4

Why Specialisation Matters -

And What We Propose To Do To Make Its Benefits More Available

The Future

of Glasgow's

Hospital Services

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GREATER GLASGOW
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in Glasgow

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Patient care can be extremely complicated. The patient expects - and has a right to expect - that decisions made concerning their care will be of the highest quality, and that practical treatments will be competently carried out. No individual practitioner - whether doctor, nurse or other healthcare professional, has the specialist knowledge and experience of all aspects of medicine to enable them to provide this level of care for every patient.

Over the years, specialisation within health services has developed. Many healthcare staff who care for patients, particularly in our acute hospitals, work in one area (or a few related areas) of the comprehensive range of clinical services provided. These areas of medical care or groups of services are called clinical specialties, and examples include orthopaedics (bones and joints), cardiology (heart disease), ophthalmology (eye problems), oncology (cancer services) and paediatrics (child health). Staff train to become specialists in a specific clinical specialty to enable patients to be provided with the best and most appropriate professional care and treatment. Even within these specialties there is further specialisation. For example in orthopaedics, some consultants specialise in hips, others in knees, or shoulders, or hands and so on.

There is growing evidence that the best results in treatment are achieved when patients are treated by specialists (not necessarily just doctors but a whole multi-disciplinary specialist team). This is now widely recognised for some cancers (such as breast or digestive system). In medicine there is some sub-specialisation - some physicians offer particular expertise in, say, diabetes or in cardiology. An acid test here is how knowledgeable NHS staff behave when ill - they will usually seek to get themselves into the hands of a specialist best equipped (knowledge, skills, back-up team and so on) for their illness. We should be ensuring that every patient gets into the most appropriate hands - automatically and not depending on the patient having some inside knowledge about the system. But at the moment specialists are often scattered between different hospitals - tough luck then if he or she is absent when you most need them.

So the challenge is how to provide better continuity of specialist skills being available when they are needed. We need better cover for specialists to

deal with out-of-hours emergencies and routine absences (holiday, study leave etc). Without better cover there is more likelihood of patients not being managed by consultants with the most appropriate expertise.

The Senate of Surgery of Great Britain and Ireland says that for a population of 450,000 the general surgery consultant team should consist of 15 general surgeons to cover the sub-specialties of vascular, breast, endocrine, upper gastro-intestinal, hepato-biliary surgery, lower digestive system ..... will provide at least two consultants per major sub-specialty, enable (cancer) site specific specialisation and allow a four surgeon emergency vascular rota in addition to a general surgical rota.

Similar principles are proposed for other surgical specialties.

The EU Working Time Directive applies to consultants and we should not organise our system on the wholly unreasonable presumption that specialists will inevitably forego their rights voluntarily. The supply of specialists cannot multiply dramatically in a few short years, so the best way of achieving better cover is to create larger teams of specialists rather than perpetuating the smaller teams currently spread between separate hospitals. Larger teams create more opportunity for better organising the work programmes of individuals. This means there can be dedicated cover for emergencies at any one time. Less interruption of planned elective work by the demands of emergencies and scope for consultants to undertake programmed ambulatory care in locally accessible centres without spending their days shuttling back and forth between individual hospitals trying to cover all aspects of their responsibilities simultaneously.

The pattern of services we propose tackles this challenge. It creates larger teams and allows them to programme their work in just this way.

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For general surgery and general medicine the aim is to create three core services in each specialty serving three main population zones of the city in a way that gets us much closer to the size of population proposed by the Senate of Surgery, the BMA and other sources of national clinical opinion. If we do not create these core service teams, we will fall well short of the population sizes now being advised.

So for each of medicine and surgery there would be:

- a team serving the Southside *347,000 population*
- a team serving the North and East *340,000 population*
- a team serving the West *226,000 population*

The Southside teams would conduct their acute in-patient work at the Southern General, day case surgery at the Victoria Infirmary and out-patient care at both the Southern General and at the Victoria Infirmary. The West Glasgow teams would undertake all of their work at Gartnavel. The organisation of the North and East teams needs further debate during the consultation period. Ambulatory care would be provided at both Stobhill and the GRI (with Stobhill as the main focus for day surgery). How best to organise the in-patient service and to achieve the desired pattern by the middle to end of the decade will be identified by consultation in late summer 2000. The proposed pattern for other specialties is shown on the following pages.

The proposed pattern for other specialties is as follows:

Specialty	Current Pattern	Proposed future of in-patient base	And to be locally accessible in ambulatory care?	Comments
Maternity	GRI, Southern General, Queen Mother's Hospital	GRI and new Southside hospital at Southern General	Locally accessible ante-natal care	Decision on principle of reducing to two units has already been the subject of consultation. Proposed future is linked to proposals to relocate all Yorkhill's services to the Southside.
Urology	Southern General, GRI, West Glasgow, Stobhill	• No change in South • One in-patient centre in North	–	Precise location in the North to be subject to consultation over coming months.
Vascular Surgery	Consultants work in all 6 existing hospital sites	• Southside vascular service based at Southern General • One in-patient base North of the river	–	In-patient base North of the river will depend on logistical practicalities as between GRI and Gartnavel.
Orthopaedics	Consultants currently do in-patient work in all existing 6 hospital sites	• Southside orthopaedic service co-located with A&E/ trauma service at Southern General • North Glasgow orthopaedic service co-located with A&E trauma service at GRI	–	New pattern allows both dedicated cover for trauma and adequate cover in sub-specialisms (hips, knees, hands, upper limbs, spine, feet).

