

Greater Glasgow NHS Board**Board Meeting**Tuesday 22nd February 2005

Board Paper No. 2005/11

Director of Planning and Community Care

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

- **The Board consider the outcome of the review of assumptions underpinning June 2002 decisions on Accident and Emergency (A&E) services and confirm that those assumptions which underpin the two site A&E model approved in the Acute Services Review remain valid.**

A. REVIEW PROCESS

1.1 At its July 2004 meeting the Board approved the three stage process outlined below to meet our commitment to retest the assumptions which underpinned the two site A&E model included in the Acute Services Review. The purpose of this paper is to report the outcome of that process.

1.2 The approved review process had three stages, these were:

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 was circulated to a wide range of key interests inviting their feedback. The programme of work covered in that paper included:

- 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 organisation of emergency care 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.

The feedback received on the discussion paper is summarised at Attachment 1.

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Stage two - a major workshop was held in October 2004 designed to enable direct debate with key interests. Those invited included patient interest and campaign groups, the Local Health Council, MSPs, a range of clinical staff and Local Authorities. The programme included presentations on ambulance services, acute medical receiving arrangements and minor injuries services. These presentations were followed by facilitated workshops which asked the three questions below of each planning assumption:

- Do you understand what has been assumed by NHSGG in relation to this planning assumption?
- Do you think this assumptions is currently valid? Please explain your answer.
- Are there any recent issues or developments that you think NHSGG should consider if it were to revisit this assumption?

A full report of the workshop was drafted and circulated to participants to check factual accuracy. **The full report is Attachment 2.**

Stage three - the third stage of this process was to report back to the Board - which is the purpose of this paper.

B. ISSUES FOR DEBATE

2.1 This section outlines and addresses the issues the review process has raised. In essence, this engagement has led to three different types of response:

- inevitably some interests simply restate positions taken in the earlier consultation;
- a number of stakeholders clearly had limited knowledge of the original proposals and the significant debate and consultation around them, over a two year period. They therefore had a legitimate desire to see a rerun of the full development and consultation process which this relatively bounded process could not meet;
- issues and discussion which did focus on the key assumptions.

The rest of this section summarises the points emerging from this last group of responses against the original key assumptions and the updated position statements included in the October 2004 discussion paper (shown in bold in the text). At headline level those assumptions were:

- patients would be streamed into the appropriate services, not all routed through A&E;
- localised Minor Injuries services would treat substantial numbers of patients and timely access for seriously ill patients would not be compromised;
- we set out the volumes of patients who would be treated in each service;
- significant changes needed to be made to arrangements for dealing with Acute Admissions and we needed to plan the right number of beds.

At the end of this section are set out further issues highlighted in the review process.

2.2 Patient Streaming of Minor Injuries

Our first key assumption was that:

Different categories of patient who currently access emergency care through the single entry point of Accident and Emergency (A&E) will be streamed into the properly organised and resourced services which will be designed to meet the needs of the that specific stream of patient. These services will be separately organised and accessed and will include, in addition to the two full A&E departments:

- minor injuries units;
- assessment and admission services for GP referred cases;
- a dedicated children's A&E service.

The rest of this section sets out the present position on these proposals about patient streaming.

a) Minor Injuries

Distinct minor injuries services are now well-established at Stobhill Hospital and have been trialled successfully at the Southern General Hospital. When operational these services are treating approximately 20% of the A&E workload at the Southern General and 40% of the casualty workload at Stobhill. A training programme is in place to develop the increased numbers of Emergency Nurse Practitioners who will be required to staff the new services.

b) Assessment and Admissions

We have produced detailed proposals about how facilities for patients arriving in A&E and referred by their GP will be organised and staffed, developing the concept of the Emergency Medical Complex. These proposals include substantially more sophisticated arrangements to assess patients, ensuring we can treat and discharge those who do not require hospital admission. These proposals will contribute to reducing the pressure on beds and provide more rapid and appropriate treatment outcomes for emergency patients attending the three inpatient sites.

c) Dedicated Children's A&E Service

Enabling capital work to create the space at the Royal Hospital for Sick Children to allow the consolidation of all children's A&E attendances is underway. A&E staffing has already been strengthened. The timing of the consolidation will need to be linked to the other changes to A&E services.

Finally, our proposals about patient streaming were challenged on the basis that patients would not be able to judge which service to access and would therefore gravitate towards A&E facilities, bypassing minor injuries services. There are two factors of relevance in response to this challenge. Firstly, minor injuries services are now well-established across the UK, with evidence that patients quickly understand

that they can attend a rapid local service and do so. Secondly, the implementation of NHS24 means that patients who are uncertain about which NHS service to access can now get direct advice to inform their decision. These factors, taken with the service developments and real patient volume information outlined above, would indicate that our assumptions on Minor Injuries Units are secure and they will deal with a substantial volume of patients offering high quality, rapid local care. Similarly, the progress in developing the concept of the Emergency Medical Complex, gives a clear illustration of how our plan can be delivered for emergency cases at the inpatient sites.

There was no substantial challenge that the patient streaming approach is correct and that our further development work on the components of the model provide greater assurance of its viability. There remain concerns about communication and public information and a desire to see longer opening hours for minor injuries units. There now appears to be much greater understanding of, and confidence in, the minor injuries model - our ability to illustrate at the seminar real life, detailed information on emergency nurse practitioners delivering this service was very helpful.

Finally, there are remaining concerns about whether children with minor injuries should all require to be treated at a centralised children's A&E. This is an issue we need to return to in delivering final clinical protocols

2.3 Access Issues

Our second key assumption related to access:

The June 2002 paper considered two primary access issues. The first was a commitment to retain local access as far as possible. The objective of the minor injuries units to be sited in five locations was designed to deliver that. The experience outlined in the section above suggests our projections on volumes for those services are realistic.

The second access issue related to ambulance travelling times to the proposed two sites. Focussing on recent ambulance services developments, the target of 60% of frontline vehicles with a paramedic by April 2005 will be delivered. In addition, the introduction of a Priority Based Dispatch - which was not in place when we developed our proposals - is beginning to reduce response times for the most seriously ill patients. That reduction in initial response times means that the time from call to arrival at hospital should be lower for the most seriously ill patients than we had expected. Finally, in Glasgow, for the year 2003/04, for the first time the Scottish Ambulance Service met its response time target.

No new issues in terms of access were raised by the review. Clearly, a number of interests remain of the view that only a full A&E service at their local hospital is an acceptable level of access. Progress in terms of the ambulance service performance was welcomed.

