Greater Glasgow Acute Hospital Services Strategy: North and South Glasgow Monitoring Groups

Joint Inaugural Meeting
1245hrs, Friday 28th March 2003, Board Room 1, NHS Greater Glasgow Headquarters, Dalian House

Present:

Dr Harry Burns, Greater Glasgow NHS Board (Chair)
Jim Whyteside, Greater Glasgow NHS Board (acting as Secretary in place of John Hamilton)

North Glasgow Group

Ian Miller, Chair of North Glasgow Monitoring Group
Dr Jo Davis, Chair of Medical Staff Association
Brian Fitzpatrick MSP
Billy Hendry, North Glasgow Staff Partnership Forum
Dr Roger Hughes, Chair of Area Medical Committee
Paul Martin MSP

South Glasgow Group

Peter Mullen, Chair of South Glasgow Monitoring Group
Pat Bryson, Convenor, Greater Glasgow Health Council
Janis Hughes MSP
Ken Macintosh MSP
Jane McCready, Staff Side Chair, Local Partnership Forum
Dr Ken O’Neill, Local Health Care Co-operative
Dr David Ritchie, Chair, Medical Staff Association
Dr Yvonne Taylor, Area Medical Committee

Apologies:

Bill Aitken MSP
John McMeekin, Greater Glasgow Health Council
Dr Jim O’Neil, Local Health Care Co-operative
Donald Sime, North Glasgow Staff Partnership Forum

1 Welcome and Introduction

Dr Harry Burns welcomed members of the Monitoring Groups and explained that the joint meeting of the North and South Groups had been called at the request of the Chairs, Ian Miller and Peter Mullen.

Harry said that he was acting as Chair for the duration of the meeting but was also a member of both groups. He was conscious that he was a Member of the NHS Board too but he had a clear ethical position that supported his independent stance: he retained an objective view of all service changes and was obliged to point out any adverse impact on the health and wellbeing of the population of Greater Glasgow to the NHS Board.
2 Remit of Monitoring Groups

Harry drew attention to the paper containing the four basic premises of the North and South Group’s responsibilities. These had been drawn up by the Deputy Minister for Health and Community Care.

Harry invited Ian Miller and Peter Mullen to lead an open discussion on the remit. Peter responded by saying that he was happy with the wide-ranging remit.

Brian Fitzpatrick agreed that the Minister’s letter had been helpful but that some of the detail should be considered. Brian did not understand the first of the four points of the remit. He felt that the role of the secretariat was important – full openness and transparency would be required. There would be little point reporting on the work of the monitoring groups if the public – and, indeed, members of the groups themselves - were not aware also of problems that might lead to failure of service specialties. Retention of ‘named services’ might not be an attractive option if patient safety was compromised due to lack of specialist cover or other factors and there had to be early warning of such circumstances.

Brian also took the view that key clinicians would also have to have the groups’ remit brought to their attention so that they could engage with the monitoring process – ‘whistle-blowing’ was too strong a term but nevertheless individual staff had to be assured that they could contact the groups independently.

Harry responded by agreeing that when services appear to the public to have collapsed suddenly – such as with Vale of Leven – it was not good for patients. Anticipation of problems was necessary and when they did occur it would be due neither to neglect nor conspiracy to let certain services fall. On the latter of Brian’s points, there was no doubt that clinical representatives on the monitoring groups would be tabling discussion about specialty pressures on a regular basis. Given the context of national and internal tensions around the changing pattern of healthcare, along with local tactical issues, there would be a great need for such discussion.

Following on from Brian’s comments, Ian Miller suggested ‘nailing down’ the meaning of remit point one. Peter Mullen professed himself happy with the original wording. However, after further debate, when it was pointed out that final implementation of the acute services strategy may be affected by changing circumstances and the emergence of service specialty issues, it was agreed to modify the wording by inserting the word ‘proposed’

Agreed -

2.1 That the first of the groups’ four remit points should be modified to read:
“To monitor that named services (General Medicine, Coronary Care, Intensive Therapy, General Surgery, High Dependency, Medicine for the Elderly {Assessment} and Diagnostic Support Services) are being sustained, through direct evidence brought to the Group and prepared by the Secretariat and to participate in discussion about proposed changes to named services provision if this was required for reasons of clinical evidence.”

