Women and Children's Directorate

Clinical Advisory Board for the New Children's Hospital
Front Door Services Sub Group

Minutes of the meeting held on Thursday 27th July 2006 in the RHSC Committee Room 10:00 – 12:00

Attendee List:

Dr Jack Beattie (Chair), Mrs Coral Brady (Management Support and Minutes). Dr Sandra Butler, Dr Christine Gallagher, Mrs Marilyn Horne, Ms Joan Marshall, Mr Stuart O'Toole, Dr Mary Ray, Mrs Lynne Robertson, Dr Fiona Russell.

Apologies: Jean Wilson, Sara Hill, Melanie Hutton, Norrie Gaw and Maureen Kinney

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1. Apologies and Welcome
Dr Beattie opened the meeting and thanked members for attending. Apologies are shown above.

2. Minutes of the Meeting of the 14th of July 2006
The minutes of the previous meeting were accepted as an accurate record.

3. Matters arising:

3.1 Updated Activity Projections

3.1.1. Emergency Department

It was presented that Alder Hey patient figures (60,000 new patients and 5,000 follow-ups per annum) may be considered slightly less than may be anticipated in the new hospital.

Dr Beattie had undertaken a sum of the current non-SSW patients (32,000), multiplied this by 173.5% (based on previous work on A&E centralisation of children's care) and added 20% uplift for the 13 – 16 year age group.

It was noted that the proposal for 4 minor injuries units (MIU's) located around Greater Glasgow with 2 separate ACAD's. MIU's will treat walk-in adults and children. Currently, the projected child numbers for MIU's is 5,000 each per annum (20,000 total).

There was a need to clarify projected child and young people attendances with the MIU planning team .

Action: Dr Jack Beattie

In a recent sample 6-week period it was noted that in the 0-12 year age bracket 3,000 patients were treated. In the same time-scales 2,000 patients aged 13 – 16 were treated. It was suggested though that the activity in general during this period has been quieter due to the increased temperatures.

It was suggested that older patients (those age 12+) were most likely to consider utilising MIU facilities rather than travelling a greater distance to attend a children's hospital.

It was noted that no uplift had been allowed in consideration for the closure of A&E of Monklands Hospital in Lanarkshire. Patient choice may see a rise in patients from this geographical location. It was agreed that the figures of paediatric patients from Monklands (utilising their EDIS system) should be noted for possible future use.

Action: Mrs Horne

Following all discussions, the group agreed on a activity projection of 73,308. This was felt to be within the 5% accuracy range required of the New Children's Hospital Planning Team.

3.1.2 Orthopaedics

Current Orthopaedics patient figures are 1,600 new patients with 10,000 follow-ups. There is an obvious link with radiology activity and inpatient activity (at present approximately 400 new patients are admitted per annum, or 3 – 4 per day in the summer). Dr Beattie offered to clarify projected orthopaedic activity with Mr Rod Duncan upon his return from leave.

Action: Dr Jack Beattie

3.1.3 Child Sexual Abuse (CSA)

It was noted that whilst the number of patients presenting with CSA are small; the clinical care of older patients (13 – 16 range) is different and needs to be carefully considered. However the overall impact of such patients in relation to ED activity is likely to be insignificant.

3.1.4 Radiology

It is estimated that an additional 20,000 X-Ray's will be required (this is a 200% uplift on current activity). It was noted that it is unclear at this stage whether Paediatric Radiologists will be required to undertake the reporting of all paediatric x-rays that are undertaken (even if off-site at an MIU). Dr Butler agreed to contact the MIU Planning Team to clarify the requirements.

Action: Dr Butler

3.1.5 Surgical

Mrs Horne will provide figures for the numbers of additional patient who have been admitted with head injuries in both the RHSC and Greater Glasgow, and include the length of stay on admission.

Action: Mrs Horne

It was considered that there may be a some impact in abdominal and chest trauma and although the numbers may be modest, there may currently be a limited clinical expertise in these specific areas.

It was estimated that there would be an increase of 10 – 20% for appendectomy.

There was concern the development of the NCH and the expansion in age range may encourage surgeons in DGH settings to further reduce activity in non-emergency paediatric surgery.

Mr O'Toole offered to provide a paragraph for the Output Based Specification relating to surgical procedures.

Action: Mr O'Toole

Mrs Horne will provide figures on West of Scotland appendectomies, laparotomy and laparoscopy procedures.

Action: Mrs Horne

It was noted that it may be difficult to accurately predict the impact from cross boundary activity, however, where possible, figures provided should be fed into the Inpatient Sub-Group, chaired by Dr Jim Beattie.

Following discussion it was agreed that clarification was required relating to Gynaecological Emergency presentations. Dr Jack Beattie to obtain clarification.

