



**NHS LANARKSHIRE BOARD  
24 MAY 2006**

**A PICTURE OF HEALTH**

**SUSTAINABILITY OF THE CURRENT  
CONFIGURATION OF ACUTE SERVICES**

# CONTENT

	Page
<b>Executive Summary</b>	<b>3</b>
<b>1. Introduction</b>	<b>4</b>
<b>2. Evidence Base for Proposals for Change</b>	<b>4</b>
<b>2.1 Quality of Care</b>	<b>5</b>
▪ <i>Volume of Work and Tolerance of Risk</i>	<b>5</b>
▪ <i>Separating Planned from Emergency Care</i>	<b>9</b>
▪ <i>Sustainability of Intensive Care Services and Impact on Accident and Emergency</i>	<b>12</b>
<b>2.2 Supporting Recruitment</b>	<b>18</b>
<b>2.3 Responding to Change in Medical Training</b>	<b>20</b>
<b>3. Development of the Proposals for Acute Services</b>	<b>22</b>
<b>4. Conclusion</b>	<b>27</b>
<b>Appendices</b>	
<b>Abstracts – The relationship between volume and health outcome</b>	<b>Appendix 1</b>
<b>Case study – Concentration of paediatric inpatient services</b>	<b>Appendix 2</b>
<b>Consultant recruitment within NHS Lanarkshire</b>	<b>Appendix 3</b>
<b>Modernising medical careers</b>	<b>Appendix 4</b>
<b>Hospital services in Lanarkshire from August 2004</b>	<b>Appendix 5</b>
<b>Interviews on emergency and trauma surgery April – May 2005</b>	<b>Appendix 6</b>
<b>Future options for critical care in Lanarkshire</b>	<b>Appendix 7</b>
<b>Presentation on Picture of Health staffing models for anaesthetics and critical care</b>	<b>Appendix 8</b>
<b>Report on general surgery and critical care configuration meeting</b>	<b>Appendix 9</b>
<b>Report on acute medicine meeting</b>	<b>Appendix 10</b>

## **Executive Summary**

The status quo for acute services is not sustainable but the quality of care can be significantly improved by moving to a new model of two emergency acute hospitals, one planned care acute hospital and an enhancement of minor injury and illness services in the community.

In relation to quality of care there is considerable evidence to show that emergency services in Lanarkshire are fragile and effected by long standing medical vacancies. With the full introduction of the WTD and the implementation of MMC significant additional pressures will be placed on services. Without change it is likely that in areas such as intensive care training approval will be lost for services leaving consultants to be pulled into work previously covered by junior staff. This will mean medical staff will have less time for planned work, such as operations and outpatients and waiting times will rise.

As an alternative to this, if the proposals in A Picture of Health are implemented the quality of care will improve due to the ability to move to larger teams of staff more able to sub-specialise. This sub-specialisation will provide the right care at the right time for patients with for example a cardiology rota enabling patients who have had heart attacks to be seen by a cardiologist immediately on admission. There is strong evidence that the outcome of patient treatment is improved when both the consultant and the unit are geared to undertake a higher number of procedures.

The provision of minor injury and illness services in the community will mean services closer to patients' homes and more activity diverted from the emergency hospitals, where those with major illnesses and injuries can be concentrated on. The quality and efficiency of planned care will be improved by having a hospital and the resources on that site focussing on planned inpatient operations. This will reduce both the waiting times and the uncertainty for patients who might be cancelled at the last minute where their operation is taking place at an emergency hospital.

There is evidence that medical staff want to work in larger units because they have the opportunity to:

- Sub-specialise
- Improve patients outcomes
- Improve patient safety
- Spend more time in patient care and less on call

Where services have been moved to larger units this has been proven to aid recruitment in Lanarkshire.

## **1. INTRODUCTION**

*A Picture of Health, A Consultation Document on NHS Lanarkshire's response to "Delivering for Health", December 2005* proposes the move away from the current provision of three general acute hospitals providing both emergency and planned care to the provision of two emergency hospitals and one planned care hospital.

This proposal for the reconfiguration of acute hospital services was developed in response to the view reached during the *A Picture of Health* engagement programme that current acute services were unsustainable.

During the formal consultation on *A Picture of Health* from 30 January to 28 April 2006 the case for the status quo option not being sustainable (the option of retaining three general hospitals providing both emergency and planned care) was questioned by the public, interest groups including Lanarkshire Health United and politicians. In response to this NHS Lanarkshire gave a commitment to set out further the case for change in acute services and the reasons why the status quo has been determined to be unsustainable.

In this paper an analysis of the reasons for change and relevant evidence will be documented. Following this a summary of the development of the proposals on configuration of acute services will be set out. Background papers with more detailed information will be referenced and made available on request.

## **2. EVIDENCE BASE FOR PROPOSALS FOR CHANGE**

The evidence base for the proposal to change acute services in *A Picture of Health* fall into three areas:

- Quality of care
- Supporting recruitment
- Responding to change in medical training

In order to set out this evidence a comparison is made between:

- Status quo as at 2006 – three general hospitals with full accident and emergency departments, medical and surgical receiving and intensive care
- Status quo after 2009 - three general hospitals with full accident and emergency departments, medical and surgical receiving and intensive care with the impact of the full implementation of Working Time Directive (WTD) and progressive implementation of Modernising Medical Careers (MMC)
- Move to one planned care hospital and two emergency receiving hospitals as proposed in *A Picture of Health*

The clinical case has already been made for the concentration in Lanarkshire of some specialities. These include:

- Urology
- Gynaecology
- Dermatology
- Ear, nose and throat
- Haematology
- Infectious diseases
- Interventional cardiology
- Maternity
- Ophthalmology

- Oral Maxillofacial surgery
- Paediatric medicine
- Renal dialysis
- Renal medicine
- Thoracic

## **2.1 Quality of Care**

### **Volume of Work and Tolerance of Risk**

As part of the *A Picture of Health* work has been undertaken to consider the sustainability of clinical services. For some acute specialities the outcomes of care are improved through the provision of larger specialist units. This is because the staff in these units can become more specialised by dealing with more patients with similar conditions and through greater critical mass, which creates greater capacity for training, research and development. This move to increased specialisation is a national trend and clinical staff are attracted to work in units, which enable them to specialise.

Building Health Services Fit for the Future, Scottish Executive, May 2005 pulled together the evidence on the relationship between volume (the number of procedures or patients with a certain condition treated by an individual or hospital) and outcome (e.g. side effects, complications of surgery, and survival rates for cancer operations). Detailed information was set out in the Report on Volume / Outcome Sub-Group, February 2005.

This showed significant volume/outcome associations in certain complex high risk surgical procedures and more modest but clinically relevant effects in a range of more common procedures.

### ***Status Quo in 2006***

There is currently some specialisation across Lanarkshire acute inpatient services but general medical and surgical receiving and planned care is provided across the three hospitals.

In key specialities providing emergency services the following number of consultant are in post and spread with their teams across three sites:

A&E	8
General Surgery	21
Anaesthetics	37.2
Orthopaedics	10
General Medicine	40

The number of FY2 junior staffing hours are currently:

A&E	19558
General Surgery	14580
Orthopaedics	13178
General Medicine	42054

### **Status Quo 2009 Onwards**

If the current configuration of services continues beyond 2009 the level of medical input to all services will be heavily reduced as set out below. Because this impact is happening nationally there will not be additional consultants available to cover this deficit in staffing.

