EMBARGOED UNTIL MEETING
BOARD: 20 APRIL 2004

GREATER GLASGOW NHS BOARD

Minutes of a Meeting of the
Greater Glasgow NHS Board
held in the Reid Hall,
Maryhill Community Central Halls,
304 Maryhill Road, Glasgow G20 7YE
on Tuesday, 20 April 2004 at 9.30 am

PRESENT

Professor Sir J Arbuthnott (in the Chair)

Dr F Angell
Mr J Bannon MBE
Mr J Best
Dr H Burns
Mr R Calderwood
Mr R Cleland
Councillor J Coleman
Councillor D Collins
Dr B Cowan
Ms R Crocket
Mr T Davison
Ms R Dhir MBE
Mr T A Divers OBE
Councillor R Duncan

Councillor A White

IN ATTENDANCE

Ms E Borland .. Acting Director of Health Promotion
Ms S Gordon .. Secretariat Manager
Mr D Griffin .. Director of Finance, Primary Care Division (for Minute 48)
Mr J C Hamilton .. Head of Board Administration
Mr A McLaws .. Director of Corporate Communications
Ms D Nelson .. Communications Manager
Ms C Renfrew .. Director of Planning and Community Care
Mr D Walker .. Assistant Director of Planning and Community Care (for Minute 50)

BY INVITATION

Mrs P Bryson .. Convener, Greater Glasgow Health Council
Ms D Paterson .. Representative, Area Nursing & Midwifery Committee
Mr H Smith .. Chair, Area Allied Health Professionals Committee
Dr B West .. Chair, Area Medical Committee

ACTION BY

43. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Dr R Groden, Mr C Ferguson (Chair, Area Pharmaceutical Committee), Mr J Cassidy (Chair, Area Nursing and Midwifery Committee) and Ms Gale Leslie (Chair, Area Optometric Committee).
Sir John intimated that Dr Richard Groden the new Chair of the LHCC Professional Committee had been appointed by the Minister for Health and Community Care as a replacement on the NHS Board for Dr John Nugent.

44. **CHIEF EXECUTIVE’S UPDATE**

Mr Divers made reference to the following issues:

(a) Sir John, Rosslyn Crocket and he had attended an important seminar on 22 March 2004 on child protection. This had emphasised the role and responsibilities of the NHS in connection with child protection and it was envisaged that a paper would be considered at the June 2004 NHS Board meeting in this regard.

(b) Mr Divers had been accompanied by Evelyn Borland to a development workshop at Glasgow City Council to discuss the continuing development of community planning and how this could be further shaped in the City of Glasgow.

(c) The Minister for Health and Community Care had made an announcement in Parliament endorsing the Centre for Population Health. It was anticipated that a launch would take place in the summer hosted jointly by Greater Glasgow NHS Board, Glasgow City Council and the University of Glasgow.

**NOTED**

45. **MINUTES**

On the motion of Mr R Calderwood, seconded by Councillor R Duncan, the Minutes of the meeting of the NHS Board held on Tuesday, 16 March 2004 [GGNHSB(M)04/3] were approved as an accurate record and signed by the Chairman.

46. **MATTERS ARISING**

The Rolling Action List of Matters Arising was circulated and noted.

**NOTED**

47. **LOCAL HEALTH PLAN AND FINANCIAL STRATEGY**

A report of the Director of Planning and Community Care and the Director of Finance [Board Paper No 04/22] asked the NHS Board to:

- Approve the update to the 2002/05 Local Health Plan.

- Confirm the proposals for the use of new monies available in 2004/05 as set out in both the Local Health Plan and in fuller detail in the annexed Director of Finance report, which thereby defined the 2004/05 Startpoint Revenue Allocation.

- Confirm the follow through into the five year Financial Plan as set out in the Report of the Director of Finance.
• Receive a further detailed report on the 2004/05 Recovery Plan at the May 2004 NHS Board meeting, that would set out how the NHS Board would return to financial breakeven over the next two years.

Mr Divers introduced the paper by emphasising its importance particularly in the context of understanding clearly the period of financial pressure the NHS Board faced over the course of the next two years. He commented on the level of change required to return to a position of financial break-even and this had resulted in the need for a series of measures to be taken to ensure the Board’s plans and commitments were affordable.

He emphasised that NHS Greater Glasgow was not in a unique position in re-examining its priorities but that this had been witnessed across other NHS Boards in Scotland.

Ms Renfrew outlined the background and context of the NHS Board’s Local Health Plan in that it set a strategic direction for the next five years and was a product of a whole range of different planning processes. The purpose of the Board paper, however, was to focus on 2004/05 and provide a summary of key local priorities for that year and describe how national priorities would be delivered.

She described the key strategies reflected in the 2002/2005 Local Health Plan and the Financial Plan which underpinned this. It was clear that in reviewing the Plan for 2004/05, a number of significant financial issues had resulted in a major gap in making realistic provision for inflation and other pressures while continuing to honour forward commitments.

This financial context had meant that a review of all the plans and priorities for 2004/05, as set out in the 2002/05 Local Health Plan, had been undertaken. Ms Renfrew summarised the outcome of that review for each of the following spending programmes:

• Mental Health
• Child and Maternal Health
• Primary Care and Other Community Services
• Acute Services
• Other Spending Programmes

She advised that the Scottish Executive Health Department had made an additional allocation intended to reflect the additional demands on health services made by deprived populations. This “unmet need adjustment” was being made pending a more detailed review of the national funding formula and gave NHS Greater Glasgow an additional allocation in each of the next two years. It had been the Board’s approach to allocate such resources to services which required development and expansion to meet the needs of deprived populations and which would otherwise have been reduced or constrained because of the financial position. Accordingly, investment in additional activity to tackle health inequalities would include the following:

• Addiction Services
• Primary Care Mental Health
• Sexual Health
• Improving Oral Health
• Reducing Smoking

Ms Renfrew outlined progress made on the Scottish Executive’s national priorities including:
• Improving Health
• Service Redesign and Modernisation
• Patient Focus Public Involvement
• 48 Hour Access to Primary Care
• Waiting Times for Inpatient Day Care and Outpatient Treatment
• Delayed Discharges
• Healthcare Associated Infection
• Cancer
• Coronary Heart Disease and Stroke
• Mental Health

The financial requirement set by the Scottish Executive Health Department was the requirement to achieve financial breakeven. The scale of that challenge had been highlighted and Mrs Hull described the 2004/05 Financial Plan under four headings:

• Income
• Inflation and Other Pressures and Allocations to Operating Divisions
• Revising the Local Health Plan and National Priorities
• Closing the Gap

She described the key points of context which had produced a financial challenge of around £50/60 million which must be addressed over a maximum of two years. Recognising that NHS Greater Glasgow was now one unified system, the proposals brought together measures to ensure the four Divisions could stay within their allocation – a critical challenge for 2004/05.