2.4 Patient Volume

Our third key assumptions were in relation to patient volumes:

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We assumed a stable volume of A&E attendances but continuing rises in emergency admissions. The volumes on which our proposals were predicated were as follows:

Southern General Hospital	84,000 A&E	28,000 admitted
	11,000 MIU	
	15,000 GPs	13,500 admitted
Glasgow Royal Infirmary	70,000 A&E	23,000 admitted
	14,000 MIU	
	16,000 GPs	14,000 admitted
Gartnavel General Hospital	9,000 MIU	
	11,500 GPs	10,000 admitted
Stobhill Hospital	10,000 MIU	
Victoria Infirmary	18,000 MIU	
Yorkhill Division	60,000 A&E	17,500 admitted

These predictions were based on a detailed study of patient attendances in 2001. In terms of the current position, the detailed appendix to this paper illustrates:

- **overall A&E attendances have declined;**
- **that a snapshot study at the SGH broadly confirms the workload distribution suggested by the 2001 paper.**

These two elements of up-to-date information give confidence to the pattern and projected numbers of attendances which underpin our plan.

There were three significant challenges in relation to patient volumes. Only one of those challenges relates to the level of activity which underpinned our 2002 decision. Firstly, there were concerns about capacity to deal with the expected admission levels - that point is dealt with in more detail in the later part of this section on bed capacity. Secondly, there was a view that the proposed acute receiving facility at GGH is too small to be economic and we should therefore have a full A&E. This point is covered in more detail later in this section. Finally, there was a debate in relation to Argyll and Clyde flows which we had flagged as a new issue and again, this is covered later in this section.

2.5 Acute Medical Receiving

Our fourth key assumption related to the management of acute admissions:

Our model proposed the streaming of GP referred cases into dedicated facilities dealing with high volumes of admissions.

Because of the level of concern from the Area Medical Committee and Greater Glasgow Health Council about emergency admissions, we gave a commitment to set out in detail how the two major acute receiving services at Glasgow Royal Infirmary

and the Southern General Hospital would be organised and staffed. We established a major review of present and future arrangements to deal with emergency admissions to address this and other related issues, looking at both short and longer term changes to improve the care of emergency patients. The review team included three experienced senior nurses, with backgrounds in A&E and acute receiving, and experienced consultants in care of the elderly and general medicine. That review has now concluded and its final report will be available this autumn. Its outputs have a number of strands.

- a) Innovative and detailed proposals for the organisation of emergency admissions, based on best UK practise, including medical staffing models.**
- b) A wide range of proposals to improve the throughput of emergency patients, complete treatment programmes without admission and improve the use of acute beds.**

Detailed papers from the Review of Emergency Admissions are available on our website www.nhs.gov.uk or on request.

Linked to the concern about the organisation of emergency admissions was a concern that there should be adequate numbers of beds to deal with the planned level of emergency admissions and realistic assumptions about growth. We have given a clear commitment that the number of beds provided in the new hospitals will be directly and transparently linked to the volume of admissions they are required to deal with. The Board's Medical Director is leading a programme of work to define the clinical models, bed numbers and infrastructure required for the new inpatient facilities. This would be clinically led and supported by a single Acute Services Planning Team with external expertise and advice to develop final proposals for bed numbers.

This work will also arrive at definitive proposals for the disposition of each specialty. These proposals will take account of:

- our core commitment that the benefit of consolidating in-patient services would be more reliable access to sub-specialist skills and interventions;**
- full analysis of the synergies between different specialties;**
- critical appraisal of the subspecialties which are central to the delivery of the highest quality acute care.**

The outcome of this work will inform the business cases for the new inpatient facilities which will begin to be developed at the end of this year. The Auditor General will continue to provide external scrutiny to the detailed planning for implementation of the Acute Services Strategy.

There has been limited comment or debate in this process on the very detailed proposals we now have in place to manage acute admissions. Clearly concerns about resources remain but these will be addressed as detailed capital planning is undertaken for the new services and do not relate to the number of A&E sites.

2.6 In addition to these assumptions from the original strategy and its consultation our discussion paper for this review highlighted the three further areas, outlined below in bold:

2.7 **Argyll and Clyde NHS Board's Clinical Strategy**

At the time of the June 2002 decision we assumed that patient flows from Argyll and Clyde would remain relatively static. The Argyll and Clyde Clinical Strategy presently out to consultation, proposes the consolidation of specialist emergency care at the Royal Alexandra Hospital in Paisley, with minor injuries services at the Vale of Leven Hospital and Inverclyde. This preferred option suggests two considerations for our own Strategy:

- a) **Consolidation at the Royal Alexandra Hospital would suggest that we will not see additional patient flows from south of the river into the Southern General Hospital - our assumptions on stable volumes in relation to that population look secure.**
- b) **In terms of the Vale of Leven proposed changes, it is important to consider the different patient volumes and charges which have already taken place.**

In January 2004, the A&E service at the Vale of Leven was closed with the retention of:

- **a medical assessment unit which;**
- **a minor injuries unit.**

Estimated annualised attendance for these services are:

MIU 8700 patients

MAU 4800 patients

The two services have transferred about 1% of their attendances for further intervention of the RAH.

There is an active debate around the Vale of Leven about where local residents would wish to access services if the Argyll and Clyde NHS Board proposals are implemented. If the outcome of the present consultation on the clinical strategy is that there is a minor injuries unit at the Vale of Leven and the other local needs are met by Glasgow services then we would need to expand the scale of the GP receiving service and its support facilities at Gartnavel General. An intermediate care service provided at the Vale of Leven would be expected to reduce the flow into Glasgow below the numbers illustrated above. In summary, if there is a pull effect into Glasgow the impact on our plans would be as follows:

- **additional GP referrals into the receiving services at Gartnavel General Hospital which would be taken account of in the final sizing of the new hospital;**
- **no impact on our minor injuries services as these would be provided at the Vale of Leven.**

The text above was produced during Argyll and Clyde's consultation on their clinical strategy. In considering the outcome of that consultation the Argyll and Clyde Board agreed in November to carry out further work to look at the future pattern of emergency services at the Vale of Leven and the potential of service provision to that population in Glasgow.

A large part of discussion and written comments focused on this issue. There was a strong view that people from the Vale of Leven catchment would wish to access services at GGH. As our paper, in the extract above, highlighted our proposals could be flexed to provide capacity at GGH to enable GP referrals to be admitted there if that is the outcome of further work on Argyll and Clyde's clinical strategy. Responses also suggested that a substantial volume of A&E patient activity displaced to the RAH, when the Vale of Leven A&E closed, would more appropriately flow into Glasgow. There are two critical issues here. At present, patients from the Vale catchment who are not transported by ambulance to the RAH could choose to access A&E services in Glasgow. However, the closure of the Vale A&E has had minimal impact on any Glasgow A&E, which would indicate that choice is not exercised. For those patients transported to A&E by ambulance the SAS decide which hospital offers quickest access. In the case of the Vale population either the RAH or SGH offer more rapid road access than GGH for a blue light ambulance.