This has led to concern about the level of clinical care possible as well as concerns about increased waiting times and delayed discharges due to lack of medical input.

The impact of MMC on these consultant numbers will mean that less time will be available for patient care. The loss of hours envisaged from MMC for consultants in key receiving specialties is:

A&E	916
General Surgery	2172
Orthopaedics	1452
General Medicine	3686

Converted in number of consultants the loss would be:

A&E	0.53
General Surgery	1.3
Orthopaedics	0.81
General Medicine	2.1

In addition, the unattractive service model will mean any consultant vacancies which arise due reasons such as retiral are unlikely to be filled. Consultants will also be called on to carry out service work which was previously provided by junior staff.

The loss of junior hours under MMC would be:

A&E	6552
General Surgery	4668
Orthopaedics	3266
General Medicine	9209

The percentage of junior hours lost:

A&E	33.5%
General Surgery	32.0%
Orthopaedics	24.8%
General Medicine	21.9%

### **A Picture of Health Proposals**

One planned care site and two emergency sites carrying out emergency and complex surgery is proposed. This proposal would enable the current consultants and their teams to split across two sites and to develop their sub speciality practice on a higher volume of patients.

Table 1 sets out the evidence on improved outcomes from bringing larger teams of specialists together.

**Table 1**

**Quality of Care Evidence Base**

**Volume of Work and Tolerance of Risk**

Building Health Services Fit for the Future pulled together the evidence on the relationship between volume (the number of procedures or patients with a certain condition treated by an individual or hospital) and outcome (e.g. side effects, complications of surgery and survival rates for cancer operations).

Across a range of procedures, there is variation in relationships between increasing volume and improved outcome (reduced mortality and/or improved recovery). For a condition that is not common, and relatively complex, the improvement tends to be greater and occurs over a relatively larger range; i.e. the more you do, the better you tend to get. For a more common, less complex condition, the improvement in outcome is relatively greater initially but tends to level off; i.e. there is a threshold of interventions that must be met but thereafter the benefits tend to diminish, relatively speaking.

The Report of Volume / Outcome Sub Group to the Advisory Group on the National Framework for Service Change NHS Scotland, February 2005 cited the following systematic reviews as demonstrating this. Halm et al (2002) reviewed studies published between January 1980 and December 2000 and Gandjour et al (2003) reviewed studies published between January 1990 and December 2000. Halm et al was a conventional systematic review covering 27 procedures and diagnoses. In the 135 studies that meet their criteria a statistically significant relationship between higher volume and better outcomes were found for 71% of studies of hospital volume and for 69% for clinician volume. The review of Gandjour et al covered 34 diagnoses and interventions and included another 26 reports not analysed by Halm et al. In a total of 76 studies, higher hospital volume was statistically significantly better in 51, non-significantly better in 21, non-significantly worse in 3 and significantly worse in only one. These authors took the additional approach of identifying the single most reliable study (based on criteria such as the quality of case-mix adjustment) for each of a number of procedures. In 20 such 'best' studies, high volume was significantly better in 10, non-significantly better in 6, non-significantly worse in 3 and significantly worse in one. Also a review by Shahian and Normand, 2003 was noted as showing evidence of poorer outcomes being observed in very low activity units.

Data from the Lothian Surgical Audit which was presented at the recent Consensus Conference of the Association of Surgeons of Great Britain and Ireland on "Modernising Medical Careers and General Surgery". (Robson et al, 2005) showed the restructuring of emergency surgical care, focused on sub-specialisation appropriate to upper and lower abdominal conditions, has led to improved quality of care and outcome.

Gandjour et al (2003) presented mortality rates for high volume relative to low volume hospitals. Absolute differences in mortality rates of the order of 10% are reported when high volume units are compared to low volume units in a number of complex high risk surgical procedures including paediatric cardiac surgery, surgery to repair ruptured abdominal aortic aneurysms, pancreatic cancer surgery and oesophageal cancer surgery. Relative differences in mortality rates of at least 10% are reported in a range of common lower risk procedures including percutaneous transluminal coronary angioplasty, carotid endarterectomy, knee replacement and surgery for hip fracture. Associations were also shown between 5 levels of relative volume and outcome, drawn from 2.5 million procedures for 14 interventions, in a study of Birkmeyer et al 2002.

## **Quality of Care Evidence Base Volume of Work and Tolerance of Risk**

The Report on Volume / Outcome Sub Group noted "there is now a core of studies of adequate methodological quality to establish striking volume/outcome associations in certain complex high risk surgical procedures and more modest but clinically relevant effects in a wide range of common procedures. The size of the effect is influenced by the index of outcome and the range of volume considered." Appendix 1 sets out in further detail some abstracts showing the relationship between volume and health outcomes.

An editorial review in a chapter of *The Effective Management of Colorectal Cancer 3<sup>rd</sup> Edition* (2003); Cunningham, Topham and Miles, chapter 4 by Faux and Thompson states that a relationship between hospital volume and outcome has been well established for:

- Breast - (Sainsbury et al, 1995. Influence of clinician workload and patterns of treatment on survival from breast cancer. *The Lancet* 345(8960):1265-1270)
- Pancreatic - (Leiberman et al. 1995 Relation of perioperative deaths to hospital volume among patients undergoing pancreatic resection for malignancy. *Annals of Surgery* 222:638-645)
- Thyroid - (Sosa et al 1998. The importance of the surgeon experience for clinical and economic outcomes from thyroidectomy. *Annals of Surgery* 228:320-330)

The chapter concludes that specialisation results in better outcomes for bowel cancer. They then go on to discuss the increasing complexity of preoperative investigations and postoperative care, plus increased patient expectations and concludes it will be increasingly difficult for a surgeon to maintain and practice his or her clinical skills in more than one cancer.

In relation to minimum activity to maintain clinical skills most professional bodies are clear about the number of patients a doctor has to see in their training. This includes:

- Colonoscopy – a minimum of 100 a year and the training unit needs to do 400 per year. With the advent of nurse endoscopists, doctors will only achieve this in specialist units larger than the current NHS Lanarkshire hospitals. These requirements are set out in the Global Rating Scale for Endoscopy (national programme) and the Joint Advisory Group for GI Endoscopy
- Cardiology – a minimum of 75 percutaneous coronary intervention procedures per year per operator to maintain competence, 125 procedures to be competent to teach junior doctors. (Joint Working Group on percutaneous coronary intervention of the British Cardiovascular Intervention Society and the British Cardiac Society, December 2005)
- Orthopaedics – minimum of 10 hip replacements and 10 knee replacements per year recommended by the Scottish Arthroplasty Register
- General surgery, anaesthetics and critical care – in these specialties there are requirements for numbers done by trainees in all areas of practice. In anaesthetics there is broad recognition that consultants should not undertake occasional practice and in paediatrics this is defined as one session a week (Guidelines on the provision of Anaesthetic Services, Royal College of Anaesthetists, January 2005). This principle is well recognised although not as well defined in other areas of anaesthetic and intensive care.

