the distribution of beds across acute specialties; that it will look at bed numbers and that it will consider the maximum number of patients each receiving team would be able to safely deal with.

2. The Area Medical Committee agrees that such a review is essential because the long term and on-going crisis in acute medical receiving with a 5% annual increase in patients requires urgent attention and because of the crucial inter-relationship which exists between acute medical receiving and A & E and Orthopaedic Services.

3. The Area Medical Committee expects the Board to find the resources to employ a suitable number of A & E staff to process the projected workload. On current projections this would amount to 18 Consultants in A & E Medicine working on two adult sites.

4. The Area Medical Committee believes that only stable GP referrals should be admitted to Gartnavel General Hospital. In addition, as a safety net, adequate resuscitation facilities should also be available in situ.

5. The Area Medical Committee recognises that the Board's proposals cover a ten year rolling programme of staged developments at the Southern General Hospital, Glasgow Royal Infirmary and Gartnavel General Hospital more or less in that order. The Area Medical Committee notes and supports the Board's intention that this programme should be subject to constant review ever mindful of the exigencies of patient safety and best clinical practice and that clinicians be fully involved in the review process.

6. The Area Medical Committee is encouraged by the Board's assurances that the numbers of medical and surgical beds required in the city will be subject to independent annual review by the Audit Commission for Scotland.

7. All paediatric Accident and Emergency referrals should be directed to the Royal Hospital for Sick Children in the expectation that adequate staffing and beds will be in place at the hospital to deal with the increased demand.

4.3 **The Views of the Greater Glasgow Health Council**

The Health Council also had the opportunity to consider the draft Board papers and met with the Director of Public Health and the Director of Planning and Community Care to discuss these. The Council's written comments, set out in a letter of 21st June, 2002 from the Chief Officer, were received shortly before the issue of the papers for the NHS Board Meeting. The Chief Officer's letter, together with a summary of the Council's key points made in response to the earlier consultation on Acute Services concluded in December, 2000, is enclosed as Attachment 3.

4.4 **Acute Medical Receiving**

- The major issue throughout the debate about Accident and Emergency services has centred on a lack of confidence that the volumes of admission generated in a 2 site option can be managed. This level of anxiety about future arrangements reflects the current sustained pressures around medical receiving.

- The core of Area Medical Committee's response to second phase consultation in December, 2000 was concern about the additional workload at the Glasgow Royal Infirmary and arrangements to deal with it.

4.5 Conclusions:

- As the analysis set out in section 1.2 of Attachment 1 shows, the Glasgow Royal Infirmary will house a very large acute receiving unit regardless of A & E arrangements in the South and West of the City. We have to be able to deliver the organisation and resources to ensure it is effective – by definition if this can be achieved in North Glasgow, a similar unit in South Glasgow can also be effective.

- The A&E Planning Group has provided a framework of requirements for high volume receiving units – the NHS Board needs to confirm its intention to construct and resource services in that way. Attachment 1 outlines the infrastructure and working arrangements which are required

- There are major current issues about acute receiving which need to be addressed as a matter of urgency. It is clear that an explicit NHS Board commitment to a detailed and rapid programme of work on this issue, and to implement its outcomes, is essential to maintain credibility in the acute strategy and to instil confidence around its implementation. That commitment should be given now at the point of decision-making on the longer term shape of Accident and Emergency services.

- The review should generate measurable targets for services – for example around bed occupancy – which are agreed to be clinically viable and drive the allocation of resources.

4.6 A&E Services

There continues to be a range of opinion about the question of 2 or 3 Accident and Emergency services. This section picks up the key strands of that debate.

- A&E Sub Committee have made a further written submission recommending 3 A&E Departments at Gartnavel General Hospital, Southern General Hospital and Glasgow Royal Infirmary. This contradicts without explanation their 27 October 2000 advice that **"there should not be main A and E departments at both Gartnavel and the Southern General sites".** However, this additional general advice is supported by a number of specific points about the construct of A&E services – all of which can be met by a 2 centre option with GP receiving at Gartnavel.

- The A&E Subcommittee analysis includes details of medical staffing arrangements illustrating a requirement for 14 additional Junior Doctors and 4 additional Consultants to staff a 3 site model. That additional Consultant staffing still generates a lower level of Consultant presence for a 3 site model.

- The direct question put to A&E Consultants on the A&E Planning Group and Hospital Sub Committee about the feasibility of 2 Units confirms that, from an A&E perspective, the volume of activity a 2 centre model would generate at Southern General Hospital and Glasgow Royal Infirmary is viable and manageable with properly resourced Departments – particularly by expanding Consultant numbers to 18. To give a comparator – there are 15 Accident and Emergency Departments in the UK seeing over 90,000 patients each year. As paragraph 3.2.1 set out, the 2 A & E sites within Greater Glasgow would see 70,000 and 84,000 attendances.

- By contrast to the above only if GP referrals continued to be streamed through A and E would a 3 site model achieve the minimum 60,000 patient volume threshold set by the sub committee's latest advice.