2.8 Waiting Times for Treatment and Admission

Concerns continue to be raised about waiting times for treatment and admission in our present services, including through the Health Council's regular Casualty watch surveys. In responding to these concerns it is important to restate the limitations of the present pattern of services:-

- i) Many of the recommendations of the Review of Emergency Admissions are still being implemented. This means that we are not using our current bed capacity to best effect.**
- ii) Although there have been improvements in A&E consultant staffing and significant progress in cross-covering between sites, spreading our consultant workforce over five departments cannot provide the model of service we intend for the new facilities.**
- iii) We cannot introduce the fully streamed model envisaged in the Acute Services Strategy until we are able to deliver the consolidation of staff and new facilities outlined in the Acute Services Review. This leaves A&E as the primary entry for many patients who do not require it, creating delays in treatment.**
- iv) Delayed discharges have substantially improved but detailed review of longer stay patients, as part of the work on emergency admissions, highlights a continuing substantial issue of patients remaining in acute facilities when they should appropriately be cared for elsewhere. In the short term, the introduction this summer of Integrated Discharge Teams - bringing together Discharge Co-ordinators, Social Work staff and Bed Managers into a single team, with additional resources – is already making an impact. The sizing of**

the new inpatient facilities will include detailed consideration of the balance between acute and rehabilitation facilities and between staffing and bed resources.

The review did enable the concerns covered above to be raised again. We are aware there are substantial challenges in the present organisation of emergency care - our future proposals are designed to address those challenges.

2.9 Major Incident Responses

The Maryhill Factory Disaster led to concerns being expressed in some quarters about Glasgow's ability to deal with a similar tragedy if we changed the pattern of A&E and related services. When the Acute Services Review is fully implemented, Glasgow will have two major A&E and trauma facilities with a substantially improved consultant presence, focused on the patients who need their expertise. We will have five minor injuries units and three services dealing with GP referrals.

In the event of a major incident this pattern of services would put us in a position to offer the highest quality A&E services to the seriously injured, to stream walking-wounded patients into a number of Minor Injuries Units and to flex the admission of GP referrals to create capacity, beyond the cancellation of elective surgery, on a particular site.

One comment, from North Lanarkshire Council expressed concern that two A&Es are not adequate to deal with a major incident. That view is entirely at odds with clinical advice which supports the durability of our proposed arrangements

2.10 Written responses and the seminar also raised a number of further issues:

- Bed Numbers

A critical concern remains the issue of bed numbers. The lack of confidence in the availability of adequate beds to meet the very large admission workloads of the two major centres translates into an argument for three centres - although that argument is not in itself a logical one we need to ensure that visible process in planning bed numbers for the new inpatient facilities builds confidence that capacity will reflect demand.

- Ambulances

There was an acceptance of progress in improving paramedical numbers but continuing concerns about lack of visibility of plans to step up ambulance capacity to address the impact of reduced A&E sites.

- Scale of GGH Unit

A number of responses suggested the patient flows into GGH would not be adequate to sustain our proposed GP receiving services. The original strategy assumptions about emergency flows into GGH have not reduced and are potentially substantially increased by flows from the Vale of Leven catchment

area. The Acute Services Programme Board will need to keep under review shifting patterns of GP emergency flows in finalising the organisation and capacity of emergency receiving at GGH towards the end of the implementation of the ASR.

- A&E without Trauma

The Hospital Subcommittee response suggested that the potential due to training regime changes to run an A&E service without orthopaedic services on site.

Other responses do not indicate clinical support for an A&E service without trauma which would either require transfer of patients who require that service or bypassing of that A&E to access the SGH or GRI. In a context where a full A&E with orthopaedics would be only three miles from GGH and there is clinical acceptance that a two site model is workable, including from the Accident and Emergency Sub Committee, it is difficult to see a case to pursue such an option which, if accepted, does not provide an optimal model of care.

C. CONCLUSION

- 3.1 The detailed emergency review process has not highlighted substantial new issues or challenges to the key assumptions which underpinned the two site A&E proposal. However, it does re-emphasise the importance of substantial and effective communication on a number of issues, highlighted in the preceding section, which continue to cause concerns among key interest groups. These particularly relate to the durability of the final arrangements for beds, ambulances and other infrastructure when we move to two sites.

Publication: The content of this paper may be published following the meeting

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WRITTEN RESPONSES

This attachment provides a short summary of each of the written responses received in response to this review of assumptions.

Argyll and Clyde NHS Board

- Agree with our key assumptions which are mirrored in their clinical strategy.
- A&E could be provided to Vale of Leven catchment by RAH and SGH.
- GGH may require capacity expansion for GP referrals if Vale service changes.

North Lanarkshire Council

- Welcome assurances on patient information and adequate bed numbers.
- Concern about capacity to respond to a major incident.

West Dunbartonshire Council

- Pleased with clear references to Argyll and Clyde service changes.
- Communications strategy will be essential given high numbers of self-referrals.
- Review does not adequately take account of CHP and Managed Care Networks potential.
- Support plans to increase GP referral capacity at GGH to ensure access for Argyll and Clyde residents.
- Not convinced assumptions have been fully tested but recognise that some cannot be fully tested prior to implementation.

Mr J Sandeman, South Glasgow Monitoring Group

- Assumptions used are not premises for decision making or agreement and are irrelevant.
- Event did not touch on number of A&E departments.
- GGNHS have misinterpreted the Minister's intentions.
- Review should be taken back to square one.

Jackie Baillie MSP

- Information on where patients will go in the future is not clear.
- A West Glasgow A&E would attract 8-10,000 patients who formerly attended the Vale of Leven A&E.
- Given population desire to access services at GGH we should not close down the option of an A&E at GGH.
- Urges us to establish an A&E at GGH.

Local Health Council

- View reiterated that there should be three A&E departments in Greater Glasgow.
- Recognises more information is available but view that key information is still not available.
- Concern about opening hours of minor injuries proposed as 9.00 am to 9.00 pm.
- Proposals on streaming patients are appropriate.
- Welcomes progress on paramedic training.
- Serious concerns about two A&Es ability to cope with demand, has not received reassurances about bed numbers.
- Concerned that there will be unacceptable pressures on admission beds of two A&Es.
- The one potentially significant change from previous consultation is the closure of the Vale of Leven A&E. Impact of this should be monitored over a longer period.
- Addition of Vale of Leven population gives an adequate catchment area for an A&E at GGH.
- The Health Council have not received sufficient information about future additional ambulance services. Lack of this information is an important factor in the Health Council's support for three departments.

Royal College of Anaesthetists

- Support thrust of A&E strategy.
- Need to consider carefully patient volumes at GGH, staffing of acute receiving facility there and adequacy of critical care and theatre support.

