THE SCOTTISH OFFICE

NHS:
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National Health Service in Scotland
Management Executive

St. Andrew's House
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11 April 1994

Addressees

For action:

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Health Boards

Chief Executives, NHS
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For information:

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To be copied to:
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Dear Colleague

EMERGENCY HEALTHCARE IN SCOTLAND:
FUTURE STRUCTURE OF ACCIDENT AND
EMERGENCY SERVICES

Summary

1. This letter brings to your attention the publication on 11 April 1994 of the policy review report 'Emergency Healthcare in Scotland: Future Structure of Accident and Emergency Services', a copy of which is attached.

2. The report provides a policy framework within which informed decisions on the pattern of A&E services can be taken by Boards as purchasers and by the Management Executive at national level. Annex A provides a brief summary of the main points of the report.

Action

3. Chapter 8 of the report sets out the various actions which need to be taken by Health Boards to implement the recommendations of the report. The Management Executive will shortly initiate discussions with Boards on the implementation of the report.

4. Additional copies can be obtained from HMSO bookshops, price £12.50.

5. This letter should be copied to Unit General Managers for information.

Yours sincerely

DAVID R STEEL
Director of Administration

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ANNEX A

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EMERGENCY HEALTHCARE IN SCOTLAND: FUTURE STRUCTURE OF ACCIDENT AND EMERGENCY SERVICES

Background

1. For at least 30 years, the most effective organisation of emergency healthcare in Scotland has been a topic of concern. The need for careful planning is dictated by the range and volume of accident and emergency (A&E) cases and the duty on Health Boards to ensure that such services are available on an all-comers basis. Planning has however been piecemeal and the evidence suggests that some categories of patient, such as those with minor injuries and major trauma, are not as well served as they might be. These factors, coupled with the reviews of acute sector strategies being undertaken by some of the larger Boards, suggested that the time was ripe for a strategic overview of A&E services.

2. The broad remit given to the group set up to study the subject was to provide a policy framework within which informed decisions could be taken at local level by Health Boards as purchasers, and at national level by the Management Executive, regarding the most effective pattern of emergency healthcare provision for each Board's population, both resident and non-resident, and for the Scottish population as a whole.

Policy Review Report

3. With the principles of the Patient's Charter in mind, the report takes as its starting point the needs of patients who require urgent healthcare without having been able to make any prior arrangements. It therefore deals with the totality of services involved, to which it gives the name "Accident and Emergency Service". This covers hospital A&E Departments, associated specialties such as orthopaedics, anaesthetics and coronary care as well as ambulance services and primary care. The Accident and Emergency Services concept embraces all emergency heathcare needs including psychiatric and obstetric emergencies even though these are not referred to specifically in the report.

4. After examining the scale and costs of existing A&E provision the report deals in turn with the various purchasers and providers of these services and with specific current issues. In Part III the report then draws together the key issues by recommending that Health Boards must first of all undertake an assessment of the emergency healthcare needs of their area. Once they have done so, they will be in a position to purchase an A&E Service for their area. The report shows that A&E

patients can be grouped into 3 broad categories:

- medical and surgical illness and "minor injuries" suitable for treatment in a primary care setting;
- patients who require treatment in the A&E Department in a hospital; and
- major trauma patients and those with complicated fractures.

5. The needs of these 3 categories can be met by the purchase of an A&E Service, which has 3 corresponding main components:

- a Primary Care Emergency Service;
- a Hospital Emergency Service; and
- a Major Trauma Service.

6. The report does not prescribe the proportion of each component which Boards should purchase to make up the overall A&E Service. This proportion will vary from one Board to another, in line with the identified needs of each population, and the decision is therefore a matter for Boards. In their strategic planning for such an A&E Service, it is essential that Boards should consider the inter-relationship between each component part, the balance to be struck between them, and their locations. It follows that changes to one component cannot be made without consideration of a corresponding adjustment to the other 2 components.

7. This applies particularly to the decision on where to strike the balance between the role of the Primary Care Emergency Service and that of the Hospital Emergency Service. The decision should be one that reconciles the degree of public preference for a readily accessible local service with the benefits in terms of outcomes to be obtained from concentration of clinical expertise in A&E Departments, and which fully addresses issues of cost-effectiveness. In this context, Boards are encouraged to conduct their own cost-benefit analysis of the various possible models of primary care emergency service. A major public communication effort will also be needed to tell Boards' populations how their emergency healthcare needs can best be met by the A&E Service purchased by their Board.

8. The Major Trauma Services is a new concept in the Scottish context. The report concludes, on the basis of a detailed cost-benefit analysis, that there would be clear advantages in terms of lives saved and outcomes generally if 3 or 4 trauma services were to be established in Scotland. It is beyond the terms of reference of the report to make specific recommendations on the exact number and location of the trauma centres which would form the core of each trauma service, as such matters relate to implementation of the report and are therefore for the Management Executive of the NHS in Scotland. This aspect of the recommendations would have public expenditure implications, and it cannot be assumed that net extra resources would be available for this purpose.

9. Following publication on 11 April the report now passes to the Management Executive for implementation of its recommendations. These will be the subject of discussion between the Management Executive and Boards during the course of this year.