

**Report on Acute Medicine Meeting
Law House
Wednesday 28 September 2005**

Present:

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|-------------------------------------|-----------------|
| T. Davison | Dr N. Kennedy |
| Dr D. Thetford | Dr G. McKay |
| Dr M. Malekian | Dr S. Tan |
| Dr L. McAlpine | Dr A. Hendry |
| Dr J. Cash | Dr H. Mackie |
| Dr I. Shiliday | Mr H. BenYounes |
| Dr R. MacKenzie | Dr B. Vallance |
| Dr T. Gilbert | Dr B. Martin |
| Dr McLaren | G. Marsh |
| D. Campbell | I. Ross |
| S. Bowhay (Area Clinical Forum) | R. Lyness |
| H. Sweeney (Area Partnership Forum) | Dr J. Browning |
| M. Hill | P. Milliken |
| C. Dunn | |

1. Introduction to the meeting

Tim Davison welcomed the group to the meeting and thanked them for contributing their time. He outlined the purpose of the meeting was to inform the Picture of Health document in relation to acute hospital configuration. It is intended to go out to consultation on A Picture of Health in January 2006.

The Picture of Health document will include information on health improvement, health status, community care, retaining services locally and secondary services. The Kerr Report will also inform the document and he noted that the Scottish Parliament debate on the Kerr Report has been delayed and therefore the Scottish Executive action plan is postponed.

For the Picture of Health document we still need clarity on sustainable major acute inpatient services, as we are not yet in a position to articulate the way forward. **The aim of the meeting is to articulate a sustainable preferred configuration for acute medicine.**

He noted that a similar event had been held with General Surgeons and Anaesthetists on 23 September. This noted that the background to reviewing acute service configuration had been an Option Appraisal paper by General Surgeons in 2004, which identified that, the status quo was not sustainable and identified one acute receiving site for general surgery emergencies as the preferred option. Since this time it has become apparent that Anaesthetics has greater sustainability issues than surgery and the view has shifted to identify that ITU / HDU is the critical factor and will drive acute medical and surgical configuration.

A group was set up with Anaesthetists, Surgeons, Physicians and an Accident and Emergency Consultant to look at the least disruptive way to support ITU and acute medical receiving on three sites. This group produced a report "Future Options for Critical Care in Lanarkshire" and identified that an anaesthetic provided ITU / HDU was not sustainable on three sites beyond 2009. This was due to a number of factors:

- Reduction of junior doctors hours to 48hours
- Need to provide an ITU critical mass for training, accreditation and recruitment
- Development of specialists in Intensive Care.

Although this group looked at the development of Medical and Surgical HDU and Critical Care Practitioners it identified that these could not provide a safe environment without ITU for acute medical receiving, emergency surgical receiving or major elective surgery. Medical receiving is the biggest single user of ITUs.

The conclusion reached at the meeting on 23 September was that from 2009 it would be possible sustain two emergency hot sites and one elective minor / intermediate site.

Tim Davison said that in a meeting with Kevin Woods it was suggested that these sites should be described in terms of the levels of unscheduled care set out in the Kerr Report. This sets out 4 levels:

| | |
|-------------|---|
| Level One | Primary Care |
| Level Two | Locally provided assessment and treatment, minor injuries, access to diagnostics |
| Level Three | a) Core admitting services, acute assessment and treatment b) Sub specialised services |
| Level Four | Tertiary, teaching, highly specialised services. |

Currently, Lanarkshire has three hybrid Level 3 (Level 3a – 3b) Hospitals and needs to move to a maximum of two Level 3 hospitals and one Level 2 hospital. Lanarkshire is out of step with Scotland in as much as it is the only Health Board that continues to support three Level 3 hospitals. The main drivers for change identified elsewhere have been quality of care, critical mass, productivity, patient safety and work force. Based on anecdotal evidence it would appear that if Lanarkshire does not consolidate its services we will have difficulty recruiting.

If we reduce to a smaller number of Level 3 sites there will be a requirement for significant capital investment / new estates and this will take time to develop. Hence, Tim Davison indicated there is only a window of 4 months to review the issue.

Picture of Health consultation document will indicate the direction of travel and outline the options for the acute hospital sites. This is required for the December Board meeting.

Tim Davison outlined the questions for the meeting to consider as:

- Is acute receiving sustainable or not on a site without an ITU?
- What are the issues with two Level 3 hospitals and one Level 2?
- What services could be provided on the Level 2 site?