Bill Butler MSP

- Accepts rationale behind one A&E in South Glasgow.
- Concerned about scale of GRI A&E.
- Population of West Glasgow justifies an A&E.
- Asks Board to address Jackie Baillie's point about Vale of Leven flows.
- Concerned about lack of detail on bed numbers.
- Anxious about whether SAS modelling on ambulances has been adequate and whether extra ambulance resources will be required.
- Suggests points above need to be addressed to secure public confidence.

Area Medical Committee

- The Area Medical Committee response highlighted four factors of significance arising from the original decision:
 - Argyll and Clyde Acute Services Review and its potential effects.
 - changes in A&E training potentially enabling A&E to be provided without an onsite trauma service;
 - potential further centralisation of acute specialties;
 - development of Beatson Oncology Centre at GGH requiring acute hospital services.

The submission went on to offer an appraisal of four potential service models for GGH although it indicated there was no clinical consensus to offer the Board advice on which model is optimal.

The Committee's appraisal of these is shown below.

1. Current Proposed Model: Two fully appointed A&E departments with acute receiving unit for stable GP referrals only at Gartnavel

Pro:

- Retains GP receiving locally in West Glasgow.
- Already has outline approval from Minister.

Con:

- Volume of work identified for the receiving unit at Gartnavel in EMC paper too small relative to the other two very large units, leading to under-utilisation of one entire medical unit, or pressure to develop an A&E service in an unplanned manner after the ASR changes have been completed.
- No currently identifiable staff group is sufficiently trained in resuscitation and medical emergencies to lead front door services in the absence of A&E consultants.
- Emergency surgical receiving workload too small to justify a surgical presence in absence of 999 ambulances, with a knock-on effect on the viability of ICU services and implications for the safety and efficiency of the medical receiving unit and the Beatson Oncology Centre

2. Three fully appointed A&E departments, with all supporting specialties

Pro:

- Ambulance workload would deliver critical mass of activity to have three full medical, surgical receiving units with viable anaesthetic and ICU support.
- Protects SGH (and to lesser extent GRI) receiving units from very large receiving workload in medicine and surgery allowing flexibility during peaks.
- Allows integration of Beatson within fully appointed general hospital.
- Allows flexibility to absorb any workload resulting from changes in Argyll and Clyde areas.
- Allows flexibility to hold some patients for transfer to tertiary units if required by specialty re-organisation.

Con:

- Requires staffing of three full A&E departments.
- Requires staffing of three orthopaedic units with consequent loss of efficiency.
- Loses opportunity to centralise surgical and cardiology services on only two major receiving sites with the benefits of sub-specialisation and patient care.

3. Two fully appointed A&E departments, with all supporting specialties, and no emergency receiving facilities at GGH

Pro:

- Concentrates A&E expertise on two sites with subsequent gains in efficiency and staffing profiles.
- Allows centralisation of surgical specialties and cardiology with benefits for sub-specialisation and the avoidance of secondary patient transfers.
- Removes all ambiguity over role of GGH as acute hospital.

Con

- Very large medical receiving units with limited flexibility to cope with peaks in demand or system failures (such as significant numbers of secondary transfers).
- Potentially de-stabilised by any significant influx of patients from other health board areas.
- Leaves Beatson oncology unit with no supporting general hospital facilities.

4. Two fully appointed A&E departments, with all supporting specialties and one A&E department at GGH without on-site orthopaedics

Pro:

- Ambulance workload would deliver critical mass of activity to have three full medical, surgical receiving units with viable anaesthetic and ICU support.
- Protects SGH (and to lesser extent GRI) receiving units from very large receiving workload in medicine and surgery allowing flexibility during peaks.
- Provides Beatson with most essential hospital specialties minus orthopaedics.
- Allows flexibility to absorb non-orthopaedic workload resulting from changes in Argyll and Clyde areas.
- Allows flexibility to hold some patients for transfer to tertiary units if required by specialty re-organisation.
- Allows development of orthopaedic centralisation and sub-specialisation

Con:

- Requires full staffing of three A&E departments.
- Requires operating A&E department with no orthopaedics, resulting in ambulance diversion with major trauma and patient transfer for in-patient care.
- Loses opportunity to centralise some surgical and cardiology units on only two sites with the subsequent benefits in sub-specialisation.

- The component Committees of the AMC views are set out below.

Orthopaedic SubCommittee	-	Support two orthopaedic and trauma sites.
Medical Staff Association SGH	-	Support two site option
GP SubCommittee	-	No significant change to assumptions
	-	Three units would have significant extra costs and workforce issues
West Glasgow Medical Staff Association	-	Full A&E and trauma at GGH
Geriatric SubCommittee	-	Broad support for two A&E strategy
A&E SubCommittee	-	View as before - three full A&Es
Beatson Oncology Unit	-	GGH requires medicine and surgery services
Anaesthetic SubCommittee	-	No major changes, support two A&Es

**NHS GREATER GLASGOW
REVIEW OF ASSUMPTIONS UNDERPINNING THE STRATEGY FOR A&E SERVICES**

Seminar Event, Glasgow Royal Concert Hall, Friday, 15th October 2004

FEEDBACK FROM WORKSHOPS

Key Issues Emerging Across the Workshops

- There will be public confusion about where to obtain emergency care following reorganisation
- There is need for extensive, sustained and strenuous consultation, communication and public education to support reorganisation
- There is worry that managerial jargon is getting in the way of public understanding – information must be presented to suit the perspective of patients and the public
- NHS Greater Glasgow has not stated a clear case as to why the reforms are necessary nor what benefits they would have for patients – its communications and consultations have been poor
- The NHS Board will have to work hard to build public trust in the reforms
- NHS Greater Glasgow may need to review the management and co-ordination of its hospitals modernisation programme
- The proposed limited opening hours of Minor Injuries Units are of concern
- Improved access to inpatient beds in wards is necessary for emergency care patients
- There is insufficient detail on arrangements pertaining to inpatient bed numbers which in turn fails to boost confidence in the strategy
- There is no confidence that all children would be treated at Yorkhill – many are still likely to attend MIUs especially
- The need for prevention through community-based action to reduce levels of emergency attendance was highlighted
- The role and efficacy of NHS 24 as part of the system of patient streaming requires close attention
- NHSGG's population projections may be flawed due to failure to take account of new house building in the area
- There is concern that the outcome of NHS Argyll and Clyde's acute service review may undermine the assumptions on patient flow behind Greater Glasgow's proposals to concentrate full A & E/Trauma at two sites only
- It is possible that the decision to go with two rather than three A & E/Trauma Units needs to be revisited in the light of the work of the Admissions Project Team
- Patient throughput at the Gartnavel General Hospital Emergency Receiving Service may be insufficient to make the service viable
- There is concern about front-line and support staffing levels being appropriate to deliver the modernisation package
- Growing car usage and ongoing issues around public transport feed public concern about the accessibility of services and locations

Please note that the feedback that follows overleaf has been summarised – this is not a verbatim report.

