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Some Recent Background History

The Future

of Glasgow's

Hospital Services

Let's Plan It

Together!

GREATER GLASGOW
HEALTH BOARD

in partnership with
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in Glasgow

Some Recent Background History

The challenge of modernising Glasgow's acute hospital services has confronted successive government and Health Board administrations.

The early part of the last decade was marked by the closure of a number of small hospitals in Glasgow. In the middle part of the decade there was widespread debate about what the fundamental shape of acute hospital services should be. This culminated in a strategy approved by the then Secretary of State in June 1996. In essence the strategy entailed two key changes in configuration.

(a) the creation of new facilities for maternity and plastic surgery services at the Glasgow Royal Infirmary, allowing the closure of both the Glasgow Royal Maternity Hospital at Rottenrow and Canniesburn Hospital. (Rutherglen Maternity Hospital was also part of the equation but falling birth numbers led to its closure in 1998).

    The new facilities at Glasgow Royal Infirmary are now under construction and should open between the end of 2000 and 2002.

(b) the Western Infirmary, comprising a mixture of 1970s ward block and some cramped and out-dated old facilities, would close and its services would transfer into new accommodation at Gartnavel General Hospital, currently a tower ward block and podium built in the 1970s.

    Implementation of this decision has not yet progressed to approved capital investment plans, mainly because the scale of the plans developed by the former West Glasgow Hospitals Trust was unaffordable.

The 1996 Strategy effectively left the acute hospital profile in South Glasgow unchanged although some changes in the location of individual specialties were sanctioned (most significantly the centralisation of maxillo-facial surgery in-patient facilities from Canniesburn and the Royal Infirmary to the Southern General).

The 1996 Strategy was stated to cover the period 1996 to 2001.

During the last two years there have been extensive discussions within the Greater Glasgow NHS, with local authority and trade union partners,

with the Greater Glasgow Local Health Council, with MPs and MSPs, and with local interest groups such as Community Councils and Health Service Forum South East about how to move forward in the development of acute hospital services for the period beyond 2001.

The debate has focused on several aspects of change:

(a) What to do about the **Southside's legacy of obsolete buildings** and plant at the Victoria Infirmary and in parts of the Southern General Hospital campus.

(b) How to achieve progress in sorting out existing **operational problems in West Glasgow**.

(c) How to provide in Glasgow the benefits of **better designed healthcare** harnessing modern digital technologies and significantly less invasive techniques. Much of this can and should be 'walk-in, walk-out', same day, without all the delays, postponements, and trekking around hospital corridors that is too often the lot of patients currently. This requires better concentration of clinic, diagnostic, day surgery and rehabilitation facilities than can be achieved in scattered departments in old hospitals. It requires high class scheduling of work and flexible use of space and staff skills. This concept of "ambulatory care" can provide for 80% or more of people's experiences as patients of an acute hospital and would transform the quality of those experiences. Much has been done to develop these ideas both for Stobhill Hospital and the Victoria Infirmary and plans for state-of-the-art Ambulatory Care Centres for both hospitals form a major part of our new proposals for improving Glasgow's hospital services.

(d) How to provide **better continuity of specialist skills** being available when they are needed. Medicine and surgery are increasingly specialised and we need better cover for specialists to deal with out of hours emergencies and planned absences (holiday, study leave etc). Without better cover there is more likelihood of patients not being managed by consultants with the most appropriate expertise.

(e) How to implement shorter working hours and better educational programmes for junior doctors. The government is committed to ensuring that their maximum working week should not exceed 56 hours. (The European Parliament is pressing for the EU maximum working week of 48 hours to apply). In any event the intensity of work should not be so great that it squeezes out the time and space for quality communication with patients and relatives. And tiredness increases the risk of mistakes.

The pressing need to achieve these standards is widely recognised.

(f) How to provide stronger multi-specialty support for trauma and multiple injuries and at the same time provide a faster service for people attending Accident and Emergency Departments with much less serious conditions.

The former requires concentration of those specialists if the necessary skills are to be rapidly available without detriment to GP emergency referrals or to planned elective work. The latter is easier to assure if the conflict between high priority patients and those not seriously ill or injured is reduced or totally separated.

Trying to find a set of proposals that would hit all the right buttons is extremely difficult in Glasgow. Some of the challenges point to concentrating services on fewer sites as a way of solving them. But equally there are strong arguments for maintaining local access and local communities within Glasgow feel strongly about this. In the debates of the last two years (and in the years before) this has been particularly evident in relation to Stobhill and the Victoria Infirmary.

