SCOTTISH HOSPITALS INQUIRY

Bundle of documents for Oral hearings commencing from 13 May 2025 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow

Bundle 30 – Acute Services Review Papers

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Procurement and Finance Group – 15th December 2008

Gateway 2

Background

All acquisition and procurement projects are subject to OGC (Office of Government Commerce) Gateway Reviews. The Gateway Review process examines programmes and projects at critical stages in their lifecycle to provide assurance that they can successfully progress to the next stage.

There are 6 Gateways:

Gateway Review 0: is applied at the start-up of a programme
Gateway Review 1: confirms that the project is affordable, achievable and appropriate
Gateway Review 2: focuses on the procurement strategy and is normally conducted just before projects go to the market
Gateway Review 3: confirms the business case and benefits plan once the bids have been received
Gateway Review 4: checks that the current phase of contract is properly completed and the documentation completed
Gateway Review 5: assesses whether the anticipated benefits are being delivered

Due to the New South Glasgow Hospitals and the laboratories, being part of the overall ministerially approved modernisation of Acute Services, Gateway 0 was not undertaken.

Gateway 1

Gateway Review 1 of the South Glasgow Project was undertaken in January 2008. The panel comprised:

William Harrod – Team Leader - William has vast experience in Gateway Reviews which he has been undertaking since 2001. He has also been involved in several NHS reviews.

Bert Niven - A public sector professional who has considerable property experience and expertise in the areas of business change and programme/project management.

Tom Steele is the Assistant Director of Facilities at Ailsa Hospital (NHS Ayrshire and Arran). He has skills in Project Leadership, Policy Development, Contract Management and Procurement.

Jim Leiper- Jim is the Director of Estates and Facilities at NHS Fife. He has skills in Project Management, Risk Management Financial Management, Managing Business Change, Contract Management and Procurement and Construction.

It is anticipated that the same panel will undertake the all the Gateway Reviews for the project.

The Gateway process uses a traffic light system for their reporting with red being critical issues to be addressed immediately, amber, issues to be reviewed before the

next stage Gateway, and green, improvements that the project team might want to consider. The Project received 0 reds, 5 ambers and 1 green recommendation.

The issues raised in the Gateway were:

- It was to be made clearer that delay would result in extra cost
- Need to firm up a procurement method
- Improve Staff communications
- Have one Consolidated Risk Register
- Governance arrangements to change for next stage
- Clarity on the wider benefits of the Project.

These issues have all been addressed and will be re-visited during Gateway 2.

Gateway 2

The Project Team is working with the Centre of Expertise at the Scottish Government on the planning for the Gateway 2 Review of the Project. The Gateway Planning meeting is scheduled to take place during week commencing 12 January 2009 and the Assessment has been organised for 27-29 January 2009.

The Review will consist of a number of interviews with the Project Team and key stakeholders and perusal of documentation on the project. The interviewees and documents expected will be agreed at the planning meeting. Due to the focus on the Procurement strategy is it expected that our Technical Advisers will be interviewed as part of the process.

The outcome of the Gateway 2 Review will be submitted to the NHS GG&C Board.

Greater Glasgow and Clyde
New South Glasgow Hospitals (NSGH) Project

Pre-Qualification Questionnaire Report

Agenda

NHS Greater Glasgow and Clyde

- Pre-Qualification Questionnaire (PQQ) Process
- Evaluation Panel
- The Evaluation
- Summary of Results
- Recommendations
- Questions and Discussion

PQQ Process

NHS Greater Glasgow and Clyde

- The PQQs returned on 20th March 2009 - Check for completeness;
- Monday 23rd March 2009 - Advise bidders of any missing/erroneous information and commence evaluation;
- Tuesday 24th March 2009 - Ongoing evaluation by individuals (Board, C&B, S+W, E&Y);
- Wednesday 25th March 2009 - Receipt of any missing/erroneous information from bidders;
- Monday 30th March 2009 – Consensus Meeting;
- Wednesday 1st April 2009 - Overall scoring agreed and draft report;
- Approval of Short listing Recommendation – Wednesday 8th April 2009

PQQ Evaluation Panel

NHS Greater Glasgow and Clyde

The Evaluation Panel comprised: -

- Alan Seabourne – NHSGG&C
- Hugh McDerment – NHSGG&C
- Alan McCubbin – NHSGG&C
- Tony Cocozza – NHSGG&C
- Gordon Beattie – NHSGG&C (observer)
- Simon Fraser – Shepherd and Wedderburn
- Michael McVeigh – Ernst & Young
- Jim Hackett – Currie & Brown

The Evaluation

NHS Greater Glasgow and Clyde

Preliminary Evaluation - PQQ's basic requirements:

- Completeness of information;
- Responses to "pass/fail" question;
- Demonstration of relevant technical experience (at least one £200m+ healthcare project undertaken in the last three years); and
- Eligibility/Form of Good Standing.

The Evaluation

NHS Greater Glasgow and Clyde

Preliminary Evaluation - PQQ's basic requirements:

Bidder	Balfour Beatty	Brookfield	FCC Elliot	Laing O'Rourke	Miller
Completeness of information	Yes	Yes	No	Yes	No
Responses to "pass/fail" questions	Pass	Pass	Pass	Pass	Pass
Demonstration of relevant technical experience (at least one £200m+ healthcare project undertaken in the last three years); and	Yes	Yes	Yes	Yes	**No**
Eligibility/Form of Good Standing	Yes	Yes	Yes	Yes	Yes

The Evaluation

NHS Greater Glasgow and Clyde

Detailed Evaluation -

The detailed evaluation involved evaluating and scoring bidder responses to the PQQ according to pre-defined criteria. Each scored question is weighted, and the weighted scores feed through into an overall quantitative assessment of:

- **Technical capability** (in terms of experience, working practices and structure);
- **Capacity** (in terms of expertise and availability);
- **Financial and economic standing and**
- **Legal**

The Evaluation

NHS Greater Glasgow and Clyde

Prequalification Weightings:

PQQ Section	Capability (wtg)	Capacity (wtg)	Financial (wtg)	Total (%)
Section A - Bidder Details	12	4	0	16
Section B - Financial Standing	0	0	26	26
Section C - Technical Ability	41	4	1	46
Section D - Information on Advisers	12	0	0	12
Sub-totals	**65**	**8**	**27**	**100**
Weighted to 90%	58.5	7.2	24.3	90
General Evaluation	-	-	-	10
Grand Total				**100**

The Evaluation

NHS Greater Glasgow and Clyde

Prequalification Scoring Assessment

Assessment	Score
Very Poor - completely **fails** to demonstrate required capacity and capability	**0**
Poor - **limited** evidence of required capacity and capability	**1 - 4**
Satisfactory - provides **sufficient** evidence of required capability and capacity to undertake the project.	**5 - 6**
Good - shows **good** evidence of capacity and capability that meet the project requirements, and in some areas shows innovation in excess of the project requirements.	**7 - 8**
Very Good - shows **considerable** evidence of capacity and capability in all areas, shows and exhibits innovation in excess of the project requirements in most areas.	**9 - 10**

The Evaluation – Technical

- Balfour Beatty Group Limited
- Brookfield Europe LP
- FCC Elliot Healthcare Limited
- Laing O'Rourke Construction Limited
- Miler Construction UK Limited

- **Capability**
  - Supply Chain
  - Track Record
  - NEC3 Experience
  - Designers
- **Capacity**
  - Manpower
  - Availability

The Evaluation – Financial

NHS Greater Glasgow and Clyde

Information Sought

The information sought from interested parties was in the following areas:

- Historic financial information
- Group and related party information
- Funding capacity
- Sub-Contract and/or joint venture arrangements
- Parent company guarantees
- Information provided was supplemented with publicly available information and credit agency checks

The Evaluation – Financial

NHS Greater Glasgow and Clyde

Analysis Elements

The following areas were focused upon in forming our view of financial capacity:

- Historic profitability
- Cash Flow performance
- Size of the enterprise relative to the contract
- Ability and experience of providing performance bonds or other guarantees

The Evaluation – Financial

NHS Greater Glasgow and Clyde

Outcome of the Financial Evaluation

The following table summarises the scores awarded. These are subsequently weighted to produce the final overall score.

	Balfour Beatty	Brookfield	FCC Elliot	Laing O'Rourke	Miller
B1 Historical Financial Information	6	3	6	5	4
B2 Group & related party information	7	4	5	6	4
B3 Funding Information	7	7	5	5	3
B4 Subcontract and joint venture arrangements	5	3	5	3	3
C3 Parent or holding companies	4	3	4	4	4
Total	**29**	**20**	**25**	**23**	**18**

The Evaluation – Legal

NHS Greater Glasgow and Clyde

Process

- Initial compliance check
- Detailed evaluation

Evaluation and Outcome

- Scored questions
- Pass/Fail - Discussion with Board requested

Summary of Results

NHS Greater Glasgow and Clyde

Prequalification Scoring Summary -

Bidder	Max. Scores	Balfour Beatty	Brookfield	FCC Elliot	Laing O'Rourke	Miller
Base Score	1000	730	618	475	708	405
Weighted to 90%	900	657	556	428	637	365
General Evaluation 10%	100	90	70	40	90	30
Totals	**1000**	**747**	**626**	**468**	**727**	**395**
% From Top Ranked		*0.00%*	*16.17%*	*37.42%*	*2.65%*	*47.19%*
Rank		**1**	**3**	**4**	**2**	**5**
Technical	630	494	447	273	506	253
Financial	270	168	117	144	130	100
Legal	30	15	15	15	15	13
Environmental	40	29	27	27	31	19
Community/CSR	30	24	12	16	26	20
Base Score (Check)	**1000**	**730**	**618**	**475**	**708**	**405**
% From Top Ranked		*0.00%*	*15.34%*	*34.93%*	*3.01%*	*44.52%*

Recommendations

Evaluation Panel consider that three bidders have demonstrated the requisite experience, capability, capacity, and financial standing that would enable them to submit competent bids and subsequently deliver a successful project in partnership with the Board and it's advisors:

- **Balfour Beatty Group Limited**
- **Brookfield Europe LP**
- **Laing O'Rourke Construction Limited**

and that they are short-listed to proceed to the Invitation to Participate in Dialogue (ITPD) stage.

The other two bidders, FCC Elliot and Miller Construction are advised that they have been unsuccessful and are offered a de-brief.

QUESTIONS & DISCUSSION

GREATER GLASGOW AND CLYDE NHS BOARD

ASR PROGRAMME BOARD MEETING

Notes of the meeting held on Monday 8th June 2009 at 3pm in Board Room 1 Dalian House

Present:
Robert Calderwood, Chief Operating Officer (Chair)
Alan Seabourne, Project Director, New Hospitals' Project Team
Alex McIntyre, Director of Facilities
Anne MacPherson, Director of Human Resources (Acute)
Grant Archibald, Director of Emergency Care and Medical Services
Helen Byrne, Director of Acute Services Strategy, Implementation and Planning
Jane Grant, Director of Surgery and Anaesthesia
Jim Crombie, Director of Diagnostics
Mairi Macleod, Project Manager, New Children's Hospital
Niall McGrogan, Head of Community Engagement and Transport
Peter Gallagher, Director of Finance (Acute)
Joanne Frame for Richard Copland, Head of Health Information and Technology
Ally McLaws, Director of Communications
Douglas Griffin, Director of Finance
Rory Farrelly, Director of Nursing (Acute)
Rosslyn Crocket, Director of Women and Children's Services
Sharon Adamson, Head of Acute Services Planning and Redesign
Jim Rundell, Audit Scotland

Apologies:
Heather Griffin – Project Manager, New Adult Hospital
Dorothy McErlean, JOC - Area Partnership Forum representative
Iona Colvin, Director South West Glasgow CHCP
Frances Lyall, Staff-side Representative
Calum Kerr, Scottish Ambulance Service
Tony Curran, Head of Capital Planning and Procurement
Brian Cowan, Medical Director
David McConnell, Audit Scotland
Ian Reid, Director of HR
Karen Murray, Director, East Dunbartonshire CHP
Ken O'Neill, Clinical Director
Kenneth Hogg, Deputy Director of Delivery, Scottish Government Health Department

In attendance: Allyson Hirst, Acute Planning PA (minutes)

		ACTION
1.	**Apologies**	
	As noted above	-
2.	**Notes of the previous meeting held on 20th March 2008**	
	The notes of the previous meeting were accepted as an accurate record.	-
3.	**Matters arising**	
	Gateway Review	
	H Byrne informed the group that after the Gateway Review in January 2009 it was recommended that the Governance arrangements of the New South Glasgow and Laboratory Project were streamlined. It was proposed therefore that the Project Executive Group and Procurement and Finance Group would amalgamate. The proposal had been approved and passed by the PRG Group at the May meeting the role and remit and membership has been altered to reflect the change, and will be called the New South Glasgow Hospitals and Laboratory Project Executive Group. It will meet on a monthly basis.	-
4.	**Ambulatory Care Hospitals**	
	A McIntyre updated the group on the opening of the two new ACH in Glasgow. A McIntyre informed the group that Stobhill and the Victoria ACH had now been handed over "snag free" and that Stobhill had been open to the public for approximately 4 weeks.	-

There was one on-going issue of the RO water quality for renal dyalisis and this had lead to a delay in the first patients attending. All other patient services and departments had now moved into their new areas and were working as planned.