Comments have been attributed to individuals where the style and flow of conversation allowed scribes to do this.

Workshop A

<p>Facilitator: Anne Harkness Scribe: Niall McGrogan</p>	<p>Michelle Boyd, Nurse Manager Pat Bryson, Greater Glasgow Health Council Dr BL Devine, Hospital Sub-Committee Louise Laing, Health Service Forum SE John McMeekin, Greater Glasgow Health Council Paul Martin MSP Derek Nelson, Senior Nurse Dr Paul Ryan, North Glasgow Clinical Forum</p>
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Emergency Care Patient Streaming

- There was concern that the public would not understand the concept of streaming to different emergency care service components (e.g. Minor Injuries, Emergency Receiving) – understanding would at least take time to achieve *JMcM, PB*
- The public will continue attending the hospitals they know best and are used to *PM*
- Confusion might lead to people putting off seeking medical attention until they could visit their GP the next day *PM*
- People in the west end might still ‘pitch up’ at Gartnavel despite the lack of services there *JMcM*
- It was not clear what the public were expected to do overnight when Minor Injuries Units (MIUs) were shut *PR, LL*
- It was pointed out that MIUs and clinics might not adhere to uniform opening hours – proposals suggested they would be open 14 hours a day, whereas the Glasgow Royal Infirmary was considering a 24 hour service *AH, DN*
- It was recognised that a lot of work would need to be done to inform and educate the public *MB*
- There is a danger of a situation similar to public transport emerging where no-one was able to tell who runs services and where they go *PM*
- The Glasgow Emergency Medical Service (GEMS) required a lot of public education during its establishment and this stops at midnight *MB*
- It was asked if level of emergency care requirement post-midnight was really as low as suggested in presentations *PM*
- It was also pointed out that treatment for night/early morning attendees is sometimes more complex as a result of alcohol consumption *DN*
- A question was asked if streaming were workable, particularly if public education was so challenging *BD*
- It was felt that there were real advantages to being able to admit frail elderly patients to wards in particular *PR*
- ‘Systems’ will need to be put in place to ensure streaming is organised *BD*
- It was asked if patients who ended up in the wrong stream could be quickly moved to the right service *MB*
- Patient experience must be considered - there was a need to convince patients of benefit from the changes *PM*
- It was felt that actual clinical experience would be the same under the new arrangements *MB*
- However, it was pointed out that even patients referred by GPs have to wait at A & E for triage and admission under the existing system *DN*
- A & Es are not a place where most people would choose to wait; the Victoria Infirmary has bays dedicated to GP-referred patients to improve the patient experience *MB*

- It was asked if it were possible to provide the patients with some gains now, rather than wait for the modernisation programme bear fruit in a few years time *LL*
- It was suggested that some streaming took place to a certain extent already – senior staff don't wait at the 'front door' any longer *AH*
- However, modernisation plans need resources to back them up *BD*
- The quickest way for a patient to be 'tested' is to be admitted *MB*
- The key issue, therefore, is the need to improve access to beds to allow admission *PB*

Emergency Care for Children

- The issue of children attending MIUs was queried – it was not clear if they had been counted in projected attendance levels *JMcM*
- It would be necessary to check the assumption that all children would be attending Yorkhill-based services
- It was not apparent if demographics had been properly examined in profiling the proposed changes – specific profiles were needed *PM*
- Little is being done regarding prevention, to reduce the overall numbers of emergency attendances *PM*
- Community Health Partnerships (CHPs) might make a difference in relation to accidents and falls afflicting children and the elderly *AH*
- It was not clear if Emergency Nurse Practitioners (ENPs) have training in child health
- Nurseries have very tight restrictions regarding procedures for dealing with hurt or ill children – more services were required *PB*

Proposed Number of A & E Units

- It was asked if the proposal to move to 2 A & E/Trauma Units was acceptable in the context of the overall reforms to emergency care *JMcM*
- It was asked what was actually unacceptable about the proposals or the assumptions behind them *AH*
- It was suggested that an unacceptable assumption was that a falling population would lead to fewer attendances *PR*
- Although the NHS has indicated a lack of clinical staff, the detail of this has never been spelled out - Which parts of the city face shortages? Where are the calculations of staff numbers? *PM*
- The situation in NHS Argyll and Clyde may have a direct impact on the validity of assumptions about patient flow *PR*
- The presentations given prior to the workshops did not make it clear why a reduction to two A & E/Trauma units was necessary in the first place *BD*
- Cases of multiple injuries are reducing, thereby lessening the requirement for orthopaedics staff to try and cover rotas at more than two sites, similarly there is difficulty for anaesthetists and surgeons covering rotas due the European Working Time Directive and other factors *DN*
- It seem to be implied that moving orthopaedics to two sites would lead to greater capacity to tackle waiting lists *PB*
- There was still no clear explanation of the benefits to patients – these needed to be clarified *PM*
- It was asked why more orthopaedics staff could not be trained to overcome difficulties with rotas *LL*
- One benefit of reducing sites would be better access to specialised doctors *BD*
- Pressure on overnight and emergency cover would be alleviated *MB*
- Neither the assumptions nor the overall strategy were acceptable – there is a lack of detail about consultant staffing and there is a lack of confidence on the part of the public in NHSGG – the

NHS has failed to demonstrate what it is trying to do and why it is trying to do it – experience from the private sector might show how change could be planned and managed better *PM*

- Gartnavel General is capable of accepting a larger role than that allocated to it under the reforms *BD, PR*
- It was not clear what would happen under the two A & E model if circumstances put one unit out of action *JMcM*

Final Comment

- It was impossible to accept or support any of the planning assumptions made by NHSGG or the entire premise of the modernisation strategy *PM*

Workshop B

Karin McInnes, Facilitator
Kate Munro, Scribe

Danny Crawford, Greater Glasgow Health Council
Stuart Donaldson, Representing Mike Watson MSP
Catherine Fleming, South Glasgow Monitoring Group
Raymond Hepburn, Scottish Ambulance Service
Dr Paul Knight, Royal College of Surgeons Physicians and Surgeons in Glasgow
Susan McFarlane, Clinical Nurse Manager
Julie Reilly, A & E Service Manager
Professor D E S Stewart-Tull, North Glasgow Monitoring Group

Inpatient Bed Numbers

- There is agreement with many of the assumptions underpinning the A & E strategy but there is insufficient detail on inpatient bed modelling and numbers to allow complete assessment of the proposals *DC*
- This lack of information could undermine public confidence and people will still fear bottlenecks in the system *DC*
- Bed numbers have been requested for many months without result – the public perception is that nobody has a grip on this issue leading to fear of premature discharge and subsequent legal claims *D S-T*
- The population projections used by NHSGG are questionable given expansive housing development north and south of the Clyde *D S-T*