Mrs Hull described the proposed actions to address the Board’s position within the Corporate Recovery Plan which the Corporate Management Team was developing. The detailed actions within the Plan would be expanded during the next month with the objective of ensuring that the Board had a deliverable set of proposals which would return NHS Greater Glasgow to a position of financial balance within two years. The current arrangements governing resource allocation within NHS Scotland prescribed that any year end overspend carried with it a double financial jeopardy; the forward financial plan needed to reflect both the year-on-year recurrent over commitment and a non-recurrent allocation reduction which matched the level of the previous year-end deficit.

It was particularly important to recognise that a managed and fair reduction in staffing was essential to reduce costs – focussed as far as possible on non frontline posts.

Mr Robertson re-iterated the point that financial shortfall was an NHS Scotland-wide issue and not solely within NHS Greater Glasgow. The NHS Board’s Performance Review Group had worked through all the documentation particularly with regard to managing expectations and meeting national priorities whilst achieving break-even. He highlighted the table shown on page 48 of the Board papers and the outstanding recurring deficit of £36.8 million for 2004/05. In response to this, Mr Divers referred to the overall achievement made by the NHS Board so far but emphasised the need to step up the effort and flesh out other elements in the Recovery Plan to meet the recurrent gap.

Mr Goudie referred to the NHS Board’s monthly waiting times report which updated NHS Greater Glasgow’s performance against nationally set targets. He asked if such a performance indicator paper could be made available for the other national targets to monitor the impact of investment made by the NHS Board. Ms Renfrew confirmed that performance outcomes could be shown to the Board against national priorities and consideration would be given to the best way of presenting this.
Mrs Smith agreed with the points made by Mr Robertson and recognised that savings needed to be made in a short time frame of two years. She referred to the positive work carried out by the Board particularly in relation to the planning of the two new ACAD Hospitals, addressing low pay, the new Beatson Oncology Centre and junior doctors working hours – it was important that such good work was not overlooked.

Mr P Hamilton referred to the £10 million shown in the Recovery Plan proposals on page 38 of the Board papers that was West of Scotland NHS Boards’ income. He asked whether NHS Greater Glasgow expected to recover this sum. Ms Renfrew referred to the cross-boundary flows between NHS systems and the legitimate issue regarding the cost of services patients received from other NHS Board areas. A process was in place with West of Scotland Boards to discuss proposals regarding the settlement of such monies – the outcome of these discussions would be considered by the Performance Review Group. It was clear that the NHS Board could not continue to provide services to residents outwith its area but recognition was given to the difficult process which had to be set to deal with this. Mr Divers further confirmed that the Scottish Executive Health Department had been involved in these discussions in terms of the delivery of regional planning.

Mr P Hamilton also referred to the £500,000 identified to reduce management costs and wondered if this was a reasonable target estimate given the move to single system working. Mrs Kuenssberg, however, urged the Board not to dilute management costs too much as they were essential to help deliver NHS services although she did recognise that any identified duplication of effort should be removed and shared services within single system working might bring further savings.

Sir John thanked the Performance Review Group for its work in preparing proposals for the NHS Board’s consideration and referred to the great deal of work now to be done to achieve the targets set out in the Recovery Plan. He re-iterated the importance of the ongoing dialogue in connection with the West of Scotland income and the ongoing series of developments where the plan contained elements of services that now had to be delayed.

**DECIDED:**

- That the update to the 2002/05 Local Health Plan be approved.

- That the proposals for the use of new monies available in 2004/05, as set out in both the Local Health Plan and fuller detail in the annexed Director of Finance Report, be confirmed thereby defining the 2004/05 Startpoint Revenue Allocations.

- That the follow through into the five year Financial Plan as set out in the Director of Finance Report be confirmed.

- That a further detailed report on the 2004/05 Recovery Plan be received at the May 2004 NHS Board meeting setting out how the NHS Board would return to financial breakeven over the next two years.

**48. LOCAL FORENSIC PSYCHIATRIC UNIT (LFPU) – FULL BUSINESS CASE (FBC)**

Mrs S Kuenssberg declared an interest in this item and, therefore, left the room during its consideration.
A report of the Chief Executive, Primary Care Division [Board Paper No 04/23] asked the NHS Board to consider the full business case (FBC) for a Local Forensic Psychiatric Unit (LFPU) to be constructed on a Greenfield site at Stobhill Hospital and approve the FBC for onward submission to the Scottish Executive.

Mr Reid introduced Mr Douglas Griffin, Director of Finance, Primary Care Division who was in attendance for this item.

Mr Reid briefly described the background to the LFPU and the processes that had taken place since July 1999 when the Scottish Executive Health Department had approved the then Greater Glasgow Primary Care NHS Trust’s outline business case submission to provide a LFPU for Greater Glasgow.

The full business case proposed the provision of an LFPU by Canmore Balfour Beatty under a PFI funding arrangement. At this stage, financial values and contractual terms and conditions were regarded as firm, however, were not yet final and would remain subject to change during the period up to financial close and final agreement. As negotiations with Canmore Balfour Beatty were well advanced and now in their final phase, it was reasonable to assume that any variations to price and/or contract terms and conditions which occurred between now and financial close would be minor.