The next phase was the demolition of the old out-patient department at Stobhill. This is planned as a car parking area which is due to start construction on 15th June 2009.

The technical specification and cost profile for an additional 60 bed extension at the Stobhill ACH has been approved by the Boards PRG Committee. Work is on-going to finalise the legal aspects with a financial close target of June 2009. If this continues on programme anticipated building will start in August 2009.

With regard to the Victoria Hospital – the commissioning work had gone to schedule and the first patients were scheduled for 8th June – not all services will be in place on this date but the building would be fully operational by 23rd June.

A McIntyre noted that as services and department are moving into their areas some minor adaptations have been highlighted eg additional power sockets. This process was being closely managed by the commissioning teams at each of the sites with the costs being managed through the ACH budget for 2009/10. On-going costs for maintenance and lifecycle are being collated and managed through the existing revenue budgets.

The decommissioning of the old buildings was being undertaken as the services transfer. There will be a period of time to clear surplus equipment and to review sites and vacant accommodation. Physical demolition of buildings is anticipated for the 3rd quarter of 2009/10.

5. Maternity Strategy Executive Group

H Byrne and R Crocket advised on the following

SG Maternity Unit - work is continuing on site with a target completion date of October 2009. Work is commencing on the fetal medicine unit and work on the design of the ambulance canopy had commenced. -

The ground floor refurbishment - short-listing for the design team is now completed and tenders issued.

GRI Gynaecology Unit – work is progress and on programme, with an August 2009 completion date.

GRI PRM Office – revised costs had been received and an order placed for fit-out works. It is anticipated that this will be completed within timescale and in line with Gynaecology unit works.

GRI Midwives Birthing Unit – scoping work completed and work will commence June 2009.

RAH Maternity Refurbishment – work on the current phase continues. Remedial action was being pursued in regard to the defective flooring. The next phase was progressing well. The invitation to tenders had been sent out. Financing is dependent on agreement of the final accounts for the first phase. The project team and users are currently discussing decanting arrangements and completion is scheduled for December 2009.

6. New South Glasgow Hospitals Update

A Seabourne updated the group on the progress of the project and current issues. He noted that a draft masterplan will be ready at the end of June 2009 which is required as the planning application for the laboratories was required to be submitted to Glasgow City Council at the end of June. Section 75 was currently with Glasgow City Council and it was anticipated that a formal response would be with the project team this week. The sub-station costs had now been submitted and was within the project budget. -

A Seabourne noted that work on the evaluation process was almost completed and would be finalised by the end of the week – he indicated that he would be discussing this with R Calderwood, H Byrne and others in the near future.

Laboratories – A Seabourne informed the group that the detailed plans were in progress and that 1:200 layouts were almost complete. Equipment list and Room Data Sheets were 60% and 30% respectively complete and would be 100% complete by the end of June.

Site adjacent to the SGH Site – A Seabourne noted that during the Competitive Dialogue (CD) process bidders had been looking at areas within and around the SG site to use during the construction process. The site adjacent to the SGH site had been suggested but it was noted that this might be costly. The project team were working with the bidders to source other options.

Competitive Dialogue (CD)

A Seabourne updated the group on the process – The CD meetings had started on the 12th May with the 3 potential bidders and was due to complete in July 2009 after which the bidders would submit their bids on the 11th September. Thereafter the project team and Executive Group would evaluate the bids and submit them to the Board in November and thereafter to the Scottish Government for final approval.

There was some discussion around the scoring system for the bidders and it was decided that A Seabourne and P Gallagher would require to have further discussions to clarify the criteria. **AS/PG**

7. ASR Acceleration – Update

J Grant gave an update on the ASR Implementation detailing the plans and services moves that would eventually lead to the hospital provision in 2011 (presentation attached) -

Stobhill inpatient service closed, 2 maternity units at GRI and SGH – QMH closed. The plans rationalising Stobhill inpatient services at GRI are key in progressing the ASR.

8. Arts Strategy – Update

A Baxendale gave an update on the arts strategy. The Stobhill arts have almost all been installed successfully in the building with only minor snagging to be carried out with completion in July 2009. Initial feedback from users indicated they were happy with the art in the hospital and grounds. A Baxendale noted that it was important for members of the public to understand the art works. The Victoria hospital arts had also been installed and well received by users. -

Maternity – the content of the arts strategy has been agreed and will continue to progress. The roof garden is progressing to schedule and the arts team was now awaiting a revised proposal from the contracted art team.

A Baxendale highlighted to the group the importance of the bidders for the new hospital project understanding the users and local people and key issues to be learned from the ACH projects in the development of the new south Glasgow project.

9. Vale of Leven – Update

H Byrne informed the group that they were awaiting a decision from the Cabinet Secretary and the Board's recommendations. -

10. AOCB

There were no further items for discussion.

12. Date and Time of Next Meeting

14th September 2009
15:00 – 17:00
Boardroom 1, Dalian House

GREATER GLASGOW AND CLYDE NHS BOARD

ASR PROGRAMME BOARD MEETING

Notes of the meeting held on Tuesday 14th September 2009 at 3pm in Board Room 1 Dalian House

Present:
Robert Calderwood, Chief Executive (Chair)
Helen Byrne, Director of Acute Services Strategy, Implementation and Planning
Jane Grant, Chief Operating Officer
Jim Crombie, Director of Surgery and Anaesthesia
Peter Gallagher, Director of Finance (Acute)
Mark McAllister, Community Engagement Manager for Niall McGrogan
Joanne Frame, ICT Change Culture Manager for ICT for Richard Copeland
Rosslyn Crocket, Director of Women and Children's Services
Jim Rundell, Audit Scotland
Iona Colvin, Director South West Glasgow CHCP
John Scott, Senior Project Manager, Capital Planning for Tony Curran
Brian Cowan, Medical Director
Alan Hunter, Acting Director Emergency Care and Medical Services

Apologies:
Heather Griffin – Project Manager, New Adult Hospital
Alan Seabourne, Project Director, New Hospitals' Project Team
Ally McLaws, Director of Communications
Alex McIntyre, Director of Facilities
Anne MacPherson, Associate Director of Human Resources (Acute)
Sharon Adamson, Head of Acute Services Planning and Redesign
Douglas Griffin, Director of Finance
Rory Farrelly, Director of Nursing (Acute)
Grant Archibald, Director of Emergency Care and Medical Services
Mairi Macleod, Project Manager, New Children's Hospital
Niall McGrogan, Head of Community Engagement and Transport
Dorothy McErlean, JOC - Area Partnership Forum representative
Frances Lyall, Staff-side Representative
Calum Kerr, Scottish Ambulance Service
David McConnell, Audit Scotland
Ian Reid, Director of HR
Karen Murray, Director, East Dunbartonshire CHP
Ken O'Neill, Clinical Director
Kenneth Hogg, Deputy Director of Delivery, Scottish Government Health Department

In attendance: Allyson Hirst, Acute Planning PA (minutes)

		ACTION
1.	**Apologies**	
	As noted above	-
2.	**Notes of the previous meeting held on 8th June 2009**	
	The notes of the previous meeting were accepted as an accurate record.	-
3.	**Matters arising**	
	There were no other items other than those already noted on the agenda.	-
4.	**New South Glasgow Hospitals and Laboratory Update**	
	H Byrne spoke to the paper submitted for the meeting by A Seabourne on the update of progress and current news on the New South Glasgow and Laboratory Project explaining that the project team were currently involved in the Evaluation Process and therefore not able to attend the meeting.	-
	H Byrne informed the group of the timetable – bids had been received from the 3 potential bid companies on the 11th September and were currently being evaluated by those involved in the Competitive Dialogue process. It is planned that this process will conclude on the 19th October	

and the NSGHLP Executive Board are scheduled to meet on the 22nd October for a workshop style meeting to discuss the 3 bids. A formal Executive Group meeting will take place on 26th October and a formal presentation to Greater Glasgow and Clyde Health Board Performance Review Group on the 3rd November. There was no reason at this stage to suggest that the programme would go off target during this period.

H Byrne reported on the Competitive Dialogue phase of the project. This concluded in September 2009 and was appreciated by both sides as a positive and informative exercise.

H Byrne informed the group that the Request For Information process (RFI's) (which followed on from and during the Competitive Dialogue period) was positive from all sides as it answered questions and issues which allowed the bidders to follow the requirements set out by the Board

Outline Planning had been submitted to Glasgow City Council on the 17th July 2009 and it was anticipated that a response would be received by 17th September 2009. Outline Planning has already been granted after agreement between the Council and the Board on Section 75 agreement. The City Council had been invited to attend the Competitive Dialogue sessions and had expressed their appreciation for being invited to attend the proceedings at a very early stage. They also noted the emphasis placed by the bidders on the regeneration opportunities. Although there were a small number of issues raised by the Council these would be dealt with during the next stage with the chosen bidder and project team.

The land acquisition discussions are progressing in regard to the movement of the Scottish Ambulance Service from the Southern General site to the potential site at Leverndale. A Seabourne and P Moir were meeting the Calum MacLeod on the afternoon of 14th September to discuss and H Byrne reported that A Seabourne and herself would update R Calderwood at their planned meeting on Thursday this week. H Byrne noted that the Project Team were working hard on seeking a solution that would satisfy everyone's requirements.

R Calderwood noted that an alternative plan would require to be in place if this land purchase was required and for whatever reason could not be concluded and this would need to be in place before the presentation to the Board. The Scottish Water acquisition was discussed although it was noted that this had progressed as far as possible at the moment and dependent on the chosen company the land may not be required.

5. Ambulatory Care Hospitals – Update

J Grant reported to the group. On the whole new hospitals are working well and the few outstanding issues that are being dealt with at this time including the renal issues reported at the last meeting, signposting and the casenote transfer to the new system. J Grant noted that the financial close was imminent for the development on the Stobhill site and issues were in hand. It was also noted that the ITU move had gone well and to plan. -

The question around the renal issues was raised and it was noted that several changes to both design and plans that had caused the problems but they were all in hand and will be taken to resolution very soon. The question of the medical records transfer was raised. J Grant explained that they were working on the transfer and that they were back on track after revising previous plans in order that there was nothing missed and that all parties involved were happy that this was the right way to move forward. J Grant indicated that it would be around 2 weeks before the IT Strategy Group would have all the processes agreed and in place and agreed to keep R Calderwood informed.

6. Maternity Strategy and Implementation Progress

H Byrne and R Crocket spoke to paper enclosure 3. R Crocket reported that the decommissioning of the QMH was progressing well with the discussions and plans for movement of staff well underway. She noted that staff were visiting their new workplaces on Friday afternoons to familiarise themselves with the layouts. -

It was reported that there were some further discussion regarding the movement of Midwifes from GP surgeries but there were discussions taking place to alleviate any worries and concerns.

R Crocket reported that a Neonatal Redesign Group had been set up and is chaired by Dr Jim Beattie – this group meets on a monthly basis. This group will work in parallel with the service redesign to cover any aspects that would not be anticipated by the moves and is currently working on arrangements for services during the period of the QMH closing and the move of the Children's Hospital to their new site at SGH.

R Crocket noted that the Community Midwifes Unit in Clyde had an increase in requests for delivery but not in uptake and there had been no increase in actual deliveries. Detailed analysis is underway to understand this.

In terms of Capital R Crocket updated as follows :-

- Completion of the maternity unit extension at SGH is due for 23rd October and a design team is in place for the next stage of refurbishment on the ground floor. The Arts Strategy for the new maternity unit at SGH was reported as going well with internal colour schemes and designs being agreed with staff within the unit.

- Work on the Glasgow Royal Infirmary Labour Suite extension is underway and is planned to complete on 23rd October this will be vital in the movement of services. Work on the Gynaecology development is due for completion on the 21st September 2009.

- The project at The Royal Alexandria Hospital (RAH) in Paisley is tendered and work planned but it was noted that this work will be done within very tight financial constraints and the team are working closely with clinicians and senior staff to facilitate this.

7. ASR Acceleration – Update

J Grant spoke to paper – enclosure 4 on the Accelerated ASR. It was noted that the transfer of patients and services from Stobhill to Glasgow Royal were targeted for the end of 2010. There are several strands of work required to fall into place to allow this work to move forward and plans were in place to allow this, including the refurbishment of wards within GRI to accommodate the new services, and changes to the A&E unit. -

J Grant reported that she H Byrne and S Adamson have planned to meet at the end of September to progress further the bed model. J Grant will discuss this further with R Calderwood.

8. Charitable Appeal for the New Children's Hospital

H Byrne spoke to the paper – enclosure 5 on the progress to date with the charitable appeal process for the New Children's Hospital. It was noted that a Feasibility Study had been carried out and the finding of this reported that it was possible to raise around £10-15M in the current economic climate and this monies were to be strictly used for the betterment of services for patients and their families. The Study also indicate the need to set up an approve charity appeals committee including an approved infrastructure and methodology. The Report suggested that there be a "silent phase" in which all the background work be carried out including – setting up the appeal committee and identifying members, and the creation of a charities co-ordination group. The Yorkhill Children's Foundation has agreed to lead this work and the Health Board is in agreement with this process. -

H Byrne reported that she and R Crocket had set up a group to meet regularly to keep the process moving forward with representation from the NHS Board, YCF and the YCF Board.

