NEW CHILDREN'S HOSPITAL PROJECT

IN-PATIENT CARE CLINICAL ADVISORY SUBGROUP
HELD ON FRIDAY 10th NOVEMBER 2006
10.30AM IN THE RENAL UNIT SEMINAR ROOM, RHSC

PRESENT

Jim Beattie (Chair)	Anne Devenny	Kay Maley
Douglas Colville	Rosie Hague	Mary McAuley
Winnie Miller	Michael Morton	Dermot Murphy
Karen Fraser	Joan Burns	

1. Apologies

Neil Geddes	Lesley Smith	Helen Thomson

2. Minute of the In-patient Subgroup 11th September 2006

The minute of the above meeting was accepted as a correct record.

3. Minute of NCH Project Steering Group 5th October 2006

Yorkhill Foundation – The issue of how charitable funding will be used in the NCH planning process remains unclear. It was felt that if it was predominantly directed towards re-equipment, a balance would have to be struck between the ongoing responsibility of NHSGGC to equipment purchase and the role of the YCF, possibly through purchase of a higher than average specification of equipment.

Community Engagement – JB agreed to circulate the electronic report and drew attention to the key messages from the survey e.g. sound proofing, kitchen facilities, bereavement centre and location of paediatric mortuary facilities.

Neonatology – A brief discussion took place on the latest draft specification for the neonatal unit in the refurbished SGH maternity hospital. The proposed number of cots (64) was felt to reflect an acceptance of a significant future re-configuration of neonatal intensive care provision in the West of Scotland.

4. Minute of Clinical Advisory Group 24th October 06

Mortuary/Viewing Facilities – Discussion took place on the possibility of a separate dedicated paediatric mortuary and its location. MM raised the question of whether bereaved parents would be included in any decision making but it was felt that the Community Engagement Team will reflect the parental opinion.

Minor Injuries Units – Jack Beattie was unavailable for update. It was clarified that the NCH A&E will be separate from adult A&E on the SGH site and will have a

separate and discrete entrance although the two departments are will be adjacent with the possibility of front and back door entrances to the departments. The site of the heliport is also being discussed.

Critical Care Transport Teams – The benefits of integrated accommodation for the Neonatal and Paediatric critical care transport teams are felt to be significant and are under discussion.

5. Minute of NCH Inpatient Subgroup 6th October 06

No issues were raised.

6. Matters arising

6.1 Procurement Workshop

The planned meeting between NHSGGC officers and the SE has not taken place however Morgan Jamieson feels it is very likely that the NCH project will become part of a whole site SGH PFPI and the ministerial commitment of £100 million will continue to be allocated to the NCH build. The potential benefits of integration with the adult build are mainly in cost savings related to potential shared facilities e.g. power plant, facilities management and catering. There may however be several disadvantages not least being the risk of an extension of the duration of separation between maternity/neonatal and paediatric services consequent on the closure of the QMH as well as the consequences of differential commissioning dates between the NCH and the SGH adult build.

6.2 CHKS Bed Modelling

JB outlined the issues raised at a meeting on 27 October involving the Regional Director of CHKS and the Director of Planning for the Acute Division at which the CHKS bed modelling for the NCH was discussed. The GROS demographic prediction of a 15% reduction in the childhood population by 2015 has been translated into an additional bed reduction factor of around 10% despite the recent increase in the number of asylum seekers and the fact that the population has risen by 45000 in the last two years. JB pointed out however that on review of RHSC activity for 2001–2006, there was an 11% increase in inpatient discharges despite a reduction in the 0 – 16-year-old population of around 6%. In addition it is very likely in the future that the survival of increasing numbers of children surviving with complex health needs will increase the average intensity level of inpatient care. In addition CHKS made no reference to the very high level of socioeconomic deprivation that exists in Glasgow and the West of Scotland, a factor that directly impacts on heath care usage or the large geographical area which RHSC, Yorkhill covers.

JB stressed that the two main drivers of the bed modelling process are the need to improve on existing inpatient bed occupancy and daycase/daycare/ambulatory rates. It is likely that the final bed model will assume around 75 – 80% occupancy

in the elective sector and 65 – 70% occupancy in the non-elective sector with an overall occupancy of around 75%. The group briefly discussed potential clinical services in which significant improvement had been made and where further improvements could be made. The specific issue of the potential impact of patient "hotel" accommodation on bed requirement was discussed and it was agreed that AD and RH would produce a short questionnaire to be used in a point prevalence study involving all inpatient services with the support of the lead nurses in order to scope the number of potential bed days that could be freed up if such a facility was available.

6.3 Draft Schedule of In-patient Accommodation.

WM and colleagues met with Peter Dunleavy to clarify some issues. KM agreed to circulate the minute.

DM and RH highlighted the concerns expressed by specialist teams regarding the future configuration of inpatient facilities and expressed the need for dedicated rather than generic facilities for specialist services.
The group identified certain areas which do not appear to have been addressed by the accommodation schedule e.g. parental facilities, education facilities, equipment storage/bed store, office for clinicians close to the inpatient areas, training facilities for both staff and parents and changing accommodation for staff. JB undertook to pass this onto Peter Dunleavy.

7. Action Points

- The group was asked to develop ideas on how to scope out the size of the future secondary and tertiary sectors in the NCH. WM happy to look at discharge information by consultant/specialty.

- Identify the potential number of bed days that could be freed up if a patient "hotel" facility was available. Issues to consider – relevant questions, duration of study and who should be targeted. WM and JB agreed to speak with Jane Peutrell, Jim Pollok, Alan Houston, Alasdair Fyfe and Rod Duncan to gain their agreement to undertaking the study in the surgical/Cardiology wards.

8. AOCB

It was felt that the next stage in the NCH process will involve very detailed discussion with a wide range of clinical colleagues at individual departmental level. JB asked group members to consider how this phase of the planning process should be undertaken.

9. Date and time of next meeting

Friday 8th December 2006 at 1030am in Seminar Room, Ward 6A