EMBARGOED UNTIL DATE OF MEETING.

Greater Glasgow NHS Board

Board Meeting
Tuesday, 29th January, 2002 **Board Paper No. 02/02**
CHIEF EXECUTIVE

CONCLUDING THE DECISIONS ON GREATER GLASGOW'S ACUTE SERVICES REVIEW

1. Introduction

1.1 Finalising decisions about the future pattern of acute services provision for the city is a key strategic decision for the NHS Board. The current strategic proposals have been the subject of public debate for just under two years; two earlier reviews of acute services undertaken during the 1990s failed to deliver on agreed, affordable, city-wide plans for the major re-development of acute hospitals which is required in order to deliver facilities and services which are 'fit for purpose' for the 21st Century. Thus, some of the major investment made in new hospital buildings over that period - though necessary - has been decided without having in place a longer-term strategic plan for acute care in Greater Glasgow.

1.2 In recent months, there has been a growing frustration among a number of key stakeholders that no definitive decisions about the future of acute services have yet been taken. The opportunity exists now, therefore, for the NHS Board to conclude decisions about this strategy, and thus to give a clarity which will allow the detailed plans to be developed and implemented which will transform, within the next decade or so, the delivery of acute care within Greater Glasgow.

2. **The Need for Change**.

2.1 A number of pressures are impacting on the provision of acute services in Glasgow. The main problems associated with delivering Glasgow's acute services are:

- **Outdated buildings,** unsuitable and unfit for modern healthcare –21st century healthcare in 19th century buildings.
- **Inpatient sites** which are unable to provide the one stop / rapid diagnosis and treatment models for the large volumes of patients treated in Glasgow hospitals.
- **Fragmentation of care** as patients are required to move around sites and different buildings, an inevitable loss of continuity and difficulties in transferring information e.g. laboratory results and x-rays between sites.
- **Unsuitable diagnostic and imaging facilities** which restrict capacity, create bottlenecks and inevitable delays in treatment.

- **Increasing sub-specialisation in medicine** – a move towards larger teams to ensure all patients can get access to the appropriate specialist .

- **Glasgow's role in teaching and research** and the links with the Universities, is critical for the service to attract and retain high calibre staff - critical in services where there are national shortages e.g. cancer, cardiac surgery, diagnostic imaging and pathology amongst others.

- **Too many inpatient sites requiring emergency on call rotas** on each site –with pressures growing on both consultants and junior staff.

- **Changes in doctors' training** – means consultants are being called in from home more often, or opting to do *resident on –call to* provide support to junior staff.

- **Restrictions on the hours doctors can work**: New Deal for Junior Doctors limits number of hours; European Working Time Directive restricts availability of consultants due to compensatory rest requirements.

- **The policy imperatives** outlined in the policy papers The Scottish Health Plan and The Cancer Plan which include waiting list guarantees, reductions in waiting times, improved access to rapid diagnosis and treatment, the provision of services designed around the needs of patients and improved integration with primary and social care.

3. The NHS Board's Approach to Finalising Decisions on the Strategy

3.1 From 1st October, 2001, a new NHS Board has been in place, with a much larger complement of Non-Executive and Executive Directors than the previous Health Board comprised: no fewer than 11 additional Directors form part of the new NHS Board. During the past 3½ months, the NHS Board Directors have spent a number of development sessions on key strategic issues, including the strategy for acute services. The NHS Board wants to approach its decision-making as a board of governance.

3.2 In addition to these working sessions within the NHS Board, the Chairman, the Chief Executive and members of the Executive Team have undertaken seventeen briefing sessions on acute services during the past 7 weeks with a broad range of stakeholder interests: these have included MSPs, MPs, Glasgow City Council, the Greater Glasgow Health Council, the Area Medical Committee, the Area Clinical Forum and the Area Partnership Forum, the Medical Staff Associations in North and East Glasgow, and 3 public meetings in Springburn, Kirkintilloch and Langside. The NHS Board has received feedback from these discussions which has further helped to shape how it will consider this strategy at the meeting on 29th January.

3.3 In order to discharge this governance role, the NHS Board wishes to consider its decisions at three levels. First, as a new NHS Board, it wishes to be satisfied that the processes which led to the series of decisions taken in December, 2000, including the arrangements for public consultation and involvement, were appropriate. Secondly, the NHS Board wishes to be satisfied that the further work flowing from the Health Board's December, 2000 decisions has advanced to a point which allows strategic decisions to be taken now, recognising the need for more detailed on-going work as part of the development of Outline and Full Business Cases. Thirdly, the NHS Board members want to have the opportunity of hearing first-hand about new or different perspectives arising from the briefing meetings with stakeholders described above, with the facility given to specific interest groups to make presentations to the NHS Board meeting supported by short, written submissions. Thus, the agenda and papers for the meeting on 29th January have been structured to reflect these arrangements.