Specialty	Current Pattern	Proposed future of in-patient base	And to be locally accessible in ambulatory care?	Comments
Breast Surgery	Consultants currently based at GRI, Stobhill, Western Infirmary, Victoria Infirmary and Southern General. Scattered too thinly	• 1 unit at Southern General • 1 unit at Gartnavel		These would be *immediate* access services with dedicated teams, diagnostic and operating capacity. Needs concentration to be able to offer this immediacy of specialist service. The key accessibility issue here is more focused on speed and right skills, and not on locality.
Nephrology	Gartnavel GRI * (Stobhill)	• 1 unit at Southern General • 1 unit in North Glasgow * * Decision to concentrate North-East nephrology at GRI now being implemented following earlier consultation.	_	Provision of service in the South is a new development. Nephrologists consider there should be two units in Glasgow. So if there is one in the South, there will be one in the North (precise location to be subject to discussion during consultation period). Renal dialysis will be *locally* available (North and South) - detailed arrangements to be debated during consultation period.

Ophthalmology	Gartnavel Stobhill (2 beds only) Southern General	This specialty is now predominantly ambulatory care. Further discussion needed on how and where to provide the few beds needed to support a Glasgow ophthalmology service.	This specialty is now predominantly ambulatory care.	Further discussion needed on how and where to provide the few beds needed to support a Glasgow ophthalmology service.
ENT	Southern General (Victoria Infirmary) Gartnavel (24 beds) Stobhill (12 beds)	• Southern General • In North Glasgow bed requirement is expected to fall to around 12 beds by 2005. Need further discussion about where to provide these 12 beds	–	Modern facilities for Southside ENT in-patient service currently under construction at Southern General. Decision to transfer ENT beds from Victoria Infirmary to Southern General already reached after consultation.
Gynaecology	Consultants currently do in-patient work at all existing sites except the Western Infirmary	• Southside in-patient service to be located at Southern General • North Glasgow in-patient service to be co-located with Maternity service at GRI	–	• Southern General and GRI in-patient beds will be in modern facilities. • Gynaecological cancer services to have stronger connections with Beatson Oncology Centre. • Current West Glasgow clinical team re-locates to the Southern General.

Specialty	Current Pattern	Proposed future of in-patient base	And to be locally accessible in ambulatory care?	Comments
Dermatology	Southern General Western Infirmary	This specialty is moving inexorably towards being predominantly ambulatory care. Future in-patient requirements to be met within overall hospital bed complements.	–	
Clinical Haematology	GRI, Victoria Infirmary	Western Infirmary Southern General	–	In North Glasgow preferable for clinical haematology to be co-located with Beatson Oncology Centre. In Southside clinical haematology service needs to have an in-patient base.
Maxillo-facial Surgery	Southern General (Canniesburn)	Southern General	–	Capital scheme to implement 1996 Acute Strategy decision is underway. Will allow maxillo-facial surgery to move from Canniesburn. Also provides significant service to other West of Scotland Boards.

Regional Services

Neurosciences	Southern General	No change	Neurology currently being considered	Already in modern facilities
Spinal Injuries	Southern General	No change	No	Already in modern facilities
Beatson Oncology Centre	Western Infirmary	Western Infirmary	May be shared care with local physicians/ surgeons	Relocated into modern facilities, move to Gartnavel later in the decade (subject to consultation)
Cardiothoracic Surgery	GRI and Western Infirmary	Western Infirmary	To be considered	Concentrated as a single centre in modern facilities
Infectious Diseases	Gartnavel	No change	No	Already in modern facilities
Homoeopathy	Gartnavel	No change	No - but many GPs have homoeopathy training	Already in modern facilities
Plastic Surgery/Burns	GRI (Canniesburn)	GRI	–	Current capital scheme provides modern facilities. Allows closure of Canniesburn
Renal Transplantation	Western Infirmary	No change, unless consultation suggests it should be on the same site as North Glasgow's nephrology service.	Nephrology	Already in modern facilities

Comments on this issue or any other aspect of the proposals to modernise Glasgow's hospital services should be sent by June 30th, 2000 to

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Leaflet request form

Getting Informed

If you want to read up on any other issue please complete this leaflet request form. Tick the box ✓ next to the leaflets you want, provide your name and address in the space provided and send it to the Freepost address below (no stamp needed).

Acute Services Review
Greater Glasgow Health Board
FREEPOST (GW 707)
Glasgow G3 8BR

- ❑ 1. The Patient's Experience
- ❑ 2. Getting It Right For Patients: What It Means For Organising Services
- ❑ 3. Cancer Services: Specialisation In Action
- ❑ 4. Why Specialisation Matters - And What We Propose To Do To Make Its Benefits More Available
- ❑ 5. Creating More Responsive Accident And Emergency Services
- ❑ 6. Ambulatory Care: What Is It?
- ❑ 7. Minimally Invasive Technologies: Keyhole Surgery And The Like
- ❑ 8. The Overall Planning Challenge For Greater Glasgow - Acute Hospitals In A Wider Context
- ❑ 9. Some Recent Background History
- ❑ 10. Impact Of Regulations On Doctors' Working Hours
- ❑ 11. The Number Of Beds We Propose To Provide
- ❑ 12. Regional Services Provided By Glasgow Hospitals
- ❑ 13. Why Teaching And Research Matters
- ❑ 14. Staffing Matters
- ❑ 15. How The Finance Works
- ❑ 16. Detailed Analysis Of The Options For South Glasgow
- ❑ 17. Maternal And Child Health
- ❑ 18. Better Access For West Glasgow Residents
- ❑ 19. The GRI / Stobhill Partnership
- ❑ 20. Why Centralise Cardiothoracic Surgery?
- ❑ 21. Radiotherapy: Linear Accelerators - A Patient's Guide

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You can also send it by fax on 0141 201 4426.

Alternatively, you can call us on Freephone 0800 85 85 85.

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