EMBARGOED UNTIL MEETING

SMG(M) 03/04

NHS GREATER GLASGOW

Minutes of the Meeting of the Greater Glasgow – Acute Services – South Glasgow Monitoring Group held at 2.00 p.m. on Friday, 5th December 2003 in Floor E Conference Room, Victoria Infirmary, Langside Road, Glasgow, G42 9TT

P R E S E N T :

Mr Peter Mullen (in the Chair)

Ms Pat Bryson
Dr Harry Burns
Mrs Margaret Hinds
Ms Catherine Fleming
Ms Janis Hughes MSP
Ms Jane McCreadie
Mr Ken MacIntosh MSP (from Item 6)
Dr Ken O'Neil
Mr David Ritchie
Mr James Sandeman
Ms Ann Simpson
Ms Nicola Sturgeon MSP

IN ATTENDANCE

Mr Robert Calderwood.	..	Chief Executive, Glasgow South Acute Trust
Dr Brian Cowan	..	Medical Director, NHS Board
Mr J C Hamilton	..	Head of Board Administration – NHS Board

ACTION BY

1. **APOLOGY**

An apology for absence was intimated on behalf of Dr Yvonne Taylor.

2. **WELCOME**

The Chairman welcomed Catherine Fleming and James Sandeman to their first meeting following their election to represent the Community Councils of South Glasgow.

The Chairman also welcomed Mr Robert Calderwood, Chief Executive, Glasgow South Acute Trust, and Dr Brian Cowan, Medical Director, NHS Board, who were attending to give a presentation on the Impact of Workforce Issues on Services.

3. **MINUTES**

The Minutes of the meeting held on 5 September 2003 were approved as a correct record subject to the following amendments:

Minute 2 – 2nd Para – 5th Line

Delete – "patients"
Insert – "episodes"

Minute 7 - 1st Line

Delete – "she"

Insert – "a member of the Forum"

ACTION BY

4. **MATTERS ARISING FROM PREVIOUS MINUTES**

a) Progress on A&E Process

The Chairman invited Robert Calderwood to update members on the process agreed by the Minister of Health and Community Care for the NHS Board to review the decision on A&E.

Mr Calderwood advised that the Minister had given an undertaking that the NHS Board review the planning assumptions which led to the decision to have two A&E/Trauma Units as part of the Acute Services Strategy. This review was to be completed in Autumn 2004 and would look at the planning assumptions and whether they remained relevant. This would include looking at the capacity and clinical size of two A&E/Trauma Units in light of the emerging workforce issues, and the identification of the capital investment required to ensure the A&E Department at the Royal Infirmary could meet the projected throughput.

Mrs Hinds asked if this was a genuine look at whether there should be two or three A&E/Trauma Units. It was reiterated that this was a review of the original planning assumptions to see if they remained relevant.

Dr Burns advised that he believed that the outcome would most likely see NHS Greater Glasgow having three Emergency Receiving Centres, of which one would not have an orthopaedics service.

The process of assessing the planning assumptions would be held over the summer and submitted to the NHS Board in Autumn 2004. A copy of the review undertaken for the NHS Board on A&E would be made available to the Monitoring Groups. **Dr H Burns**

NOTED

b) Named Services

The Chairman confirmed that the orthopaedics specialty was part of the named services and would be part of the regular monitoring process by the Group.

NOTED

5. **CAR PARKING DURING DEMOLITION**

On the issue raised by Dr Ritchie about car parking during the demolition work to create the space for the ACAD, Mr Calderwood advised that the current arrangement of opportunistic parking on the former Grange Road School would cease due to construction work, as would on-street parking in Annand Street. It was recognised that this was not ideal or what the Trust would aspire to. The plans for the ACAD would see 450 car park dedicated spaces being available for staff and the public. More than 3 times the current provision at the Victoria Infirmary.

NOTED

6. **BED NUMBERS – VICTORIA INFIRMARY**

On the above issue raised by Mrs Hinds, the Chairman invited Mr Calderwood to do a presentation on the impact the Health and Safety Improvement Notice will have on bed numbers.