Janis Hughes raised the issue of communications. She suggested that guidelines should be drawn up to avoid further repetition of previous poor communications on the part of NHS Greater Glasgow. She cited the example of the 18th March NHS Board meeting where it had been revealed with no prior announcement that ‘soft services’ in the Stobhill and Victoria ACADs were to be put out to tender to the private sector. Staff and MSPs only found this out from the media – it did not augur well for genuine, structured involvement.

Harry agreed that this was unfortunate, the specific incident being due to a legal advisor answering questions before the Board. Again, there was no conspiracy, merely lots of people working within their own ‘boxes’, which tended to frustrate managed communications.

Paul Martin backed up Janis: this was an issue that had come up at a public meeting the previous Sunday (23rd March). He did not think that PFI/PPP had worked in the NHS in the past. He also felt that NHS Greater Glasgow’s communications had been poor.

Paul continued. He had a problem with remit points one and four. At the outset, it seemed simple that there was a commitment that named services would be retained for a period of five years. However, Paul had contacted Tom Divers on many occasions to access detail on what services were provided in which wards of Stobhill. He had been unable to obtain this information from Tom and this would make it impossible for him to determine if there was a genuine service retention problem and this gave an unnecessary appearance of hidden agendas. This was pertinent as UNISON was claiming that there had been a continual rundown of services at Stobhill over the last few years.

As regards remit point four, Paul wished to make it clear that the monitoring groups did not have role in ‘implementing’ the Acute Hospital Services Strategy. His opinion was that the Glasgow Royal Infirmary could not absorb the workload from Stobhill and he would not be deemed responsible for implementing something that cannot be delivered. He also said that local people had not heard anything of the other extant Acute Services groups - e.g. North Glasgow ACAD Group, which in itself offered a different opportunity for public involvement in service redesign.

Peter responded that he thought the wording of remit point one was in fact a big advantage to MSPs as it ensured that they would be able to obtain information in any format they required from Tom Divers. He said that he had been happy to retain the wording of remit point four because he felt so strongly about stakeholder involvement. However, he felt that it would be possible to move forward by deleting the word ‘implementation’. It was agreed to do this.
Agreed -

2.2 That the last of the groups’ four remit points should be modified to read:

“To create an opportunity for stakeholder involvement in service design and other key aspects of the Acute Services Plan.”

Ian picked up on Paul’s request for service data. He thought it reasonable that if the monitoring groups have targets to achieve the starting points should be clear. This suggested that a breakdown of the named NHS services in layman’s terms be provided for the purpose of measuring progress. Paul said that it worked both ways. The NHS Board had to be objective – if the monitoring groups uncovered serious problems with the Acute Services Strategy in moving services from Stobhill to Glasgow Royal Infirmary, then the Board would have to act.

Harry said that he sympathised. He too could be frustrated by a ‘management blinkered attitude’, which imposed fixed timescales for change on clinical services. Change would have to be achieved so long as it did not compromise patient safety – this was the spirit of remit point four.

Dr David Ritchie asked who had decided what the ‘named services’ were. He was surprised that A & E and Orthopaedics had not been included and the impression therefore given was that these could be changed without public or staff discussion.

Harry explained that the Minister for Health and Community Care had made the decision. David responded by asking how A& E and Orthopaedics could be left out, as these were crucial to providing a viable Victoria Infirmary. Being the fourth biggest receiving unit in the UK, it would be impossible to transfer its workload elsewhere. Harry replied that evidence was required to test this proposition and part of the South Group’s remit was to monitor the situation.