Action: Dr Jack Beattie

3.2 CHKS benchmarking

CHKS are a commercial organisation. It is understood that they provide clinical activity benchmarking for health services. The Clinical Advisory Board for the New Children's Hospital have commissioned CHKS to undertake this work. It is thought that this may be in the format of a software package that will analyse all patient figures, in particular in-patient and outpatient activity. It was noted that it is impossible to analyse Emergency Department activity as this was not coded, and only local figures would be able to provide activity information for this particular area.

3.3 National Arrangement for A&E Response following Death

There are currently discussions taking place for new arrangements relating to the viewing of children and young people who have died, regardless of whether that death took place within the hospital or prior to arrival. Sensitive consideration needs to be given to the location of that facility (for example co-location to the Emergency Department and PICU), and the specific technical issues such as availability of environmental temperature controls etc. Some discussion has taken place relating to the replacement of a dedicated children's mortuary, but any final decision was awaited.

3.4 GEMS

It was noted that there is currently an on-going discussion within NHSGG&C regarding the locations of GEMS (and MIU's). It was not known what impact this may have on Emergency Department activity.

4.0 The Paisley Factor

The issue of increased paediatric care that is currently provided at the Royal Alexandra Hospital (RAH) in Paisley is known to be politically sensitive, and as yet has not undergone any form of public consultation (which would be an essential factor). Obviously any drift in service provision is an emotive subject, and careful consideration needs to be given to this.

Emergency Department presentations at RAH currently result in a 2% transfer to tertiary services (Dr Ray agreed to provide exact figures)

Action: Dr Ray

It is possible the through patient choice there may be a drift towards the NCH, particularly from the East Renfrewshire geographical location. However, there may also be the opposite affect from the Vale of Leven area, with more presentations to the RAH (historically 12 years ago there was an 80% presentation to RHSC, currently 10%).

In 2005 at the RAH there were 5280 emergency department paediatric presentations with 50% of patients being admitted. In the winter this equates to a 60% medical, 40% surgical split, and in summer 60% surgical and only 40% medical. These figures are for children aged 0 – 16 years. The total of all paediatrics (including outpatients, follow-ups etc.) for 2005 was 52,000.

5.0 Issues from Other Sub-Groups

5.1 Outpatient Department Follow-Up Clinics

At present Emergency Department follow-ups are offered within the Emergency Department. This includes minor burns, fractures etc. that are often swiftly dealt with. In total it was noted that this equated to approximately 2% of all new patients. Medical follow-up patients were often seen in a short-stay clinic.

Mrs Brady (who has dual role as management support for the Outpatient sub-group) suggested that it should be considered that all outpatient clinics should be held within a dedicated outpatient environment, freeing up the expertise of emergency staff to deal with unpredicted emergencies.

Dr Russell proposed that there was scope for some consideration of this, however, it would be difficult for the emergency doctors (who currently run the return ED clinics) to leave the dedicated Emergency Department for lengthy periods. Within the current set-up they are obviously on-hand immediately to deal with any presentations. It was also noted that the emergency department staff have become skilled in the particular wound dressings etc. required. Mrs Brady wished it to be noted that outpatient staff would be equally able to assist in this particular area.

Dr Beattie proposed that the existing ED clinics remain within the plans for the new Department, however to limit any increase in this activity.

5.2 Laboratories – Near Patient Testing (NPT)

It was clear that although there would not be dedicated paediatric hot lab facilities, there was an expectation that enhanced NPT was likely in the ED to facilitate patient management. This needed to be included in the OBC.

5.3 Adjacencies – PICU/HDU

It was noted that there was a desire for co-location with PICU / HDU, however, it was known that a number of other areas have equally expressed this wish.

6.0 Hospital At Night

It was not yet known how this might relate to the ED (either before or after the move to the NCH). A model whereby there is a central communications facility located within the ED had been proposed. Dr Jack Beattie is now on the Hospital at Night Planning Group and will provide an update to this group as required.

It was generally supported that if it proposed for the communication room to be located within the Emergency Department that this would be acceptable.

7.0 Medical Staffing Projections

At the request of Mr Jamieson (Chair of the New Hospital Planning Team), Dr Jack Beattie and Dr Russell have agreed to work together to provide estimated figures.

8.0 Schedule of Accommodation

The draft schedule of accommodation that was constructed for a previous project was circulated. All views are requested to be provided to Dr Jack Beattie prior to the next meeting.

Action: All

9.0 AOCB

How to Build an A&E

A 126-page PDF document has been produced by the Scottish Executive and has been provided in draft format for consultation. Comments were to be returned to the Scottish Executive by the 1st of September. Dr Jack Beattie and Dr Russell will undertake this task together.

Action: Dr Jack Beattie / Dr Russell

10.0 Date and Time of the Next Meeting

The next meeting is scheduled for 10:00 – 12:00 on Thursday 10th August 2006 in the QMH Conference Room.