The structure of the proposed financing arrangement for the LFPU, supported by the work carried out to complete the financial appraisal of the project, led to the conclusion that the transaction would be classified as “off balance sheet”. This, however, remained to be confirmed by NHS Greater Glasgow’s external auditors, PricewaterhouseCoopers, who would provide written confirmation of their opinion on this on conclusion of a contract with Canmore Balfour Beatty.

Following approval by the NHS Board, the full business case would be submitted to the Scottish Executive Capital Investment Group in May 2004. Assuming that this timetable was achieved, it was anticipated that construction would commence after financial close was reached on 30 June 2004 and would be completed by March 2006, with the service becoming operational thereafter.

Mr Robertson referred to the long process in getting to this stage but the considerable milestone that had been achieved in taking this full business case forward.

In response to a question from Councillor Handibode, Mr Reid confirmed that support services (as noted on page 136 of the Board paper) would be retained in-house. Mr Griffin confirmed that hard Facilities Management (FM) services would be provided by the preferred bidder but that soft FM services would be provided in-house.

DECIDED:

- That the full business case for a Local Forensic Psychiatric Unit to be constructed on a Greenfield site at Stobhill Hospital be approved and that it be submitted to the Scottish Executive Capital Investment Group for consideration.

Mrs Kuenssberg returned to the NHS Board meeting at the conclusion of this item.

49. **COMMUNITY HEALTH PARTNERSHIPS (CHPs) – OUTCOME OF CONSULTATION ON INITIAL BOUNDARY AND SERVICE PROPOSALS**

A report of the Director of Planning and Community Care [Board Paper No 04/24] asked the NHS Board to:
• Note the outcome of consultation.

• Approve the proposed boundaries subject to the final review outlined in the paper.

• Remit to the CHP Steering Group, the important wider issues which the consultation had raised for consideration in developing the detailed schemes of establishment, which would be submitted for Board approval.

• Confirm its commitment to the full engagement of all primary care practitioners in the migration from Local Health Care Co-operatives (LHCCs) to CHPs.

Ms Renfrew set the background for the Board’s proposals for consultation stemming from the proposals within the White Paper to evolve Local Health Care Co-operatives to Community Health Partnerships. She described the consultation process and how this was managed through a wide range of mechanisms. She restated the boundary proposals put to consultation and set out responses to these proposals suggesting how the Board should now proceed.

The boundary proposals had been developed as organisational boundaries and it was not intended to disrupt natural patterns of care. As such, it was acknowledged that cross-boundary flows and their impact on services and budgets required further detailed work. It was also accepted that CHPs would have substructures within their primary boundaries to reflect different communities and neighbourhoods and the different population clusters for their varied functions.

The proposals were that there should be single CHPs covering each of the following Local Authority areas with boundaries coterminous with the Local Authority:

- East Dunbartonshire - population 109,400
- West Dunbartonshire - population 93,300
- East Renfrewshire - population 90,000

For Glasgow City Council, five CHPs were proposed:

- Western - population 138,284
- Northern - population 115,769
- Eastern - population 146,155
- South West - population 114,337
- South East - population 120,910

No proposals had been made for the Rutherglen/Cambuslang and the North Lanarkshire part of Greater Glasgow, reflecting the earlier stages of discussion with Lanarkshire NHS Board and Lanarkshire Local Authorities. It had to be questioned, however, whether the Rutherglen/Cambuslang LHCC population of around 55,000 was large enough to represent a viable CHP.

Ms Renfrew described the implications of the proposed boundaries for existing LHCC structures. It was important to recognise that key to the further development of CHPs and addressing the issues was reaching agreement on final boundaries. As such, Ms Renfrew led the Board through the proposed further elements of work intended to offer certainty to enable progress to be made. She highlighted the various concerns and issues raised with the boundary proposals and a suggested response to these.

Throughout the consultation exercise on boundaries, the opportunity was taken to include two sets of other issues about CHPs in connection with their roles in managing services, resources, staff and functions and the potential organisation and resources of CHPs.
Ms Renfrew restated the position that CHPs had massive potential to deliver better services and decisions for their population, anchored in local accountability and responsibilities which connected wider health improvement with service delivery. CHPs were not only seen as a way of better managing and integrating NHS services but also as offering an organisation which could be a partnership with Local Authorities, giving the opportunity to integrate services and drive a joint health improvement agenda.

Ms Renfrew described the consultation process as very successful in terms of attracting a wide range of thoughts and constructive responses which needed to be considered carefully. It was critical to achieve two objectives in the next phase of work:

- Firstly to ensure that there was particular effort to retain the support and engagement of health staff and those who had contributed so much to the success of LHCCs.
- Secondly to ensure the many and detailed issues raised were comprehensively worked through in the development of detailed schemes of establishment.

The CHP Steering Group and the processes established with Local Authorities would need to achieve these two objectives and the Board would want to test progress at regular intervals.

Councillor Handibode, was sympathetic to the Rutherglen/Cambuslang issue and saw many advantages of a CHP being populated with 55,000 but was not unhappy with the Board’s proposal. He did, however, suggest caution in terms of the negotiation of the boundaries.

Councillor Collins referred to the further detailed discussions to take place regarding Thornliebank Health Centre which lay just outside the Glasgow City boundary but with most of its patients living in Glasgow City. As such, detailed discussions would take place with East Renfrewshire and Glasgow City Councils to establish how the practices within the Health Centre could be incorporated into a Glasgow CHP.

Councillor White welcomed the proposals and sought concentration of effort on services rather than boundaries.

In response to a question from Mr Cleland, Ms Renfrew confirmed that the Prince and Princess of Wales Hospice had been consulted and lines of communication would remain open in taking forward proposals for which CHP boundary it lay within.

Mr Robertson commended the work done throughout the consultation exercise and encouraged such commitment through to the delivery phase.

Dr Burns referred to the ongoing work being undertaken with all Local Authority partners to discuss how health improvement services could be delivered and taken forward through CHPs.