Peter confessed that when he originally met with the Minister and Tom Divers he did not fully understand what ‘acute services’ were: the definition provided in the remit was the answer received. Brian reminded everyone that a parallel group was overseeing the A & E issue – the ‘named services’ in the remit were those defined by the Minister in the 12th September 2002 debate. However, there should be little difficulty in the monitoring groups looking more widely.

Dr Roger Hughes noted that there were other key services that had not been ‘named’ – urology, for example, may not be sustainable under current arrangements as junior staff rotas are affecting surgical services. He was very anxious that the best services could continue without being run down by the ‘back door’.

Ken Macintosh had two questions: What was the relationship between A & E and named services; Are there any services at the Victoria Infirmary not on the ‘named’ list that should be. Harry said that there were issues of definition. For example, ‘General Medicine’ is named but covers an extensive range of sub-specialities. Paul said that he was aware that a full definition of services could obtained via the North Glasgow Trust’s website.
Harry promised that data on the number of patients going through each service and site would be provided. This would be kept simple even though there were data recording issues concerning access to multiple specialties. Ken said data that would provide a baseline to allow comparison of service provision with the past was required. Harry explained that this was complex – some Royal Colleges will allocate certain numbers of consultants to particular sites and this had an impact on patient flow. Even so, he took the view that it was up to the groups if they wanted to examine data about A & Es.

Janis was concerned as she thought there would be dialogue with the A & E group. Maintenance of services was the issue and much was to be decided on the future of the Victoria’s A & E. There had been no discussion whatsoever about the Glasgow Royal Infirmary taking on the Victoria’s A & E workload, yet for many people A & E was the most important issue in the entire Acute Hospital Services Strategy.

Peter said he was looking for answers; there was a need to know what was in the remit. Pat Bryson commented that she took the point about A & E but felt that Orthopaedics should also be included in the remit – this was a vital service and already there were insufficient beds. Harry said he could take this issue back to the Minister.

Harry went further: he felt it was possible to ask the separate groups involved in other aspects of acute services to submit reports to the monitoring groups.

Dr Jo Davis responded. He didn’t think the groups should get bogged down in A & E. Stobhill had been downsized to the point where it ‘only just functions’. There was a need for detailed service definitions if it was to be kept going and Casualty was important in this sense – this need had to be pointed out to the Minister. He felt that the wording of the remit as it stood allowed the NHS Board to manipulate definitions and so the definitions had to be tightened to prevent managers subtly diminishing provision.

Peter said that remit point 4 already included the words “other key aspects” and perhaps Orthopaedics and A & E would fall with this definition. Harry agreed with this suggestion.

David agreed with Jo. As services ‘spiral down’ staff recruitment and retention became more difficult. A & E impacts on virtually every function of the hospital. Harry suggested that it could be agreed that the groups’ remit as drafted allowed discussion of those services not ‘named’.

Ken pointed out that there was no Orthopaedics service at Stobhill and perhaps each group should have a separate list of ‘named services’ as the loss for Orthopaedics at the Victoria would cause an outcry. Paul asked what was left of Stobhill to put in a ‘deep freeze’ – in his view this was not what was meant by ‘named services’. The definition had emerged from excluding a list of various services out to consultation – and, in fact, the rest were to remain.

Harry disagreed with David as he took the view that in the next 10 years it will be clear that all A & Es do not have to be co-located with Orthopaedics. However, he accepted that A & E was closely linked to General Medicine.
Janis felt that Paul’s and Ken’s requests for a list of services would be helpful. Paul elaborated – the data had to be on a ward-by-ward basis as that is what local people understand. Harry said that this kind of data would have to be sourced.

Billy Hendry asked for group members’ view of the increasing role of the Primary Care Trust on the Stobhill site. Peter Mullen felt this was straying away from discussion of the groups’ remit. As Chair of one of the groups, he was anxious to get ‘named services’ defined and the previous discussion had clarified this.

Harry proposed that in the next few weeks that data on the named services, Orthopaedics and A & E services would be provided. This would be based on patient throughput for each service and site and reason for admission. This was agreed.