In relation to local experience there has been evidence of the effective outcomes gained by concentrating inpatient paediatric services at Wishaw General. Appendix 2 sets out a case study on the concentration of paediatric services and the benefits delivered. The change was precipitated by introduction of New Deal for junior doctors in 2001. This led to an insufficient number of training posts being approved and an inability to recruit sufficient SHOs. As a consequence the demand placed on consultant staff increased to the level that there were concerns about patient safety. Attempts to recruit medical staff were unsuccessful. The

**Quality of Care Evidence Base**  
**Volume of Work and Tolerance of Risk**

service was concentrated on one site. Benefits derived from this concentration include: safer practice with staff not travelling between sites, ability to develop a assessment and short stay unit, consultant expansion of three posts, retention of educational approval for junior doctor posts, further sub-specialisation and fewer patients being referred to Yorkhill. Audits of the impact of the changes have been undertaken which show that patients and parents were generally prepared to travel to access high quality care. The longer travel times did not have a detrimental effect on the condition of children. Most people travelled by private car, although those using public transport did not report any significant difficulties.

In Lanarkshire the move to two hospitals taking medical and surgical receiving will mean that the sub-specialty rotas could be developed. For example cardiologists in Lanarkshire have been trying to develop a separate rota, which would mean that a patient who has had a heart attack would be seen immediately by a cardiologist. Currently on admission in an emergency patients are seen by the physician on call. This could be a diabetologist or a respiratory consultant etc. The cardiologists have been unable to do this because they participate in the general medical receiving rota across the three sites. If there were only two medical receiving sites these could be covered by other physicians and enable to cardiologists to staff a separate rota. This would mean patients would have immediate access to the most specialist care. A similar separate rota could be developed by the respiratory consultants.

The status quo would make the development of a single cancer centre problematic and a single centre supports meeting the 'Clinical Standards for Colorectal, Breast and Lung Cancer', QIS, 2001 and would also facilitate delivery of the West of Scotland Oncology Services Strategy.

**Separating Planned from Emergency Care**

Building a Health Service Fit for the Future indicates that one of the main threats to the smooth delivery of much elective or planned care is pressure from emergency services.

Where the same staff and resources are available for both planned and emergency care, emergency treatment will always come first. Before a surgical procedure can be carried out, a range of resources have to be brought together at the right time and the right place: surgical, nursing and anaesthetic staff, theatre time and a bed. Remove any one of these components and the operation has to be cancelled. The need to perform emergency treatment can mean the loss of one of more of these components.

Building a Health Service Fit for the Future recommends that a major solution to this is the streaming of planned care away from emergency care where possible.

***Status Quo 2006***

Currently the three general hospitals provide emergency and planned care treatment alongside each other. Resources such as theatres, staffing, beds and support services such as radiology, laboratories and portering are shared.

Stresses in the provision of emergency care have knock-on effect to planned activity causing the frustration of cancellation and delay. Part of the answer to providing better and quicker planned care lies in smoothing the mis-match between the variation in demand and supply of emergency care and by carrying out more role enhancement and smarter working and streaming planned care away from emergency care supports this.

The sharing of resources between elective and emergency care can lead to planned care procedures being cancelled.

Over the period April 2005 to March 2006 there were approximately 300 planned procedures postponed. These postponements were due to a variety of reasons, the main one being patient medical constraints on the day, other reasons include unavailability of specialist consultant, constraints in theatre time due to emergency slots being required and beds.

On an operational basis the sharing of beds also means great uncertainty and stress for patients who may be requested to call the hospital on the day of their planned operation to ensure a bed is available.

### ***Status Quo 2000 Onwards***

The requirement of planned care provision to be as efficient and streamlined as possible will increase with the tightening of waiting times targets.

The NHS Scotland publication of "Fair to All Personal to Each" outlines enhanced targets for access to health services across Scotland.

All of these targets must be achieved by December 2007.

Specific to surgical areas include:

- No patient will wait more than 18 weeks from GP referral to an outpatient appointment
- No patient will wait more than 18 weeks from a decision to undertake treatment to the start of that treatment.
- No patient will wait longer than 24 hours from admission to specialist hip surgery following fracture
- No patient will wait longer than 9 weeks for diagnostic investigation – this includes endoscopy and cystoscopy

The ability to respond will be constrained by the current service configuration and the reduced availability of medical staff.

Table 2 sets out the evidence base on the outcome for patient care from separating emergency and planned care.

**Table two**

**Quality of Care Evidence Base  
Separating Planned from Emergency Care**

Building a Health Service Fit for the Future recommends that a major solution to improved waiting times and efficiency is the streaming of planned care away from emergency care where possible.

The benefit for patients of separating out planned care treatment is that it enables the development of specialist multi-disciplinary teams, therefore the right specialist is available at the right time as well as resulting in fewer cancelled operations and shorter waiting times.

The Association of Surgeons of Great Britain and Ireland, Executive Newsletter, No. 7, Nov. 2004 has reflected this by recommending changes in training of surgeons to support the development of these teams for planned surgery.

Other research supports this separation, for example a recent study (Biant et al, Eradication of methicillin resistant Staphylococcus aureus by "ring fencing" of elective orthopaedic beds, BMJ 2004) on splitting elective orthopaedics from trauma found that a ring fenced ward or stand-alone unit along with simple infection control measures, significantly reduced all post operative infections.

In relation to efficiency, NHS Lanarkshire has been able to demonstrate through carrying out dedicated waiting list initiative sessions that improved organisation and dedicated resources enables improved theatre utilisation and time management. This has been due to the ability to focus on planned care cases, agree the case mix in advance to fully utilise the sessions, ensuring all pre-assessment and diagnostics have been undertaken prior to the procedure as well as the ability to slot in replacements for cases cancelled on medical grounds. A study carried out activity in 2003/04 demonstrated decreased late starts, higher average theatre occupancy and higher number of average cases completed in waiting times initiatives sessions.

The National Framework for Service Change in NHS Scotland, Elective Care Action Team Report, Scottish Executive, 2005 refers to a Department of Health analysis of planned procedures by prevalence and associated critical care stay. This provides an indication, at a very high level, of what could safely be streamed in a facility, which does not have critical care facilities readily accessible. The provisional results are as follows:

- **89%** of elective care by volume requires a critical care stay in fewer than **1%** of cases
- **96%** of elective care by volume requires a critical care stay in fewer than **4%** of cases

These volumes give some indication of what work could be carried out safely at the planned care hospital, if risks are carefully managed and with relatively modest predictive filtering out of higher risk patients (e.g. using ASA / BMI criteria). The range of procedures, which might be streamed in practice, will clearly depend on safety factors such as the extent of back up as well as economic factors.

The Senate of Surgery of Great Britain and Ireland in a report Reconfiguring of Surgical, Accident and Emergency and Trauma Services in the UK recognised the clinical and administrative advantages to the patient of separating emergency, planned and ambulatory care surgical services.