Councillor Duncan acknowledged the further work and discussion with the Anniesland, Bearsden and Milngavie practices to see how the LHCC migrated into two CHPs and how the service issues could be addressed

**DECIDED:**

- That the outcome of consultation be noted.
That the proposed boundaries, subject to the final review outlined in the paper be approved.

That the CHP Steering Group be remitted to consider the important wider issues which the consultation had raised and lead the developmental detailed schemes of establishment which would be submitted for Board approval.

That commitment to the full engagement of all primary care practitioners in the migration from Local Health Care Co-operatives to CHPs be confirmed.

50. MODERNISING NHS DENTAL SERVICES IN SCOTLAND: SCOTTISH EXECUTIVE CONSULTATION PAPER

A report of the Director of Planning and Community Care [Board Paper 04/25] asked the NHS Board to agree and submit the report as a response to the Scottish Executive consultation paper.

Ms Renfrew introduced Mr David Walker, Assistant Director of Planning and Community Care, who was in attendance to present this paper.

Mr Walker, Chair of the Dental Planning Group, welcomed the opportunity to contribute to this consultation document confirming that the officers agreed with much of its analysis, principles and proposals.

It was recognised that the present General Dental Service system was no longer in tune with the realities and complexities involved in the delivery of modern dentistry and that arguably the resources were not having the correct strategic impact. Similarly, there were concerns at what was perceived to be widespread disillusionment amongst General Dental Practitioners about the current system. Consequently, the need for change was recognised but the Executive would be encouraged when implementing any new proposals to do so in concert with the profession and to phase change over time to minimise any risk of destabilisation.

Mr Walker summarised the overall aims to modernise dental services including:

- Prevention.
- Access – encompassing infrastructure support, incentives in deprived areas, mixed payment methods, developing a comprehensive dental health system and workforce planning.
- Remuneration – including simplifying charges, future range of NHS dental treatments, payment, quality and clinical pathways.
- Opportunities for integrated working.
- Investment.

Dr Angell confirmed that the draft response reflected the Area Dental Committee’s views and highlighted that although many dentists within NHS Greater Glasgow were dissatisfied with the current system, the area had been fortunate in that it had not suffered in terms of lack of availability of NHS dental services. In taking forward the consultation, he encouraged the Scottish Executive to be realistic particularly in relation to the remuneration for NHS dental services. Mr Walker confirmed that the Oral Health Planning and Implementation Group was looking further into this and he was hopeful that such issues would be addressed.
Dr Angell also expressed his disappointment that the consultation had not included any suggestion of fluoridation in the public water supply which the Area Dental Committee would support. Dr Burns confirmed that if the public water supply included fluoridation, there was evidence to show that it would reduce dental caries with no adverse harm to the population. It was not an issue for this consultation but acknowledged that the Public Health community at large would be supportive.

In response to a question from Mr Bannon, Mr Walker confirmed that the “secondary care” referred to in paragraph 2.3 of the document did include Glasgow Dental Hospital and School.

In response to a question from Mrs Murray, Mr Walker confirmed that “Professions Complementary to Dentistry” as referred to in paragraph 3.2 of the document referred to Dental Hygienists and Dental Nurses. Dr Angell advised that Glasgow was now training Dental Therapists who could carry out many such procedures.

Ms Borland was keen that the health inequalities gap in relation to dental care was also addressed and that the supply of dentists should be evenly spread throughout NHS Greater Glasgow regardless of affluent or deprived areas.

Mrs Kuenssberg referred to the captive audience at schools and encouraged work with Education Departments to ensure that this opportunity was not missed in promoting oral health amongst children.

**DECIDED:**

That, subject to drafting changes, the report be agreed and submitted as a response to the Scottish Executive consultation paper.

51. **WAITING TIMES**

A report of the Director of Planning and Community Care [Board Paper No 04/26] asked Members to note progress on meeting waiting time targets.

Ms Renfrew referred to the changed reporting format from specifically monitoring over nine month waits, to six to nine month waits for inpatients and day cases. As before, this was presented separately for residents without availability status codes and those with availability status codes. Over the coming month, the Board would develop this further to include outpatients as well as performance against the targets.

It was considered that sustaining the nine month maximum wait guarantee was a major challenge. Also the move towards delivering a six month maximum wait in a constrained resource environment would be a serious problem when set alongside the outpatient target.

In conjunction with the Divisions, the Board was preparing its plans for incremental performance improvement in waiting times in 2004/05, moving towards achieving the December 2005 targets.

**NOTED**
52. **MEMBERSHIP OF THE GREATER GLASGOW HEALTH COUNCIL**

A report of the Head of Board Administration and Convener of Greater Glasgow Health Council [Board Paper No 04/27] asked the Board to approve offering five Members a further 12 month extension to 31 March 2005 and to note that the remaining Health Council Members already had a term of office to 31 March 2005.

**DECIDED:**

- That offering the following five Members a further 12 month extension to their term office to 31 March 2005 be approved:
  - Patricia Bryson – Convener
  - Suzanne Clark
  - Caroline McCalman
  - Margaret McNaughton
  - William May

- That the following Health Council Members already having a term of office to 31 March 2005 be noted:
  - John McMeekin – Vice Chair
  - Stewart Daniels
  - Anne Jarvis
  - Cynthia Mendelsohn
  - Williamina Shields
  - Gordon Connell
  - Patricia Munro
  - Maureen O’Neill

- That approval be given to the Head of Board Administration to make appointments to the seven casual vacancies which had now arisen utilising the usual methods of recruitment.

53. **PERFORMANCE REVIEW GROUP MINUTES – 9 MARCH 2004**

The Minutes of the Performance Review Group held on Tuesday 9 March 2004 [PRG(M)04/2] were noted.

**NOTED**

54. **AUDIT COMMITTEE MINUTES – 9 MARCH 2004**

The Minutes of the Audit Committee held on Tuesday 9 March 2004 [A(M)04/1] were noted.