Emergency Care Patient Streaming

- Streaming is regarded as a logical system *DC*
- The descriptions of how the system would change was good but did not address the issue of how this would affect the training of doctors on a smaller number of sites, number of hours worked and so on – unless people are immersed in this detail they feel that the decisions taken are unwarranted – it is important to link the issue to the requirement to reduce the number of sites *PK*
- Information has not been laid out in a logical fashion – a layman’s guide is needed – consequently people will be confused as to what to do when the MIU closes at 9.00 pm *D S-T*
- People will go to the site most convenient for them and most appropriate *DC*

- The general public perceive there will be a reduction in services and that will raise issues like transport – there is a need to educate the public and patients about access to services *JR*
- Raymond Hepburn’s assertion in a statement given to the NHS Board in June 2002 was challenged. He had said that a “two-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”. It was doubted if these values were meaningful with the volume of traffic at today’s levels but Mr Hepburn pointed out that traffic gives way to ambulances (*D S-T*)
- A timed journey from the M8/M77 interchange to the Kingston Bridge earlier that week with all three lanes blocked took ten minutes – the figures quoted in 2002 were doubted (*D S-T*)
- From personal experience - ten-month old grandson would have died without access to emergency care at Stobhill Hospital - MIU closure at 9.00 pm is inexplicable – current 10.00 pm closure of service at Stobhill is logical and understood. Without a clear explanation of the reformed emergency care system, the ambulance service and NHS 24 will bear the brunt of public confusion *D S-T*
- It is agreed that clear information is needed – in the absence of this the worry is that people will abuse the 999 service *RH*
- Community transport may offer a solution – local authority involvement would be necessary as Scotland is far behind with this *D S-T*
- It is agreed that public education is a priority, which has to include the detail that underpins the decisions, as people are not expected to take them on trust *PK*
- People must understand that change is needed, as well as the shape of reformed services *JR*
- It was notable that medical opinion on the two A & E option was split – given this, convincing the public will be hard *DC*
- Given the level of services planned for Gartnavel General, it is very close to being a full A & E – why not go the ‘full hog’ and make it a third centre? *DC*
- The decision to go to two units was made before the work of the Admissions Project Team got under way – a case of ‘cart before horse’?
- It was notable that in the aftermath of the Stockline Plastics explosion in Maryhill that casualties were sent to Stobhill – if the service at the Glasgow Royal Infirmary was so effective, why was this necessary? *D S-T*
- There are good clinical reasons for this, and NHSGG has to work with the distribution of services it has at present *RH*
- If there were a major disaster, NHSGG could not cope based on the bed numbers available *D S-T*
- There are well-rehearsed procedures which support a system for ensuring that beds are made available to those who need them and to ensure that patients are given the appropriate level of stabilisation by paramedics and ambulance crews before they are taken to hospital *JR, RH*
- This must be explained to the public – it is not just a matter of saying ‘we’ll be OK’ – people don’t understand why the status quo isn’t an option, why there should be fewer sites and what this will mean *PK*
- The NHS Board has a dilemma - it cannot mislead people into thinking that the decisions are still open – but there is a great need for information to tell people what these decisions are *DC*

Jargon/Terminology

- It is wrong to call the ACAD (Ambulatory Care Hospital) a ‘hospital’ – this seems like trying to pull the wool over the public’s eyes *D S-T*
- There is much confusion as to what the ACADs are – few are aware of the scale of the developments *DC*

- There is a need to co-ordinate the work of the different groups taking forward the acute services strategy *D S-T*

Workshop C

Kevin Hill, Facilitator
Dan Harley, Scribe

Mark Cooper, Lecturer/Practitioner in A & E
Suzanne Clark, Greater Glasgow Health Council
Elizabeth King, North Glasgow Monitoring Group
Rosemary Pearce, Greater Glasgow Health Council
Mari Rough, representing Robert Brown MSP
Kevin Rush, representing Janis Hughes MSP
Ann Simpson, Chair, Friends of the Victoria Infirmary
Gerry Wright, Senior Nurse

Consultation/Engagement

- It felt as if very little consultation was carried out by NHSGG around the A & E proposals *EK*
- It was understood that A & E was consulted upon as a part of the overall acute services programme *GW*
- The changes proposed will lead to 11 separate emergency care elements being established as opposed to only the two A & E/Trauma Units as popularly believed *MC*
- To take the public along with the strategy, consultation has to be better, more transparent and use less jargon *EK*

Ambulance Response Times/Emergency Nurse Practitioners/MIUs

- The ambulance service statistics as presented seem dubious – all of the presentations (delivered before the workshops began) were too well rehearsed. It is felt that assumptions that ambulances would arrive on time were inaccurate, as anecdotal evidence suggests *EK*
- This is not the case in South Glasgow *AS*
- There are always issues around good and bad experiences for individual patients getting to hospital *KH*
- Should patient choice not feature in the determination of how they get to hospital? *EK*
- Choice is still available to all patients – at a MIU, patients may choose to see a nurse or a doctor *GW*
- Most people attending A & Es at this moment don't actually need to be seen by a doctor *AS*
- Research suggests that the service provided by Emergency Nurse Practitioners have been met with great satisfaction *GW, MC*
- A survey sample of 100 patients is unrepresentative *EK*
- The survey was a snapshot of patients using the service and represented the actual numbers seen *MC*
- There is confusion as to what arrangements will be in place when MIUs close overnight *RP*
- Services are linked and this allows patients to be cared for by another part of the network *GW*
- There was concern about finding new staff to support the reformed services, given existing nursing shortages *RP*
- Training figures show a high level of interest in and uptake of ENP courses – a substantial amount of planning and resources have been invested in the process *MC*

Streaming of Patients Requiring Emergency Care

- NHS 24 seems to be under-utilised in the scenarios described – to alleviate pressure on the A & E service, NHS 24 needs to be better publicised - many people feel it is too difficult to use or there was a barrier from too many questions asked by staff *SC*
- NHS 24 uses a process of cross-referenced questions to help determine diagnosis or the next stage of treatment required *GW*
- The efficacy of NHS 24 is disputed. Anecdotal evidence revealed the story of a sick child being taken to A & E following the mother’s dissatisfaction with the service offered by NHS 24 *EK*
- A culture change is required to educate the public on the role of NHS 24 *GW*
- The communications and planning process for A & E services is flawed – this is the fault of the NHS Board ‘up in Dalian House, smoking their cigars’, not front-line staff *EK*
- A & Es will retain direct access to core specialist services *GW*
- There is an anecdotal example of poor care offered at the modernised Edinburgh Royal Infirmary – a male attending the A & E with chest pain was refused admission and transferred to the Victoria Infirmary in Glasgow – in a second case, a male with deep vein thrombosis was also transferred to Glasgow – both cases were examples of negligence *EK*
- The first scenario could not happen – it is possible the anecdote does not reflect full possession of the facts about the case – in the second scenario, there may well have been a good medical reason for patient transfer to a local facility *GW*
- Based on experience from ‘Casualty Watch’, patients did seem to wait a long time *SC*
- Acute beds are not being used properly – they are filled with patients ‘not going anywhere’, however measures coming into place would alleviate the situation, such as the creation of a discharge co-ordinator post *GW*
- Work by the Chest Pain Emergency Nurse Practitioner had reduced inpatient stays from three days to two *MC*
- Many GP referred patients still seem to end up at A & E *SC*
- A pilot project is in place to reduce this trend *GW*