4. The Appropriateness of the Process Leading to Decisions by Greater Glasgow Health Board in December, 2000

4.1 The NHS Board wishes to approach its consideration of the series of decisions related to this strategy from a standpoint of governance. In order to ensure continuity in the Board's consideration of these matters, all previous papers related to the strategic decisions taken by Greater Glasgow Health Board have been made available to the extended complement of Directors who now form the NHS Board itself.

4.2 The paper included as Appendix 1 summarises the consultation processes undertaken during 2000\2001. This paper demonstrates that a substantial programme of consultation events and publications was worked through during a period of nine months. There was ample opportunity created for any individual or organisation interested in commenting on the Health Board's proposals to participate in the consultation process over that period of time.

5. Testing the Validity of the Preferred December, 2000 Decision on the Disposition of Acute Services.

5.1 The arguments covering the future pattern of acute hospital in-patient services were set out in detail in the March, September and December, 2000 Board papers. In considering its approach to deciding the future pattern of acute services, the NHS Board wishes to hear at first hand from those who supported the Health Board's preferred model but also from groups which have different perspectives. Arrangements for the NHS Board meeting on 29th January have been structured to reflect this through a series of short presentations, supported by a brief written submission from each interest group.

5.2 In this part of the meeting, the NHS Board is asked to consider this aspect of the Clinical Strategy with the help of the following presentations and papers:

i) The case for three sustainable in-patient units.

Presentation: Dr. W.G. Anderson, Medical Director, North Glasgow University Hospitals Trust .
Dr. B.D. Cowan, Medical Director, South Glasgow University Hospitals Trust.

Paper: Appendix 2

ii) The extensive arrangements for care to be delivered from Ambulatory Care Centres.

Presentation: Mr. D. Simpson, Consultant ENT Surgeon, Stobhill Hospital.

Paper: Appendix 3

iii) The perspective from Greater Glasgow Health Council.

Presentation: Mr. P.F. Hamilton, Convenor.

Paper: Appendix 4

iv) The perspective from the Medical Staff Association, Stobhill Hospital.

Presentation: Dr. J. Davis, Chair; Mr. J. Smith, Consultant Surgeon;
Dr. F.G. Dunn, Consultant Physician and
Mr. A. McMahon, Consultant Surgeon.

Paper: Appendix 5

v) A counter-proposal from the South-East Glasgow Health Forum.

Presentation: Professor D. McGregor and Mr. E. Canning.

Paper: Appendix 6

5.3 The NHS Board will wish to take account of all of these inputs, together with the papers available from previous Greater Glasgow Health Board meetings, in determining its broad Clinical Strategy.

[Decision 1: The NHS Board is asked to determine whether a Clinical Strategy, based on three adult in-patient sites, supported by two large Ambulatory Care developments, is the appropriate pattern for future years]

6. The Provision of Accident and Emergency, Trauma and Emergency Receiving Arrangements

6.1 The detailed arguments presented on this aspect of the Clinical Strategy were set out in full in March, September and December, 2000 Board papers. This section of the paper picks up the first of the elements of additional work which Greater Glasgow Health Board had instructed in order to test the deliverability of the preferred model for Accident and Emergency Services re-affirmed following consultation in the December, 2000 Strategy. In its submission, the Area Medical Committee supported the principle that Consultant led Accident and Emergency Services should be developed on two sites (viz the Southside Hospital and Glasgow Royal Infirmary) with acute medical and surgical receiving continuing at Gartnavel General Hospital. In making this recommendation, however, the Area Medical Committee sought assurances that its previously stated concerns about the additional workload which might ensue at Glasgow Royal Infirmary were being satisfactorily addressed in order to find agreed solutions with the Accident and Emergency staff and other key Clinicians involved.

6.2 In considering this key issue, the NHS Board has access to the following presentations and papers:

i) The benefits of two fully resourced A & E\Trauma Units, with emergency receiving undertaken in West Glasgow.

Presentation: Dr. T.J. Parke, Clinical Director, South Glasgow Trust; Dr. W.M. Tullett, Clinical Director, A & E Services, North Glasgow Trust; and Mr. S. McCreath, Clinical Director, Orthopaedic Services, South Glasgow Hospitals Trust.

Paper: Appendix 7

ii) The case for retaining Accident and Emergency and Orthopaedic Services in West Glasgow (and therefore having three fully resourced A & E\Trauma Units).

Presentation: Mr. K. A. Harden, General Practitioner.
Mr. J. Crossan, Consultant Orthopaedic Surgeon.

Paper: Appendix 8

6.3 The NHS Board will wish to consider all of these inputs and the associated discussion, together with the material available from previous Greater Glasgow Health Board meetings in determining this aspect of the Clinical Strategy.