**NOTED**

55. **ADJOURNMENT**

The NHS Board agreed to an adjournment of 30 minutes to allow Members to have lunch before the next item on the agenda.
56. MODERNISING MATERNITY SERVICES : OUTCOME OF CONSULTATION

A report of the Chief Executive, Director of Planning and Community Care and Medical Director [Board Paper No 04/28] was submitted on the outcome of the consultation held on Modernising Maternity Services in NHS Greater Glasgow.

Sir John introduced the paper and commented that it was the end of a long and difficult process beginning in 1999. He outlined why it had been so difficult:

- Proposals for changes in medical service were controversial. Where change affected maternity services it was particularly sensitive. The Board recognised this and understood the strong views that had been expressed and had listened to those views in forming its decisions.

- Since 1999 there had been a strong clinical consensus about the need to move from three to two delivery units because the level of medical cover required could not be sustained – this was now an urgent issue which had to be addressed.

- There had always been conflicting clinical advice from the key medical specialties about which unit should close. Those differences being played out in the media had meant the process to arrive at a decision had been particularly difficult.

These issues could not, however, undermine the Board’s primary responsibility to move to a decision and to make that decision based on the clearest and most objective appraisal of the best services for women and their babies. The Board had worked for almost a year to bring forward the proposals for a decision which aimed to meet that responsibility.

He outlined how the paper would be presented.

Mr Divers would begin by giving a brief introduction to the paper followed by three short presentations covering the consultation process, the main themes which had emerged from it and, finally, an outline of the work undertaken by the Maternity Planning Group. Following that, a broad discussion with Board Members would take place.

**Introduction to the Board Paper – led by Mr Divers**

Mr Divers described the context in which the Board had to make its important decision. He reminded Members about the bigger picture within which the decision about maternity units was framed. This context confirmed the Board’s ability to improve maternity services in implementing the recommendations included in the Board paper in a number of ways outlined in page 229 of the Board paper. The Board paper had three substantive attachments:

- The report of the Maternity Working Group – page 257 to 283.

- An index and summary of responses to the consultation including the issues raised in public meetings – page 284 to 305

- The report of the Maternity Planning Group – page 306 to 324

He restated the background to the proposal to confirm the process the Board had followed in reaching this decision point since May 2003 and advised that Board Members had heard directly from clinicians, participated in public meetings and a number of Members had visited the maternity hospitals.
Consultation Process – led by Mr Divers

Mr Divers went on to present the four key strands of process which had brought the Board to the point of decision today:

- 1999 consultation
- 2003 preconsultation
- 2003 public consultation
- 2004 decision making

He took each one in turn and described their outcomes.

1999 Consultation

Having undertaken detailed work on which unit should close, the Board concluded that maternity and children’s services should be considered together as part of the ongoing Acute Services Review consultation.

There was a lack of clinical consensus about the triple co-location of maternity, children’s and adult services and that process proved inconclusive.

The Board knew, however, that it would need to return to the issue of maternity services, given the clear clinical view that the present pattern was not sustainable.

2003 Preconsultation

The Board knew this would be a difficult and sensitive decision and agreed to establish a major preconsultation exercise to enable it to develop proposals for formal public consultation. In May 2003, the Board approved a process which included three strands:

- A Maternity Working Group – which would be chaired independently and include three non Executive Members. Evidence would be given to the Working Group by open sessions and the Group itself was to be supported by external clinical advisers.

- Midwifery Advice

- MATNET – the Maternity Services Users Network

2003 Public Consultation

In October 2003, the Board received, in public, the three reports and then continued on that day, in seminar discussion and concluded that the preconsultation reports should form the basis of public consultation.

A formal Board paper was prepared on that basis and the October Board meeting endorsed seven consultation proposals including the proposed closure of the Queen Mother’s Hospital (QMH) but with the addition of questions designed to ensure contrary views could be freely expressed.

Alongside the public consultation process, the Board established the Maternity Planning Group to report in detail on how services could operate if the QMH closed and to address issues emerging from the consultation.

2004 Decision Making

The Board had had a number of Seminar and Board meeting discussions during the consultation process, considering emerging issues.
Board Members had received a full set of 329 consultation responses, accompanied with a summary. Recent seminars had enabled Board Members to consider the detail of the Maternity Planning Group’s conclusions, hear direct clinical perspectives and, on a number of occasions, to discuss the development of the structure and content of the Board paper.

Mr Divers asked Ms Renfrew to lead the Board through the themes which had emerged from consultation.

**Main Themes Emerging from Consultation – led by Ms Renfrew**

Ms Renfrew referred to Attachment 2 of the Board paper which summarised all the responses and issues raised at public meetings. The Board paper set out and responded to the main themes and Ms Renfrew highlighted, in particular, the Board’s response to three of these themes:

- **Potential rise in population** – Ms Renfrew referred to the Table on page 248 which illustrated the decline in births in Greater Glasgow over the last ten years. The 2003 figure of births in Glasgow hospitals included around 700 additional births due to the closure of Vale of Leven Hospital which had now re-opened.

  To arrive at the future projections for births in Glasgow Hospitals, the Board had assumed that around 300 Greater Glasgow women would deliver outside Glasgow and around 2,000 non Greater Glasgow women would deliver within Glasgow hospitals. Both of these numbers had been stable over a number of years, since the closure of Rutherglen Maternity Hospital.

  With the Vale of Leven Community Midwifery Unit re-opened, this would suggest that planning for between 11,000 and 11,500 deliveries was a prudent approach, particularly as relatively conservative assumptions about throughput in sizing the physical capacity of the two units had been made.

- **Regional planning** – the Board had worked closely with Lanarkshire and Argyll and Clyde NHS Boards throughout the last decade to ensure maternity plans were coherent. Lanarkshire had an established pattern of flows into its single and relatively new delivery unit at Wishaw. Argyll and Clyde concluded a major strategic review of maternity services in the middle of last year, closing two Consultant led units, at Inverclyde and Vale of Leven and consolidating services at the Royal Alexandra Hospital (RAH) in Paisley. The Board had engaged fully in that review and the only outstanding issue was the definitive assessment of how many women from the Dumbarton area would opt to deliver in Glasgow. The maximum impact of this factor was an additional 200/300 deliveries above the planned 11,200 – those numbers would not require a third delivery unit.