It was suggested that if any of the monies are to be used in the structural content of the hospital eg Medicinema, this would require early discussions with the chosen company to get this included into the plans. It was noted that it needs to be clear to all that the money is to be used for the betterment with clearly defined priorities agreed by the NHS Board and the YCF with input from the Family Panel members.

9. Vale of Leven – Update

H Byrne informed the group that they had received a letter from the Cabinet Secretary in July agreeing to implementation of the Vale Vision. The programme on actioning is well underway to progress with implementation of the vision. H Byrne noted that the Cabinet Secretary has requested the establishment of a Monitoring Group to monitor the changes and this would include members of the local community including members from Helensburgh and throughout West Dunbartonshire. The first meeting taking place on 23rd November and will be chaired by Bill Brackenbridge. -

10. Community Engagement and Transport - Update

Mark McAllister spoke to a paper – enclosure 6 on the Community Engagement and Transport Update.

Substantive work was carried out with the community in advance of the ACHs at Stobhill and Victoria opening. In partnership with CHCPs and PPFs, a programme of outreach activity was undertaken with communities in East Dunbartonshire, East Renfrewshire and Glasgow City. He reported that there was a total of 61 events that Community Engagement took part in with 4570 members of the public taking part.

In advance of series going 'live' at the ACHs a number of test patient journeys were undertaken. Involving respective commissioning managers, NHSGG&C staff and members of the public , the overall patient experience of attending the new facilities was tested easy as possible . Feedback from participants was positive and identified issues that the commissioning teams were able to action.

In July 2009, the “Better Access to Healthcare Buildings” report was launched. This report builds on the work undertaken by the Better Access to Health Group and is a resource to assist in the design and commissioning of new buildings and facilities.

M McAlister reported that the visit to Toronto by Kate Munro and members of the Youth Panel had been very successful with many ideas and experiences taken onboard by the members. A full audio visual presentation would be given to the next meeting of the Group in November. The Group members showed their appreciation and looked forward to seeing this.

The Community Engagement Manager for the New Children’s Hospital is working closely with the West of Scotland Boards to impart information on the new Children’s Hospital and this work will continue throughout.

The Community Engagement for the children’s hospital will support the charitable appeal for the new children's hospital by working with the non exec director to engage charities, parent and patient groups in the fundraising process.

The Community Engagement team is working closely with the project team in the New Adult Hospital to support patient groups who will be using the facilities engage in the design process. A series of events and briefings were undertaken throughout the summer to support key planning milestones. A recurring theme from the engagement process was a degree of anxiety around single room accommodation. This has been fed back into the design process and further work will be required in the future.

On the South Glasgow Campus work has been begun on a Health Impact Assessment requested by Glasgow City Council and that this will be completed in December 2009. This was an unusual move as this is not normally carried out in relation to healthcare facilities but feedback so far had been positive.

Communications had been strengthened with the support of the South West CH(C)P and work continues to engage with partners in South West Glasgow.

The team is working closely with partners in South West Glasgow to establish education, learning and training programmes and in the delivery of childcare provision.

M McAlister noted that during all this work the team are keeping the local MP, MSP involved and briefed on progress.

Progress on transport was acknowledged, including work undertaken in partnership with SPT and other health boards.

The paper was welcomed and it was recognised that the work of the Community Engagement Team was far reaching in scope.

11. AOB

The chair noted there was no further business to discuss and the meeting was concluded.

12. Date and Time of Next Meeting

11th December 2009
09:30 – 11:00
Boardroom 1, Dalian House

GREATER GLASGOW AND CLYDE NHS BOARD

ASR PROGRAMME BOARD MEETING

Notes of the meeting held on Friday 11th December 2009 at 9.30am in Board Room 1 Dalian House

Present:
Robert Calderwood, Chief Executive (Chair)
Helen Byrne, Director of Acute Services Strategy, Implementation and Planning
Jane Grant, Chief Operating Officer
Mark McAllister, Community Engagement Manager for Niall McGrogan
Joanne Frame, ICT Change Culture Manager for ICT for Richard Copeland
Jim Rundell, Audit Scotland
Alex McIntyre, Director of Facilities
Sharon Adamson, Head of Acute Services Planning and Redesign
Niall McGrogan, Head of Community Engagement and Transport
Stephen Gallagher, Scottish Government Health Department
Grant Archibald, Director of Emergency Care and Medical Services

Apologies:
Jim Crombie, Director of Surgery and Anaesthesia
Peter Gallagher, Director of Finance (Acute)
Rosslyn Crocket, Director of Women and Children's Services
Iona Colvin, Director South West Glasgow CHCP
Brian Cowan, Medical Director
Alan Hunter, Acting Director Emergency Care and Medical Services
Heather Griffin – Project Manager, New Adult Hospital
Alan Seabourne, Project Director, New Hospitals' Project Team
Ally McLaws, Director of Communications
Anne MacPherson, Associate Director of Human Resources (Acute)
Douglas Griffin, Director of Finance
Rory Farrelly, Director of Nursing (Acute)
Mairi Macleod, Project Manager, New Children's Hospital
Dorothy McErlean, JOC - Area Partnership Forum representative
Frances Lyall, Staff-side Representative
Calum Kerr, Scottish Ambulance Service
David McConnell, Audit Scotland
Ian Reid, Director of HR
Karen Murray, Director, East Dunbartonshire CHP
Ken O'Neill, Clinical Director

In attendance: Allyson Hirst, Acute Planning PA (minutes)

		ACTION
1.	**Apologies**	
	As noted above. RC welcomed Stephen Gallagher to the group. Stephen would replace Kenneth Hogg as a representative from the Scottish Government.	-
2.	**Notes of the previous meeting held on 14th September 2009**	
	The notes of the previous meeting were accepted as an accurate record.	-
3.	**Matters Arising**	
	ACH – AMcI reported that the final financial close would take place next week for the new build at Stobhill ACH. He reported that all areas in both ACHs were now fully operational with positive feedback from both staff and patients using the new facilities.	-
	JG reported that the discussions surrounding the IT implementation at the ACH were progressing. The HI&T Board discussed the progress and future plans recently and that the portal plans were going well. JG noted that there was a review planned for the scanning processes and that she would be in a better position in the latter part of January 2010 to report back on timescales.	JG
	RC raised the question of the Disability reports and the consequences for the buildings. Some of the issues raised in the reports were being undertaken but RC requested that an action plan be put together noting the economical and non-economical issues and what actions were to be taken forward in the future. RC asked that views from the 2 previous reports be linked up for future	

reference. AMcI and NMcG agreed to meet to discuss taking this forward.

AMcI / NG

4. New South Glasgow Hospitals and Laboratory Update

H Byrne spoke to the paper submitted for the meeting by A Seabourne on the update of progress and current news on the New South Glasgow and Laboratory Project since the PRG meeting on 3rd November. HB reported that the unsuccessful bidders had received feedback from the project team and from that there had been several questions returned which have been responded to. HB also reported that over 20 Parliamentary Questions had been received by the Board and also a FOI enquiry. The questions and responses are now posted on the Scottish Government's website.

Since the successful bidder was announced there have been meetings with Brookfield in the pre-contract phase which included resolving issues that arose during the evaluation process. These are being resolved to the Board's satisfaction.

Briefing meetings have been held this week with key members of the Board's team in the run up to the signing of contracts next week. HB reported that there was a planned further briefing meeting held early next week just before the contracts are signed. Once the contract is signed there are numerous workstreams to be carried out to take the project onto the design phase including meetings with facilities staff, relocation of waste services and the set up of meetings with the user groups and taking forward the Laboratory and Masterplan design.

HB reported that work had been carried out by the project team and communications to ensure that the relevant information was being given to staff with participation by the project team at Directorate meetings, foyer events, staff news, presentations to staff and to West of Scotland regional groups and Area Partnership Forum.

HB reported that Governance arrangements for the project were in the process of being reviewed and the outcome of this review would be brought to the next meeting of this group. — HB

5. Maternity Update

HB reported on the Capital programme. HB noted that the SGH site was now fully operational with the first patients in place and the first births happening at the unit yesterday. HB reported that the internal refurbishment of the ground floor would be complete by end of 2010 with the decommissioning of QMH being complete and the unit closed on 13th January 2010. -

There is a separate capital project for the midwives birthing unit at PRMH which was completed in November 2009 and the internal phase of refurbishment taking place at RAH aligned with current capital investment to enable the delivery of the project.

The formal handover of the WoS Ovarian Cancer model at the Gynaecology Unit at GRI was completed with formal handover in October 2009 .

6. Design and Health Environment Working Group

HB reported on this paper for Anna Baxendale. HB reported to the group that this matter was being taken forward and that lessons would be learned from previous projects. The relevant information was included with the project brief to the bidders in the earlier phase of the project. The use of art has been incorporated into the full design brief for the buildings as a whole. The Design and Healthy Environment Group will meet regularly with the clients and with the builders to ensure the brief is fully realised. Brookfield are entirely involved and are keen to progress with the part of the project. HB reported that the output of this group would regularly be fed back to the NSGHLP Systems Redesign Group. The issue of finance was raised by RC and there were assurances from HB that the bidder had an allocation of funds within their bid that would allow a full programme of arts to be incorporated into the buildings with the project team having tight control of the budget. -

The group discussed the possibilities of incorporating key elements from buildings that were due for demolition and AMcI agreed that an audit of what could be used will be collated by his Directorate and fed back for agreement. **AMcI**

7. Community Engagement in the South Glasgow Project

NMcG spoke to the paper – enclosure 6.

NMcG reported that there were now in place robust links within RHSC and related community and the team were working on building stronger contacts with the users and adult hospital links. He noted that each area was led by a Community Engagement Manager who works closely together with the Project Team to ensure that all areas are covered. These processes are for the long-term and will be used throughout the project. NMcG noted that several groups have been established to support the work around the project which was targeted at ensuring the input of users, carers and staff and let them have their say in the design of the new buildings and facilities included in them. He also noted that the Community Engagement team were working closely with the project team to get the correct input from community groups and users. NMcG reported that during several community events the feedback has been positive for the new hospitals he also indicated that he was about to embark on meetings to start the discussions on the transport systems to and from the new buildings. NMcG indicated that the issue of single rooms had been raised and required further information before he could respond fully to these questions. He reported that his team were progressing with gathering information and planning their presentations to groups further afield than the local communities.

NMcG reported that the Community Engagement Team had, along with their Youth Panel, been invited to attend a meeting with the project team involved in the creation of the new children's hospital in Dublin and to meet with their Health Minister – he indicated that the young people had gained from the visit and had been very positive so far in their hopes for the new facility and were being realistic about what could be provided. He also reported that the Youth Panel had also visited the Scottish Parliament and this was also a positive and enjoyable experience for the panel.

NMcG reported that he and his team had plans in place to work with the project team during fund raising and also with the Design and Health Environment work.

8. New South Glasgow Hospitals Regeneration Update

MMcA spoke to the paper marked enclosure 5. MMcA described in detail the work being undertaken with partners to maximise opportunities for communities and business from the NSGH. This included a programme of community benefit which included a target of 10% of the total labour required to construct the new hospitals to be new entrants. In meeting the 10% target, the contractor has committed to recruiting 250 "new entrants" on an apprenticeship, trainee or employment contracts. The community benefit programme also includes a commitment to support Small/Medium Enterprises and Social Enterprises in the procurement process. The successful contract will partner with Glasgow south West Regeneration Agency to deliver the community benefits programme.

Work is ongoing with Education Services on the establishment of a Community Campus in Govan that includes a focuses on "Healthcare Skills".

Working with Glasgow city council NHS staff qualify under the priority purchase scheme to improve access to affordable housing. Work is underway to support the marketing of opportunities currently under development by Govan and Elderpark house association.

It is important that the local community see the potential benefits but also understand the impact of such a massive build on the surrounding area. The full range of community benefits was still to be finalised with the successful contractor. Once complete, these opportunities would be communicated to the wider community.

To support the successful delivery of the programme, the report recommended that the community engagement manager for the new hospitals is closely aligned with the project team.

9. Vale of Leven – Update

HB gave a verbal feedback on the work carried out since the last meeting. The Monitoring Group had their first meeting which was reported as being positive with some further works to feedback to the next meeting in late January 2010. Work was continuing from the vision generated in July and the capital works programme for improvements had been agreed. HB noted that she was meeting with Scottish Ambulance during the course of next week to agree their plans for the Vale

of Leven.

Travel

NMcG reported that he had been involved in launch of a new bus service from Helensburgh for people using the Vale of Leven and the Royal Alexandria Hospital and also in the discussions which arose around the costs to the Health Board. NMcG was pleased to inform the group that the costs to the Health Board had been reduced with some input from other Health Boards whose patients would be using the service. He also reported that a further "ring and ride" service was being trialled at the moment to cover those living around the peninsula which would take them to the starting point of the main service. Costs involved were unknown as the numbers would not be known for sometime.

Recruitment

GA reported that the process for attracting staff to work at the Vale of Leven was going well and he was taking forward the medical model and the patient pathways. There were some retrieval issues but this was being worked on.

