New Children's Hospital

Front Door sub-Group

Wednesday, 28 June 2006

Notes from Meeting

Present: Jack Beattie (JB) (Chair), Maureen Kinney (MK), Scott Hendry (SH), Elaine Lockhart (EL), Joan Marshall (JM), Sandra Butler (SB), Rod Duncan RD), Sarah Hill (SH), Marilyn Horne (MH), Kalsoom Mohammed (KM), Fiona Russell (FR), Jean Wilson (JW), Pamela Joannidis (PJ)

Apologies: Coral Brady, Lynne Robertson, Elaine Love, Melanie Hutton, Norrie Gaw

1. Jack Beattie welcomed everyone. JB briefly outlined the other sub-groups, and briefly covered the agreed principles and remit of the group (already circulated).

2. He outlined the tight timescales all the sub-groups were working to with an Outline Business Case (OBC) expected to be ready in 3 months (end September); therefore this sub-group will meet fortnightly.

3. JB discussed the previous significant bodies of work that had already been completed in recent years in relation to emergency care at Yorkhill, in particular the business case in relation to the anticipated centralisation of all children's emergency care at Yorkhill that preceded the announcement of the new Children's Hospital development. In addition there was separate work currently going on in relation to the Unscheduled Care Collaborative Programme (UCCP) and the internal merger of A&E and the Short Stay Ward into an integrated Emergency Department.

4. JB proposed using the final document on Centralisation of Paediatric A & E (version8?) as a basic template to inform/ work from in relation to our current remit. All agreed; the most up-to-date version available (version 8?) would be distributed. **Action: JW**

   However a number of significant issues would be different from the original specifications on which the A&E Paediatric Centralisation case was based. These included:
   - That a number of Minor injury Units (ACAHs, open 23h/day) were to be located across the city and, contrary to original planning, these would involve some children/ young people attendances.
   - That the age range for the new Children's Hospital would be up to the 16th birthday, while the original assumption previously was that we would cover up to 12/13 year-olds.
   - The current reconfiguration of patient flows, and the integration of A&E/SSW care processes.

While there was a detailed specification of Equipment/ Rooms in the original centralisation document, we would need to take account of the new age ranges and different activity projections. FR emphasised the value of exploring the configuration of the new GRI A&E model, which was perceived to be a significant success.

5. **Activity projections and demand modelling**.
   The most important issue for the group would be to accurately predict future activity. Only then could rational planning and a secure OBC be developed. There would need to be robust data, at a minimum within of 90% correct figures for secure projection. We will split age groups and look at under 1 year old; 1-5; 5-12;13-16 years old.
   The current concept of the remodelling of the Emergency Department patient journey would also have to be considered, with the planned patient flows of Resuscitation, Assessment, Minor Injury and Extended Observation likely to impact on any departmental configuration.
   FR noted that some work had already been completed reviewing the patient journey from arrival to discharge/admittance and time taken. This could be extended.
   External activity data was unsound at best. SMR 1's from all areas would need to be checked, but if patient is not admitted there is no coding/SMR1 data. Also need to check the Dataset of minors/majors.
   Orthopaedics (RD). Projecting fracture clinic numbers is very insecure, since they are not recorded in an age-stratified manner anywhere. The elective clinic numbers are going to be easier to predict. It is likely that Stobhill and Victoria ACADs will send all under 16s with fractures to the new RHSC, whether or not they need I/P treatment. GRI's approach is very uncertain. Conceivably, we may have to deal with all fractures in individuals less than 16 yrs in Glasgow (? + Paisley). This is significantly more than predicted in the centralisation document (details to be checked). **Action: RD**

   CHKS (a major UK independent provider of comparative information analysis and benchmarking services to the NHS had been invited to support work of all the groups. However it was acknowledged that finding appropriate benchmarking comparators was difficult.

6. **The "Paisley issue"**. JB advised the group that there were no formal plans to consider the downgrading of the RAH paediatric Activity by NHS GG & Clyde, but the general professional view was that the close geographical association of the new Children's Hospital to the Paisley area would inevitably mean that there would be significant drift of acute clinical activity to the New Children's Hospital from that area with relocation. However this was a highly sensitive issue politically, and there was no official Health Board acknowledgement of this. It was conceivable that in due course the in-patient general paediatric facility at the RAH would close, with their activity becoming subsumed with the new hospital.
   While this could not be formally discussed, the issue posed a significant risk to activity that it could not be ignored. Our activity modelling would have to consider this issue, whether or not the origins of the patients was to be explicitly acknowledged.
   If this were to happen it would mean more space would need to be planned for and current RAH paediatric activity would need to be confirmed. Approx 6-7k patients attend RAH at present but it is not known what percentage are medical admissions. FR would explore children/young people activity levels with colleague(s) at the RAH A&E department. **Action: FR**
   Similarly, it was uncertain what impact might occur with the announced downgrading of the Monklands A&E; some families may prefer to take their children to New Children's hospital rather than Wishaw?

7. **Projected adolescent activity** (13-15 year-olds)
   The Group will need to get profile of this additional patient demand: numbers; admissions; specific clinical problems such as trauma, Mental Health (self harm) and/or OBS/Gynae problems?