  The suggestion had been made that because the RAH was marginally nearer the Southern General Hospital (SGH) than the QMH that would offer a basis to close the Southern General and retain the QMH. It was difficult to see relative proximity as a definitive factor in reaching a decision. The pattern of maternity hospitals did reflect historic patterns of residence and delivery and, as always, decisions needed to be made about future services with the present pattern as a start point. The suggestion that a further regional planning exercise could result in Glasgow retaining three units could only be made on the basis that either the delivery unit at Wishaw or the RAH would close. Both served distinct populations and it was unlikely there would be support for their closure in order that Greater Glasgow could retain three units within a three mile radius of each other.
• **Interests of women and their babies** – consideration of this proposition had a number of dimensions which suggested the status quo did not serve the best interests of women and their babies:

  - There was strong clinical consensus that three units would not provide safe and sustainable services. The Board’s professional advisory committees supported the closure of one unit.
  
  - Retaining unused capacity had an opportunity cost in terms of resources available to other services. The vast majority of maternity care was delivered in community settings – the Board’s proposition had seen that was where resources should be concentrated and would have most impact in addressing the effects of poverty and the health inequalities it created.
  
  - There was no evidence that the very marginal additional travelling times, no more than five minutes by blue light ambulance, represented any risk to safety, particularly when that pattern of service retained units north and south of the river, addressing the City Council’s point that over reliance on cross river routes in dealing with time critical emergencies might be unwise.

There had never been an argument that the ideal arrangement for the very small numbers of neonates who needed specialist intervention was the co-location of maternity services and specialist paediatric services. The Maternity Working Group Report had stated this and the relevant policy guidance confirmed the desirability of co-location of neonatal intensive care and surgical services, achieving in utero transfer for prenatally diagnosed disorders. That ideal service arrangement could not be achieved if the Board was also to meet the imperative that major obstetric services should be alongside adult and intensive care services. Ms Renfrew re-iterated, however, that:

1. The reviews of maternal and neonatal morbidity and mortality did not appear to offer any support to the view that risks to women were theoretical and risks to neonates were substantial. The reverse was concluded by these reviews.

2. There did not appear to be any information that illustrated worse outcomes in UK children’s hospitals which were not co-located with maternity services.

**Maternity Planning Group – led by Dr Cowan**

Dr Cowan described the work of the Maternity Planning Group which the Board had established to test its proposal to close the QMH and to address issues arising from the preconsultation and consultation. The final report of the Group described current patterns of service, how services would be organised if the QMH closed, including neonatal transfer arrangements.

The Group was chaired by Dr Cowan as the Board’s Medical Director and included members from all three Divisions. Dr Cowan referred to the work of the Group having a number of different strands:

- Detailed clinical input from a range of staff across maternity, neonatal and paediatric services.

- Numeric analysis.

- Establishment of subgroups on specialist paediatrics, aspects of fetal maternal medicine and workforce.
Visits to other services that did not provide co-located maternity and specialist paediatrics.

He highlighted the main issues covered by the Group as follows:

- **Consolidated fetal medicine service** – there were a number of high quality, major regional services providing all that QMH did without a children’s hospital alongside. These services illustrated the importance of clinical networking with the specialist children’s hospital. A larger service would offer greater potential for subspecialisation and improved cover.

- **Transfer arrangements** – the principle which informed the Group’s work was to minimise additional transfers and the report included detailed data on the current pattern of transfers. The Group suggested a second transfer ambulance to ensure that the Board could deliver expeditious transfer when it was required.

- **RHSC neonatal arrangements** – this was an important issue for the Group particularly as a continued neonatal intensive care unit was proposed by the Neonatal Subcommittee. It did, however, recognise this not to be viable and the need, therefore, for another safe option. Dr Cowan referred to the capital work underway to develop proposed new Intensive Therapy Unit (ITU) and High Dependency Unit (HDU) facilities alongside cardiac and surgical wards and the multi-disciplinary clinical input from surgeons, cardiologists, paediatric intensivists and neonatologists.

- **National Services** – the Group considered and made specific proposals on how the following national services would be sustained if the QMH closed:
  - Paediatric cardiology and cardiac surgery.
  - ECLS (Extra Corporeal Life Support)
  - Interventional fetal medicine

A further critical issue was to ensure that the pattern of referral into Glasgow of fetal abnormalities continued. It was the Group’s view that this would depend on the Board’s ability to ensure that the Princess Royal Maternity Hospital (PRMH)/Royal Hospital for Sick Children (RHSC) service was seen as an integrated service provided on two sites. The centres the Group visited which were not co-located reported a strong pattern of regional referral. Dr Cowan summed up by commenting that the pattern of services proposed in the consultation could be provided in a safe and sustainable way, avoiding separation of mothers and babies, increasing specialist input to SGH and PRMH services and addressing access concerns.

The Chair opened the discussion to points and questions from Board Members.

Ms Crocket re-emphasised the overarching issue of reducing from three to two delivery units. She referred to the many associated advantages of this in terms of community services development and enhanced public health midwifery services.

In response to a question from Mr Robertson about national services, Dr Cowan confirmed that the Maternity Planning Group had considered these issues in its proposed service model and had made clear proposals to ensure these services were secure, practically based on other UK centres. Discussion would continue with the National Services Division in taking these forward following a decision.
Mr P Hamilton was concerned about conflicting clinical advice with regard to transport. He confirmed to the Board the clear advice the Maternity Working Group had received from Dr Charles Skeoch’s, (Regional Director of Neonatal Transport, West of Scotland), written submission made to the Maternity Working Group on 25 September 2003 “…… we have undertaken 440 transfers since 10 March 2003 with no deaths and no major morbidity due to transfer. ……My personal view regarding the role of transport is non judgemental as regards the location of maternity services. Our service will respond to the needs of the hospitals requiring to move their infants ……. I would not like your Group to get the view that there were surgical babies dying because they cannot receive timeous surgical intervention. Transport medicine is about stabilisation and safe transport for staff and baby – not speed!”