[Board Decision 2: The NHS Board is asked to determine whether the provision of A & E and Trauma Care from 2 fully resourced A & E Centres, located in the North-East and South Glasgow, working with an Emergency Receiving Unit in West Glasgow, is the appropriate basis for the future delivery of Accident and Emergency care]

7. Bed Modelling and distribution of clinical specialties.

7.1 Further detailed work on this aspect of the Clinical Strategy was the second piece of additional work which Greater Glasgow Health Board had instructed following its decisions taken in December, 2000. An updated report is attached as Appendix 9.

[Board Decision 3: The NHS Board is asked to receive this status report on the work on bed modelling; to recognise that bed modelling and capacity planning will continue as a dynamic part of the development of the detailed Business Cases for the provision of new hospital facilities; and to entrust to the Bed Modelling Group a governance responsibility for the continuation and overview of this work]

[Board Decision 4: In addition, the NHS Board is asked to agree that a detailed paper, flowing from the decisions about the broad Clinical Strategy, which will set out the proposed distribution of clinical specialties by hospital site, will be brought to the NHS Board in February for adoption, subject to the outcome of a six week period of public consultation.

8. Assessing the Options Carried Forward from the December, 2000 Health Board Strategy Against the NHS Board's Adopted Clinical Strategy

8.1 In this section, the NHS Board is asked to determine which of the options which were carried forward from the December, 2000 Health Board Strategy are compatible with the Clinical Strategy which the NHS Board decides to adopt.

8.2 When Greater Glasgow Health Board took its strategic decisions in December, 2000, Three options for North-East Glasgow were under consideration: option one involved in-patients at Glasgow Royal Infirmary, with ambulatory care and minor injuries unit at Stobhill; option two involved moving away wholly from the Royal Infirmary site and re-providing all in-patient acute services at Stobhill; while the third option involved the "status quo" option, which forms the starting point for consideration of all business cases. In terms of the trail of governance, the affordability of the second of these options is shown in the affordability section of this paper.

8.3 In subsequent discussion within the North-East Reference Group, the option of moving away from the Royal Infirmary site was dismissed at an early stage as unrealistic. Accordingly, subsequent discussion has centred on four options within North-East Glasgow. These options were as follows:

Option 1

The Glasgow Royal Infirmary would be the in-patient hospital, with an Ambulatory Care And Diagnostic Centre and Minor Injuries Unit only at Stobhill. In west Glasgow, the Western Infirmary would close and Gartnavel General hospital would become the in-patient site with both core and specialist services. Gartnavel General would include a minor injuries unit and an acute medical receiving unit. In this option 40% of the current inpatient activity currently provided on the Stobhill site would transfer to Gartnavel General.

Option 2

Glasgow Royal Infirmary would serve as a specialist elective hospital for North and East Glasgow. It would provide no *core* clinical services e.g. general surgery/general medicine, no accident & emergency /trauma or orthopaedics. Stobhill Hospital would be developed as a District General Hospital with Accident and Emergency and an ACAD for the north and east of the city. In west Glasgow the Western Infirmary would close, with all services excluding Accident and Emergency to be provided at the redeveloped Gartnavel General Hospital.

Option 3

Glasgow Royal Infirmary retains its current role with all existing on-site specialties and Accident and Emergency. Stobhill would be a local hospital providing general medicine, general surgery, an ACAD, facility and a minor injuries unit. In west Glasgow the Western Infirmary would close, with all services excluding Accident and Emergency to be provided at the redeveloped Gartnavel General Hospital. In this option there is no assumption that additional clinical activity would transfer from Stobhill This option is based on refurbishment of both sites as opposed to new build.

Option 4.

As for option 3 above, but in new build accommodation at both GRI and Stobhill sites.

8.4 NHS Board will have heard the views from Stobhill Clinicians in the earlier part of the meeting.

[Board Decision 5: The NHS Board is asked to determine which options continue to meet the Clinical Strategy and are carried forward for consideration as part of the "affordability" section of this paper]

8.5 At December, 2000, Greater Glasgow Health Board's position in respect of options within South Glasgow was more clear cut. There had been a strong body of agreement that a single in-patient site represented the preferred option and that that site would either be a substantially re-built Southern General Hospital, or a "green field" new build hospital on sites at Cowglen. However, in its earlier consideration of Clinical Service Strategy, the NHS will have heard a counter-proposal in favour of two acute general hospitals in South Glasgow. Thus, the NHS Board will wish to take account of those earlier discussions in determining its Clinical Strategy prior to assessing which options fit that pattern of service delivery.

[Board Decision 6: The NHS Board is asked to determine which options meet the Clinical Strategy for service provision in South Glasgow and are thus carried forward for consideration as part of the "affordability" section of this paper.