Agreed -

2.3 That the Secretariat would provide information for the North and South Monitoring Groups concerning patient throughput and reasons for admission to the named services, Orthopaedics and A & E for the Victoria Infirmary and Stobhill as appropriate.

Jo said that he felt that it was impossible for the Minister to withhold Casualty and A & E from the Group’s remit as the functions of the hospital depended upon them. Peter said that the position would be clarified at the next meeting. Paul replied that the Deputy Minister, Mr McAveety, had intended that the groups have sufficient scope to review all evidence they felt to be necessary.

Billy asked again about the position of Primary Care services at Stobhill. Brian was of the opinion that these services were encompassed by the wording of remit point four and noted that the NHS Board had promised adequate land on the Stobhill site for development of acute provision.

Paul, however, thought Billy’s point was a fair one – accommodation could not be knocked down before the strategy was shown to be viable. Harry felt the remit as written would allow groups flexibility to review all service provision on the sites.

Ian’s view was that conversation was drifting away into the provenance of the next meetings of the groups. Harry concurred, saying that information would be provided as agreed to the following meetings of the groups. Ken said that he felt Orthopaedics and A & E should be explicitly in the groups’ remit. Harry said that this would have to be checked out with the Minister, although the spirit of the remit allowed access to information about these services anyway.

David asked why the groups were to report to the NHS Board and not to the Minister direct. He also asked if there was a link to Audit Scotland. Harry explained that the latter organisation had a role in monitoring decisions on provision of inpatient bed numbers. Paul said he was not sure about that – he thought it was monitoring the entire Acute Hospital Services Strategy.
He also thought that the monitoring groups were not in fact reporting via the NHS Board. Harry said that under the remit they were. Paul replied that he did not see that as the groups’ responsibility.

Peter said that although the remit included a link to the Chairman of NHS Greater Glasgow, the groups were not by any means part of the NHS Board – the debate was therefore really a matter of semantics. Ken said that the role of the groups was to protect the public interest. Peter agreed: therefore, the groups had to inform the Chairman of the NHS Board of their findings, as he was ultimately responsible for the public interest.

Paul said ‘reporting’ and ‘providing evidence’ were entirely different things. He did not want to be part of an arrangement with NHS Board in the former role. Peter said he was happy to see the wording of remit point two changed but he was clear that he would have to liaise with the NHS Board if he were to discharge his duties. Paul said that the groups had been set up by the Minister and should therefore report to the Ministerial team – this was necessary in the scenario where problems arose from contact with the NHS Board. Peter replied that the remit was supplied directly by the Deputy Minister. Harry said that it had occurred to no one that the monitoring groups would be anything other than independent. Paul proposed that in the wording of remit point two that ‘providing evidence’ would be better than ‘reporting’.

Ian said there was no debate about the group’s autonomy and its relationship with the NHS Board. Harry was chairing this joint meeting at his and Peter’s request, not on behalf of the Board. He wanted it formally minuted that the groups had no relationship in terms of accountability to the NHS Board.

Agreed -

2.4 That the North and South monitoring groups had no relationship of accountability to the NHS Board.

Brian reiterated that it was the Minister’s decision to establish the groups, not the NHS Board’s. He was reluctant to provide a report that would sit on a shelf somewhere gathering dust. He saw the groups as continually highlighting service log jams and strategic issues on the shape of services, not merely reporting annually to the NHS Chairman as the remit appeared to suggest. Peter said that Harry was to report to the groups on urgent issues as and when required and reminded everyone again that Mr McAveety had drawn up the remit.

Paul said that everyone present had been asked to agree to the remit but he understood that scope had been given by the Minister to debate its parameters. Ken felt that remit point two could be altered by removing the word ‘to’. Peter again said that the Deputy Minister had drawn up the remit and the wording as it stood allowed group chairs the flexibility to take urgent action. Paul repeated his view that the reporting element could only be via the Ministerial team.

