

**NHS GREATER GLASGOW**

Minutes of the Joint Meeting of the Greater Glasgow – Acute Services – North and South Glasgow Monitoring Groups held at 10.30 a.m. on Friday, 4<sup>th</sup> June 2004 in the former Library, North Glasgow Division Offices 300 Balgrayhill Road, Glasgow, G21

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**P R E S E N T :**

Mr Ian Miller (Joint Chair)	Mr Peter Mullen (Joint Chair)
Dr Harry Burns	Dr Donald Blackwood
Dr Jo Davis	Ms Pat Bryson
Ms Janis Hughes MSP	Ms Catherine Fleming
Ms Elizabeth King	Ms Margaret Hinds
Mr Paul Martin MSP	Mr Kenneth MacIntosh MSP
Ms Cathy Miller	Dr Ken O'Neill
Ms Mary Murray	Dr David Ritchie
Dr Paul Ryan	Ms Ann Simpson
Professor D E S Stewart-Tull	Mr James Sandeman
Dr Jean Turner MSP	

**I N A T T E N D A N C E**

Mr R Calderwood	...	Chief Executive, South Division
Mr T P Davison	...	Chief Executive, North Division
Ms J Grant	..	General Manager – Division of Surgery, North Division
Mr J C Hamilton	...	Head of Board Administration
Mr M McAllister	...	Community Engagement Manager

**ACTION BY**

**1. APOLOGIES AND WELCOME**

Apologies for absence were intimated on behalf of Mr Bill Aitken MSP, Mr Lex Gaston, Dr Roger Hughes, Ms Jane McCreddie, Mr John McMeekin, Mr Donald Sime (represented by Ms C Miller) and Ms Nicola Sturgeon MSP.

The Chairs welcomed everyone present to the Joint Meeting of the North and South Monitoring Groups, which gave both Groups the opportunity to share ways of working and hear presentations on the implementation of the pan-Glasgow Acute Services Strategy and its timescales, together with a discussion on the emerging pressures in acute services.

The Chairs welcomed Dr Paul Ryan – Lead GP for the Local Health Care Co-operative, to his first meeting. Dr Ryan replaced Dr Jim O'Neil on the North Monitoring Group. It was agreed that the Secretary write to Dr O'Neil to thank him for his contribution to the work of the North Monitoring Group.

**J C Hamilton**

The Chairs also welcomed Mark McAllister, Community Engagement Manager, who, along with a colleague, will attend future meetings of the Monitoring Groups and assist with communicating the issues discussed with local community groups.

2. **APPROVAL OF MINUTES OF THE MONITORING GROUP MEETINGS HELD ON 5<sup>th</sup> MARCH 2004**

i) North Monitoring Group: NMG(M)04/2

The Minutes of the previous meeting held on 5<sup>th</sup> March 2004 were approved and would be distributed in the normal way.

iii) South Monitoring Group: SMG(M)04/02

The Minutes of the previous meeting held on 5<sup>th</sup> March 2004 were approved subject to the following change:-

Minute 13 – Presentation on Transport and Access Issues Affecting Acute Services – Page 5 – 2<sup>nd</sup> paragraph, 1<sup>st</sup> line – delete “Mr Sandeman” and insert “Ms Hughes”.

The approved Minutes would be distributed in the normal way.

3. **MATTERS ARISING**

In view of the nature of the business to be conducted at the joint meeting, the Chairs asked that only substantial or crucial matters be raised as matters arising from the Minutes of 5<sup>th</sup> March 2004.

i) North Monitoring Group

Mr Miller asked if Matters Arising could be deferred until the next meeting and this was agreed.

*J C Hamilton*

ii) South Monitoring Group

a) Mr Mullen asked if there were any critical matters arising which required to be considered at the Joint Meeting.

Mr Sandeman indicated that as this was not a regular business meeting, there would be some issues which will have waited six months to be dealt with. Ms Hinds raised concerns that this will lead to some issues not being ratified until December 2004 – a delay of unacceptable proportions. She raised, in particular, questions about the increase in emergency admissions in South Glasgow and the bid for additional monies to open further beds at the Victoria Infirmary. Ms Hinds also raised the reasons for the increased costs of the ACADs and re-development of the Southern General Hospital.

The Chair of the South Monitoring Group stated that these matters were not critical and would be deferred to the September 2004 meeting of the Monitoring Group. Ms Hinds and Mr Sandeman protested at this decision.

b) Minute 12 – Update on Implementation of Next Phases of Acute Services Strategy affecting the Southern General Hospital

Mr Sandeman asked about the bed numbers today and the bed numbers projected for 2012 across the specialties.