10. ASR Acceleration - Update

JG reported that the complete transition of services to the New Stobhill hospital would be complete during 2010/11.This included the solutions to the impacts on other hospital sites. JG noted the importance of keeping to targeted dates as there was impacts on other sites if not. It was reported that the ITU beds (7) had been commissioned as this was all that was required at this time.

JG reported that the bed model would be progressed this week and further work was required to plan the implementation of this work.

JG reported that the Scottish Health Council had met with regard to patient involvement. A sample of patients would be used and taken forward in the 1st ½ of February 2010.

11. AOB

RC reminded the meeting of the wider issues that need to be addressed in completion of the ASR including services moving in from the Clyde Hospitals which had been consulted on in 2007. There are also some specialty issues across the West of Scotland Boards that need to be finalised

12. Date and Time of Next Meeting

The next meeting would be scheduled for February 2010 – date, time and venue would be confirmed to the group as soon as possible.

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ASR PROGRAMME BOARD

ACUTE SERVICES REVIEW
PROPOSED GOVERNANCE ARRANGEMENTS

Recommendation

The ASR Programme Board is asked to approve the proposed new governance arrangements for the Acute Services Review Implementation

1. Purpose of this paper

This paper sets out the proposed new governance arrangements to oversee the Acute Services Review (ASR) acceleration programme and the next phase of the New South Glasgow Hospitals and Laboratory Project, with the appointment of the preferred bidder and commencement of stages 1 and 2 of the contract.

2. Background and context

The Acute Services Review, as agreed in 2002, is moving in the final stages of implementation with the successful delivery of the:

- New Cancer Hospital for the West Of Scotland;
- Two new Ambulatory Care Hospitals on the Stobhill and Victoria sites;
- Completion of the new maternity wing on the Southern General Site and Closure of the Queen Mothers Hospital.

Work is underway currently as follows:

- Acceleration of the ASR to enable closure of Stobhill Hospital in 2010/11. Funding for related capital projects across the north, east and west of the City (at GRI, GGH and WIG) is in the Board's capital plan;
- The New Hospitals and Laboratory Project Team are working with Brookfield Europe, who have been selected as the preferred bidder for the new Hospitals and Laboratory Project on the SGH site, to take forward the contract: stage 1 (construction of the new laboratory facility) and 2 (design of the new adult and children's hospital) with work to ensure delivery of the Full Business Case (FBC) by November 2010, and subsequently stages 3 and 3A of the contract.

The final configuration of adult acute services in Greater Glasgow sees three adult inpatient sites in 2015 once the new adult hospital is complete on the Southern General site these being the (GRI, New SGH and GGH). The new Children's Hospital will be co-located with the new Adult Hospital and maternity services on the SGH site, with the closure of the current children's hospital on the Yorkhill site.

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Delivery of the ASR acceleration programme and New Hospital and Laboratory Project are crucial in achieving this final configuration. In light of this it has been decided that governance arrangements underpinning both programmes of work need to be amended.

3. Proposed New Arrangements

A diagram setting out the proposed new arrangements is shown in appendix 1.

A summary of terms of reference and membership for the Groups are set out in detail in appendix 2.

4. Key Changes

The key changes proposed are as follows:

- Creation of a bi-monthly Acute Services Strategy Board with the amalgamation of the ASR Programme Board and New South Glasgow Hospitals and Laboratory Project Executive Board;
- Creation of a weekly Acute Services Strategy Board Executive Subgroup;
- Creation of the Construction Management arrangements which support joint working between NHS GG&C and Brookfield Construction;
- The Acute Services Redesign Group to undertake the necessary system modernisation and to work in achieving service and clinical transformation

5. Next steps

Assuming approval is given at this meeting the next step will be to submit this paper to the Performance Review Group on 16th March.

Helen Byrne
Alan Seabourne
9th February 2010

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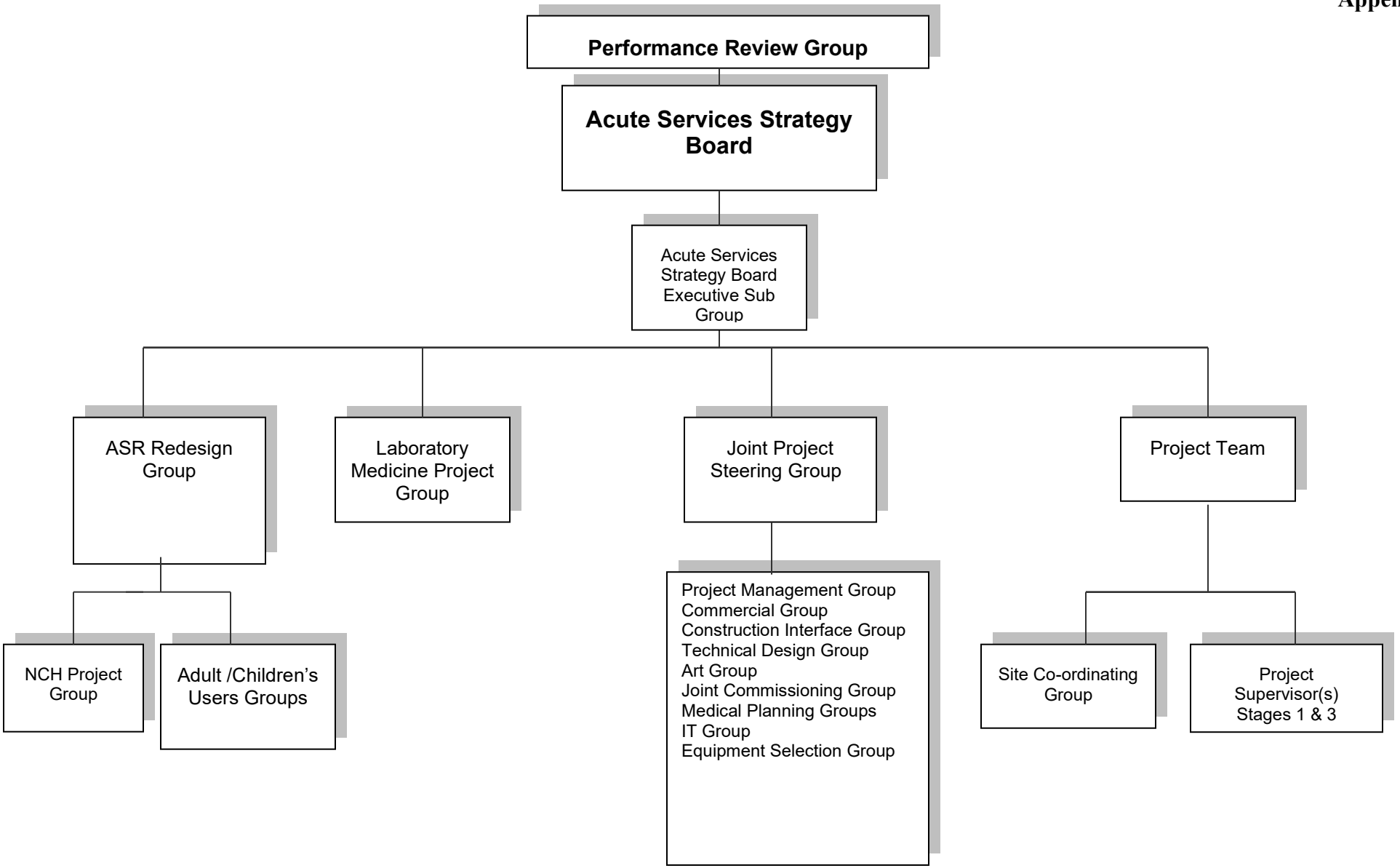
Appendix 1



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Appendix 2

NEW SOUTH GLASGOW HOSPITALS AND LABS PROJECT

GOVERNANCE ARRANGEMENTS

Performance Review Group

Terms of Reference

- Monitor Boards organisational performance
- Monitor resource allocation and utilisation
- Monitor the implementation of Board agreed strategies
- Oversee all aspects of property matters and transactions

Membership

Mr A O Robertson OBE - Chair	Mr R Cleland
Ms R Dhir MBE	Cllr D Mackay
Mr P Hamilton	Cllr D Yates
Mr D Sime	Mrs E Smith – Vice Chair
Mr P Daniels OBE	Mr I Lee
Mr K Winter	

Frequency - Bi-monthly

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Acute Services Strategy Board

Terms of Reference

- Overseeing the delivery of the Acute Service Review
- Oversee the performance of the Acute Services Acceleration Plan
- Report and advise the Performance Review Group on all aspects of the implementation of Acute Services Review
- Monitor all aspects of performance of the implementation of the New South Glasgow Hospital Development.
- Approve change control in that any change which impacts upon the project must be authorised by this Board before it can be implemented.
- Ensure that progress is maintained and business is concluded especially where time is critical to the New South Glasgow Hospital Development with respect to financial aspects and the implementation of works programme and exercise appropriate delegated authority to enable the progress on the contract
- Ensure that all activities of the Acute Services Review Systems Redesign Group are co-ordinated and achieving the appropriate progress.
- Review updates regarding all aspects of planning and implementation of Acute Services Review
- Consider the wider implications of implementing the Acute Services Review including any impact on local communities
- Ensure necessary linkages between elements of Acute Services Strategy are in place to enable delivery of Acute Service Review
- Ensure financial control is being managed and kept within the agreed parameters.
- Approve and monitor the appropriate governance is in place to ensure successful outcome for each major element of the Acute Services Review.
- Approve Full Business Case for New South Glasgow Development and any subsequent Business Cases for associated projects such as; car parks; education centre and academic centre etc

Membership

Robert Calderwood (chair)	Jane Grant
James Stewart	Alan Seabourne
Alan McCubbin	Audit Scotland Representative
Mike Baxter (Scottish Government – Observer)	Representative from Scottish Government Performance Dept – Observer
Douglas Griffin	Brian Cowan
Rosslyn Crockett	

Frequency - Bi-monthly

DRAFT

Acute Services Strategy Board Executive Sub Group

Terms of Reference

- Exercise delegated authority to make decisions on project issues to maintain programme
- Exercise delegated authority to commit funding for new or additional works associated with project
- Receive reports from Acute Directors and Project Director on changes being proposed with financial implications
- Keep NSGHLP Executive Board informed of all issues and decisions taken regarding the project
- This group has delegated authority in line with Boards SFI's which has an agreed delegated limit for the Acute Service Review Executive Board and the Project Manager.

Membership

Robert Calderwood	Jane Grant
Alan McCubbin	Peter Gallagher
Alan Seabourne	Brian Cowan (as required)
Rosslyn Crocket (as required)	
In attendance : relevant Director	

Frequency - Weekly

DRAFT

Acute Services Review Redesign Group

Terms of Reference:-

- Participate in the development of the overall Acute Services Strategy for the NHS Board
- Monitor the delivery of the programmes agreed within the Acute Services Strategy
- Discuss significant programme deviations by exception (either in relation to programme delivery dates or financial limits) and agree remedial actions required to bring delivery programmes on time and within budget
- Agree governance and performance management arrangements for the Division covering the range of the Division's responsibilities in relation to the delivery of the Acute Services Strategy and the Accelerated Capital Programmes and monitor performance against these arrangements
- Develop a structured re-design programme to maximise patient and service benefits in the new hospital
- Maximise PFPI input along with other key stakeholders in new hospital design
- Ensure health inequalities issues are addressed in a structured and focused manner
- Ensure issues such as art in design and transport have a distinct focus and plan within new hospital project
- Co-ordinate regeneration aspects of project to ensure greatest impact
- Consider and manage key areas of clinical and non-clinical risk, drawing any significant issues to the attention of relevant Board officers

Membership:-

Jane Grant (Chair)	1 Representative from each Clinical Directorate (6)
Anne MacPherson	Alan McCubbin
Sharon Adamson	Brian Cowan
Alex McIntyre	Richard Copland
Rory Farrelly	Iona Colvin
Donald Sime	Anna Baxendale
Ann Crumley	Niall McGrogan
Karen Murray	Alan Seabourne + Team

Frequency:- Monthly

DRAFT

Laboratory Medicine Project Group

Terms of Reference

- Act as an Overarching Governance Group to ensure delivery of ASR Programme
- Ensure a coherent and coordinated approach to the delivery of the Laboratory Project
- Manage communications to all stakeholders
- Ensure project programmes are delivered on time
- Oversee sign-off Reviewable Design Data
- To ensure IT and equipment requirements are addressed and embedded in design detail
- Provide decision on all potential changes and to ensure any decisions fall within the current cost programme plan
- Facilitate progress when situations are complex and/or difficult
- Review and advise on project risks
- Responsible for all staff issues and the commissioning programme
- Receive reports and take necessary action from Laboratory Sub Group

Membership

Alieen MacLennan (chair)	Isabel Ferguson (deputy chair)
Rachel Green	Penelope Redding
Diagnostics Labs Project Manager - TBC	Lorraine Pebbles
Winnie Miller	James Farrelly
Ken Robertson	Jane Gibb
Bernadette Findlay	Bruce Barnett
Kenny Birney	Margaret Burgoyne
Mike Connor	Edward Fitzsimons
Alan Hutchison	Craig Williams
Richard Shaw	Colin Smith
Alan Seabourne	Peter Moir
Alex McIntyre	Mary Anne Kane
Marian Stewart	Karen Connelly
Frances Wrath	Ian Forbes
Ross Ballingall	