Ken asked if Peter minded a change to the wording in remit point two. Peter replied that he was clear about his own remit and therefore did not object. Harry suggested that remit point two be altered simply to state that the groups would report annually on their monitoring role. This was agreed.
Agreed -

2.5 That the remit point two should be modified to read:

“To report annually on the groups’ monitoring role.”

Peter said that publication of the group’s reports could only be possible once the Deputy Minister had seen them – therefore, whether or not to publish would be Mr McAveety’s decision. Ken said this was clear as the Chairs had been appointed by the Minister and were accountable to him.

3 Discussion on Remit and Future Working Arrangements for Both Monitoring Groups

Ian said that he had drawn up a short agenda to describe items crucial to the modus operandi of the monitoring groups. He then tabled a paper laying out points for discussion consisting of:

- Format of meetings – plenary followed by groups;
- Venue;
- Dates – first Friday in June, September, December and March;
- No voting;
- 5-minute rule;
- Meeting cycle – Chairs agree agenda, meetings and debriefing and feedback to Chairman and Chief Executive.

Ian said that they felt it would be useful to for both monitoring groups to meet in a joint plenary session when items of mutual interest occurred. He also suggested that the venue should be Dalian House for future meetings of the groups as this provided a central location.

Peter added that this arrangement was proposed as both Chairs understood how busy NHS staff were and, where technical and clinical issues had to be discussed, they did not want staff having to give evidence on more than one occasion.

Brian said he could see a need to discuss pan-Greater Glasgow issues and there was no problem with this but thought it was not a good idea to meet in Dalian House as this sent out the wrong message. When shared issues arose, a joint meeting was desirable and this was task for the secretariat to pursue but otherwise each group should meet apart – he did not want to see the Stobhill ACAD delayed by issues in South Glasgow. Smaller, separate groups could also challenge assumptions between North and South more easily.

Paul had similar points to make. There was a need for each group to meet at the facilities in question and to debate the issues on site. Those issues were quite different in the North and South. He and other MSPs had made a political commitment to provide their time. It may be possible to debate wider points of view as happened previously at Hampden Park and subsequently it may be a good idea to hold joint group meetings maybe twice a year.
David disagreed as he felt that the problems in acute services in Greater Glasgow were not divided by ‘100 yards of water’. There was a need to jointly consider Glasgow’s problems – lack of co-ordination had led to a shambles. Harry thought it was possible to do both joint and separate meetings. Peter said that was what he and Ian wanted. There were key issues, such as staffing, that had to be considered jointly and they had already advised Tom Divers that they wanted group members to have an opportunity to visit all of the locations in question.

Brian said he had no difficulty with this but it was important to maintain local involvement. Harry said that an understanding of city-wide strategic issues acted as a counterbalance to local issues. Paul said David’s point had been well made but human instinct is parochial. However, he saw the need for strategic partnership and agreed that joint meetings once or twice a year would be necessary, but otherwise each group was required to reflect parochial interests.

Ian said he appreciated this and thought Paul’s input provided him and Peter with a way ahead. Harry asked if it was agreed that each group would meet separately in local venues and that joint meetings would follow as required. These, in addition to ongoing communication between the groups, would be facilitated through the secretariat. This was agreed.

Agreed -

3.1 That the North and South Monitoring Groups meet separately in venues pertinent to the Victoria Infirmary and Stobhill Hospital and that joint meetings and communication between groups would be facilitated with prior agreement by group members through the secretariat.

Paul asked if it could be agreed that evidence gathering by the groups would be an opportunity to interview key NHS staff. Peter said that this had already been agreed with Tom Divers. Harry agreed that in connection with ‘technical’ issues clinical and NHS Board staff would be required to come forward and provide explanations and evidence.

Peter moved on down the list of points for discussion. He asked if it were agreed that there would be no voting on points of debate by group members and that a five-minute speaking rule would be in place at future group meetings. This was agreed.

Agreed -

3.2 That there would be no voting at meetings of the North and South monitoring groups and that members would in the course of meetings be limited to speaking for no more than five minutes – details of matters requiring more time should be submitted in writing.