It would be useful to explore Alder Hey (Liverpool) figures for 13-16 year olds, as they have similar population. Jean Wilson will explore this with contacts there. We also need to look at local Glasgow figures, if possible. **Action: JW**

There was a general understanding that there was already a significant number of adolescents currently cared for by a variety of (tertiary) specialties at Yorkhill; it was unclear if this would actually change significantly. We would need to be aware of this issue, and link with the other subgroup projections to let us assess any potential impact on Front Door activity.

There were a number of specific Adolescent issues to clarify:

- Adolescents – Adults shared services and transitional care arrangements. How would this work? Check the Nottingham arrangements.
- Chronic illness Discuss with Jim Beattie **Action JB**
- Teenage Cancer Currently up to 18yrs
- It was recognised that there would need to be a separate area for adolescents for Mental Health assessments. This would include a safe interview room. Elaine Lockhart will look at figures for adolescent attendees at present.
  Action: EL; **Dougie Fraser**
- Gynaecology – numbers/ projections? How this would link to the Specialist Suite at Sandyford. What happens at Alder Hey?
  Action: Sarah Hill

8. **Adjacency and interface issues**.

The Group discussed a number of topics. FR had attended a meeting in relation to the general “footprint” of the new hospitals development. This primarily related to high-level adjacency arrangements of the different individual components of the campus. It was perceived that the New Children’s hospital would be effectively a standalone facility, but with appropriate links to the Maternity Unit, and a common ambulance route to paired but separate Adult and Paediatric Emergency Department entrances.

A variety of specific internal adjacencies were proposed:

- It was recognised that in particular there was a need for PICU and urgent imaging services to be close to the Emergency Department. CT must be adjacent to the ED, with a dedicated CT for children and young people. (There may be a link corridor to adult services for limited overflow use).
- Other imaging (US/X-Ray) must be close by, and probably have dedicated satellite unit within the ED.
- A (combined) trauma/medical/surgical extended observation ward would be part of the Emergency Department development
- PICU should be close by e.g. next level with direct lift; also linked to Theatres.
- It was likely that further functional associations would continue to blur the traditional Surgical/Medical labels of services (e.g. an integrated gastroenterology service), and these services would primarily be tertiary in nature.

- There was a need for close association of the ED with remaining secondary level inpatient Medical/Surgical ward(s). Acute receiving will be multifunctional with children being transferred there or to specialist wards as happens at present.
    - **Hospital at Night team** - This should be based within the ED, (dedicated rooms?), to maximise communication and handover arrangements. The acute receiving team & Hospital at Night could share accommodation, with direct access from department via lift. An anticipated configuration would be ground floor ED, PICU on first floor, and secondary care inpatient wards on second floor.
    - There would be a need for a multifunctional interview room within the ED, designed appropriately for complex risk cases. Including child protection and initial mental health interviews. However it was clear that adolescent self-harm patients would have to be accommodated within any dedicated adolescent facility and not in the ED.
    - Child protection. We would need clarity where acute assessments take place. SH noted that numbers were relatively small and that most children have elective examinations. There was a need to clarify what aspects of the current child protection activity the Sandyford assessment centre will be picking up.

      Action: SH

      Laboratories – will apparently be located remotely on the campus, with a tube system? It was unlikely there would be a dedicated hot paediatric laboratory; this may have implications for near-patient testing facilities, and implies that the ED may have to have a small in-house laboratory area for gases etc.
      We need to link with the Imaging/Laboratories group to clarify this.

      Ophthalmology – It was understood that this would be based at the Gartnavel site. We would need to be clear how this would impact on the need for specific equipment/ accommodation within the ED.

      Neurosciences – It was unclear at present where this service would be based, but it was likely to be a centralised service. It was not clear if children and young people would be cared for within the SGH neurosciences complex, or within the new children's hospital.

9 **IT**

Plans were not known but appropriate investment in Information Technology would be an essential component of the department's future success and UCCP compliance. It was essential to introduce the nationally recommended Emergency Department Information System (EDIS), and not to continue with Meditech. The Meditech A&E module was known to be poor, while EDIS was established to have dramatically improved ED patient flows in England. It allows organisation of care more efficiently, thereby providing a more patient-centred service, and maximise the opportunity to ensure that 98% of patients will be seen, discharged or admitted within 4 hours.
Additionally, we would need full implementation of PACS, with an expectation that we would be a 'film-less' department on opening.
Access to Telemedicine facilities was important. While the use of such techniques in remote acute consultation was uncertain, there was a perceived need from external clinicians in other areas (Western Isles) to use such techniques to discuss cases, and seek support while awaiting retrievals. It was already an established educational resource.

10. **Other issues**:
Security would have to be considered. This would involve the use of swipe card access, panic buttons/ alarms. A functional separation of staff/care areas would be important, with strict control of public access.

Pharmacy - This would have to be clarified. The group were uncertain whether there would be a dedicated children's pharmacy and an OPD pharmacy on site, but the group felt strongly that a dedicated paediatric pharmacy would be a useful resource. This should include electronic prescribing, including a weekend service.

11. It was recognised that well-founded projected activity patterns for specific age groups would be the cornerstone of sound project planning and this would be the group's priority meantime. There were already available DOH validated design templates for EDs, including Children's EDs (SH).
However it would also be useful for all group members to consider the previous centralisation document that JW would supply, to allow a baseline for further discussion. **Action: All**

Date of next meeting – Friday 14 July in QMH Classroom 1000-1200.