But we cannot run away from the difficulties. They are arising elsewhere in the UK and the Western World. An article by Jeremy Laurance, The Independent's Health Correspondent, which appeared in August 1999 is reprinted here (with the kind permission of 'The Independent'). Despite its deliberately provocative headline and colourful opening two paragraphs it provides a thoughtful analysis of the issues of specialist skills and knowledge, patient safety, junior doctors' hours, efficiency and changes in clinical practice generally.

Our proposals aim to find the "best fit" for Glasgow. We believe that they are (possibly) unique in maintaining as much local access as possible in contrast to other cities which have often gone down the road of closures of some hospitals.

Text of an article by Jeremy Laurance in 'The Independent', 24 August 1999

Farewell to the Dear Old District General Hospitals

The Doctors have a plan. It is a grand plan and it calls for a bold political initiative. They want to close or downgrade the local hospitals, many housed in outdated buildings, that litter the country and replace them with fewer, larger palaces of disease which are able to provide the advanced medical care that patients will expect in the 21st century.

But there is a problem. It can be summed up as the mums-with-prams syndrome. No local community welcomes the closure of a local hospital, as MPs, NHS managers and doctors have learnt to their cost. Mums-with-prams make vocal and photogenic demonstrators quite capable of derailing the best laid plans. Politicians confront them at their peril.

This is how the battle lines are drawn. As the latest report calling for widespread hospital closures, from the Royal Medical Colleges, lands on health secretary Frank Dobson's desk, it is worth asking what sort of health service we want?

The argument can be summed up in a phrase: access versus quality.

Which is more important to the patients of tomorrow: to be able to hop on a Number 9 bus and get to hospital in 20 minutes where basic care will be good but you will take pot luck if you are in need of specialist attention? Or to face a journey of 40 to 50 miles with the promise that when you get to hospital the care you will receive will be the best the NHS can offer?

Most people naturally reject these alternatives demanding the best care on their door-step, but the gloom-mongers of the Royal Medical Colleges say it simply isn't possible. Under their Chairman, Charles Collins, a consultant surgeon in Taunton, Somerset, their report says: "It is important for the public to recognise that it is not possible for each locality to have its own small hospital to provide anything other than a restricted service. This may well not include an accident and emergency unit or acute medical and surgical services".

There are good reasons why this is the case. Medical care has advanced to the point where no single specialist has the knowledge and expertise to provide top quality care. Medicine is now a team activity in which groups of specialists combine their expertise to tackle disease and secure the best outcomes for patients. In a report a year ago, the British Medical Association, the Royal College of Physicians and the Royal College of Surgeons said there should be no single-handed consultants in any of the main medical or surgical specialties, regardless of the size of the hospital. The growing complexity of medicine meant specialist treatment could no longer be provided without the backup of a full medical team.

A consequence of this increased complexity is a shortage of patients. There are not enough doctors to staff specialist teams to the requisite standard in every hospital because there are not enough patients requiring specialist care to sustain the expert teams to care for them. Doctors in training require raw material - patients - on which to hone their skills but these can only be provided in sufficient numbers in centres serving large populations.

Last year's joint report by the BMA and the colleges of physicians and surgeons called for "super hospitals" serving the populations of 500,000, about twice the size currently served by the average district general hospital, to overcome the problem.

The current Royal Medical Colleges' report has grown out of the earlier one as the surgeons and physicians recognised that they would strengthen their case if they can get their colleagues in the other colleges (gynaecology, paediatrics and so on) to join the cause.

Their vision does not require the outright closure of large numbers of hospitals but they argue many might be downgraded to provide low-tech care in co-operation with nearby specialist centres.

There is nothing new in this suggestion. Similar recommendations have been made in a clutch of reports over the years. What patient would willingly undergo an emergency operation in the dead of night by an unsupervised junior doctor? The regular surveys by the confidential enquiry into perioperative deaths (within 30 days of surgery) in 1997 identified operations by

unsupervised juniors - accounting for one fifth of all those performed out of hours - as those carrying the greatest risks. The response of the Royal College of Surgeons was to call for emergency work to be concentrated in half the present number of hospitals, leaving the remainder doing routine work.

On the same grounds the Audit Commission in 1996 suggested the closure or merger of more than a quarter of accident and emergency departments because they were seeing too few patients - less than 50,000 - to support a full range of specialist services. Intensive care beds are being grouped in fewer centres to concentrate expertise - which means we can expect more helicopter dashes with mortally ill patients in search of expert care.

The argument behind this drive to centralise is that doctors and hospitals treating larger numbers of patients provide better care. But it is not accepted by all. Critics argue that the strategy is flawed as it still remains to be proved that bigger necessarily means better. A study by the Centre of Health Economics at the University of York found "no good evidence" that increasing the size of hospitals improved outcomes.