Mr Calderwood advised that the Minute of the meeting of 5<sup>th</sup> March showed the current bed complement of 1747 beds in South Glasgow. The bed model projections across each specialty and sub-specialty were still being worked up with the full involvement of clinical staff. The final model would reflect the nature of services to be provided, based on certain specialties being centralised and the creation of pan-Glasgow services.

On being asked about the timetable for the completion of the bed model for acute services, Mr Calderwood advised that while it was not definitive, he would speculate that the outcome of the discussions with the multi-disciplinary clinical groups could be completed by late autumn/early winter. Thereafter the recommendations would need to be discussed by the NHS Board and then Scottish Executive Health Department (SEHD) agreement sought to the finalised bed model as part of the business case. This was likely to take place in early 2005.

Mr Sandeman was horrified at the lack of information on planning and Dr Turner asked about what the outcome this process would have for the 400 new beds at the Glasgow Royal Infirmary. In reply, Mr Calderwood described the process of data collection and trends across all the specialties and sub-specialties to assist in arriving at a final bed model for the city. This process would have an impact on the final make-up and final number of acute beds at the Royal Infirmary, but for planning purposes there would be approximately 400 new acute beds located in the area of the hospital site where the old buildings were to be demolished.

**NOTED**

**4. OUTCOME OF THE CHAIRS MEETING WITH THE MINISTER FOR HEALTH AND COMMUNITY CARE ON 17<sup>th</sup> MAY 2004**

The Chairs had submitted a short report on the topics they had discussed with the Minister for Health and Community Care when they met him for an hour on Monday, 17<sup>th</sup> May 2004.

Prior to the meeting with the Minister, the Chairs had met the NHS Board Chairman and officials on 11<sup>th</sup> May – this had been the day of the tragic explosion at the Plastics Factory in Maryhill. The Chairs had advised the Minister of the professional way in which the NHS Board had responded to the early news of a major incident and that the response of all the emergency services was a credit to those involved and to the pre-planning and co-operation amongst the emergency services.

Concerns were expressed about the role the two hospitals which were scheduled to close, had played in this incident. Also, what would have happened if this had been a larger-scale disaster. How would the NHS have coped and how will it cope in the future with fewer hospital sites.

Dr Burns spoke about the critical role of staff in such incidents and indicated that their numbers were not changing. Future emergency plans would take account of the location and number of sites and the service coped well with the 11<sup>th</sup> May incident with no adverse impact on existing services, although there was some disruption to clinics being closed at the Western to facilitate the treatment of casualties.

The Chairs took each discussion area with the Minister in turn, as follows:-

i) Commencement of Work

Both Groups had settled into their own ways of working and had received any information or attendance of senior officials at meetings when requested. The support to the Groups had been appreciated.

ii) Base-Line of Information

The bed statistics had been submitted to the June 2003 Group meetings and was to be reviewed annually as part of the Monitoring Group's role.

**H Burns**

Mr Sandeman raised an objection: he did not believe that the statistics in June 2003 had been an adequate base-line and they had been incomplete and not updated.

iii) PR and Communication Issues

The Monitoring Groups' communications had been established and the Community Engagement Manager would assist in improving links with community groups in the future.

The issue of the NHS Board and the Divisions promoting their services better was raised with the Minister. Often the NHS Board had been unable to get its message across effectively.

Professor Stewart-Tull was concerned that the 'monitoring' of named services element of the remit had not yet taken place and the first year's work seemed to be concentrated on talking about services and issues affecting the future shape of services. He commented on the lack of transparency and the fact that new decisions conveniently arose weeks after Monitoring Group meetings. With regard to the Casualty at Stobhill, he stated that at the January and March meetings it had been portrayed as a lack of Consultant cover and a scheme of pooling Consultants had been proposed. In April the Royal College visited and made their recommendation and at the NHS Board meeting the blame had been put on the Junior Doctors New Contract. This was very convenient for the NHS Board and politicians.

Mr Martin reminded members of the Groups' remit, which was to monitor that named services are being sustained through direct evidence for the 5-year period stated by the Minister. The Groups were able to participate in discussions about any changes to services if this was for reasons of clinical evidence.

The issue of public relations was a matter for the NHS Board and Mr MacIntosh was concerned that the public's confidence in what the NHS Board was trying to achieve had not been gained. Ms Hughes reiterated the point by stating that the stakeholders in the NHS did not feel involved.

The Chairs agreed that the next phases of the Groups' work would lead to increased monitoring of services to patients as advanced plans are made to commence demolitions of buildings and alterations to services, particularly as a result of the emerging pressures in acute services.

iv) Capital Charges

The process of capital charges being paid by the NHS Board for its property and the fact that it leads to a revenue cost was highlighted.