The Elective Care Action Team report outlines the benefits of separating planned from emergency care as:

## **Quality of Care Evidence Base**

### **Separating Planned from Emergency Care**

- Streaming of scheduled care will undoubtedly provide significant improvement in a range of key outcome indicators, for example, a predictable and increased workflow, reduction in cancellations, value for money, improved recruitment and retention and importantly reduced waiting times for patients. It recommends streaming can be carried out on a local, regional or national basis. Locally a hospital could be designated an elective care centre. These beds would not be available for emergency admissions, as there is always a risk of that happening if it is on the same hospital site as an A&E department. Within a health board area, it may be possible to stream elective care across hospital sites, so that one hospital is designated as primarily planned care
- Would enable predictable high volume workload with minimal cancellations, therefore making effective and efficient use of staff, equipment and public money. Importantly, patient satisfaction is improved
- Control of infection and adverse incident rates can be improved through dedicated facilities and staff (e.g. theatres, wards, specialist teams).
- Dedicated elective facilities can improve recruitment as many professionals look for stability of specialty and case mix, which in turn will support training, research and development.
- Opportunities exist to develop new roles in a purely elective environment. Recruitment from previously untapped sources such as science graduates rather than from current shortage groups like nurses should be seriously addressed. This might include roles:
  - Anaesthesia and Critical Care Practitioners
  - Physician Assistant
  - Specialist Nurses such as arthroplasty nurse
  - Specialist Practitioner
  - Extended Scope Practitioner
  - GP with a special interest

The concentration of elective work unaffected by emergency care will provide excellent opportunities to concentrate planned training more reliably in shorter periods of time for all the health care groups.

In Lanarkshire currently, emergency medical patients are placed into other specialty beds at times of peak demand, which reduces access to specialist nursing and medical input. Separating out emergency care will result in ensuring access to an appropriate multi-disciplinary team and enable prompt treatment in the most appropriate setting.

### **Sustainability of Intensive Care Services and Impact on Accident and Emergency**

As part of *A Picture of Health* a group was set up with Anaesthetists, Surgeons, Physicians and an Emergency Medicine Consultant to look at the future provision of intensive care in Lanarkshire. This group concluded that an anaesthetic provided intensive care service was not sustainable on three sites beyond 2009. This was due to a number of factors:

- Reduction of junior doctors hours to 48 hours
- Need to provide an intensive care unit critical mass for training, accreditation and recruitment
- Development of specialists in intensive care
- Limited ability within small units to improve patient care to standards possible

This view was reached following detailed work by Anaesthetists considering the number of medical staff in anaesthetics and intensive care required to provide cover for a number of options for service delivery (see table 3).

Similarly, the General Surgeons in Lanarkshire have been considering the future sustainability of general surgery. Details on the development of views about general surgery and intensive care sustainability are outlined in section 3 of this paper.

The view of Consultant Physicians and Consultants in Emergency Medicine is that acute medicine and full accident and emergency services are not sustainable at any hospital without intensive care provided on the site.

**Table three**

Quality Indicator	Status Quo 2006	Status Quo 2009 Onwards	Two Emergency Hospitals and One Planned Care Hospital
<p><b>Sustainability of Intensive Care Services and Impact on Accident and Emergency</b></p>	<p>There are currently three small intensive care units in Lanarkshire, one in each of the three hospitals. Each of the units has 5 beds with the capacity to expand to 6 beds in the winter.</p> <p>To support these facilities there is a requirement for 42 consultants and 47 non-consultant medical staff. There are 5 consultant and 2 staff grade vacancies</p> <p>The rota requirement is 1 in 6 for consultants and 1 in 8 for non-consultants.</p> <p>The status quo model requires anaesthetic trainees to spend 50% of their time in intensive care.</p>	<p>The status quo would require the same level of staffing however in 2009 onwards due to WTD and MMC the amount of time medical staffing will be involved in training will rise significantly. This will mean they have less time available to deliver a service to patients. In anaesthetics, the work, which takes priority, is intensive care and emergency surgery. This will mean there will be less time for planned care surgery. This will put a pressure on waiting times.</p> <p>In addition, due to MMC changes, it will not be possible to have junior staff spending 50% of their time in intensive care as more time will need to be spent in non service work and in theatre in order to fulfil training requirements. If these training requirements are not met training status will be withdrawn.</p>	<p>The proposal would be to have two large intensive care units with 8/9 beds each. These intensive care units would support emergency receiving and accident and emergency departments at the two emergency hospital as well as complex major planned surgery</p> <p>To support these facilities there is a requirement for 46 consultants and 44 non-consultants.</p> <p>The rota requirement would be 1 in 8 for consultant staff and 1 in 10 for non-consultant staff. This improvement in requirement should support recruitment.</p> <p>A two emergency hospital configuration would enable there to be two larger intensive care units. The junior doctors would still undertake 50% of their work in intensive care but the intensive care units would be recognised for training. This percentage could be decreased as low as 33% if Critical Care Practitioners are available. This model would be the most future proof, as it would support intensive care moving to a separate speciality. This would provide better quality of intensive care, as intensive care specialists would staff it.</p> <p>Intensive care is essential to the delivery of acute medical and surgical receiving. This in turn affects accident and emergency facilities as a full accident and emergency department requires the back up of medical and surgical admitting services, emergency theatre and intensive care.</p> <p>The Senate of Surgery of Great Britain and Ireland in a report Reconfiguring of Surgical, Accident and Emergency and Trauma Services in the UK noted with the pressures of WTD and medical training, the shortage of skilled manpower and the requirement for critical care services, there will be “an inescapable need to provide elective (planned) and emergency surgical services in larger hospitals for complex inpatients”</p>

Quality Indicator	Status Quo 2006	Status Quo 2009 Onwards	Two Emergency Hospitals and One Planned Care Hospital
	<p>The current configuration of emergency care in Lanarkshire is three hospitals all taking an increasing number of medical emergencies each year which is leading to pressures around the provision of beds and longer waits in accident and emergency departments due to the mix of minor and major</p>	<p>be withdrawn.</p> <p>Critical Care Practitioners (nurses with specialist training for intensive care) could not decrease the amount of junior doctor time in intensive care, as they cannot replace a doctor if there is only one doctor covering a unit.</p> <p>Anaesthetic vacancies currently exist and these will be exacerbated over time as intensive care units across the rest of Scotland and the UK become bigger. Newly trained consultants will want to work in units with more ability to specialise as intensivists only and with less on call requirements.</p> <p>“Fair to All Personal to Each” requires that by December 2007 patients should not wait for more than 4 hours in accident and emergency for assessment, treatment, discharge or admission to hospital. This position will not be</p>	<p>service in larger hospitals for complex inpatients”.</p> <p>The National Framework for Service Change in NHS Scotland, Elective Care Action Team Report highlighted the need for further sub-specialisation to achieve improved quality of care for patients requires these services to be concentrated in units of appropriate size to allow staff to maintain skills and trainees to obtain the necessary experience. This they felt was exemplified in intensive care where there is a need to move towards intensive care being provided by intensivists rather than general anaesthetists.</p> <p>The proposal in Lanarkshire is that two intensive care units would support emergency receiving at the two emergency hospitals with full accident and emergency departments. <i>A Picture of Health</i> proposes that minor illness and injuries should be treated more locally relieving the full accident and emergency departments to concentrate consultant expertise and deal more efficiently with attendances for major illness or injuries. To do this minor illness and injury services will be developed at the planned care hospital and in Clydesdale and Cumbernauld. Also minor injury and illness services will be enhanced at community hospitals in Biggar and Douglas.</p>

