

Greater Glasgow NHS Board

Board Meeting

Tuesday 16th December 2003

Board Paper No. 2003/73(a)

Medical Director

Emerging Pressures in Acute Services

Recommendation:

- the Board considers the issues raised in this paper and agrees to receive a further report in February.

A. BACKGROUND AND PURPOSE

1.1 General acute services in Greater Glasgow are currently provided as follows:

- six sites with general acute services at Gartnavel, the Western Infirmary, Stobhill, Glasgow Royal Infirmary, Southern General and Victoria;
- four Accident and Emergency and one Casualty departments.

1.2 In March 2000 we set out proposals for significant service change. The key drivers for these proposals were:

- **Outdated buildings**, unsuitable and unfit for modern healthcare - 21st century healthcare in 19th century buildings.
- **Inpatient sites** which are unable to provide the one stop / rapid diagnosis and treatment models for the large volumes of patients treated in Glasgow hospitals.
- **Fragmentation of care** as patients are required to move around sites and different buildings, an inevitable loss of continuity and difficulties in transferring information e.g. laboratory results and x-rays between sites.
- **Unsuitable diagnostic and imaging facilities** which restrict capacity, create bottlenecks and inevitable delays in treatment.
- **Increasing sub-specialisation in medicine** – a move towards larger teams to ensure all patients can get access to the appropriate specialist .
- **Glasgow's role in teaching and research** and the links with the Universities, is critical for the service to attract and retain high calibre staff - critical in services where there are national shortages e.g. cancer, cardiac surgery, diagnostic imaging and pathology amongst others.
- **Too many inpatient sites requiring emergency on call rotas** on each site - with pressures growing on both consultants and junior staff.

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- **Changes in doctors' training** – means consultants are being called in from home more often, or opting to do *resident on-call* to provide support to junior staff.
- **Restrictions on the hours doctors can work:** New Deal for Junior Doctors limits number of hours; European Working Time Directive restricts availability of consultants due to compensatory rest requirements.
- **The policy imperatives** outlined in the policy papers The Scottish Health Plan and The Cancer Plan which include waiting list guarantees, reductions in waiting times, improved access to rapid diagnosis and treatment, the provision of services designed around the needs of patients and improved integration with primary and social care.

1.3 In August 2002, after a prolonged process of planning, clinical and public debate the Minister approved proposals to reshape acute services, with a major programme of capital investment in the period to 2012. The pattern of acute services at that point would be:

- two major in-patient units with Accident and Emergency and Trauma services, at Glasgow Royal Infirmary and the Southern General;
- an in-patient hospital at Gartnavel providing local medical and surgical emergency services for General Practitioners colocated with the new West of Scotland Cancer Centre;
- ambulatory care hospitals at Stobhill and the Victoria, including minor injury services.

1.4 The purpose of this paper is to raise a number of significant issues which create major challenges to sustain the current pattern of services for the timescales envisaged in the Acute Services Review. **It is important to emphasise none of the issues suggest a pattern of provision outside the framework agreed by the Minister and described above. The challenge is about the sustainability of current services until the date envisaged.**

B. KEY PROBLEMS AND PRESSURES

2.1 This section briefly describes the most significant problems and pressures which are currently facing us.

2.2 New Deal for Junior Doctors

This agreement requires junior doctors to work no more than 56 hours in a full shift pattern or 64 hours on a partial shift pattern. We have not been able to achieve these targets on all rotas and a number of rotas which do comply do so on a fragile basis ie small additional demands will make them non compliant. Our most acute frontline rotas such as Accident and Emergency, Anaesthesia and Surgery slip into non-compliance if the intensity of work increases and doctors are unable to get the required amount of rest. The new deal also has a significant impact on consultants. Junior staff are available for less hours and have less experience. That means consultants are much busier when on call and, therefore, the frequency of on call is becoming a major issue.

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2.3 Consultant Contract

The consultant contract, to be introduced from April 2004, will have a number of effects. It will require us to recognise and pay for hours and activities above core sessions and, therefore, makes intensity and frequency of on call activity of greater significance.

2.4 SIMAP

In August 2004, all time spent in work will be counted as working hours - requiring a maximum of 56 hours for all junior doctors. Currently many junior doctors are on partial shifts where they can work legally up to 64 hours if they are able to get guaranteed sleep during their time in hospital. This type of rota will have to disappear and will therefore reduce dramatically the number of hours juniors are available for work.

2.5 Modernising Medical Careers

This UK wide policy radically changes the training of Senior House Officers (SHOs) from August 2006. It puts a much heavier emphasis on training rather than service input. Its effect will be to put major pressure on hours of work for SHO rotas in all specialties and reduce the number of SHOs available to be on-call, especially in Accident and Emergency and Anaesthesia.

2.6 European Working Times Directive

The European Working Times Directive requires us to achieve a maximum of 58 hours for all junior doctors by 2004, reducing to 48 hours by 2009. The New Deal allows junior doctors to work up to 56 hours. Consultant medical staff currently work an average of 57 hours and should already be working 48 hours at present.

2.7 Capacity

The new waiting times target of 6 months require us to step up efficiency, higher levels of productivity could be achieved by working on fewer sites.

2.8 Conclusion

These points put particular pressure on the following services:

Stobhill : Casualty, Anaesthesia and General Surgery.

South Glasgow : Surgery and Trauma, Accident and Emergency, Anaesthesia and Intensive Care.

C. POSITION IN OTHER HEALTH SYSTEMS

3.1 The factors outlined above are not unique to Greater Glasgow. This section briefly outlines the position in other health systems.

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3.2 Lothian

An Acute Services Review Group was established last summer to produce proposals to rationalise services onto fewer sites. It is likely that a full range of services, out of hours, may only be provided from one site for the whole of Lothian.

3.3 Argyll and Clyde

Argyll and Clyde are undertaking a full clinical strategy review due to be submitted to the Minister by October 2004. Meantime, they have introduced a number of contingency arrangements, for example, in General Surgery and Accident and Emergency services to reduce in-patient site and out of hours coverage.

3.4 Lanarkshire

Lanarkshire are currently consulting on proposals to move to single on call rotas across their area and to consolidate emergency surgery onto a single site.

D. CONCLUSION

- 4.1 We need to establish an open and transparent process to properly explore and debate the impact of the problems and pressures outlined in the above section. It will be of particular importance to engage a wide range of clinical and other staff interests in that debate and also to ensure appropriate political and public briefing.
- 4.2 It is not an option simply to wish away these issues but we do need to carefully consider the options to provide safe and sustainable services. We will also need to review whether our present organisational and clinical leadership arrangements are best organised to enable us to tackle these major challenges.
- 4.3 The outcome of the initial phase, on the areas of greatest pressure, will be reported to the Board's February meeting.