Frequency - Monthly

DRAFT

Joint Project Steering Group

Terms of Reference

- On a monthly basis identify key Strategic Drivers for the coming quarter
- Carry out a monthly review of Project Strategic Drivers providing direction to the Project Management Group (PMG) as required
- Carry out a monthly review of project issues (reported from sub groups via the PMG) that have not been cleared at sub group level
- Provide direction to the sub groups on the resolution of issues
- Monitor and identify any shortfalls in Project resources
- Monitor critical path of Project Programme

Membership represents the Board and Brookfield

Alan Seabourne	Chris Lovejoy – Brookfield
Facilities Dept Rep	Ed McIntyre – Mercury
David Hall	Neil Murphy – Nightingale Associates
Peter Moir	Ross Ballingall – Brookfield
Alan McCubbin	Steve Pardy – ZBP
Douglas Ross	Tim Bicknell – Brookfield

Frequency - Monthly

Appendix 3 – shows the Terms of Reference/Remit and Membership of each of the group accountable to this group

DRAFT

Project Team

Terms of Reference

Responsible for the overall delivery of the project including programme, costs, quality, health and safety etc

Membership

Alan Seabourne (chair)	Peter Moir
Mairi Macleod	Heather Griffin
Karen Connelly	Fiona McCluskey
Frances Wrath	Sam Suddese
Hugh McDerment	Stephen Gallacher
Jane Peutrell	Shiona Frew

Frequency - Weekly

DRAFT

NCH Project Group

Terms of Reference

- To oversee the work of the Clinical Planning Group
- To recommend, sign off proposals in regard to development of NCH
- To ensure work programmes are completed on schedule by the NCH User Groups
- To inform and updated NSGH&L Project Executive Board
- To ensure involvement of staff and other stakeholders
- To make recommendations on any financial consequences regarding the cost of the NCH

Membership

Rosslyn Crockett (chair)	Jamie Redfern
Elaine Love	Alan Seabourne
Jim Beattie	Jane Peutrell
Mairi Macleod	John Morse
Linda Black	Gerry Hope
Associate Medical Director Women and Children's Directorate/Acute Services	

Frequency - Monthly

DRAFT

Adult/Children's Users Groups

Terms of Reference

- Review architectural design progress for 1:200 and 1:50 drawing detail
- Provide professional input into design process
- Communicate with other colleagues and stakeholders
- Liaise with Acute Directors on progress and any issues requiring their attention
- Do not add costs to project budget
- Sign off design details

Membership

Available on request	

Frequency - every 6 weeks

DRAFT

Site Co-ordinating Group

Terms of Reference

- Ensure there is an overall site development plan which identified all aspects of change planned for SGH site
- Monitors the critical path to ensure key milestones are planned and met
- Ensures adequate level of health and safety planning is maintained
- Received reports from individual project on SGH site to ensure they are planned and implemented in a co-ordinated way to take account of all interfaces and risks

Membership

Tony Curran	Alan Seabourne (chair)
Frances Lyall	Alex McIntyre
Alistair Maclean	John Green
Frances Wrath	John Scott
John Hughan	

Frequency - Bi-monthly

DRAFT

Project Supervisor (Stages 1 & 3)

Terms of Reference

- Compliance with agreed specifications
- Testing of installed product strength and tolerance
- Quality of finish checks
- Area compliance checks
- Exemplar rooms checks
- Monthly reporting
- Inspections identify, record and sign off as complete – defects
- Health and safety assurance
- QA/Document control management

Membership

Alan Seabourne	Peter Moir
Technical Advisors	Supervisors

Frequency - Weekly

DRAFT

Appendix 3

NEW SOUTH GLASGOW HOSPITALS PROJECT CONSTRUCTION MANAGEMENT

Group	Project Steering Group	Project Management Group	Commercial Group	Construction Interface Group	Technical Design Group	Design and Healthy Environment Strategy Group *(Sub-group of Technical Design Group)*	Joint Commissioning Group	Medical Planning Groups	IT Group	Equipment Selection Group
Remit (refer to Group remits paper)	- On a monthly basis identify key Strategic Drivers for the coming quarter. - Carry out a monthly review of Project Strategic Drivers providing direction to the Project management Group as required. - Carry out a monthly review of project issues (reported from sub groups via the PMG) that have not been cleared at sub group level. - Provide direction to the sub groups on the resolution of issues. - Monitor and identify any shortfalls in Project resources. - Monitor critical path of Project Programme	- Manage change control - Monitor short term design, procurement and construction programmes - Monitor project administration ie diary, document control, meetings -Oversee work of sub groups - Monitor sign off progress of sub groups - Monitor Community Benefit progress - Unblock sub group issues - Report key issues to Steering Group	- Manage Changes to Brief - Manage Payment Process - Manage valuations and costs - Manage Risk Register - Manage Early Warning/Compensation Event process - Report key issues to Project Management Group	- Identify short term works on site particularly any that may impact upon the hospital activities - Identify short term Hospital activities that may impact upon the construction works - Communicate construction activities to relevant 3rd parties - Monitor impact of works on surrounding area - Report key issues to the Project Management Group	- Ensure that planning Applications are submitted on time - Ensure that Planning Conditions are discharged on time - Ensure that Building Warrant application is submitted on time and all queries closed out - Monitor design compliance with the ER's and CP's. - Monitor design sign off - Monitor progress of key design strategies – fire, access control, acoustics etc - Manage any derogations from ER's and CP's - Manage any clarifications required against ER's and CP's - Monitor design programme - Manage Mock up and samples programme and signoff - Report any key issues to the Project Management Grp	- Review how art can best be incorporated into the scheme - Agree Project Art Strategy - Advice the design process of opportunities for art - Advise the design process and spatial and technical requirements for art - Report any key issues to the Technical Design Group	- Monitor the production of a Project Commissioning Plan - Monitor the production of a Project Commissioning Programme including operational commissioning - Review the design for "commissionability" - Manage specialist validations required ie pharmacy, CSSD, mortuary - Ensure equipment installation programme co-ordinated with main commissioning programme - Report any key issues to the Project Management Group	- Monitor the Medical Planning Programme and clear any blockages - Monitor resource levels required to meet programme - Monitor the medical planning sign off process and identify any critical delays - Ensure that other sub groups ie IT and Equipment feed into the medical planning process - Manage mock ups for functionality sign off - Monitor production of Room Data Sheets - Report changes to the Project Management Group	- Produce Project IT Strategy in sufficient time to inform the main design - Ensure that IT spatial requirements are co-ordinated with the main design - Ensure that IT technical requirements are incorporated into the design - Ensure that Equipment IT requirements are identified sufficiently early to inform the main design - Report any issues to the Technical Design group	- Monitor the inclusion of Equipment spatial and technical information on the Loaded Plans and Room Data Sheets - Ensure that Equipment spatial and technical information is provided to meet the design programme - Ensure that Equipment selection and procurement is carried out in time to meet the design and construction programme - Manage the approval of Equipment Selection - Manage change control in relation to Equipment provisions - Ensure that Equipment installation and commissioning is integrated into the Joint Commissioning Group - Report key issues to the Project Management Grp
Member-Ship **(Leads indicated in red)**	**Alan Seabourne** Alan McCubbin Alex McIntyre David Hall Douglas Ross Peter Gallagher Peter Moir Chris Lovejoy Ed McIntyre Neil Murphy Ross Ballingall Steve Pardy Tim Bicknell	**Alan Seabourne** David Hall Peter Moir Douglas Ross Mark Baird Ross Ballingall Paul Serkis David Bower Darren Smith Ed McIntyre Tom Allan	Alan McCubbin Alan Seabourne **Douglas Ross** Peter Moir Paul Serkis Eric Napier Tom Allan	Hugh McDerment Sam Suddese Shiona Frew Estates Dept Facilities Dept Health & Safety Supervisor **Alan Keeley** Dave Jordan Kevin Graham Dave Bower Norman Sutherland	Alan Seabourne David Hall Frances Wrath Heather Griffin Karen Connelly Mairi Macleod Peter Moir Infection Control Supervisor **Darren Smith** Manny Ajuwon Chris Lovejoy Ed McIntyre Emma White Alastair Leighton	Alex McIntyre **Anna Baxendale** Dan Harley David Hall Dorothy Cafferty Frances Wrath Heather Griffin Jackie Sands Kate Munro Louise Watson Mairi Macleod Peter Moir Darren Smith Neil Murphy Liz Petrovitch Tom Littlewood	**Fiona McCluskey** Frances Wrath Heather Griffin Karen Connelly Mairi Macleod **Peter Moir** Supervisor C&B Support Ross Ballingall Chris Lovejoy Ed McIntyre Dave Bower Ron King	Alan Seabourne David Hall Fiona McCluskey Frances Wrath Heather Griffin Mairi Macleod Infection Control **Darren Smith** Emma White Paul Britton Dave Bower	**Alan Seabourne (tbc)** Frances Wrath Hugh McDerment Karen Connelly Mark Greig Marion Stewart and/or Alisdair Finlayson C&B Support Chris Lovejoy Tony Duddy Ed McIntyre Steve Pardy	Frances Wrath Hugh McDerment Karen Connelly Peter Moir **Robert Stewart** C&B Support Dave Bower Darren Smith Manny Ajuwon Chris Lovejoy Steve Pardy
Attendees	To be identified as required	To be identified as required	To be identified as required	TA Advisers as required	TA Advisers as required	To be identified as required	Clinical reps/ Technical Advisers as required	To be identified as required	To be identified as required	To be identified as required
Frequency of Meetings	Monthly – Last Tuesday of each month 4pm	Every Tuesday 2pm	Every Tuesday 9am	Every Thursday 2pm	Every Thursday 9am	By Agreement	2nd Friday of every Month 9am	Every 2nd Thursday 1pm	3rd Friday of every month 9am	3rd Friday of every month 1pm
Reports to:	New South Glasgow Hospitals and Labs Project Executive Board through Alan Seabourne	Project Steering Group	Project Management Group	Project Management Group	Project Management Group	Technical Design Group	Project Management Group	Project Management Group	Technical Design Group	Project Management Group

The agenda of the Project Management Group may expand to create a separate Construction Group

These groups will merge at some point

ASR Programme Board

Update on Progress

The contract for the construction of the New South Glasgow Hospitals and Laboratory project was signed by NHS GG&C and Brookfield Construction Limited on the 18th December 2009.

Since the signing of the contract work has commence on Stages 1 & 2 of the works. The following is an update of progress on both stages.

New Laboratories (Stage 1)

As part of the contractual agreement the design team, let by Boswell, Mitchell and Johnston were novated to Brookfield to complete the final stages of design.

The current status of the design is that all 1:200 department layouts are complete and signed-off by the users with the 1:50 room layouts signed off for Blood Sciences, Genetics, Pathology and Mortuary with Microbiology being signed off week beginning 8th February. Final sign off of FM areas is being undertaken in conjunction with the finalisation of 1:200 FM layouts within the new hospital and will be completed during the month of February 2010.

The contractor is now in the process of mobilising his team to prepare for the construction process. The first part of this mobilisation is to establish the works site and this will continue over the next few months when the first stage site accommodation will be established (end of April 2010). This accommodation will be for Brookfield and the project team.

The building warrant for stage 1 i.e ground works has been granted.

The key programme dates for the new laboratory build are set out below

Contracts signed	18th December 2009
Noviate Design Team	18th December 2009
Site Mobilisation and Establishment start	4th January 2010
Start on Site	4th March 2010
Substructure works complete	26th August 2010
Superstructure complete	17th November 2010
Cladding Envelope complete	1st June 2011
Fitting Out/Finishes – start	3rd October 2010
- complete	9th February 2012
Testing, Commissioning of M&E Services – start	10th October 2011
- complete	10th March 2012
Completion – Handover of Building	10th March 2012
Board Commissioning – start	10th March 2012
- complete	9th May 2012
Building Operational	9th May 2012

New Adult and Children's Hospital Design (Stage 2)

Work has commenced on the development of the detailed design of the New Adult Hospital. The first meeting, of a series of six with each User Group, commenced on 20th January 2010. The output of these meetings will be to discuss, agree and sign off the 1:200 design layouts and 1:50 detailed room requirements.

The majority of first round User Meetings for the New Adult hospital have been completed. To date the is a nil return, in other words the output of these meetings have remained within the footprint/cost.

Possible changes are for a potential reduction in the number of haemodialysis stations and also a reduction of the number of haemato-oncology inpatient beds. Once confirmed these changes will be submitted through the change control process for consideration and sign off.

The initial meetings for detailed design of the New Children's Hospital commenced on 8th February and this traunch of meetings will end on 25th February. To date there have been no cost implications.

Alan Seabourne
9th February 2010

ASR Programme Board

Accelerated ASR 2010-2011 Progress Report

19 February 2010

Recommendation

The ASR Programme Board are asked to note this summary report of progress in relation to the Accelerated ASR.