Quality Indicator	Status Quo 2006	Status Quo 2009 Onwards	Two Emergency Hospitals and One Planned Care Hospital
	cases attending.	<p>achieved without the redesign of services. This is because the demand on the hospitals for emergency admissions is increasing and the services in the community and in A&amp;E and medical receiving are not robust enough to divert patients who do not need admission but could be supported in the community and to quickly assess patients and determine a course of treatment without admission.</p>	<p>This proposal is in line with the recommendations set out in the National Advisory Group A Framework for the Sustainable Provision of Unscheduled Care (which advised the Kerr Report). This emphasised that the paradigm for unscheduled (emergency) care should shift from “assess, transport, diagnose, treat” to “assess, diagnose, talk, treat” – with transport if absolutely necessary. This emphasised the vast majority of emergency care takes place outwith hospitals, and there is the potential for more care to be delivered in the community. The paper argued this would need to be done if the growing pressure on emergency services is to be ameliorated. It stated NHS Scotland should work to ensure that as much unscheduled care as possible is delivered in or near the home by telephone advice/ triage services e.g. NHS 24, the Scottish Ambulance Service or local unscheduled care providers.</p> <p>This report recommended NHS Scotland should work to:</p> <ul style="list-style-type: none"> <li>• Maximise the number of patients requiring unscheduled care who are safely assessed without having to leave their homes</li> <li>• Provide services capable of dealing with non-complex injury and illness on a local level, potentially in hybrid facilities bringing together GP, paramedic and practitioner led casualty services. These should have access to appropriate diagnostic services, and should be linked to other levels of the service by tele-health links in order to facilitate local assessment</li> <li>• Reconfigure admission services to more appropriately serve the population.</li> </ul> <p>In Grampian, for example, the A&amp;E department at Aberdeen Royal Infirmary provides remote access to specialist skills to areas around rural Grampian. By using teleconferencing and email facilities, A&amp;E consultants support trained nurses and GPs in dealing with non-complex injuries and illnesses.</p> <p>This paper argues that current configuration of services do not make the best use of NHS Scotland’s constituent parts. NHS Scotland patients are often not receiving the services they require because of an adherence to models of care which no longer reflect the demands on the service. In particular, the current configuration of services too often brings patients to hospitals for assessment and diagnostic tests that may be delivered locally, i.e. at home, in diagnostic and treatment centres, in primary care centres, in nurse or</p>

Quality Indicator	Status Quo 2006	Status Quo 2009 Onwards	Two Emergency Hospitals and One Planned Care Hospital
			<p>paramedic led casualty units or other configurations.</p> <p>This leads to disruption for patients and increasing numbers of “emergency” attendances, which use the time of highly qualified staff who should be focusing on the complex emergency cases, which require facilities only available in acute hospitals.</p> <p>This contributes to the problem of patients who are simply admitted when the right test, or test result, or the most appropriate treatment or care package cannot be delivered locally.</p> <p>The aim should be to develop a network of unscheduled care services which does not move patients by default to hospital emergency services as a result of the absence of other, more appropriate, types of provision. The report concluded that the public wants high quality services, with shorter waiting times and improved outcomes. These goals may only be delivered with change. In particular it is important that honest discussion regarding the number of traditional Accident and Emergency departments should take place.</p> <p>With the move to two emergency hospitals the team of consultants working in accident and emergency receiving will be much bigger on the two sites. This means, for example, the hours of the day when there will be consultant cover in A&amp;E will be increased providing better quality of care for patients but also more expertise to work up treatment plans and enable patients to go home rather than to be admitted. There is evidence the patients are admitted by junior doctors who would not have been admitted if a consultant had assessed and treated them.</p> <p>A Department of Health report the Configuration Hospitals Evidence File: Part Two, July 2004 provide evidence for the effectiveness of minor injury units in Cornwell, Lothian, Plymouth and Wembley London.</p> <p>Local audit work in Motherwell has shown the impact that services in primary care can have on supporting patients post myocardial infraction.</p>

## **2.2 Supporting Recruitment**

NHS Lanarkshire needs to provide a workforce of well trained and supported health professionals with the knowledge and skills to deliver modern effective services. This means continuously educating staff and working in ways, which meet accreditation standards and legislative requirements. It also means being able to attract new much needed staffing into the NHS and retaining our existing staff.

Traditional roles and ways of working are likely to be less attractive to nursing staff. Retention may be a problem in the longer term if new, challenging roles are not developed.

The provision of better training for medical staff will attract Specialist Registrars and so improve the recruitment potential of these locally trained staff once they have completed their training.

NHS Lanarkshire needs to manage its resources better and use them more efficiently. Our acute hospitals are under particular strain, stretched as they are across three hospital sites with limited and often small numbers of specialist clinical staff. If we do not tackle it, this strain will increase as the national workforce and legislative changes are made and we will not be able to maintain services, or improve the quality of clinical care to the levels we expect.

With consultants working in three relatively small teams, their on-call is significantly more frequent than those working in larger teams. The more time worked at night, means the less time worked during the day and less time with patients.

The expectation is that NHS Lanarkshire will move towards a consultant-provided service and this will require consideration of extended day working, for example, 8am to 8pm followed in due course by consultant presence 24-hours; most likely initially in acute medicine/ accident and emergency acute surgery, obstetrics and anaesthetics. It is assumed that as a first stage the move will be towards a career grade provided service with initial expansion of the Staff and Associate Specialist (SAS) grade and subsequent focus on consultant expansion depending on availability and affordability. This is then set against a background of current consultant vacancies in Lanarkshire as well as a national shortage of consultants in many specialities.

As at 30 April 2006 there were:

- Three consultant and five staff grades vacancies in Accident and Emergency
- Eight consultant and four staff grade vacancies in Anaesthetics
- Seven consultants, one associate specialist and three staff grades vacancies in Medicine
- Eight consultant vacancies in Surgery.

Recruitment to consultant posts is seen to be problematic in Lanarkshire. Appendix 3 sets out more detailed information on recruitment. There is a vacancy rate of 16% against a Scottish average of 8%. There are a number of factors that effect the recruitment to senior medical and dental posts within NHS Lanarkshire which include the following:

- The Deanery has confirmed that approximately 8% of students move south of the border after their first year in post. Statistics have proved that Dundee and Edinburgh attract a lot of students from south of the border who historically return home after their 5 year training is complete.
- NHS Lanarkshire is the third largest Board in Scotland. However it often competes with the 2 larger Teaching Boards, Edinburgh and Glasgow where many local candidates prefer to apply. Candidates who are attracted to rural settings are drawn to Borders, Dumfries and Highland.

- The size and resources of small departments can be a major drawback when recruiting to senior vacancies. Often SpRs are drawn to specialist units where resources are concentrated, support is available, team working is effective and opportunities exist for sub-specialisation.
- There are recognized “shortages” throughout Scotland that all Boards have difficulty recruiting to e.g. Histopathology.

The consultant establishment within NHS Lanarkshire has increased over recent years and although some of these new posts remain vacant at present. their input to service provision.

During the financial year 2005/06, 19 Consultants have left NHS Lanarkshire’s employment either due to retiral or taking up new appointments. NHS Lanarkshire was successful in recruiting to 36 Consultant posts in various specialties; however, this still resulted in 43 Consultant vacancies at the year end. In the previous financial year for 2004/05 NHS Lanarkshire were successful in filling 16 posts but lost a total of 16 posts to retirals and individuals moving to other Boards. This resulted in 54 vacancies at the year end. Not all new posts were recruited to.