Mr Calderwood advised of the 10-year financial plan to underpin the acute services strategy and explained the NHS Board's commitment to fund this strategy ahead of other priorities. Ms Miller was concerned about the funding of the new Consultants Contract and the shortfall in resources from SEHD to fully fund its implementation.

In discussing the costs of the Acute Services Strategy, Mr Calderwood indicated that the £733M was not an accurate figure. He advised that definitive plans were not available and published pictures were still an artist's impression at this stage.

Dr Turner was concerned that the public believed the funds to meet the full cost of implementing the acute services strategy were available immediately. The public would not understand that the NHS Board had to clear its recurrent debt before identifying the additional funds necessary to ensure the strategy was affordable. The additional funds required amounted to £70M per annum after the completion of the building programme.

v) Revenue Raising Opportunities

The Chairs had encouraged the SEHD to consider any options which could raise revenue for the NHS.

vi) Acceleration of Acute Services Strategy

The Chairs advised that the Minister understood and accepted the drivers for change and the possible need to accelerate elements of the acute services strategy and will look carefully at any specific and detailed proposals put to him. This was what was now being worked up by the NHS Board officials.

It was also important to keep to the timetable of planning, building and commissioning the ACADs at Stobhill and the Victoria Infirmary.

Some members were concerned about the shift in name from Ambulatory Care and Diagnostic Centre to Ambulatory Care Hospital. They did not believe it was a hospital – it was a Day Surgery and Out-patient facility and the new name was misleading. Also, the NHS News quoted that there would be an £85M Acute Hospital built on the Stobhill site. This would not be the case. It was advised that public relations advice had suggested that patients and the public identified better with the term Ambulatory Care Hospital.

The Chairs agreed to raise this matter with the NHS Board and Minister if necessary. Mr MacIntosh made it clear that he preferred the use of the term "hospital" in any description of the new facilities.

Mr Martin advised that the Group did not accept the term “acceleration” of the acute services strategy. He emphasised that the clinical argument had to be made before any changes to existing named services should be considered. Clinical evidence must be presented to the Monitoring Groups and the Groups could then determine if they accepted the arguments made and whether any amendment to named services would have their support or not. If they did not accept the reasons then the Groups would communicate that to the Minister.

The Chairs would send an extract of this Minute in a letter to the Minister for information.

**Chairs**

**5. PROGRESS ON TIMESCALES ASSOCIATED WITH IMPLEMENTING THE ACUTE SERVICES REVIEW AND EMERGING PRESSURES ON ACUTE SERVICES**

The Chairs invited Mr Calderwood to present to members the progress in implementing the acute services review and the impact of the emerging pressures.

Mr Calderwood’s presentation is attached to the Minute for information.

In addition to the timescales and points covered in the attached presentation, Mr Calderwood highlighted the following:-

- As discussed earlier, the bed modelling across all specialties was being constantly reviewed and assumptions were being continually tested.
- Working Groups had been established to take forward the following areas:-
  - i) Financial Planning
  - ii) Workforce Planning
  - iii) Clinical Groups (Review of Acute Admissions; Cancer/Diagnostic Review and Medical Workforce/Junior Doctors)
  - iv) Services/Beds/Activity
  - v) ACADs
  - vi) Community Engagement
  - vii) Communication
  - viii) Transport and Accessibility
- The affordability of the acute services strategy was critical; the NHS Board and Minister would only accept proposals which demonstrated that the plans were affordable.
- The papers submitted to the NHS Board in December 2003 and May 2004 on emerging pressures in acute services had been made available to Monitoring Group members; in addition Mr Calderwood raised:-
  - the availability of accommodation at the Golden Jubilee National Hospital provided opportunities to explore bringing forward the creation of a single Cardiothoracic Unit (originally planned for completion on the Gartnavel General site in 2012). The consultation of these proposals would involve NHS Greater Glasgow, Lanarkshire and Argyll & Clyde in the autumn 2004. The outcome would be reported to the Minister.

- coherent plans were required for wider public debate to respond to the clinical drivers. Following previous consultation processes, specialty rationalisation was under way in specific areas – Gynaecology services moving from 5 to 2 sites; Ear, Nose and Throat services from 3 to 2 sites and Vascular services from 2 to 1 site. Clinical groups had been established to advise on further rationalisations. Proposals would be submitted to the October NHS Board meeting.
- plans were required to address the Royal College's withdrawal of training accreditation from the Casualty Service at Stobhill from August 2005 and its subsequent closure.
- senior managers were being seconded to create a team charged with bringing together proposals for the NHS Board to consider.