Workshop D

David Stewart, Facilitator
Mark McAllister, Scribe

Dr Douglas Colville, Area Medical Committee
Dr Robert Cumming, North Glasgow Monitoring Group
Patrick Harvie MSP
Josie Livingston, Friends of the Victoria Infirmary
Mhairi Lloyd, Emergency Nurse Practitioner/Clinical Educator
Cynthia Mendelsohn, Greater Glasgow Health Council
Caroline McCalman, Greater Glasgow Health Council
Ken Macintosh MSP

Public Perception of the Modernisation Strategy

- Most people understand many of the assumptions behind the strategy but the general public are still anxious. Medical staff ‘have made the leap’ but the public still need to come to terms with the changes *KM*
- Public concern is focussed on access to emergency care and its location *KM*

- People perceive a loss of services – there is a need to convince them that the modernised arrangements will be at least equivalent or better – some actions on the part of NHSGG have undermined public trust *RC*
- The public want to see more staff brought into services – but none are in the pipeline and re-organisation is what is needed to help fill the gaps – the reality of the situation needs to be communicated to the public *DC*
- Political elected representatives don't understand the debate and help to raise public expectations – the NHS is being undermined by short term thinking *CMcC*
- There is a need to be open-minded about what can be achieved; the evolving models are 'great'. Recruitment issues must be addressed in the long-term *JL*
- Staff drop-out rates and shortages aren't purely a Glasgow problem – there is a need to assess the whole picture *ML*
- Society doesn't value health very highly, or the health professionals. People don't understand clinical terminology – what about assumptions about people? How will people access services in the long-term? *PH*
- The message has been negative. The NHS Board's communications (public relations) have been lacking – people want to understand the practicalities rather than clinical information *CMcC*
- Newspapers have led the debate, there is a need to get the correct message across *CM*
- Controversy has flared up over the issue of the location of services. The (NHS approach) thus far has been top down – it needs to be done from the grass roots *DC*
- The public must be informed better and the issues need to be looked at from the public perspective – there is a lack of trust that the NHS Board would take up issues raised by the public. Can the public actually influence decisions? *KM*
- Historical mistakes in planning the pattern of hospital care have undermined planning now. What is the role of clinical staff in building trust? There is a need to understand the issues and relate these to the patient journey *RC*
- Once people actually use the system they find that they like it. The patient/public involvement agenda is difficult; patients ultimately go with what they experience and there are two different sorts of service users – active and potential *KM*

The Main Issues Impacting on the Strategy Assumptions

- The unfolding changes at the Vale of Leven in NHS Argyll and Clyde may affect patient flows
- Growing pressure on inpatient beds
- NHSGG needs to supply accurate statistics in its papers – 14,000 from 47,000 admissions to the Casualty Unit at Stobhill is not 40% - a point acknowledged by Dr Brian Cowan
- Greater Glasgow's transport infrastructure – the Clyde Tunnel is not a barrier and this needs to be clarified
- Emergency Nurse Practitioner services require reorganisation: in general they demonstrate a good experience
- The impact that NHS 24 will have on reducing emergency care attendance is questioned
- The location of services remains a key issue - growing car usage may impact on assumptions – in particular, this is critical in relation to ambulance service provision – what effect will congestion have on this?

Integration of Services

- It must be emphasised that a high percentage of patients will continue to access services in existing locations

- The role the new ACADs (Ambulatory Care Hospitals) should be highlighted within the new and integrated system
- Signage and signs of progress are important – the key benefits need to be explained
- NHS 24's role needs to be examined and assumptions on its impact on A & E services assessed

Assessment and Admission of Patients

- The model proposed has some validity and mileage – but the consultation carried out thus far was purely with clinical staff
- There is a need to learn from the assumptions that underpinned the building of Edinburgh Royal Infirmary and avoid making the same mistakes – Glasgow has taken a different approach
- The public need reassurance that the reformed services will provide better care than received at present.
- There must be education for the public as to where to present themselves in an emergency
- The working assumption must be built into planning that people will present at the wrong place and the system will have to cope with that

Workshop E

Iain Wallace, Facilitator
Shirley Gordon, Scribe

Margaret Hinds, Chair, Health Service Forum South-East
Hugh McDonald, A & E, Glasgow Royal Infirmary
Lawrence McGlynn, Emergency Nurse Practitioner
James Sandeman, South Glasgow Monitoring Group
Dr Jean Turner MSP

Overview

- Everyone understood the assumptions but are these the right assumptions and can we make assumptions at all if we are not sure what the Minister wants?
- Are these assumptions based on accurate facts and figures? - particularly as there is insecurity about the information that has been provided (and the presentations prior to workshops failed to enhance confidence)

Two A & E/Trauma Sites

- The Group had no problem with the proposed two Trauma Units but no confidence in there being only two A & E sites.
- There is no confidence in only three inpatient sites across NHS Greater Glasgow, as quite simply this would not provide enough beds.
- Given that NHS 24 has been put in place we need to capitalise on its strengths.
- Staff skills should be enhanced to undertake other roles as skill sharing is important particularly, to cite an example, acute medical receiving staff and A & E staff could have more generalised roles rather than specialised roles.
- How can we get acute physicians? – skill-sharing is all very well but Medical Consultants do not want to be Acute Physicians
- There still is not enough information available for the public to convince them that two A & E sites are enough in NHS Greater Glasgow. This should be seen in the context of:
 - Financial implications
 - Staffing implications
 - Capacity implications

- Not enough beds
- Can blocked beds be avoided?
- Patient population and geographic spread
- Have other UK demographics been looked at as a comparison?
- Access and transport – currently an impossible situation to get to the two proposed A & E sites – will this be resolved?
- How can enhanced care in the community work better to avoid re-admission to hospitals?
- What steps is NHS Greater Glasgow taking to ensure enhanced community services?
- Clarification of these matters should be well publicised before proceeding further

Financial Implications

- NHS Greater Glasgow has a current deficit of £58M. At the outset, therefore, it has to find ways of saving but continuing and improving service provision. How can this be achieved when the NHS Board intends to pay £70M per annum to pay for two new ACAD buildings for 25 to 30 years?
- Plans may have been made to address this but members of the public are not getting to hear about it and therefore they are not reassured
- Furthermore, how can a hospital be rebuilt (for example, Southern General/Stobhill) whilst still maintaining service provision?
- Is there any chance that the Scottish Executive Health Department could forego the £58M deficit?