1. PURPOSE OF PAPER

The purpose of this paper is to provide a summary of the progress in relation to the Accelerated ASR Implementation – closure of Stobhill Hospital and transfer of inpatient services to Glasgow Royal Infirmary (GRI).

The target date for the completion of the transfer of inpatient services from Stobhill Hospital to the GRI and the closure of Stobhill Hospital is the end of 2010**.**

The key strategic strands of work that support the closure of Stobhill are as follows:

- Provision of an increased capacity A&E at GRI to service all the activity in north Glasgow.
- Transfer medical and surgical receiving and inpatient services from the Stobhill site. This relies on the following
    - Centralisation of renal and vascular services in the Western Infirmary / Gartnavel General Hospital
    - Rationalisation of Urology Services to Gartnavel General and the Southern General Hospital

2. UPDATE ON PROGRAMME OF ACTIVITY TO DELIVER THE ACCELERATED ASR

The capital project programme of work in relation to support the transfer of inpatient activity by end of 2010 and to close Stobhill is underway. The key activities being progressed to keep the work on schedule include -

GRI A&E and Plastics

The construction phase of the GRI Plastics project is due to complete on 28 March 2010. This will allow the GRI A&E construction to start on 5 April 2010 and is expected to offer a functional A&E in December 2010 with full completion of discharge and triage facilities in January 2011.

GRI Inpatient Ward Refurbishment

The refurbishment of the inpatient ward areas is well underway and will continue over the next six months.

Intensive Care Beds

The work to create the increased critical care capacity at the GRI site is progressing with construction running to schedule and due to complete in October with commissioning in November 2010.

Centralisation of Vascular and Renal Services

Construction work is nearing completion to refurbish F and G blocks. This is due to complete on 15 February to allow the work on WIG level 7 and 9 to start on 1 March and complete in June 2010 to house the centralised vascular and renal services.

Urology Service Transfer

To support the Urology Service move to Gartnavel General Hospital the construction of 2 new laminar flow theatres and the Same Day Admission Unit (SDAU) at GGH is now underway. Construction is on schedule seeing the theatres operational by 28 June 2010 and the SDAU ready in September 2010.

Operational Planning

Work is ongoing to develop the detailed organisational plans to support the transfer of services and activity and the supporting bed model work for the North East is nearing completion.

Sharon Adamson
Head of Acute Services Planning and Redesign

10.02.10

ASR Programme Board
19th February 2010
Enc 4

NHS Greater Glasgow & Clyde
ASR PROGRAMME BOARD

NHSGGC Maternity Strategy Implementation
Progress Report – February 2010

1 Introduction

1.1 This report to the ASR Programme Board provides an update of progress made to implement the NHSGGC Maternity Strategy to end of February 2010.

2 Capital Programmes

2.1 The capital project to build a new extension to the existing maternity unit facility on the Southern General Hospital (SGH) campus was achieved within the target timescale set for the project of October 2009. The remaining component of the capital programme, a refurbishment of the ground floor at the existing SGH maternity unit is now being taken forward for completion by end December 2010.

2.2 At the January 2010 meeting of the Maternity Strategy Capital Projects Board (MS/CPB), all groups set up to implement the strategy reported successful completion of work plans. In addition, mitigation of all high/medium risks were achieved as part of the risk management processes put in place for governance by the MS/CPB.

2.3 The MS/CPB meets again on 16th February 2010, and thereafter the MS/CPB plans to disband its arrangements by end of March 2010; reflecting completion of its work programme. Any outstanding issues for attention in relation to the maternity unit refurbishment programme will be addressed within the Women & Children's Directorate management arrangements. The Maternity Strategy Executive Group (MSEG) which was set up in 2006 to provide Executive level scrutiny of strategy implementation will also be disbanded by end March 2010. An FBC Post Project Evaluation process is currently being developed in line with SGHD Capital Investment Group guidance.

2.4 The next phase of the refurbishment of maternity facilities at the Royal Alexandra Hospital (RAH) in Paisley is now progressing within the 23 week planned programme at a cost of £1.7m.

2.5 There is a planned visit by the Cabinet Secretary and the Health Board's Chairman to the new maternity facility at the SGH on 16th March 2010. There is also to be an official opening of the unit and a date for the event is to be agreed.

3 Service Strategy Implementation

3.1 A commissioning programme saw the implementation of a two site maternity services model taking effect on 9th December 2009, and services provided at the QMH finally transferring on 13th January 2010.

3.2 Increased capacity has been identified to increase the EPAS service from 5 to 7 days per week. A City wide sonography services business case and implementation plan were also completed. The Maternity 'Hub and Spoke' model of service has also been successfully implemented.

3.3 The NHSGGC gynaecology ovarian cancer service model was commissioned to plan in October 2009, with additional theatre sessions established to support the service model. Full West of Scotland service commissioning is being taken forward in 2010, pending successful recruitment to a 5th Consultant Gynaecologist post in 2010. Additional nursing staff have already been recruited with 4 new appointments successfully made.

4 Summary

4.1 **T**he FBC capital programme to build a new extension to the existing maternity unit on the SGH campus was successfully completed in October 2009. Service handover was also successfully achieved in October 2009. The QMH formally closed to maternity services on 13th January 2010. In addition, capital programmes to enhance facilities for patients and staff at the PRM, RAH and GRI have also successfully been completed to plan, with only the remaining refurbishment programmes now being taken forward for completion in 2010.

4.2 With the successful completion of the maternity programme to target timescale, it is the intention to disband the governance and management arrangements that were put in place in 2006 to develop, implement and to performance monitor delivery of the strategy. Any future service or capital programme issues will therefore be addressed within the governance and management arrangements within the Women & Children's Directorate. A Post Project Evaluation will be undertaken in line with SGHD guidance.

4.3 The ASR Programme Board is asked to note the successful achievement of completion of the capital programme and service design within the project timescale, and the planned closure of the Maternity Strategy project arrangements by end March 2010.

Rosslyn Crocket
Director
Women & Children's Directorate

Helen Byrne
Director Acute Services Strategy,
Implementation and Planning

February 2010

Contact: dorothy.cafferty [redacted]
Tel: [redacted]

ACUTE SERVICES REVIEW BOARD
Meeting to be held on 19 February 2010

ASR HEALTH IMPROVEMENT AND EQUALITIES FRAMEWORK

1. Purpose of Paper

To provide the ASR Board with an update on progress achieved in relation to the ASR Health Improvement and Equalities Framework.

2. Background

The ASR Health Improvement and Equalities Framework was agreed by the ASR Board in March 08 with a number of subsequent updates provided. The framework is currently being implemented as part of core Health Improvement activity by Directorates or within existing ASR work streams.

The ASR Health Improvement and Equalities Framework encapsulates activity identified in relation to NHSGGC Single Equality Scheme, Chief Executive Letter 14, Design Action Plan and locally identified priorities.

3. Progress

A detailed update is appended but key areas of progress include:

3.1 The development of Patient Information Centres (in conjunction with the 'i' points) within the new Ambulatory Care Hospitals to provide:

- Interactive Patient information service
- Information on prescription
- Signposting to community services
- Delivery of health promotion and voluntary sector services
- Programmed lets for voluntary sector services
- Volunteering, volunteer centre & advocacy support
- Healthy Working Lives Activities for staff

3.2 The incorporation of a significant number of Framework Actions in to the New South Glasgow Commissioning process and subsequent programme including:

- Social economy policies and clauses within commissioning process
- Patient Information Centre model
- Health Impact Assessment / Equality Impact Assessment
- Application of the Design Action Plan (green space, non-clinical environments, arts, travel planning etc)

3.3 Ongoing action to improve staff health including the achievement of Healthy Working Lives and Healthy Living Awards and the enhancement of the Occupational Health Services.

3.4 Increased engagement and interface with Third Sector agencies to support and compliment NHS functions in relation to retail provision, pastoral care and health improvement.

3.5 Continued progress on the delivery of CEL 14 and Health Improvement HEAT targets.

4. Outstanding areas of action

Progress in relation to 5 areas of action has been limited. A number of specific issues in relation to childcare and hotel accommodation aspirations are being considered outwith the scope of this report and feedback directly into alternative governance arrangements. Further consideration as to the appropriateness of the remaining actions to ensure these actions remain of current relevance will be undertaken.

Work to improve appropriate access to transport re-imbursement for patients will be delivered during 2010.

5. Recommendation

The framework will continue to be considered in the context of the 3 year planning period from 20010/11 and in relation to future ASR developments. The ASR Board are asked to note progress and consider any additional opportunities for delivery.

Anna Baxendale
19 February 2010

ACTION PLAN PROGRESS REPORT – FEB 10

AREAS OF ACTION FROM ASR HII FRAMEWORK	CURRENT POSITION	ACTION	ANTICIPATED OUTCOMES	RESPONSIBILITY	FINANCIAL IMPLICATIONS	TIMESCALES
STANDARD 1: MANAGEMENT POLICY						
1.1 Undertake a managed process of Equality Impact Assessments (EQIA) within relevant ASR work stream	Maternity Strategy pilot EQIA completed.	EQIA tool and guidance revised accordingly by Head of Policy. EQIA tool and guidance to be piloted once Maternity service moved to SGH.	Exemplar approach developed for other workstreams	Health Improvement / Inequalities	To be determined	Ongoing
1.2 Consider need for a socio-economic impact assessment (health impact assessment) where service change has a significant impact on communities	Socio and economic analysis completed for NSGH Combined EQIA and Health Impact Assessment approach developed for NSG	Combined EQIA and Health Impact Assessment to completed by Summer 2010	Partners engaged in supporting New South Glasgow development	Community Engagement	To be determined	Ongoing
1.3 Implement the Design Action Plan within all new developments and refurbishments to promote Health Improvement and Inequalities	Design Action Plan core part of Brief development. Active involvement from Capital Planning Team /New Hospitals Team in approach. Inclusion of DAP within number of new developments including: Maternity, ACHs, NSGH, Labs Buildings and Estates Equality Action plan developed.	Explicit briefing of successful Project teams Development of work programme within project management arrangements Development of Accessibility Network to support patient engagement and DDA compliance		NSG Project NSG Project / Health Improvement / Inequalities Capital planning / Health Improvement / Inequalities / Community Engagement	Existing resources Existing resources Volunteer expenses / administration	Jan 10 Jan 10 Mar 10

1.4 Ensure new health service environments promote healthy living through compliance with Board policies e.g. equality/ food / alcohol policy and extend to contractor and commercial spaces.	Review of Retail contracts under way. Explicit inclusion within new contracts/let agreements.	Work underway with existing contractors to support food policy inc WRVS.	Compliance with Healthy Living Award	Facilities /Health Improvement	Existing resources	Ongoing
1.5 Explore the potential for the provision of onsite hotel accommodation for carers and patients accessing services.	Confirmation of current status and relevance to be discussed with NSGH team			NSG Project	Resource implications	Jan 10
1.6 Include social economy policies and clauses within the contractual process to promote local regeneration through employment and procurement.	Socio and economic analysis completed for NSGH and evident in response to tender Social economy policies clauses incorporated in to contractual and procurement documentation	Partnership model under development with Stakeholders	Partners engaged in supporting New South Glasgow development	Community Engagement	Existing resources	Ongoing
1.7 Support the development of contractors role in Healthy Working Lives through procurement clause	Relevance to be discussed with Capital planning / NSGH project team					
1.8 Address Health Improvement and Inequalities within the development/ and implementation of a Retail Policy for facilities	Review of Retail contracts under way. Explicit inclusion within new contracts/let agreements.	Work underway with existing contractors to support policy inc WRVS.	Compliance with Healthy Living Award Increased quality of retail provision	Facilities /Health Improvement	Existing resources	Ongoing
1.9 Equalities and Health Improvement practice to be included within Learning &	Detailed review of Acute L&D plan underway.	Priorities for L & D to consider Equality implications	Increased awareness and skill associated with quality patient experience	Learning and Development	Existing resources	March 10