- Access for the population of West Glasgow is raised as an issue. The tension between local access and the gains of centralisation is an issue across the acute services strategy. A number of points are relevant:
  - Providing GP receiving and minor injuries services enable around 20,000 patients to access a local service, while around 30,000 patients currently attending the Western Infirmary would be expected to flow to the Southern General, about 30% of those travelling by ambulance. Car journey times for most of West Glasgow are marginally longer to the Southern than to Gartnavel – in almost all cases less than 10 minutes longer. Public transport journey times need to be addressed – a commitment we have given across the Acute Services Review. Journey times for West Glasgow on a 2 centre model are broadly comparable with those for residents of South East Glasgow.
  - A 2 centre model delivers virtually 100% of our population within 30 minutes of hospital by 'blue light' ambulance at all times and over 95% within 20 minutes at all times.

4.7 Conclusions:

- The critical concern running through A&E advice is around medical receiving – this issue is covered in more detail in the preceding section.

- We have confirmation that a 2 A&E service is workable and can meet the detailed series of requirements put by A&E Subcommittee.

- Two other commitments from GGNHSB are necessary:
  - Absolute clarity on the function of Gartnavel General Hospital dealing with GP receiving only.
  - Commitment to adequate resourcing of 2 services – particularly upfront commitment to A&E Subcommittee's proposals on consultant staffing.

- With the proviso of the general requirement to implement changes to public transport routes, access is not a material issue in decision-making.

  It seems reasonable to conclude that if the question was 'how many Accident and Emergency Services does Glasgow need?', the answer would be 2. The proposition of a 3 in-patient configuration does not, in itself, justify a different conclusion to that question.

4.8 **Trauma Services**

There is now a detailed analysis contrasting 2 and 3 orthopaedic site options which is included in section 4 of Attachment 1. There has been limited challenge to that analysis. The issues raised by West Glasgow Orthopaedic Consultants are also dealt with in section 5 of the paper.

4.9 Conclusion:

- There is a strong and coherent case for 2 orthopaedic services with serious questions about the sustainability of the alternative proposition.

4.10 **Gartnavel Front Door**

- The proposition made in the Acute Services Review was that Gartnavel should provide a GP receiving service for West Glasgow. This would maintain local access and contribute to ensuring that an appropriate level and mix of clinical specialties was provided in Gartnavel General.

- There has been a debate about whether the role of the Gartnavel Receiving Unit should be extended to include cases triaged into it by paramedics – either in a limited way – for example chest pain – or more extensively to create a model of service much like that found in an Accident and Emergency Unit. This latter model would be similar to the current arrangement in Stobhill, but is not one for which we have been able to find significant examples elsewhere in the UK. In addition, creating such a service does not reduce volumes in any significant way at the Royal Infirmary and so does not offer relief from properly organising and resourcing acute receiving on that site. The A&E Sub Committee has supported a GP receiving model but their advice is that any extension of that would offer a sub optimal service.

- Some interests have indicated a view that the GP receiving model is unsafe and offers a sub-optimal service to patients compared to Accident and Emergency. Providing GP receiving as a separate service to Accident and Emergency is a model of service well established in UK cities. A number of centres with Accident and Emergency services now stream patients referred by their GPs into separate units for assessment and admission or discharge. There are several reasons for this approach including the benefits to patients of immediate access to the specialty team to which they have been referred, the potential to reduce admission rates through more structured and senior assessment and reducing the volume of patients who have to be dealt with in A&E. This latter objective is critical to ensuring A&E can focus on rapid triage of high volume unselected attenders and care of the most seriously injured and ill patients. Our proposition is that all three sites should operate in this way for GP referral patients.

- There has been a challenge to the efficiency of these arrangements – both in terms of medical staffing, but also in terms of clinical infrastructure. Gartnavel will be a busy hospital with major cancer and cardiac services dealing with acutely ill patients – high quality and rapid imaging, intensive care and laboratory services are needed in support of those activities as well as the GP receiving unit.

4.11 Conclusions**:**

The Board has already decided that adult acute in-patient services will be provided from three sites. Our aim is to design services on those 3 sites to maximise clinical quality and efficiency. Weighing up the choices - for A&E, orthopaedics and acute receiving against the 3 site model and considering local access the proposed combination of GP receiving and minor injuries services provides the optimal service solution.

- Our proposed Gartnavel Front Door provides a viable and safe entry point for patients referred by their GPs. Capital planning needs to reflect this defined role.

- With appropriate forward planning we can be confident of recruiting consultants with the required acute medicine skills to lead the junior medical infrastructure which will be consolidated onto the Gartnavel site as the Western Infirmary closes.

- For cases which have not been triaged by GPs, the skills and expertise of Accident and Emergency Consultants offers the safest and highest quality clinical services: all such cases should be dealt with in A&E Departments.

- Capital planning for the Royal Infirmary and Southern General needs to be based on providing the physical infrastructure – including beds – for the volumes of admission this arrangement would generate.

5 CONCLUSION

5.1 The Board is asked to re-affirm from this programme of further work and debate that its working hypothesis:

- 2 full A&E services at Southern General Hospital and Glasgow Royal Infirmary
- 5 minor injuries units
- 2 orthopaedic and trauma services
- A GP- referred acute admissions service at Gartnavel.

is a viable solution to achieve its primary objectives:

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

5.2 The major issues around medical receiving need to be resolved, as a matter of urgency, to build confidence in our ability to deliver longer term strategy.

5.3 A detailed implementation planning process is required – linking further work by the A&E Planning Group and the acute receiving review to ensure that there is an explicit, phased and resourced plan, including workforce implications.

5.4 That detailed implementation plan needs to include further work on any changes to patterns of service through the NHS 24 telephone nursing service and the introduction by the Scottish Ambulance Service of the Priority Based Despatch system.