2. Drivers for Change for Acute Medicine and the Medical Subspecialties

Dr Nick Kenney provided a presentation on drivers for change. A copy of this presentation is available.

He defined Acute Medicine as *“The part of General (Internal) Medicine which is concerned with the immediate and early specialist management of adult patients with a wide range of medical conditions who present to hospitals as emergencies”*.

He identified the current issues affecting acute medicine as:

- Emergency admissions increasing
- Increased referral from Primary Care and A&E
- Bed occupancy
- Consultant recruitment and retention
- Junior Doctors hours / MMC
- Redesign bed numbers / LOS increasing
- Co-location critical care
- Acute medical sub specialisation.

He provided information on activity and identified that there appears to be no sign of the growth in demand for acute medicine tailing off.

He outlined the work undertaken already to address the junior doctor workload driver:

- Already moved to full shift rotas for junior doctors
- Moving towards the target of maximum 48 hour week for 2009
- Other places have reduced tiers of junior doctors but these were not in place in Lanarkshire
- Introduction of HECT.

It was noted that at Monklands junior doctors work 50 hours a week currently and at Hairmyres 54 hours.

In relation to MMC he noted that this will have a significant impact on SHOs' contribution especially during the day, which will impact on consultant time.

Is Acute Medicine in Lanarkshire sustainable in its current configuration?

Dr Nick Kennedy highlighted that the Physicians in Lanarkshire have not reviewed this as a group and the question "Are current services sustainable up to 2009 and beyond?" is difficult to answer as the hospitals are already closing due to bed demands and bed occupancy levels are high. It is known that this has an impact on quality and clinical risk. Rota monitoring exercises have also shown that it is a struggle to maintain compliant rotas.

The type of issues that would impact on sustainability would be:

- Integrated care teams – enabling juniors to work more effectively
- Work in primary care – reducing referrals / admissions
- Avoiding admissions, supporting discharge and links to older peoples care project
- If bed capacity was expanded then time would not be wasted chasing beds
- Implication of GGHB changes
- Ability to deliver on outpatient targets as well as 4-hour A&E target
- A&E / Acute Medicine/ Medical Sub-speciality interface
- Consultant recruitment and retention.

It was noted there are less SPRs in Lanarkshire than elsewhere. Overall in relation to junior doctor WTD it is felt that the 2007 target will be achieved but there will be issues in achieving 2009.

Would a move to concentrate Acute Medicine and the (acute) medical sub-specialities on a smaller number of sites (1 or 2) in Lanarkshire be beneficial in the long-term overall?

Dr Nick Kennedy noted the changes are driven by General Surgery and Anaesthetics but are there gains for Acute Medicine from the reduction to two Level 3 sites.

Issues to consider include:

- Rota rationalisation (junior and senior), including sub-specialities, geriatrics, etc.
- Departmental sizes and implications
- Post-graduate Education – including Foundation programme
- Research and Development
- Consultant recruitment and retention
- Establishing Emergency Medical Complexes (EMCs)
- Bed numbers: AMRU, medical specialities, geriatrics (including rehabilitation)
- Potential economies of scale – without negative clinical impacts
- Accessibility for patients
- Acceptability to public and politicians; strategic fit with Kerr report

It was noted that the key questions set out in Dr Nick Kennedy's presentation would be reviewed as a Group.

Tim Davison highlighted he was very aware of the impact of any changes Lanarkshire might make on Glasgow. The regional implications of acute service configuration is being

considered by the Unscheduled Care Board which he Chairs and he is meeting with Tom Divers in relation to Glasgow. He has also activity engaged NES about the inequality of distribution of SPRs between the East, West and North and within the West. He noted that another "given" would be the achievement of the 4-hour waiting list target by 2007. He also noted that the new pan Lanarkshire organisational structure should be considered.

3. Presentations on General Surgery and Critical Care Models and Rotas

Mr Hakim BenYounes outlined the work undertaken by General Surgeons. In 2003 a paper was produced by Dr Terry Nunn on Hospital Configuration and in response to this an option appraisal was completed by General Surgeons. The drivers identified at the time are still the same. This noted there was 24-hour theatre availability on 3 sites but these are hardly used at night. The option appraisal considered General Surgical receiving on 1,2, or 3 sites. The impact on medicine was considered (e.g. non availability of General Surgical support for GI bleeds). In 2004 this group determined that the status quo was not sustainable and a one site receiving option was felt to be the best. This position has recently been reviewed in light of information on the sustainability of critical care.