9 The Affordability of the Clinical Strategy and of Individual Options; and a Potential Implementation Plan

9.1 The Director of Finance has prepared a detailed paper which sets out a broadly based approach to the affordability of this Strategy: it is attached as Appendix 10. In addition, this paper offers for the NHS Board's consideration some initial proposals about both the overall timescales for investment and a potential order within which major capital investment might be carried out.

9.2 In summary, the key points arising from this overview of affordability are as follows. For the next two financial years, the priority with the acute care sector is to ensure that financial deficits are eliminated, thus bringing the acute and paediatric sectors into recurring financial balance no later than 1st April, 2004. The NHS Board can begin to generate the revenue necessary to fund the revenue costs of a capital programme approaching £700M at that point.

9.3 The recent round of stakeholder discussions has brought a consistent reaction that any plan to effect this strategy which extends much beyond ten years will lack credibility. Indeed, a number of groups have expressed disappointment that the implementation plan will take so long, but the reality is that, given the need to take proper account of the commitments and development needs across each of the programmes of care on which the Board's approach to resource allocation is based, affordability cannot realistically be achieved more quickly. A second principal which has been applied to this implementation plan is that it should regenerate the acute services facilities in all three sectors of the City - South, North-East and West.

9.4 Following the "likely" funding stream available for investment in the Acute Services Review (Annex A, Table 1 in Appendix 10) - a scenario which will pose a substantial challenge in "protecting" new investment for this purpose - a cumulative total of £60.1M can be amassed by the year 2012\13 (year 11 from now). As the NHS Board is already committed to completing the second phase of relocating the Beatson Oncology Centre adjoining the Tom Wheldon Building at Gartnavel General Hospital, at an additional revenue cost of £4M to be met in early 2006\7, the balance of accumulated revenue available to meet the options for implementing the Acute Services Strategy in North and South Glasgow is £56.1M.

9.5 Against this cumulative sum of £56.1M, the costs of the combinations of options are as follows:-

a)	North (1) - In-patients at Glasgow Royal Infirmary; Ambulatory Care and Minor Injuries at Stobhill (£36.9M)	}
	South (1) - In-patients at Southern General; Ambulatory Care and Minor Injuries at Victoria Infirmary (£24.9M)	} £61.8M
b)	North (1) - In-patients at Glasgow Royal Infirmary; Ambulatory Care and Minor Injuries at Stobhill (£36.9M)	}
	South (2) - In-patients at Cowglen; Ambulatory Care and Minor Injuries at Victoria Infirmary (£33.7M) - based on occupancy achieved by 2008\9	} £70.6M
c)	North (2) - In-patient Services and Ambulatory Care at Stobhill (shown for governance purposes) (£45.2M)	}
	South (1) - In-patients at Southern General; Ambulatory Care and Minor Injuries at Victoria Infirmary (£24.9M)	} £70.1M
d)	North (2) - In-patients and Ambulatory Care at Stobhill (£45.2M)	}
	South (2) - In-patients at Cowglen; Ambulatory Care and Minor Injuries at Victoria Infirmary (£33.7M)	} £78.9M

* The estimated cost of the option which involves retaining core medicine and surgical in-patient beds at Stobhill is £41.9M.

9.6 The impact of this is that, at year 11, the lowest cost combination of options (North 1 and South 1) exceeds the cumulative total available by £5.7M. The option which would see in-patients for North-East Glasgow located at Glasgow Royal Infirmary, with a Southside in-patient development at Cowglen exceeds the sum available at year 11 by a minimum of £14.5M.

[Board Decision 7: The NHS Board is asked to determine which options it views as affordable to be carried forward to more detailed option appraisal, as part of Outline Business Case preparation]

10. Transport Implications

10.1 As part of the work following the December, 2000 Health Board decision, a survey was commissioned in order to assess the broader transport implications of the options which remained broadly under consideration. The detailed analysis which will flow from this survey will be of particular value in planning the implementation of the Strategy. There is attached at Appendix 11 a headline summary of the main strategic findings arising from the detailed accessibility study which has been commissioned. When the shape of the Clinical Strategy has been determined, the transport implications will form an important part of the implementation programme in the years ahead.

12.1 Next Steps in taking the Strategy forward

i) Formal submission to the Scottish Executive Health Department, the Minister for Health and Chief Executive of NHS Scotland, including papers previously considered by Greater Glasgow Health Board.

ii) An early meeting will be arranged with the Chief Executive of NHS Scotland, the Director of Finance and members of the Executive Team in order to agree the arrangements for progressing the supporting Business Cases.

iii) A detailed paper will be brought to the NHS Board to take forward and finalise consideration necessary for the distribution of specialties between individual hospital sites.

12.2 The NHS Board will return shortly to the further work required to conclude Strategies for Child Health and Maternity Services.

EMBARGOED UNTIL DATE OF MEETING.

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