Mr Calderwood advised that the Health and Safety Improvement Notices which had been served on the Victoria Infirmary had led to the commencement of a significant programme of works within the hospital. This would lead to a reduction in beds in each upgraded ward. Typically this bed reduction was 4 or 5 beds per ward. The nursing staff had found that this had led to an increase in the quality of care given to patients and had increased staff morale. The improvement programme was just over half way through, with a further nine clinical areas to be completed by Summer 2004.

In terms of existing bed numbers, excluding the previously consulted upon changes to ENT and Gynaecology, the total number of operational beds had been 431. Following completion of the Health and Safety Improvement Programme this would reduce to 383 beds; however, this would be offset by the 39 new beds for elderly care and surgical being commissioned at Mansionhouse Unit and Southern General Hospital. Also by the end of 2004 it was planned to:-

i) open 30 beds for orthopaedic rehabilitation;

ii) open a new 20-bed haemato-oncology unit;

iii) seek the resources to fully open Ward South 3 at the Mansionhouse Unit an increase of 16 beds.

Overall the Health and Safety Improvement Notice would lead to an increase in the quality of care, both in terms of the surroundings and the nurse-to-patient, and nurse-to-bed ratios. However the impact on the Victoria Infirmary would see an overall re-distribution of bed numbers across South Glasgow.

In response to a number of questions raised by members, Mr Calderwood confirmed the following:-

i) Haemato-oncology beds would be located in the Southern General and would be part of the general medical unit;

ii) If winter pressures increased, elective surgery would be delayed in order to give priority to emergencies;

iii) To date the impact of the Improvement Notice was currently a reduction of 48 beds, with 39 extra beds for elderly and surgical having been applied to off-set that figure;

iv) The waiting time target of treating in-patients and day cases within 9 months by 31 December 2003 remained an important target to be achieved – despite the recent changes, the Trust was committed and confident of achieving that target.

Dr Burns commented on the political imperative to achieve waiting time targets – this, on occasion, could skew clinical prioritisation.

v) The NHS Board continued to monitor delayed discharges – the investments in Community Care by Glasgow City Council and East Renfrewshire and South Lanarkshire Councils were having positive impacts on releasing beds for front-line services.

vi) In response to Mr David Ritchie reporting that for emergency medical admissions patients were on occasions kept for long periods on trolleys whilst awaiting a bed, Mr Calderwood advised that the Medical Assessment Unit was being kept open overnight on occasions for patients.

ACTION BY

vii) There was no doubt the Improvement Programme had brought about improvements for patients and staff, but had also led to operational pressures. Medical patients were on occasions boarded-out to surgical wards. Mixed sex wards were not part of the reconfiguration plans at the Victoria Infirmary.

The Chairman thanked Mr Calderwood for the comprehensiveness of his presentation and for dealing with the questions which flowed thereafter.

NOTED

7. **PRESENTATION ON IMPACT OF WORKFORCE ISSUES ON SERVICES**

The Chairman invited Mr Calderwood and Dr Brian Cowan to give their presentation on the impact of medical workforce issues would have on existing services. The Chairman asked members to listen to the presentation carefully and restrict questions at the end to points of clarification. Due to the importance of the issue, he was keen that a special meeting of the Group be arranged for 2.00 p.m. on Friday, 23 January 2004. This would be to consider further the implications of the presentation and the role the Monitoring Group would have in delivering on its remit to monitor named services and to participate in discussions about proposed changes to named services if this was required for reasons of clinical evidence.

Mr Calderwood explained that there were significant changes in working and training regulations for frontline staff, particularly medical staff, and in the pressures they would bring for the delivery of acute services within the city.

The key points of the presentations were:-

i) The difficulty of sustaining out-of-hours cover for the current configuration of:-

- 6 adult sites, each with anaesthesia, intensive therapy, surgery, medicine
- 4 A&E and 1 Casualty Department
- 3 Maternity rotas, each with anaesthesia, paediatrics and obstetrics
- Anaesthesia, medicine, surgery at Gartnavel
- 2 Cardiothoracic Units + 2 Renal Units.