Dr Rory MacKenzie provided a presentation on the work completed on critical care sustainability and rotas. This work identified that ITU on 3 sites was sustainable but not for long. In doing this work they were aware of the impact on service users (Surgery and Medicine). The Critical Care Working Group was established to review options for a Level 2 site and considered if any model would sustain critical care without Anaesthetics on site. The Group established two sub groups. One considered HDU provision and one considered ITU. This group concluded it was not possible to provide ITU without Anaesthetic input and for HDU to be effective it required the support of ITU.

Work was also undertaken to consider staffing models. This identified that Anaesthetic trainees are spending too much time in ITU. The College is likely to identify that this does not meet training requirements. The smaller ITUs will also develop major issues in relation to recruitment and retention.

Three main options for configuration were considered for their impact on Anaesthetic services:

Option A – Status Quo

This leads to small ITUs on each site and gives problems with EWTD and obstetrics.

Option B – Single site General Surgery Receiving and 3 ITUs (Medical Receiving and A&E on three sites)

The size of the ITUs were modelled based on usage over a year. This identified that one site would have 9.5 bed ITU (over 8 beds need to have an enhanced team). A second site would have an ITU for postoperative major electives and medical receiving and the third site for medical receiving only. This third ITU would be 2.5 beds only. This size of ITU would not be sustainable or recognised for training. If a transfer team were utilised instead this would require staffing.

Option C – Two sites ITU and two sites General Surgical and General Medical receiving

This would lead to 2 ITUs around 8-9 beds. The quality of care provided would be optimised and the Anaesthetic input to the elective programme would be maximised.

He noted that it was hoped to take forward Critical Care Practitioners to reduce demand on junior doctors. MMC is not envisaged as having an impact on Anaesthetics at this time. This rota model did not consider the development of HDUs.

Tim Davison stated he would like to achieve a principle for all consultants to avoid multi-site working.

Mr Hakim BenYounes noted following the work of the Anaesthetists, a group of General Surgeons reviewed their options and now accept a 2 site ITU model. This discussion needs

to be widened out to all General Surgeons and there is still a debate about single site or two site General Surgery emergency receiving. The benefits of one site receiving would be that it would enable a more effective elective programme as well as the development of strong units for sub specialisation. This debate will be informed by looking at how many cases now come in as emergencies that could be treated on a planned basis in a specialist unit. He noted the intension would be to have a surgical presence on both the Level 3 sites.

Discussion

Dr John Browning asked for views on whether medical receiving could be provided without an ITU. Dr Medrad Malekian noted that beyond 2009 it would appear there is no way there could be more than 2 ITUs and given this it would not be useful to consider sustaining the current model of medical receiving. Dr Barry Vallance highlighted that it had been shown that this was not possible at Stonehouse Hospital. Dr Anne Hendry noted a concern that if we are stopping medical receiving on a site due to the lack of an ITU we are in effect disadvantaging 10,000 admissions to a local site due to the 108 people who will require ITU admission. She queried if the transfer issue had been fully exhausted. Rosemary Lyness noted the debate in the Critical Care Working Group had been that it was not just the 108 patients but the many other patients for whom Anaesthetic support and advise is requested. The unanimous view of the Physicians on the Critical Care Working Group was that this was to big a risk to take. Dr John Browning and Tim Davison noted Dr Anne Hendry's question would be one asked by the public and we would require strong evidence and arguments for the changes planned. Tim Davison noted that FAIs would also be a strong driver for change and that the case for obstetrics to be co-located with ITU was already generally accepted and the number of cases for this was lower.

4. Sustainability of Acute Medical Assessment Units

The Group discussed the "given" set by Dr Nick Kennedy:

A busy modern hospital which is going to be accepting Acute Medical Emergencies requires on-site Intensive Care.

The Acute Physicians, Accident and Emergency and Care of the Elderly Consultants were very supportive of this view making the points:

- Intensivist support is required across Medical receiving starting at A&E to assist with the management of patients. This is a big hidden workload for Anaesthetists.
- Acute Surgical presence is required too
- More than airways skills are required for the cover in the emergency care team for intubations
- Benefit of the interface at the trainee level between specialities
- Having Intesivist support to A&E enables the A&E staffing to concentrate on other aspects of care.
- Experience in Glasgow at Gartnaval has shown that not having access to Anaesthetists caused difficulties for some patients (e.g. respiratory) and the Western was only 7 minutes away.
- Must not discriminate against Care of the Elderly patients.