Mr Davison referred to the capability of the PRMH to cope with increased deliveries. Senior staff at PRMH had assessed the building in terms of space and confirmed that if the QMH closed, adequate space provision could be made available at the PRMH. Mr Davison supported co-location of adult and maternity services and, therefore, the recommendations.

Mrs Smith thanked Board officers who had provided so much information throughout the consultation period and who had supported this with a vast array of clinical information being made available. In considering the issues of morbidity and mortality at pages 242 and 243 of the Board paper, Mrs Smith referred to triple co-location as a gold standard. She commended the Yorkhill model where excellent services had been provided for 40 years but agreed that the current position was not sustainable. In such circumstances, she recognised that managing change was never easy but saw no reason for it not being managed effectively should the QMH close. She referred to the high rate of deprivation within the NHS Greater Glasgow area and the hard work being undertaken in terms of health promotion which the proposed changes would strengthen.

In response, Mr Divers referred to the clinical views on triple co-location as outlined in pages 246 and 247 of the Board papers. There was now strong clinical support for the co-location of adult, paediatric and maternity services. It was proposed that the process be put in place to bring proposals for the longer term disposition of specialist children’s services to formal public consultation by the end of 2004. It should be explicit that the Board was making that commitment to bring forward those proposals based on the responses it had received from clinical staff to the consultation on maternity services.

Professor Smith agreed that maternity services should be provided in an environment where adult services were available particularly intensive care units and specialty consultant led teams – these were not available on a paediatric site. He referred to the strength of the clinical advice that consultant units should be on an adult site and that there were real, not theoretical, risks to women. He was strongly supportive of recommendations.

Mr Cleland referred to his strong personal link with Yorkhill particularly as he had been Vice Chair of the former Trust for four and half years. He was familiar with staff views, expectations and arguments and agreed that concerns should be around services and not the buildings. He supported the move from three to two delivery units and agreed that the Board should pursue the gold standard of triple co-location. He was strongly supportive of recommendation 3 that in implementing this closure there was a real need to engage the clinical staff. He confirmed that North Glasgow University Hospitals Division staff would work with the Board to take forward the new service proposals should the QMH close and set in place proposals for an enhanced service for mothers and babies.
Mrs Kuensberg offered views from a different perspective. As Chair of Yorkhill NHS Trust until the end of March 2004, she had been closely involved in this difficult debate and had a particular interest in its outcome. As a Member of the NHS Board, however, she had also tried to take a wider view and to focus on the interests of the mothers and babies whose care the Board had a responsibility to provide. She strongly supported a number of the proposals:

- The move from three to two delivery units.
- The enhancement of services in the community, the development of co-ordinated midwifery services on a Glasgow-wide basis and the idea of maternity and paediatric services being managed within the single structure across Greater Glasgow – three proposals which would have significant benefits for mothers, children and the wider family.
- That the ideal model of care would be the triple co-location of a maternity unit, a children’s hospital and an adult hospital.

She was, however, consistently opposed to the proposed choice of the QMH closing, breaking the vital link between maternity services and paediatrics provided at the RHSC.

She referred to the Working Group Report presented to the Board on 7 October 2003 and, at that time, had argued that more would be lost than gained by closure of the QMH – she had not changed her view.

She referred to the Board paper where it stated repeatedly that it was the Board’s responsibility to provide the safest possible services for mothers and babies. In an ideal world this would require direct access to intensive care facilities for both groups – not currently an option for Greater Glasgow. Choosing to close the QMH because of the lack of on-site adult intensive care would leave two delivery units co-located with adult services but would remove the similar advantages for babies of access to paediatric services.

Mrs Kuensberg considered that the Board fell short of conducting an open, transparent and involving consultation process. On the basis of the Working Group Report recommending closure of the QMH, public consultation went ahead with this one option only removing any comparative element from the debate.

The lack of comparison between potential options had also prevented searching analysis of various practical aspects which would normally be fundamental elements of a strategic review. In terms of workforce issues, one of the main drivers of the review, the closure of either the QMH or the SGH would relieve pressures on some key groups.

She lastly referred to the positive element to come out of the consultation process which was the new volume of clinical support for the co-location of adult, paediatric and maternity services, described as the gold standard. In the interests of mothers and babies, NHS Greater Glasgow should not settle for less and accordingly the Board should commit to this exciting vision. She recognised that great care would be needed in formulating these proposals – to decide where this new centre should be and to tackle many issues about resourcing and timescale.

She argued that commitment to this new vision for the future, fundamentally changed the context of the current debate. Decisions about the future of maternity services and children’s services should take place in tandem and it was the Board’s responsibility in the interim period to retain the safest and best of the existing services for mothers and babies. She considered this could be done in two complementary units – at the Princess Royal Maternity and the Queen Mother’s with close networking between them.
She concluded by indicating she could not support the closure of the QMH.

Sir John noted the four important themes from Mrs Kuenssberg’s comments. He asked Ms Renfrew to respond to the points on risks and outcomes, Mr Divers to deal with consultation and Dr Cowan to respond to the points about the Maternity Planning Group.

Ms Renfrew responded to a number of Mrs Kuenssberg’s points:

- intensive care for women and babies could be provided on one site in Glasgow – but only at the Southern General, not the QMH.

- it was wrong to suggest that there was no concrete evidence – fifty years of confidential enquiries into maternal deaths and many years of similar reviews of neonatal morbidity and mortality provided a very strong base of evidence in support of the closure of the QMH.

- While triple co-location may be the gold standard it clearly could not be delivered in a timeframe which would enable the Board to safely sustain three maternity units.

Mr Divers addressed the points about consultation. The Board had agreed to consult on the Working Group’s recommendations but with a clear statement that challenges to those conclusions were entirely legitimate and questions to encourage those. Responses to consultation clearly indicated that there had been no sense of restriction on alternative views and options being put forward.