Cross Boundary Flow

- Clarity is needed around the cross-boundary flow - particularly from NHS Argyll and Clyde
- This should be seen in the context that patients have a choice to either attend the new build at the Southern General or remain within NHS Argyll and Clyde
- Not only is there further clarity required around the cross-boundary flow but the system of payment needs to be ironed out as if NHS Greater Glasgow was to receive an increased amount of NHS Argyll and Clyde patients a payment structure would need to be in place to support this
- More work needs to be done around demographic and patient numbers as an increased number of patients from NHS Argyll and Clyde has huge ramifications for NHS Greater Glasgow
- More modelling needs to be carried out

Minor Injuries Units

- Minor Injury Units are a good idea but have to be used appropriately
- Will patients ‘play ball’ and attend the correct place where they can be best treated?
- In reality, how will they know the difference and what publicity materials will inform them where to go and in what circumstances?
- MIUs should all have a resuscitation room
- Furthermore, if a patient attends a MIU and then has to receive acute care how will transfers be made?

ACADs (Ambulatory Care Hospitals)

- ACADs are OK but need the back-up of an acute hospital and should not, therefore, be stand-alone

Streaming of Patients Requiring Emergency Care

- Streaming is a good idea but the internal organisation must support it. No point in having this way of organisation if we cannot staff it
- Protocols are fine up to a point but they can only establish so much
- There is no point in having a complicated overdose of bureaucratic processes
- Patients prefer direct contact with staff (Stobhill was cited as an exemplary example of this) and not simply protocols

Conclusion

- There were general concerns about the overall Acute Service Review
- This was seen against the backdrop of the recruitment and retention of staff which was a national difficulty
- The whole session should be reconvened when NHS Greater Glasgow has the adequate facts and figures and has clarified what the Minister wants

Workshop F

Dr Brian Cowan, Facilitator
Liz Watt, Scribe

Stewart Daniels, Greater Glasgow Health Council
Mr Eric Gardner, Hospitals Sub-Committee
Dr Alistair Ireland, Chair, A & E Sub-Committee
Charlie McCarthy, A & E Nurse and representative of
Carolyn Leckie MSP
Fiona MacKelvie, Lay Conciliator
Agnes Stewart MBE, NHS Board Member
Dr Barbara West, Chair, Area Medical Committee

General Issues

- Were the numbers quoted in the paper based on the original work carried out for 2002?
- The figures had been adjusted to include figures up to April 2004 and this was stated in the Appendix at the back of the paper
- *The issue of potential problems with the proposed move of interventional cardiology to a specialist unit at the Golden Jubilee Hospital was raised*
- *There are a number of proposals being examined, but if interventional cardiology moved, there would still be coronary care units retained in Glasgow*
- *Group members felt that there required to be a full range of specialties at each major site*

Transport and Access to Emergency Care

- Self-referring patients would find it more difficult to get to the new A & E sites, as would visitors
- However, local Minor Injury Units might take a substantial number of self-referrals, therefore mitigating some of the transport issues
- Transport work had been carried out by Niall McGrogan's Community Engagement team at the NHS Board and work was ongoing with the Green Transport system
- The issue of the cost of visiting patients in hospital was significant and visitors having to use different modes of transport in future would make it even more difficult

- Most in-patients are not in hospital for long periods of time. This would be a trial for relatives, but not as bad as in the past when there were longer lengths of stay

Proposed Emergency Receiving Model at Gartnavel General Hospital

- The question of the size of the new acute admissions service at the new Gartnavel site came under discussion - the consensus was that it would not be big enough to be viable
- It was suggested that patients being referred by Argyll and Clyde NHS Board would have a significant impact on Glasgow
- GPs from North West Glasgow may refer patients to West Glasgow but self-referred care would have to be sought in the Southern General Hospital or at the Royal Alexandra Hospital in Paisley. All secondary care within a given area should be rather than divided
- This raised the issue of the problem with medical records if people were using different NHS Boards and sites

Trauma Service

- The success of A & E as a specialty had brought problems. Support and beds were needed, particularly to deal with the large number of acute medical admissions
- A discussion ensued on the role of orthopaedics. Orthopaedics staff felt their service was best delivered from two sites
- The amount of trauma needed in Glasgow could be handled by two sites and this would free up surgical time for more elective activity
- Acute Medicine was a major role for A&E and this may supersede the role in trauma in the future
- It was possible to look to A & E consultants as well as acute physicians to deal with this workload
- GPs were concerned at Gartnavel not having an A&E department
- Minor injuries units would have A & E Consultant back-up and support and there should be sufficient numbers of A & E consultants to provide some on-site support to stand-alone Minor Injuries Units
- What could an orthopaedic surgeon do that an A&E consultant could not in the acute trauma situation?
- A scenario where a GP had sent an elderly patient to Gartnavel was discussed: When leaving the hospital the patient slips in the car park and requires to go to Glasgow Royal Infirmary - It seemed strange that the unfortunate patient would have to leave one hospital and be taken to another
- It was suggested that this was acceptable if we could ensure that all necessary services were immediately available at the other site

A & E Services

- There is a need to streamline services from A&E
- Medical receiving is getting bigger in Glasgow with a continued year on year rise in numbers
- The question arose - can we handle acute receiving at Glasgow Royal Infirmary and Southern General by streaming patients?
- It was noted that there would be approximately 70 admissions per day in each hospital
- It was suggested that these numbers could be handled but there were anxieties about efficiency and bed availability
- There required to be a serious investment in consultants
- Staffing was crucial in A&E, care should be consultant delivered

- As a large number of A & E SpRs are graduating from the West of Scotland training programme in 2005, they would be lost to the service locally if an immediate investment in new posts was not made

In-patient Bed Numbers

- What is the back-up plan for beds?
- It was pointed out that the In-patient Strategy was being developed in terms of hospitals sizes and bed numbers
- A similar strategy had been implemented in Edinburgh but there had been some controversy about the results.
- A bed model was being developed
- How do acute medical admissions in Glasgow compare with those in England? There were units in England as large as those planned in Glasgow
- A question arose on whether, with the new General Medical Services contract, the GP out of hours emergency service would continue
- This was the case in Glasgow but no one knew what the situation was in outlying areas and what impact this would have on Glasgow
- If out of hours services were not as good as those in Glasgow, then there might be more patients utilising Glasgow hospitals