Dr Anne Hendry highlighted the need to have Anaesthetic support for post acute care patients who have difficulties. It was noted that there would be the capacity to transfer these patients.

Is Acute Medicine in Lanarkshire sustainable in its current configuration?

The Group noted the status quo was sustainable but had the following difficulties:

- MMC has a big impact on Consultant's time in terms of training. Consultants will need to renegotiate their job plans
- Service posts not previously are envisaged in MMC
- Post graduate education review – expectations of consultants for service delivery will decrease sustainability
- It is possible to focus junior doctor time on emergency services but this will impact on the number of clinics and waiting time targets.

The advantages of a two Level 3 sites configuration were given as:

- Concentration of services would be helpful to develop and improve the quality aspects of the specialty.
- Would provide the potential for larger receiving teams, which would enable services to be provided differently.
- Two sites will attract consultants with specific interests.
- Reducing number of sites would improve recruitment opportunities
- Would assist with the pressure of meeting increasingly tight waiting list targets e.g. for Cardiology.
- Options would be available to develop sub specialisation this could assist medical receiving as patients could be picked up by sub specialities earlier.
- Could move to block or team working instead on individual rotas.

Dr John Browning noted changes could be made in advance of 2009 if this would bring some of the benefits above. He noted that Anaesthetics and General Surgery have identified support required to maintain their sustainability up to 2009 and it would be interesting to know if there are similar issues for Acute Medicine.

Dr Nick Kennedy felt it was unlikely that three Emergency Medical Complexes could be established for Lanarkshire and that two would be possible.

For Care of the Elderly, it was noted that the junior doctor rotas are closely integrated and as this speciality has a high number of beds the service will be eroded with the reduction in SHO support.

Summary

In summary it was agreed Acute Medical receiving in Lanarkshire could not function successfully if there was no on-site ITU. Hence, if there were two Level 3 sites and one Level 2 site the Level 2 site could not take medical receiving.

The current service is sustainable but sub optimal.

Tim Davison noted that any reconfiguration should facilitate 70–80% of all patients' contacts remaining at their local hospital. In order to do this we need to describe a Level two hospital for Lanarkshire and this should include a major busy ambulatory hospital with full diagnostics and an up swept medical triage.

A discussion took place with the Accident and Emergency Consultants over what minor illness / minor injury services could be on the Level 2 site. It was noted that the co-location of the GP OOH service with A&E had advantages but there needs to be clarity about who assesses patients. Dr Julie Cash noted that GPs would not see patients who turn up without an appointment. Tim Davison noted there would need to be a minor illness and injury service on the Level 2 site and one is currently being considered for a new hospital in Clydesdale. Dr Julie Cash was concerned this offered a sub optimal service although Dr Ian McLean felt this would be possible.

5. Services on the Level 2 Site

The Group considered the list set out at the meeting with Anaesthetists and General Surgeons of what could be provided on the Level 2 site. In general there was a reticence about services being on this site and a view was expressed that it might be better to make the two Level 3 sites big enough for all inpatient services.

The Medical services were agreed as:

- Some rehabilitation – but the questions below were noted.
- Minor illness, minor injury and GP OOH services
- Consider what patients never require ITU. View that a stand alone HDU would be a backwards step.

- Could a 24/7 medical rota be continued for this site?

For rehabilitation it was queried:

- Rehabilitation can also be provided for the younger patients as well as Care of the Elderly.
- Is it day or overnight rehabilitation?
- Is it a false economy to provide this in an intermediate setting if the patients could move to nursing homes?
- Should consider referral patterns, the increasing population and current bed capacity (Glasgow has twice as many beds for the over 75's)
- What are the requirements of the stroke wards?

The Group considered the services identified by the General Surgeons and Anaesthetists at their meeting for the Level 2 site and felt there was a need to define the concentration of sub specialties at the third site and the future role of the HECT team. It was noted that the Level 2 site would need to have good diagnostics and support structures to enable 23-hour day surgery and outpatients.