Answering these intellectual challenges (what patient would reject the offer of expert care for lack of evidence that it was superior?) may be less difficult than the political objections. Change is hampered by the fear, shared by all MPs, of demonstrators (mums-with-prams) turning out in their constituencies, waving placards and rattling tins. Yet the fierce dependence on the local hospital may be about to change.

New styles of care mean increasingly that the "hospital" is moving out into the community. Consultants are holding clinics and performing tests in GPs' surgeries, and patients are having remote consultations with consultants in hospital using advanced video technology. New walk-in clinics announced by Mr Dobson in June, which are being piloted in 20 places around the country, may ease the pressure on, and demand for, accident and emergency units.

The future of the NHS clearly lies, at one end, with palaces of disease providing the full panoply of specialist care and, at the other, with local clinics and day surgery units offering easy access to routine care. But the days of the district general hospital, promising more than it can deliver, are numbered.

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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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- ❑ 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
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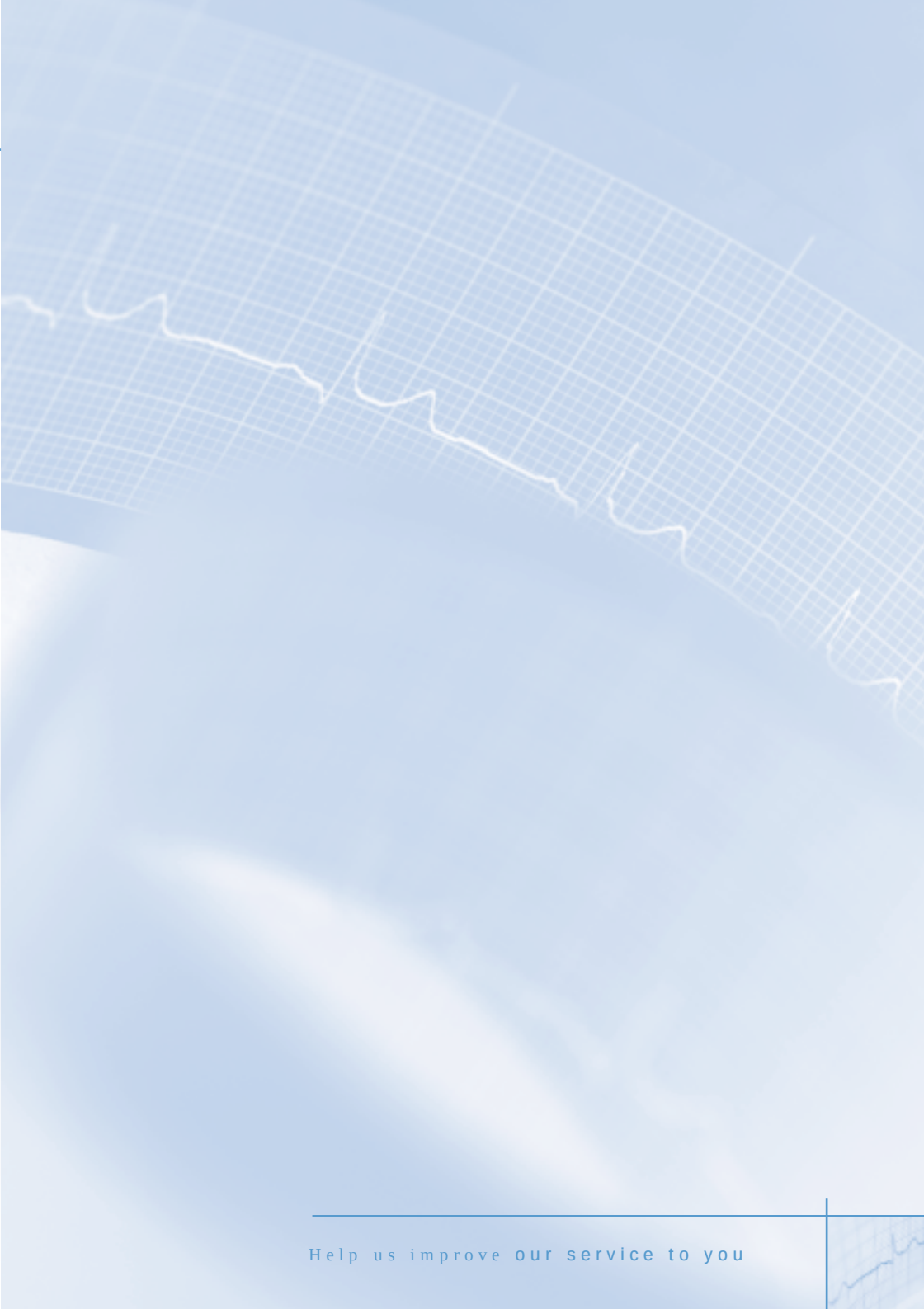

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