Consultant recruitment is an extremely complex business and NHS Lanarkshire must abide by strict rules set down within the Statutory Instrument. A considerable amount of effort is put into filling Senior Medical Staff vacancies and several initiatives have been tested over the last few years. These are specifically:

- Recruitment drives are underway via world wide journals
- A Medical Workforce Group within the former Primary Care Division set out an active recruitment programme for Psychiatry in 2002. This involved all current consultants acting as “Recruitment Agents”, which included proactive contact with potential candidates and significant flexibility around job descriptions. At the start of the process there were 15.6 whole-time equivalent vacant consultant posts in an establishment of 38.7 whole-time equivalent. By August 2004 the situation had altered to having 5.9 whole-time equivalent vacancies in an expanded establishment of 43.5 whole-time equivalent posts, unfortunately some consultants have departed since then and the process of active recruitment is ongoing
- Consultant Radiology cover from South Africa is in place. This involves a fixed term contract with a series of experienced Radiologists who undertake work within both Monklands and Wishaw Hospitals
- Investment in a website specifically to target Histopathology. The site was fully developed in conjunction with the Histopathologists within NHS Lanarkshire.
- Assistance was received from the Scottish Executive to help NHS Lanarkshire recruit to the Consultant Expansion Programme. The financial assistance aided the recruitment of 2 Consultant Radiologists, 6 Consultant Anaesthetists and 4 Staff Grade Anaesthetists via Bluecare Medical Agency. These consultants are contracted on an initially fixed-term basis during which time assessments will take place and following which, if the candidates are suitable, a substantive post will be advertised and interviewed for in the normal way.

Concentration of services has successfully helped NHS Lanarkshire attract consultants to specialties that have proved difficult to recruit to. Two Consultant Urologists were recruited to long term vacancies only when the concentration of the in-patient service onto a single site was agreed. There was also difficulty in recruiting to Consultant, Staff Grade and junior medical vacancies within the children’s services specialty. Following centralisation of in-patients in 2002, children’s services has appointed 4 Consultants and 3 Staff Grades. There is no longer any shortage of applications for their junior medical staff. This in turn has led to an expansion of the medical establishment with 6 new Consultant posts being created within the specialty since its services were concentrated, 4 of which have been filled.

Haematology has also been a difficult specialty to recruit to for NHS Lanarkshire. However with the agreement that this specialty will centralise in-patient facilities on a single site, NHS Lanarkshire after receiving several very good applications have successfully recruited to two Consultant Haematology vacancies.

If a comparison is made of how services in Lanarkshire are configured against the rest of Scotland it is clear that all health systems in Scotland are moving to either one or two emergency hospitals only. This includes Lothian and Glasgow with the largest populations as well as in geographically dispersed health systems such as Ayrshire and Arran and Highland. Given this if Lanarkshire does not move to a smaller number of emergency hospitals and so larger units and teams of staff Lanarkshire will become increasingly unattractive in terms of recruitment and retention.

Out of NHS Lanarkshire's 334 current consultants (including locum staff) 130 are aged 50 or over. There is nothing within the new consultant contract to encourage staff to remain beyond age 60. There is a risk that those in the age range 57 to 59 may retire even earlier once they have reached the maximum of the new consultant scale. Examples of potentially significant areas of impact include:

<b>Consultants</b>	<b>Age 57 to 59</b>	<b>Age 60 or over</b>
General Medicine	6	9
Surgery	4	1
Anaesthetics	6	1
Obstetrics	4	2

### **2.3 Responding to Change in Medical Training**

#### **European Working Time Directive**

The European Working Time Directive and New Deal is having a major impact on the availability of junior doctors for service delivery. They are required to work no more than:

<b>European Working Time Directive Requirements versus the current New Deal</b>				
<b>Maximum contracted hours for each working pattern</b>	<b>New Deal</b>	<b>European Working Time Directive</b>		
		<b>2004</b>	<b>2007</b>	<b>2009</b>
On-call rotas (resident)	72	58	56	48
(non-resident)	64	72	72	72
Partial shifts and 24hr partial shifts	64	58	56	48
Full shifts	56	58	56	48
<b>Maximum number of actual hours</b>	56	58	56	48
For all shift types, if resident in hospital, all hours count as work				

In order to maintain current capacity alternative models of staffing are required. In response NHS Lanarkshire has recognised that roles of many staff, especially other health care professionals, will need to change to meet the potential gaps in service provision and this will need a team approach to planning the services of the future. Significant work has been undertaken to respond to the impact of the WTD including the appointment of additional consultants and the implementation of the Hospital at Night scheme (Hospital Emergency Care Team – HECT), which was developed to help meet the needs of compliant rotas for junior doctors.

### **Modernising Medical Careers**

However, compounding the impact of the WTD is the implementation of Modernising Medical Careers (MMC). The implementation of run-through training in August 2007 will be accompanied by a 30% reduction in numbers of trainees and in addition a 25% loss of service activity from the remaining posts.

MMC provides a new set of training arrangements for the medical workforce and is helping to drive the redesign of the whole clinical workforce. It aims to improve patient care by delivering a modernised and focussed career structure for doctors and aims to develop demonstrably competent doctors who are skilled at communicating and working as effective members of a team. This will provide an opportunity for NHS Lanarkshire to streamline a range of services in maximising the use of medical staff available which will result in increased efficiency and effectiveness.

A considerable amount of work has been undertaken to explore the service impact of implementing second year of MMC (FY2) and this has been reported to NHS Education for Scotland. The current planning assumptions are set out in Appendix 4. Work continues on planning measures to support the implementation across the individual specialties from a multi-disciplinary perspective. This work is being co-ordinated by Medical Workforce Planning Group, which reports to the NHS Lanarkshire Workforce Steering Group. There is also ongoing work between the Lanarkshire hospitals, Glasgow Royal Infirmary and Stobhill hospital and a group meets regularly under chairmanship of NHS Lanarkshire Medical Director.

Due to the working patterns within A&E and the significant reliance on junior staff for service provision there will be a considerable impact on the departments from the introduction of MMC for both FY2 and for run-through specialist training.

The impact of the implementation of MMC on general medicine will be considerable in view of the extensive use of junior medical staff for service provision, particularly in relation to out-patient clinics, but also for daily inpatient ward rounds. A similar impact will occur in general surgery.

A range of solutions is being explored to minimise the effect on activity. The Lanarkshire Hospital Emergency Care Teams (HECT) have now been in place for 18 months and we are planning to extend the hours and remit as part of minimizing the impact of MMC. NHS Lanarkshire has expressed an interest in a pilot of both Anaesthesia Practitioners and Physician Assistants in Scotland, projects that are being promoted by NHS Education Scotland. NHS Education Scotland has agreed to the creation of temporary additional short-term training posts which will assist in filling the gap created by implementation of FY2. Funding has been identified for these developments. The role of the Major Minor Illness Nurse Treatment Service (MINTS) nurses will also have an impact in supporting the provision of unscheduled care.