Dr Cowan responded that the Maternity Planning Group had carefully considered workforce issues and its recommendations reflected what was required. It was the Yorkhill proposal on neonatology services which would increase the pressure on staff. The Group report included financial analysis and estates issues had been reviewed in three different reports, summarised in the Board paper.

Professor Smith confirmed his view that it was not clinically viable to have two consultant units with patients neatly divided between high risk mothers at the PRMH and high risk babies at the QMH. There was no credible clinical advice which would support such a proposition.

Ms Dhir indicated she had thoroughly reviewed all of the evidence, responses and advice with fresh and objective eyes and had concluded the opposite of Mrs Kuenssberg and that the closure of the QMH was the right decision. She also referred to the whole host of community based maternity services which were being enhanced and agreed that a better service provision would be provided if the QMH was to close.

Councillor Collins respected the views of all NHS Board Members and commended Board officers for the time and effort put into presenting the vast array of information. He was keen that the Board Members respect collective responsibility for any decision made.
Councillor White supported the points made by Mrs Kuenssberg and agreed that the gold standard was triple co-location. It had been a lengthy and detailed process and he had read all responses and visited both maternity units. He opposed closure of the QMH on the basis that more was to be lost than gained. He referred to the clinical excellence provided at Yorkhill, made only possible with the co-location of the QMH and RHSC. He did not believe that the regional planning discussions had been adequate and made reference to the “Minority Report” issued yesterday by members of Yorkhill Staff Association within the Maternity Planning Group exercise. He suggested that the decision be suspended until further work and feasibility be undertaken on the proposal for triple co-location. It had gained strong clinical support and there was no public support for the closure of the QMH.

Mrs Bryson conveyed the views of Greater Glasgow Health Council who agreed that the status quo was not sustainable. The Health Council also considered that information should have been made available on the finance and estate elements of the proposals.

Mr Goudie acknowledged the considerable body of work and the huge effort involved. The Board must recognise, however, that the existing services were greatly cherished by the community as a whole, so any change to that service must be evidence based. He believed that there were a number of gaps in providing such evidence – namely:

- There needed to be a robust scoping exercise on how the closure of either maternity unit would affect the people of Greater Glasgow. He did not believe that there was sufficient evidence of this to satisfy all the communities of Greater Glasgow.

- Maternity services needed to be planned strategically on a West of Scotland basis. The Board needed, therefore, to initiate a planning mechanism for maternity services with neighbouring Boards which would greatly help address current medical staffing issues.

As such, he could not support recommendations 1 and 3 at this time and considered that maternity services be re-assessed on a West of Scotland basis.

Councillor Duncan and Mrs Nijjar stated that they supported the comments made by Mrs Kuenssberg and did not support closure of the QMH.

Mr Divers summed-up the discussion by stating that this was a difficult decision for the NHS Board, particularly with deeply held views on both sides and no clear clinical consensus. The Minister for Health and Community Care had asked the NHS Board to address the regional issues with Argyll and Clyde and Lanarkshire NHS Boards and this had been done. It was important to reach a decision now and work together with clinicians to deliver in the future the best and safest service for mothers and babies.

Sir John intimated that the ten recommendations were inter-linked and, therefore, he was seeking a vote on the acceptance or otherwise of the recommendations as a single package. The outcome would then be submitted to the Minister for Health and Community Care for consideration.

Twenty-two Members indicated their support for the full set of recommendations; five Members had already indicated their dissent from the closure of the Queen Mother’s Hospital. Mrs Kuenssberg asked that her support for many of the other recommendations be recorded.

The Chairman thanked Members for a full and thorough discussion and the officers for the detailed papers on the outcome of the consultation on Modernising Maternity Services.
DECIDED:

1. That delivery services be located in the new facilities at the Princess Royal Maternity Hospital and high quality provision at the Southern General Hospital – the Queen Mother’s Hospital be closed as soon as physical capacity was available and the necessary planning could ensure a safe transition for all the services it provided. This was likely to be around 12 to 14 months from a Ministerial decision.

Chief Executive/ Director of Planning and Community Care

2. That in the context of the abolition of Trusts, the move to single system working and the need to look at appropriate organisational arrangements across NHS Greater Glasgow during spring and summer of 2004, the Corporate Management Team develop an appraisal of a single structure to manage maternity and paediatric services across Glasgow.

Chief Executive/ Director of Planning and Community Care

3. That the report of the Maternity Planning Group form the basis of a change implementation plan to ensure that the quality of specialist paediatric services was not compromised.

Medical Director

4. That community services be strengthened and extended by the provision of a maternity centre in West Glasgow providing an extended range of services, redeployment of midwives into community services and the implementation of public health midwifery, as proposed by the Maternity Services Liaison Committee.

Director of Planning and Community Care

5. That both delivery units provide midwifery delivery beds aimed at low risk women.

Chief Executives

6. That the Maternity Services Liaison Committee be asked to develop proposals to enable women to have the choice of direct access to midwives.

Director of Planning and Community Care

7. That fetal medical services be consolidated into a single major fetal-maternal centre at the Princess Royal Maternity Hospital, with a strong clinical network to paediatric and genetic specialists at Royal Hospital for Sick Children, providing services to the West of Scotland and a national interventional service.

Director of Planning and Community Care

8. That the proposed pattern of community services would minimise access and transport issues but the Board should build on the programme of work established for the Acute Services Strategy implementation to address transport issues identified by communities during this consultation.

Director of Planning and Community Care

9. That the decision on maternity services was taken within the new context where there was now strong clinical support for the co-location of adult, paediatric and maternity services. A process be put in place to bring proposals for the longer term disposition of specialist children’s services to formal public consultation by the end of 2004. The Board should be quite explicit that it was making that commitment to bring forward those proposals based on the responses received from clinical staff to the consultation on maternity services.

Chief Executive/ Director of Planning and Community Care

10. Confirm the commitment that any redeployment of staff required as a result of this decision should ensure the retention of skilled clinicians and the best use of their skills.

The meeting ended at 2.20 pm