There were currently 43 Consultants and 70 Junior Doctor rotas every night.

ii) Junior Doctors

- New Deal – 56 hours full shift – currently 84% compliant
- European Working Time Directives – 58 hours by 2006 and 48 hours by 2009
- SIMAP – European Court ruling that if doctors are in hospital, then this is working time – starting from August 2004
- Modernising Medical Careers – radical change to training; emphasis on training and not service – removes service input in a number of posts – starting from August 2005.

ACTION BY

iii) Hospital Consultants

- European Working Time Directives – 48 hours – current average is 57 hours – with prescribed rest periods
- New Deal – impact for Consultants is that their supporting staff are less available and less experienced – more disruption to elective work and frequency of on-call has become a major issue

- New Consultants Contract – to be implemented from 1 April 2004: increases awareness of hours at work, maximum 48 hours, impact on on-call arrangements.

With these changes affecting every health care system in the UK, the only way to prevent services from collapsing due to non-compliant rotas was to implement more quickly the approved current acute hospitals modernisation plan for Greater Glasgow. There was now a clear need to change the work culture where staff worked more than 70 hours per week – the change should be welcomed and would lead to better care and treatment of patients.

Mr Calderwood and Dr Cowan were keen to involve the Monitoring Groups in how to take the issue forward and welcomed the opportunity for the issues to be further discussed at the special meeting on 23 January. By that time members would have had the opportunity to discuss with their representative bodies and formed a view of some of the key issues for discussion, together with thoughts on possible options.

The following questions and points were raised:-

- The clinical staff working at the new ACAD would also be involved in the out-of-hours rotas for the in-patient sites.

- The drivers for change were regulations affecting doctors/clinical staff – would it not be better to get a patient focused service with patient care outputs and outcomes?

- It appeared that the service was being designed for staff and not patients – there was a need to highlight the benefits for patients.

- The original Acute Services Strategy remains intact – the implementation of some parts of it may need to be quicker than first anticipated.

- The options and solutions to the challenges thrown up by the presentations need to be tackled in a planned and co-ordinated way and by engaging the public and clinicians. Welcomed the fact that the Monitoring Group were presented with this information early and were part of the solution.

- The public will not have understood the impact these issues will have on services – how can this be addressed?

  NHS Board Members received a presentation on 2 December and a paper would be submitted to the NHS Board meeting on 16 December; would be discussed with staff and there would be further publicity to air the issues more widely and engage stakeholders in how this can be taken forward.

- Medical workforce planning was the problem – previously well trailed and now the problem was huge.

ACTION BY

- There was also the impending implementation of the GPs Contract; there would need to be a more flexible and integrated way to approach the provision of services.

The Chairman thanked Mr Calderwood and Dr Cowan for their presentation – this was an evolving situation with many challenges. The Monitoring Group had been given a significant role to play; the main issues seemed to be:-

i) the Acute Services Strategy remained intact;

ii) the timescale may require to be altered to take account of the increasing medical workforce pressures;

iii) options required to be found and the Monitoring Group had a role to play.

The Special Meeting on Friday, 23 January 2004 at 2.00 p.m. would be a single item agenda. If members had any further questions to those already raised at the meeting, they should be passed to John Hamilton, Head of Board Administration, NHS Board, early enough to be included in the agenda for the meeting.

DECIDED:

i) That a Special Meeting be held at 2.00 p.m. on 23 January 2004 to discuss further the emerging pressures on Acute Services. — **Head of Board Administration**

ii) That members submit questions to John Hamilton, Head of Board Administration prior to the next meeting. — **All Members**

8. **DATE AND TIME OF FUTURE MEETINGS**

a) Special Meeting: Friday, 23 January 2004 – 2.00 p.m. in Floor E Conference Room, Victoria Infirmary, Langside Road, Glasgow, G42.

b) Regular Meetings: Friday, 5 March 2004 – 2.00 p.m.
Friday, 4 June 2004 – 2.00 p.m.
Friday, 3 September 2004 – 2.00 p.m.
Friday, 3 December 2004 – 2.00 p.m.

all in Floor E Conference Room, Victoria Infirmary, Langside Road, Glasgow, G42.

The meeting ended at 4.05 p.m.