Development plans	Range of L&D programmes in place to address: ▪ Diversity Awareness ▪ Customer Care ▪ Communication		and management of legislation compliance	Learning and Development / Health Improvement	Existing resources / Staff release	Ongoing
	Range of L&D programmes in place to address: ▪ Behaviour change ▪ HI practice			Learning and Development / Health Improvement	Existing resources / Staff release	Ongoing
STANDARD 2: PATIENT ASSESSMENT						
2.1 Ensure patients wider social and diversity needs are robustly and routinely incorporated into the scheduling and care planning process including: ▪ EQIA service pathways	EQIA action plan for 40 service pathways progressed across Acute Division.	Continued implementation and Divisional action associated with cross cutting themes.	Increased focus on patient centred care model and quality patient experience.	All Directorates / Acute HI &I co-ordinating group	Existing resources/ Various resource implications within actions	Annual commitment
▪ Single patient record ▪ Appointing process ▪ Standardised admission information for planned / unplanned	PMS development to support single approach to care planning, appointing etc. PMS EQIA underway.	Completion of EQIA and associated action.		PMS project Board	Existing resources/ Various resource implications within actions	March 10
▪ Assessment of communication and language need	HIT Equalities action plan developed.	ASR implications addressed.		HIT	Existing resources/ Various resource implications within actions	?
▪ Collection of data and analysis for service pathways	Equality checklist for Planning Mgrs developed.	Ongoing implementation		Acute Planning	Existing resources	Ongoing
2.2 Develop and co-ordinate communication and marketing strategy for Health Improvement and Equalities action across acute setting and	Acute HI &I co-ordinating group established	Activity to be undertaken	Increased awareness of HI &E issues and actions for staff and public	Health Improvement	Existing resources	May 2010

staff groups						
2.3 Develop training programme to enable staff to deliver Health Improvement and equalities sensitive practice within patient journey. Including: ▪ Customer care ▪ Equality and diversity awareness ▪ Health Related Behaviour Change	'customer care' pilot completed Range of HI and Equality & Diversity training available	As above	Increased awareness and skill associated with quality patient experience and management of legislation compliance	Learning and Development / Health Improvement	Existing resources	Ongoing
2.4 Develop and implement models of prehabilitation, and rehabilitation to support health improvement and supported self care including: ▪ Behaviour change assessment and pathways ▪ Links to voluntary sector / pastoral care / self care support agencies	Patient pathways developed for Smoking/ Physical activity /Healthy Eating/Financial inclusion/Employability Specific 'pathway' training delivered to key specialities Patient information centres established in ACHs	Continued roll-out to service areas.	Increased focus on patient centred care model and quality patient experience.	Health Improvement / Directorates	Existing resources	Ongoing
2.5 Ensure seamless access to transport re-imbursement for eligible patients	No progress	Scoping of programme to be undertaken and proposal for SMG developed.	Reduced barrier to patient attendance	Health Improvement	Resource implications	Sept 10
2.6 Create a 'help desk' function for patients to access services provided by primary care and social work e.g. ordering of equipment with a physical point of contact.	Patient information centres established in ACHs Inclusion of PIC within NSGH & Children's	Continued development of PIC model.	Increased focus on patient centred care model and quality patient experience	Health Improvement Health Improvement	Existing resources / additional staffing implications Existing resources / additional staffing implications	Ongoing Ongoing

STANDARD 3: PATIENT INFORMATION AND INTERVENTION						
3.1 Develop a single visible 'hub' of services to support Health Improvement and Equalities within the hospital. ▪ Provide access to Health Promotion services supporting patients and staff to address health behaviours in relation to smoking, physical activity, alcohol and weight management ▪ Provide a helpdesk / information facility to promote access within the hospitals including structured way finding, booking for interpreting services, a volunteering center, chaplaincy services, carer support, and where possible appointment setting.	Patient Information Centre in ACH s established Sep 2009. Staffed model identified as integral to feasibility of model. Information prescription currently being piloted Active programme of 'health improvement' services established	Financial package for staffing to be secured. Continued development of PIC model. Inc ongoing programming of services Community signposting pathway's to be fully developed	Exemplar model of Patient Information Service developed building on previous Patient Info Points with extended role of supported community signposting	Health Improvement / Knowledge management Health Improvement / Knowledge management Health Improvement / Knowledge management	Financial Implications – mixed source funding to be agreed Existing resources Existing resources	Ongoing Ongoing March 10
3.2 Establish a group to develop a patient and staff information strategy including: ▪ Use of IT / Multi media / info pod opportunities ▪ Consider outreach connections to PHRU/libraries ▪ Use HI hub as source of patient information.	Patient Information Centre in ACH s established Sep 2009.	Ongoing development of patient information service to cater for 'off-site' enquiries and support further IT developments	Exemplar model of Patient Information Service developed building on previous Patient Info Points with extended role of supported community signposting	Health Improvement / Knowledge management	Additional resources to support internet access / IT management systems	Ongoing
3.3 Implement Patient Information policy within service pathways	Board policy drafted and implementation group established. Patient info toolkit	Implementation plan required.	Quality assured patient information compliant with equalities legislation	Acute HI &I co-ordinating group / All Directorates	Additional resources	Ongoing

	developed.					
3.4 Support smoking cessation for inpatients and out patients in all acute settings	Acute Service rolled out across GG and Clyde. ▪ Redesign under way in Maternity. ▪ Outpatient pilot completed.	Monitor and address support actions required to achieve HEAT targets. Additional support for staff cessation.	Smoking Cessation Service delivery maximised. HEAT target delivery	Health Improvement / EMCS	Resource secured from Tobacco PIG.	Ongoing
3.5 Register as an European Smoke Free Hospital	Limitations within ESFH and support from Health Scotland as national sponsor. Relevance to be discussed with national programme		Accredited smoke free environment	Health Improvement	Existing resources	Tbc Tbc
3.6 Progress Baby friendly Initiative in all acute settings	Baby Friendly Status secured in all areas.	Actions required to address ongoing maintenance.	Accredited practice in all maternity units	Women's & Children's	Funding implications Infant Feeding CEL 36	Ongoing
3.7 Provide opportunistic screening and brief interventions for patients in relation to Alcohol intervention in accordance with SIGN 74	Development of appropriate model of support for screening and brief intervention in Acute services and action plan developed.	Ongoing staff training	Opportunistic brief intervention delivered in acute relevant model HEAT target delivery	EMCS	Funding Implications Addictions PIG	Ongoing
3.8 Implement Gender based violence action plan prioritizing Women and Children	Local gender based violence action and implementation plan developed within Women's & Children's and A&E.	Implementation of Local Directorate action plans. Development of a phased training programme in A&E.	Development of inequalities sensitive practice in key services.	Women's & Children's / EMCS and Health Improvement & Equalities	Existing Resources	March 10
STANDARD 4: PROMOTING A HEALTHY WORKPLACE						
4.1 Provide smoking cessation support for staff	Drop in clinics in all acute settings and . PiC's.	Ongoing promotion of service through local HWL and Occ. Health referral and NSD	Staff focused service	Health Improvement / EMCS	Existing resources	No smoking Day / Various
4.2 Ensure healthy eating opportunities through Health Living Award/ Healthy Vending Provision of fruit in all	All internally operated Acute sites successfully achieved HLA.	Maintain award and work towards gold HLA.	Compliance with Healthy Living Award in all catering units and external contractors to	Facilities / Health Improvement	Existing resources	Ongoing

acute sites	Promotional strategy developed. Healthy Vending policy drafted and under market testing. Fruit and veg models including NHS supply, community food initiatives and retail options established.	WRVS application to be supported. Implement current workplan and promotional strategy Support implementation based on national developments. Ongoing development	support food policy. All vending machines in line 50% minimum specification Fruit and veg availability in all Acute sites	Facilities / Health Improvement Facilities / Health Improvement	To be determined Funding Implications FFN PIG	TBC
4.3 Maximise the use of facilities where possible for staff use through out of hours access to rehabilitation gyms, showers, staff training facilities etc.	Relevance to be discussed with Facilities					
4.4 Ensure HWL award progressed in all acute sector clusters	All 6 acute clusters completed bronze and currently awaiting review for silver	Ongoing implementation	Support quality staff working environment	HR	To be determined	Ongoing
4.5 Create a safe environment for both staff and patients through on site extended community safety and policing	Relevance to be discussed with Facilities / Health and Safety					
4.6 Ensure Occupational Health services promoted support to access HI and rehabilitation services at every opportunity.	Health Improvement training and onward 'sign posting' patient pathways developed for Occupational Health management team	Ongoing implementation	Staff access to HI services in communities	HR / Health Improvement	Existing resources	Ongoing
4.7 Ensure the availability of child care facilities for both staff and	Confirmation of current status and relevance to		Consistent approach to childcare provision across	HR		Tbc

patients.	be discussed with HR		all Acute sites			
4.8 Develop and implement green travel plan including active travel options and facilities.	Staff health plan and physical activity strategy workplan agreed. Walk and Jog leaders trained. Cycle to work scheme in place. Upgrading of cycle facilities across acute sites underway.	Continued implementation of plan	Increased opportunities for active travel and active recreation by staff	Health Improvement / Facilities	To be determined	Ongoing
4.9 Maximise the development of affordable and sustainable housing for staff through partnerships	Confirmation of current status and relevance to be discussed with CHCPs / Community Engagement					
4.10 Promote accessible green space within the hospital design to encourage use by patients and staff including well light and clearly marked walkways across the campus.	Core part of NSGH Identified as Physical Activity Action plan / Staff Health Plan development. Hospital in the park development at stobhilll / Springburn park	Continue to incorporate in new developments Continued implementation of plan	Support quality staff and patient environment	NSGH Project / Capital planning Health Improvement / Facilities	Within capital costs Staff health fund applications	ongoing March 11
4.11 Ensure non-clinical environment promote staff health and wellbeing.	Various Art and Design working groups established including NSGH.	Continue to incorporate in new developments	Support quality staff and patient environment	NSGH Project / Capital planning / Health Improvement	Within capital costs/ External fundraising	
4.12 Maximise the employment of local people through social benefit clauses / recruitment strategy	Vocational rehabilitation action plan developed. Rheumatology pilot underway. Employability	Continued development and implementation. Service model to be evaluated	Increased focus on patient centred care model and quality patient experience Inclusive HR policy &	Rehabilitation and Enablement / Health Improvement HR	Existing resources Existing resources	Ongoing Ongoing

	initiatives established with Glasgow Works/ modern Apprentice schemes.		procedure Aligned and co-ordinated employability services in Glasgow			
STANDARD 5: CONTINUITY AND CO-OPERATION						
5.1 Develop 'shop front' for the voluntary sector, encouraging patients to utilise the range of specialist support and counselling services in cases of disease diagnosis and bereavement as well as life circumstances support such as debt management and benefit maximisation	Patient Information Centre in ACHs support Voluntary sector service delivery and referrals. PiC Volunteer service in development with CHCP Employability service and external organisations.	PIC role in supporting wider NHS volunteering programme to be developed.	Exemplar model of Patient Information Centre developed building on previous Patient Info Points with extended role of supported community signposting to Voluntary sector / CHCP services	Health Improvement	Existing resources	March 2010
5.2 Within retail policy development, consider not for profit or social enterprise opportunities are considered.	Procurement working group developed social enterprise clauses and market support structures. Socio and economic analysis completed for NSGH	Number of social enterprise pilots underway. Development of programme with WRVS etc.	Social economy role of NHSGGC supported	Procurement Facilities	Existing resources To be determined	various March 10
5.3 Maximise the use of facilities where possible for community use through community lets and out of hours access for structured service based activities e.g. training / voluntary groups	Numerous community services now utlising PiC meeting rooms.	Ongoing implementation	Community access as part of structured activities	Health Improvement / Facilities	Existing resources	Ongoing
5.4 Support voluntary sector agencies (e.g. WRVS) to participate further in the operation of acute services	Initial action plan agreed with WRVS now under review	Development of programme with WRVS etc.	Social economy role of NHSGGC supported	Health Improvement / Facilities	Existing resources	Sept 10

through volunteering policy and Healthy Living Award Schemes						

GREATER GLASGOW AND CLYDE NHS BOARD

ASR PROGRAMME BOARD MEETING

Notes of the meeting held on Friday 19th February 2010 at 11.30am in Board Room 2 Dalian House

Present: Robert Calderwood, Chief Executive (Chair)
Helen Byrne, Director of Acute Services Strategy, Implementation and Planning
David McConnell for Jim Rundell, Audit Scotland
Niall McGrogan, Head of Community Engagement and Transport
Stephen Gallagher, Scottish Government Health Department
Melanie McColgan for Grant Archibald, Emergency Care and Medical Services
Peter Gallagher, Director of Finance (Acute)
Ally McLaws, Director of Communications
Anne MacPherson, Associate Director of Human Resources (Acute)
John Scott, Senior Project Manager – Capital Planning
Anna Baxendale – Head of Health Improvement for item 4

Apologies:
Jane Grant, Chief Operating Officer
Joanne Frame, ICT Change Culture Manager for ICT for Richard Copeland
Alex McIntyre, Director of Facilities
Sharon Adamson, Head of Acute Services Planning and Redesign
Jim Crombie, Director of Surgery and Anaesthesia
Rosslyn Crocket, Director of Women and Children's Services
Iona Colvin, Director South West Glasgow CHCP
Brian Cowan, Medical Director
Alan Hunter, Acting Director Emergency Care and Medical Services
Heather Griffin – Project Manager, New Adult Hospital
Alan Seabourne, Project Director, New Hospitals' Project Team
Douglas Griffin, Director of Finance
Rory Farrelly, Director of Nursing (Acute)
Mairi Macleod, Project Manager, New Children's Hospital
Dorothy McErlean, JOC - Area Partnership Forum representative
Frances Lyall, Staff-side Representative
Calum Kerr, Scottish Ambulance Service
Ian Reid, Director of HR
Karen Murray, Director, East Dunbartonshire CHP
Ken O'Neill, Clinical Director

In attendance: Allyson Hirst, Acute Planning PA (minutes)

		ACTION
1.	**Apologies** As noted above.	-
2.	**Notes of the previous meeting held on 11th December 2009** The notes of the previous meeting were accepted as an accurate record.	-
3.	**Matters Arising** No items other than those listed on the agenda	
4.	**Health Improvement Framework** A Baxendale spoke to the paper marked Enc 2 which was intended to update the Programme Board on the progress achieved in the ASR Health Improvement and Equalities Framework and its linkage to the Single Equalities Scheme. Key areas of progress were noted as • Interactive patient information service • Information on prescription • Signposting to community services • Delivery of health promotion and voluntary sector services • Programmed lets for voluntary sector services • Volunteering, volunteer centre and advocacy support • Healthy working lives activities for staff	

ABaxendale noted outstanding areas of action were mainly in relation to the provision of childcare, transportation reimbursement, these would required to be fed in via other national government arrangements and hotel accommodation aspirations.