### **Questions**

Professor Stewart-Tull asked who was the "Mr Big" co-ordinating the Strategy. Mr Calderwood was the Acute Services – Programme Director, reporting to the NHS Board Chief Executive and NHS Board.

The North Monitoring Group Chair asked about the plans to hold an emergency meeting of the Group on the Royal Colleges' withdrawal of training accreditation from the Stobhill Casualty Service. It was explained that the intention had been to do this if the service required to be closed in August 2004. The fact that the accreditation was not to be withdrawn until August 2005 gave the Group more time to meet on this matter.

Dr Davis spoke about the training accreditation process for all medical and surgical specialties; the timescale of visits and the comprehensive nature of the Royal College's visits. The delay to August 2005 allowed for proper and sensible planning and the timescales of the Colleges' decision had been such that the Monitoring Groups were receiving this information very quickly after the decision.

The NHS Board were working up two options for consideration in response to the withdrawal of training accreditation from the Stobhill Casualty Service. Ms Miller stated that staff had only just met with managers about the change to the Casualty Service and how it would affect their posts. Mr Davison advised that the NHS Board had accepted that the Casualty Service will close in August 2005; what was now happening was the working up of options to plan for that eventuality.

One of the primary drivers for this change had been the Junior Doctor Contract, yet what was clearly emerging was the difficulty in recruiting Accident and Emergency Consultants. This and other issues required to be discussed at the North Monitoring Group on 3<sup>rd</sup> September 2004 or earlier.

The Chairs would discuss with Mr Divers the possibility of the Monitoring Groups having access to the proposals for dealing with the emerging issues in acute services at the September meetings of the Groups.

**Chairs**

It was agreed to arrange an early meeting of the North Monitoring Group to discuss the withdrawal of the Casualty Service from Stobhill.

**J C Hamilton**

Mr Calderwood indicated that a Planning Team had been established for North Glasgow; the South Planning Group was about to be established and the West Planning Group would be established soon.

Ms Hughes advised that she has written to Mr Divers about issues affecting South Glasgow and awaited a reply. Staff needed to be involved and the public needed to be persuaded of the arguments for further change.

**6. MINUTES AND IMPROVING COMMUNICATIONS**

Dr Turner had raised concerns that 3 months was too long for Monitoring Group minutes to be approved and then distributed to local groups and made publicly available. Much of the information had been overtaken by events and a speedier process was required.

It was suggested that for both Groups, their draft Minute be circulated to all members for comment; the suggested alterations be made and the amended Minute submitted to the Monitoring Group Chair for approval and thereafter the approved Minute be distributed as normal. The aim would be to achieve this within one month of the Monitoring Groups meeting. The approved Minute would then be submitted to the next meeting of the Monitoring Group for formal adoption by a proposer and seconder and any discussion would only be on any Matters Arising.

The above process was accepted by both Monitoring Groups and, in addition, the Groups agreed to share each other's Minutes.

**J C Hamilton**

Additional meetings to the regular quarterly meetings may be needed and this would be up to each Group to determine, based on the business to be conducted.

**7. ANY OTHER COMPETENT BUSINESS**

Ms Miller highlighted concerns she had read on the internet about the preferred bidder for the development of the ACADs. The company in question were a multi-national company and it was confirmed that no expressions of concern about them had been submitted to the NHS Board.

Mr MacIntosh was concerned that clinical staff in South Glasgow were struggling to cope with the pressures and that specific proposals for accelerating the acute services review would be required soon. The public and patients should be involved in the process of developing options. If definitive proposals/options were not available for South Glasgow at the September meeting then a full description of the process for developing the options should be available.

**8. DATE OF NEXT MEETING**

Members were reminded to write to John Hamilton with any agenda items for the forthcoming meetings.

i) North Monitoring Group

- a) John Hamilton would canvass dates over the next 6/7 weeks for a Special Meeting of the North Monitoring Group to discuss the implications of the withdrawal of training accreditation from the Stobhill Casualty Service in August 2005.

**J C Hamilton**

**ACTION BY**

- b) The next regular meeting of the North Monitoring Group will be held at 9.30 a.m. on Friday, 3<sup>rd</sup> September 2004 in the former Library, North Glasgow Division HQ, 300 Balgrayhill Road, Glasgow, G21 3UR.

ii) South Monitoring Group

The next meeting of the South Monitoring Group will be held at 2.00 p.m. on Friday, 3<sup>rd</sup> September 2004 in the Floor E Conference Room, Victoria Infirmary, Langside Road, Glasgow, G42 9TT.

The meeting ended at 12.30 p.m.