6. Clinical Advantages and Disadvantages of Options

The Group considered the clinical advantages and disadvantages of the options. The options considered were the Status Quo, the preferred option of two Level 3 sites and a Level 2 site and an option of two Level 3 sites and a Level 2 with medical receiving on all three sites. These are listed in Appendix 1.

7. Site Options

The Group considered the advantages and disadvantages of each of the current NHS Lanarkshire acute hospitals being either a Level 3 or a Level 2 site. Those identified at the meeting with General Surgeons and Anaesthetists were reviewed, agreed and added to. These are listed in Appendix 2.

Concern was expressed that Monklands Hospital might be disadvantaged because of the condition of its buildings.

8. Next Steps

The next steps were noted as:

- Engagement event on 27 October with wider stakeholders.
- Attendees were requested to disseminate the discussion at this meeting to colleagues to gain a wider view from specialities.
- Meetings will be taking place with Medical Staff Associations on each acute site.
- The direction of travel will be outlined in the Picture of Health consultation document.

Appendix 1: Clinical Advantages and Disadvantages of Options

| Option 1 Status Quo | Option 2 2 Level 3 Sites with medical receiving and a Level 2 Site with no medical receiving | Option 3 2 Level 3 Sites with medical receiving and a Level 2 Site with medical receiving |
|---|--|---|
| Advantages <ul style="list-style-type: none"> • Minimal disruption | Advantages <ul style="list-style-type: none"> • Sustainable • Quality of care • Less movement of patients (continuity of care – less infections) • Recruitment and retention | Advantages <ul style="list-style-type: none"> • Local access verse socially deprived areas • Assist with capacity • Minimum cross boundary flow • Current systems favour lower LOS |
| Disadvantages <ul style="list-style-type: none"> • Difficult to sustain into the future • Increasingly difficult to sustain quality of care. | Disadvantages <ul style="list-style-type: none"> • Local access • Movement / disruption for staff • Capacity issues / significant investment in beds due to distribution • Impact on Regional flows • Retention of staff initially | Disadvantages <ul style="list-style-type: none"> • Not viable due to clinical risk • Experience of Gartnaval • Stand alone HDU – difficulties for workforce, training and step up and down • Any transfer system would involve another Anaesthetists team. |

Appendix 2: Site Options

| Hairmyres Level 2 | Hairmyres Level 3 | Monklands Level 2 | Monklands Level 3 | Wishaw Level 2 | Wishaw Level 3 |
|--|--|--|--|--|--|
| Advantages | Advantages | Advantages | Advantages | Advantages | Advantages |
| <ul style="list-style-type: none"> • Smallest activity • Adaptability • Ophthalmology • Existing health status of population better | <ul style="list-style-type: none"> • Regional perspective • ITU • Cath lab (demand increasing) • Purpose built and room to expand • Space for maternity • Recruitment of medical staff | <ul style="list-style-type: none"> • Purpose built facilities (cheaper) • Cheaper to expand / reconfigure | <ul style="list-style-type: none"> • Airdrie Health Centre moves Feb 2009 • Renal • Communicable diseases, ENT inpatients • Deprived community • Regional perspective | <ul style="list-style-type: none"> • Theatre capacity • Purpose built psychiatry • Relocate Wishaw • Health Centre • Less impact on Glasgow | <ul style="list-style-type: none"> • Maternity • Paediatrics • Theatres • ITU • PFI (potential) • Capacity |
| Disadvantages | Disadvantages | Disadvantages | Disadvantages | Disadvantages | Disadvantages |
| <ul style="list-style-type: none"> • Move the Cath lab • Increase follow to Glasgow • Ageing population / increase service demand • Smallest number of theatres • PFI • Well informed and motivated community (high level of complex complaints) • Lowest car usage • Poor public transport to other areas | <ul style="list-style-type: none"> • Too small • Recruitment of nursing staff • Attract activity from Glasgow | <ul style="list-style-type: none"> • Facilities expensive to upgrade • Theatre capacity • Renal • Communicable diseases • A&E • Emergencies will go to Glasgow • Busiest acute site • Highest mortality / morbidity • Transport | <ul style="list-style-type: none"> • Size, infrastructure • ? Space for paediatrics • Cath lab • Regional perspective • High cost of replacement | <ul style="list-style-type: none"> • Move maternity / paediatrics • ? Too big | <ul style="list-style-type: none"> • Psychiatry • Increase cross boundary flow |