NHS Lanarkshire also awaits information from NHS Education Scotland about details of “run-through” or training in a speciality which will follow on from FY2, particularly in relation to anticipated numbers of trainees, specialty curricula and implementation dates as this will have a potentially greater impact than FY2. NHS Education Scotland and Scottish Executive Health Department (SEHD) are being encouraged to ensure more equitable provision of senior training posts i.e. run-through training in comparison to the present distribution of SpR posts which leaves Lanarkshire with very few. The outcome of national negotiations for new staff grade and associate specialist contracts will be of significance in relation to further workforce planning.

The full impact of MMC on service delivery in surgical/critical care areas is not yet fully understood. However, there is evidence to suggest that this will have a significant impact on service delivery, in particular on the delivery of planned and unplanned care.

### **3. DEVELOPMENT OF THE PROPOSALS FOR ACUTE SERVICES**

The proposal to move towards one planned hospital and two emergency hospitals developed over a couple of years.

#### ***Hospital Services in Lanarkshire from August 2004***

In October 2003 a paper, Hospital Services in Lanarkshire from August 2004 was produced by the Acute Division’s Associate Medical Director (Appendix 5). This paper identified that from August 2004 the Working Time Directive (WTD) would progressively apply to doctors in training with a target of an average of not more than 56 hours for trainee medical staff by August 2004 reducing to not more than 48 hours by 2009. In addition it highlighted that the SEHD was committed to implementing the “Donaldson Report – Modernising Medical Careers” (MMC) which introduces a much more structured training for doctors in their first two years following qualification and that plans were required to respond to this by March 2004. MMC requires an increased educational element in training with on-call supervision requirements meaning there is less time available for service commitment by junior doctors. It was noted that there would be no new trainee medical staff post created to fill this gap. The report noted that traditionally junior medical staff provided most aspects of out of hours clinical services. The changes under WTD meant it was necessary to reconsider the tasks performed out of hours and who should undertake them. The paper made two proposals, although it highlighted that more radical solutions may be required over time. The two proposals were:

- The formation of overnight “hospital emergency care teams” – this would comprise medical and nursing staff who would provide medical care for attendees at A&E and new medical and surgical admissions overnight. Within these teams nurses would have a wider role and a more advanced set of competencies. These teams were successfully introduced in August 2004.
- Changes in overnight arrangements in surgical specialties – the paper noted WTD and MMC would have greatest impact on the trainee medical staff in surgical specialties overnight (general surgery, orthopaedics and anaesthetics) with the current number not being able to sustain the emergency services provided. The view set out was that it was difficult to develop a solution to this other than reduce the number of sites or times at which services are provided, or increase the involvement of consultants in out of hours arrangements. The latter would have an impact on waiting times, as it would reduce the level of daytime commitments possible for consultants. The paper proposed one integrated area-based out of hours emergency service for surgery rather than the current model of three parallel hospitals services.

#### ***Emergency Surgery Option Appraisal***

In response to the paper Hospital Services in Lanarkshire from August 2004 the Area Surgical Group asked for further options for emergency surgical service provision to be assessed. This

was undertaken by an option appraisal group made up of consultants and a General Manager. Several options were considered and the clear choice of the surgeons from the appraisal was that there should be one permanent receiving and operating site for emergency surgery in Lanarkshire. It was recognised this would be major change with the consequent need for bed and specialty reconfiguration, and that this could not reasonably be achieved in 2004. Hence in order to respond to the changes required by August 2004 a modified three site receiving and operating model was agreed. It was concluded that this model would not be sustainable in the longer term and that work should commence towards implementing a single permanent operating and receiving site.

### **Work on Progressing a Single Receiving Site**

In the autumn of 2004 the interim model of modified three site receiving was implemented and its impact monitored. At the same time the engagement process for *A Picture of Health* commenced and as part of the public engagement document outlined that changes were envisaged to be necessary in emergency surgery and invited comments on this. In spring 2005 more detailed work commenced to consider implementing the single site receiving option proposed by Area Surgical Group. In April to May 2005, 31 individual interviews (Appendix 6) were undertaken with 20 Anaesthetists, 8 General Surgeons and 3 Orthopaedic Surgeons. In summary this identified the following views:

<b>Sustainability of the Status Quo</b>	<b>Number holding this view</b>
View it is sustainable	7
View it is not sustainable	18
Don't know or the case has not been made	6

  

<b>Most Workable Option</b>	<b>Number holding this view</b>
One centralised site	10
Two sites receiving	7
Status quo	8
One or two sites receiving	2
Don't know	4

From this it was apparent that although overall the view was that the status quo was not sustainable, there was not a consensus about the preferred alternative model. It also became clear in interviewing the Consultant Anaesthetists that there were separate sustainability issues for anaesthetics which were explored by a group looking at the future options for critical care as outlined below.

### **Summer Engagement Event**

In June 2005 an *A Picture of Health* Summer Engagement Event took place covering a wider range of proposals which had been developed by the *A Picture of Health* project boards. This included the proposal for single site receiving for surgery.

The group discussion gave the proposal limited support and identified:

- The need to communicate the detail of the arrangement to the public and to explain the benefits of the proposal and the safety mechanisms
- The view that debate on this proposal so far had been very driven by surgeons and there are differences of opinion amongst anaesthetists over whether one site emergency receiving is the best option
- A debate had commenced about the provision of critical care and whether it would be possible to continue three intensive care units at the three hospitals

- There is a need to take into account changes taking place elsewhere in the West of Scotland as these may impact on where Lanarkshire has its single receiving site if this proposal is agreed

### ***Future Options for Critical Care in Lanarkshire***

Following the Summer Engagement Event a working group was established to consider the sustainability of critical care services. This group comprised consultants from General Surgery, General Medicine, Emergency Medicine and Anaesthetics, senior nursing staff and general management. The findings of this group were set out in the report Future Options for Critical Care in Lanarkshire, September 2005 (Appendix 7).

The report set out the drivers for change as:

- The WTD (full implementation by 2009)
- MMC foundation and seamless training
- Increases in consultant workload associated with appraisal, training and revalidation
- Public expectations of a consultant based service
- Medical development in acute and critical care management that are labour intensive
- Difficulties in recruiting and retaining staff with specialist shortfalls

It noted critical care is divided into three levels of care:

- High dependency care – level 1 (there are no designated level 1 facilities in Lanarkshire)
- High dependency care – level 2
- Intensive care

It was also noted that the three main user groups of intensive care are acute medicine, acute surgical receiving and major planned surgery.

The group looked at the number of medical staff in anaesthetics and critical care required in order to provide cover for a number of options for emergency receiving delivery. This consideration took into account out of hours rota frequency, the balance between intensive care and planned work and meeting working regulations (WTD and Royal College of Anaesthetics). Detailed modelling was completed for demand and capacity and this is summarised in a presentation drawn up for stakeholder (Appendix 8).