Peter then asked if the proposed meeting cycle was acceptable. This was agreed.
Agreed -

3.3 That the North and South monitoring groups would meet on the basis of the Chairs agreeing the agenda, meetings taking place at agreed dates and thereafter Chairs debriefing the Chief Executive of the NHS Board and Chairman of NHS Greater Glasgow.

Harry asked if the proposed meeting dates were acceptable. Brian said that Fridays were the best days for MSPs’ diaries. Peter suggested that the date of the first independent meeting of each group should be agreed and that the following dates would be agreed at that meeting. It was pointed out that Harry was a member of both Groups, but he said that if one meeting were held in the morning and the other in the afternoon, he would clear his diary to make sure he could attend both.

Roger Hughes asked if it were possible to substitute with a deputy if meeting dates did not suit. This was agreed.

Agreed -

3.4 That the North monitoring group would meet on the morning of 6th June 2003 and the South monitoring group would meet in the afternoon of 6th June 2003. The venues and timings would be confirmed by the secretariat. It is acceptable for group members to send deputies in their place when particular meeting dates do not suit them.

4. Any Other Business

Dr Yvonne Taylor requested that documents be forwarded to group members well in advance of meetings so that there was sufficient time to scrutinise them.

Brian said that communications were vital. There was a need to reassure the public that change would ultimately be good for health: the Monitoring Groups would review NHS Board decisions to make sure that patient needs were met. He went on to say that the NHS Board had failed dismally in its consultation and subsequent communications about the acute services strategy. The Board had to reflect the political landscape - the public had followed bits of the debate but not a lot and there was a lot of ground to make up. There was a need for the NHS Board’s communications strategy to be clear and understandable – the recent newsletter was progress but could only be found with some difficulty in hospital waiting areas and Brian wanted reassurance that there would be more effort with communications.

Paul wanted to discuss the issue of how the public profile of the group chairs would be supported – they had to be seen as being independent from the NHS Board. There should be a mechanism to support press releases and other forms of communication.

Harry confirmed that the Chairs would be properly supported by the secretariat. Where communications may have been an issue in the past, this was more because of ‘cock-up’ rather than ‘conspiracy’.
Harry continued by saying that the entire NHS was facing difficulties in major change management, as other NHS Boards were now beginning to discover. Greater Glasgow was in a position to learn from past experience. It should be remembered that in twelve years, what emerges from the strategy might well be different from what is currently envisaged.

Yvonne said that she had wide-ranging experience of other NHS Boards and found Brian’s words harsh. She and her fellow GPs liked Greater Glasgow NHS Board and found it easy to work with, in contrast to colleagues elsewhere. In Greater Glasgow the Board had done its best to overcome many problems in taking forward the Acute Hospital Services strategy.

Yvonne concluded by saying that she wanted to see less confrontation on the strategy given that the NHS Board had worked hard to get joint agreement on a way forward. Roger concurred: much had changed since the days of Laurence Peterken and GPs did indeed want to see the ACADs in place. Paul replied that two years ago he had learned that none of the GPs in Springburn had heard anything about the ACADs.

David said that he supported Yvonne’s point of view. It is hard to deal with public apathy. Furthermore, with the Scottish Executive pulling £15 million out from the local health economy through unjustifiably early application of changes to the ‘Arbuthnott Formula’, there was no need for confrontation with the Board given its difficult job. Roger commented that clinical staff wanted new hospitals, not more fighting after ten years.

Brian said that he thought it was important that the work of the monitoring groups was reported to NHS staff through partnership forums. Jane McCready agreed that information should be placed in staff newsletters.

Ken asked what arrangements were being made to ensure that local communities would be represented on the monitoring groups. Harry confirmed that the Deputy Minister would be writing imminently to Community Councils and local campaign groups to seek nominations.

Ian concluded the meeting with his remark that the groups’ primary function was to ensure that £700 million of NHS money was invested wisely for the people of Greater Glasgow.