The conclusions reached were that critical care could not be sustained on three sites beyond 2009 due to:

- The deficit in junior medical staff could not be replaced by increased consultant input to intensive care without an impact on planned surgery and waiting times. There were 5 whole time equivalent consultant vacancies which have not been possible to fill because the mix of service requirement and out of hours cover is unattractive to new trained consultants
- Changes in junior doctors working time would lead to an increased percentage of time in service provision in critical care and insufficient time in anaesthetics training which would not be acceptable to training authorities and lead to a likely loss of training recognition
- Critical care practitioners could undertake tasks traditionally assigned to junior medical staff but could not cover critical care services without medical input
- Acute medical receiving could not continue at a hospital without a resident anaesthetist on site to carry out immediate resuscitation and follow on intensive care. This would be a major clinical risk

### **Workshops with Clinical Staff**

In September 2005 workshops were held with Consultant Surgeons, Consultant Anaesthetists, Consultant Physicians and Consultants in Emergency Medicine and senior nursing staff (Appendices 9 and 10). The work undertaken on Future Options for Critical Care and rota information for general surgery post 2009 were fed into the workshops. It was concluded from an anaesthetic and surgical point of view that the status quo of acute surgical receiving on three sites was unsustainable beyond 2009 and that there would be benefits derived from moving to a two site emergency receiving model. These included:

- The potential for a separation of emergency and elective activity to reduce cancellations
- Supporting the reduction of waiting times
- Inefficiency in running three theatres out of hours on each of the hospital sites
- Developing arrangements to improve the recruitment and retention of senior medical staff
- Develop a consistent and efficient way of managing surgical admissions for NHS Lanarkshire, to improve quality of care
- Exploring the formation of sub specialty units enabling training, development and research, to continue to improve quality of care, e.g. colorectal
- Balancing geographical access and best outcomes for patients

The Physicians concluded that acute medicine receiving was sustainable on three hospital sites but only if critical care services are available and the advantages of a reduced number of acute receiving sites included:

- 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
- Fewer sites will attract consultants with specific interests
- Reducing number of sites would improve recruitment opportunities
- Would possibly assist with the pressure of meeting increasingly tight waiting times targets
- Options would be available to develop sub specialisation this could assist medical receiving as patients could be picked up by sub specialties earlier
- Could move to block or team working instead on individual rotas
- It is unlikely that three emergency medical services could be established for Lanarkshire while two would be possible
- The provision of better training for medical staff will attract Specialist Registrars and so improve the recruitment potential of these locally trained staff once they have completed their training

It was also concluded by the Emergency Medicine consultants that full accident and emergency services would not be possible at a hospital without access to intensive care, emergency surgery and emergency medical receiving.

### **Emergency Services – Public Focus Groups**

In October 2005 public focus groups were undertaken to gain views from the public on the emerging proposals for emergency services. The proposals set out were a move to two emergency hospitals and one planned care hospital for Lanarkshire. The provision of two full accident and emergency services was outlined with a minor illness and injury service on the planned care hospital site as well as smaller minor illness and injury services in Clydesdale and Cumbernauld. These focus groups were independently facilitated and a report was produced. The full report is available on the A Picture of Health web site [www.a-picture-of-health.org](http://www.a-picture-of-health.org).

The format of the focus groups was an initial introduction and presentation of the context and topic to be discussed, then the groups were asked a series of questions. The following is an extract from this report and gives an abbreviated summary of the responses to the questions.

*“Are there any areas you do not understand about this new thinking?”*

In broad terms the concept of ‘splitting’ the minor and serious emergencies was well understood by the groups and in broad terms generally welcomed. There are, however, key questions to be answered related to the detail of information currently available and which will have an impact on the way this thinking is viewed.

The detail needs to include what exactly will be provided in the minor injury units, who will work in them, where they will be located and most important of all what opening hours will they operate. Most of the groups acknowledged that the current abuse of accident and emergency services and the security issues for both staff and patients don’t appear to be included in the thinking. There was also a concern expressed that the current thinking is as a result of pressures on recruiting staff for these services, there is a question as to where the staff for these new facilities will be recruited.

*Could we (NHS Lanarkshire) communicate these ideas better and how?*

Explaining the proposals in detail and recognising that the public will understand the pressures for change supported by a positive message about improving the service not reducing it will help to communicate the ideas. Suggestions on where to communicate and the media to be used were made by some of the groups but the principal message appeared to relate to the openness and detail of the information to be communicated. Emphasis was also placed on the information being communicated to all levels in the community and education of the public and schools and younger members of the community would be helpful.

*What are your views about the new thinking on A&E in general hospitals?*

The new thinking of dividing the minor from major emergencies was acknowledged as a good principle. There remain concerns on the access to these services – hours of opening and availability together with the transfer and risk issues associated with having two rather than three centres. For some participants rather than change the current practice, efforts should be made to recruit more staff and improve the current working practices.

*What do you think the advantages might be?*

There is generally a feeling that the service will reduce waiting times, be more readily accessible and be of a higher quality with appropriate staff at each of the facilities. It might also be viewed as an improvement to provide additional services at the hospital that would lose its A&E department by extending the range of specialist services in Lanarkshire.

*What do you think the disadvantages might be?*

The disadvantages were more difficult to identify largely due to the lack of detailed knowledge of what will be provided and where it will be provided. There is a concern that by doing this funding may be directed away from other services and the public’s perceptions of reduced services will need to be addressed. Security in smaller units and the abuse of the service might also be viewed as a disadvantage.

*Could any of these disadvantages be turned into an opportunity?*

Time and investment in education of the public together with detailed implementation and planning of these services would be an opportunity to involve the public. Using familiar buildings – health centres, etc. – would help support this transition and the return to the

“cottage hospital” where local services are provided and are accessible at times to suit the patient (patient centred) could support this involvement with the public. Data on the frequency of mention of issues by the groups in their responses in the workshop sessions together with a record of the written responses to questionnaires completed at the time are included as appendices to this report.”

#### **4. CONCLUSION**

In conclusion a clear argument can be made that not only is the status quo for acute services not sustainable, but also that quality of care can be significantly improved by moving to a new model of two emergency acute hospitals, one planned care acute hospital and an enhancement of minor injury and illness services in the community.

In relation to quality of care there is considerable evidence to show that emergency services in Lanarkshire are fragile and effected by long standing medical vacancies. With the full introduction of the WTD and the implementation of MMC significant additional pressures will be placed on services. Without change it is likely that, in areas such as intensive care, training approval will be lost for services leaving consultants to be pulled into work previously covered by junior staff. This will mean medical staff will have less time for planned work, such as operations and outpatients and waiting times will rise.

As an alternative to this, if the proposals in A Picture of Health are implemented the quality of care will improve due to the ability to move to larger teams of staff more able to sub-specialise. This sub-specialisation will provide the right care at the right time for patients with for example a cardiology rota enabling patients who have had heart attacks to be seen by a cardiologist immediately on admission. There is strong evidence that the outcome of patient treatment is improved when both the consultant and the unit are geared to undertake a higher number of procedures.

The provision of minor injury and illness services in the community will mean services closer to patients’ homes and more activity diverted from the emergency hospitals, where those with major illnesses and injuries can be concentrated on. The quality and efficiency of planned care will be improved by having a hospital and the resources on that site focussing on planned inpatient operations. This will reduce both the waiting times and the uncertainty for patients who might be cancelled at the last minute where their operation is taking place at an emergency hospital.

There is evidence that medical staff want to work in larger units because they have the opportunity to:

- Sub-specialise
- Improve patients outcomes
- Improve patient safety
- Spend more time in patient care and less on call

Where services have been moved to larger units this has been proven to aid recruitment in Lanarkshire.

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