RC questioned if the hotel accommodation would be included within the Ronald McDonald work with the NCH appeal. HB responded that a feasibility study was being carried out but this would be for parental accommodation although there were some discussions on whether or not "hotel" accommodation could be provided within the same building but there were some concerns around the revenue costs. These discussions would continue with the project team and the appeal group. It was noted however that the site identified for the Ronald McDonald House would just fit the accommodation that they have requested. It was considered by the group that if "hotel" accommodation was to be provided it may be possible to partner a hotel group.

5. New South Glasgow Hospitals and Laboratory Update

HB spoke to the paper marked Enc 3. RC asked if the sod cutting plans were confirmed and AMcL responded that the date was set at the 16th March but there were some finer details to be finalised. AMcL noted that the "theme" of the sod cutting would concentrate on the investment, apprenticeships etc. The group agreed that this was appropriate. -

6. Maternity Strategy Implementation – Progress

HB spoke to the paper marked Enc 4. On the capital programmes the following was noted :-

The maternity extension was achieved on target and timescale and JS confirmed that the remainder of the work was on plan for completion by the end of December 2010.

The refurbishment of RAH in Paisley was now progressing within the planned 23 weeks and within costs previously agreed.

The two site maternity implementation took effect on 9th December 2009 with services transferring from QMH on 13th January 2010 and that work on the GRI was now completed.

It was noted that now that the work was almost at completion for the maternity programme it was intended to disband the groups set up to take these projects through to completion and any further issues will be taken on by the Women and Children's Directorate.

7. Accelerated ASR 2009-2011 – Progress

HB spoke to the paper marked Enc 5. The Group were asked to note this summary report in relation to the Accelerated ASR work being undertaken. There were a few key strategic pieces of work that supported the closure of Stobhill hospital and the transfer of relevant services to Glasgow Royal Infirmary including the increase in capacity at GRI the transfer of surgical services and inpatient services from the Stobhill site. It was noted that this work is all progressing well with programmes on target for completion to enable this to continue. The question of the works completing before the Winter was raised but the group were assured that the works were planned to complete in December for those department affected by the increase in patients and only minor works would still be undertaken through December and January. -

8. Proposed Governance Arrangements for ASR

HB spoke to the paper marked Enc 6. HB reported that this paper had been submitted to the New South Glasgow Hospitals and Laboratory Project as it moves the next stage. The key changes to the process of meetings is

- Creation of a bi-monthly Acute Services Strategy Board with the amalgamation of the ASR Programme Board and New South Glasgow Hospitals and Laboratory Project Executive Board;
- Creation of a weekly Acute Services Strategy Board Executive Subgroup;
- Creation of the Construction Management arrangements which support joint working between NHS GG&C and Brookfield Construction;
- The Acute Services Redesign Group to undertake the necessary system modernisation

and to work in achieving service and clinical transformation

The group were informed of the proposed changes that came from the paper being submitted to the Executive Board and it was noted that the changes proposed would be made and taken to the meeting of the Performance Review Group in March for final approval before groups would be informed of changes in membership and group titles.

AMcL drew the groups attention to the fact that there were no groups looking specifically at the communication, marketing and staff communications within this governance arrangement. RC suggested that AMcL prepare a Terms of Reference and proposed membership for the meeting of the Performance Review Group in March with input from ASeabourne and NMcGrogan where necessary.

SG asked if accountability structure within the project was solid and RC reported that lessons were learnt from previous projects both successful and unsuccessful project and they were treating this project as a PFPI in regard to the costings and changes to design that would have an impact on costs and that there is a structure in place which only allows major changes in costs to be processed through at Health Board level with accountability at each stage below this. It was also noted that Brookfields original quote allowed for some fluctuation without impact on costs.

9. Ambulatory Care Hospital Update

HB spoke to the paper marked Enc 7. the paper indicated the successful conclusion of negotiations with Glasgow Healthcare Facilities Ltd for the provision of short-stay and elderly rehabilitation beds at the New Stobhill Hospital. This concluded with financial close of the project being reached on 22nd December 2009. Completion of this project is programmed to complete and handed to the Board on 25th February 2011 followed by a four week commissioning programme and will be ready to accept patients late March 2011.

10. Vale of Leven – Update

HB gave a verbal update to the group. HB reported that the Cabinet Secretary had approved the main recommendations of the Monitoring Group. HB noted that the implementation of the changes was dependent on the following

- Recruitment of new consultant physician posts – interviews were being held
- Reconfiguration of medical beds
- Increase of beds at RAH and assessment facilities to support additional patients from VoL
- Redeployment of staff to RAH from VoL

HB noted that Elderly Mental Health had increased their beds by 6 and that Scottish Ambulance Service were increasing their services to accommodate the changes. Review of Dental services in Alexandria was concluding with a Gateway being carried out.

HB reported that local users were appreciative of participation in the Monitoring Group meetings and that activities were moving in the right direction – HB noted that the 2nd meeting of this group had taken place.

11. AOB

RC closed the meeting as there was no further business to discuss but wished to convey has appreciation to Helen Byrne for all her work and wished her well in her new post.

12. Date and Time of Next Meeting

This was the final meeting of the ASR Programme Board in its current format and the next meeting of the new formed group would be in April 2010 – final date and time arrangements still to be confirmed and members would be informed as soon as possible.

16. DETAILED ANALYSIS OF THE OPTIONS FOR SOUTH GLASGOW

Why is there a need for change?

Throughout the western world hospitals and the services they provide are changing fast. Many of the most important services are on a "same day" basis – in out-patient clinics, minor injuries units, x-ray and rehabilitation departments, day case surgery. Doctors are becoming more specialised – especially in surgery – and there is growing evidence that specialist teams get the best and safest results, especially where the illness or injury is most serious.

Patients expect the benefits of these changes. Faster, more convenient services in patient-friendly modern surroundings. The confidence of knowing that you are in the best possible expert hands.

But at the moment Glasgow's hospital services – including those on the Southside – can't provide these benefits in the way they should. Too many dilapidated old buildings with scattered services and dispersed staff.

Only a major redesign of our services will give Glaswegians the standards of service they are entitled to expect.

Most cities have faced similar problems. Some have tackled them by closing some of their large acute hospitals altogether. Sometimes they have replaced old hospitals with new ones on the edge of the city or town. We do not think that's the right way to go. But nor can we carry on as we are.

The position is made all the more pressing because there are new regulations limiting the working hours of hospital consultants and junior doctors. It will be impossible to maintain safe 24 hour cover, keep doctors' skill levels sharp and well-exercised and at the same time comply with the regulations if we keep the present pattern of in-patient services which require 24 hour cover.

We have produced some leaflets which describe some of these issues in more detail:

- "The Patient's Experience"
- "Getting it Right for Patients – What it means for organising services"
- Why Specialisation Matters"
- Impact of Regulations on Doctors' Working Hours"

Discussions in the last two years

Since the autumn of 1997 in the Southside hospital doctors, GPs, nurses, other health professionals and managers have worked together to see how we can provide the sort of services patients need. There have also been regular discussions with MSPs, community councils, city councillors, East Renfrewshire Council, MPs, the Local Health Council and various local interest groups.

Three main messages have come from these discussions:

- local people want local access for as many services as possible.
- a population the size of the Southside (350,000 people) need one comprehensive set of well-staffed specialist services rather than two over-stretched and patchy sets of services.

- the need for modern well-designed user-friendly services and buildings is urgent.

On the face of it, the second of these two is not easy to reconcile with the first. But the development of "same day" services (known as "Ambulatory Care") provides a way in which we can fully achieve the second (essential in the interests of safety and best possible results in diagnosis and treatment) and at the same time get very close indeed to also fully providing the first.

The third message led to a request that the South Glasgow Trust should look at several different options – including the creation of a brand new hospital for the Southside on a new central site.

Our proposals now are the result of working up more detail based on the discussions of the last two years.

What is the present pattern of services?

The South Glasgow Trust services are provided from five sites:

Victoria Infirmary

This busy hospital is located in the heart of the population it serves (approximately 200,000). It has a busy Accident and Emergency Department and offers a range of acute district general hospital services. Its buildings mostly date from phased development over the first fifty years of the last century. Links between related departments are often poor and it is increasingly difficult to provide modern diagnostic and treatment methods. A number of services are integrated between the Victoria Infirmary and Southern General Hospital (i.e. ENT, eyes, Urology, Dermatology and Maternity) and for these services in-patient and day case facilities are only at one or other site.

Southern General Hospital

Unlike the Victoria Infirmary, the Southern General not only provides the full range

of district general hospital services for the population of South-West Glasgow

(approximately 150,000) but has a number of specialties which serve not only the whole of South Glasgow but Greater Glasgow, the West of Scotland and further afield

(i.e. National Spinal Injuries Unit, Institute of Neurosciences, WESTMARC (the wheelchair and artificial limb service) and, shortly, Oral and Maxillo-facial Surgery).

The emergency and trauma nature of the specialties located at the Southern General Hospital requires good access to the West of Scotland motorway network and helicopter access - the site's location and large campus make this possible. Although some parts of the Southern General are in old buildings, it also has some 600 beds in modern facilities.

Mansionhouse Unit

This unit has beds for assessment, rehabilitation and continuing care for the elderly.

Assessment beds should ideally be on the same site as acute medical services.

Cowglen Hospital

This hospital has 120 beds for elderly continuing care. There is a separate review underway about how best to provide continuing care for elderly people and a consultation exercise will be launched in the late spring of 2000.

Mearnskirk House

This site has 72 elderly continuing care beds recently provided under a PFI arrangement. This site would not be affected by any of the options for acute hospitals.

Local access

Our proposal is that whatever choice is made about where to provide in-patient beds, there should be a new, state-of-the-art **Ambulatory Care Centre** built at the **Victoria**. It would provide:

all out-patient clinics for South-East Glasgow	no less than at present.
all day case surgery	no less than at present.
23 hour (overnight) elective surgery for South Glasgow with fully equipped recovery and resuscitation facilities	a new service
Out-patient rehabilitation services -	such as physiotherapy, speech therapy etc. No less than at present.
Regular renal dialysis -	kidney machines. This service does not even exist in the Southside at present.

Minor injuries unit -	which would probably deal with at least 50% to 60% of the present attendances that go to the Victoria Infirmary Accident and Emergency Department.
GEMS Centre (GP out-of-hours service)	- as at present.
Diagnostic services	- to support all of these activities.

These services would deal with at least 85% to 90% of all patient contacts that currently use the Victoria Infirmary. So local access is preserved for the services used by most of the patients most of the time. In addition we propose that there should be 120 rehabilitation beds in a new building next to the Ambulatory Care Centre – this would particularly help local people needing to visit a patient who needs more extensive time in hospital to recover.

The local access position for people living near the **Southern General Hospital** would depend on which option is chosen for providing the single in-patient service base for the Southside. If the Southern General is developed for this their local access would remain unchanged (although we think the Victoria Ambulatory Care Centre would be the most suitable place to provide day surgery for the whole of the Southside).

Our proposals also include providing **nephrology** (kidney disease) in-patient services and **investigative cardiology** (for heart disease) on the Southside for the first time, which will provide local access to these services for Southside people.

Our leaflets:

- "Ambulatory Care – What is it?"
- "Minimally Invasive Technologies : Keyhole Surgery and the Like"
- "Creating More Responsive Accident and Emergency Services"

explain some of the background of these local access issues in more detail.

Specialist in-patient services

The proposal to create a new single set of facilities for in-patient work on one site to serve the Southside has strong support from Southside doctors. It has also been supported in much of the wider public debate that has already taken place.

At the moment we have to maintain two 24 hour rotas in orthopaedics, general surgery and gynaecology when the workload to be covered could be dealt with by one. Having two rotas instead of one adds to the longstanding problem of junior doctors working scandalously long hours and often means less consultant time is available to tackle waiting times for clinics and operations.

A single set of specialist services for the Southside means that specialist teams are larger. With their beds concentrated together, some of them each day will cover the beds and emergencies while others do clinics and day cases, so keeping waiting times down.

A stronger Accident and Emergency service

The Accident and Emergency consultants in the Southside have said emphatically that there should only be one "A & E Department". This would allow more consultant presence in dealing with serious cases for a greater part of each 24 hour period than is the case at the moment – it would be a major step forward in quality of service.

Our leaflet "Creating More Responsive Accident and Emergency Services" goes into this in much greater detail, but obviously a beefed-up A & E service dealing with major cases needs to be on the same site as the in-patient services.

Our proposal to include a Minor Injuries Unit in the new Ambulatory Care Centre at the Victoria maintains local access for the great majority of people who currently use the Victoria Infirmary

A & E Department. A very similar service has existed at Stobhill for years – people are very pleased with it and there have been no problems about its safety.

Our leaflet on Accident and Emergency Services goes into detail about the concerns that people have expressed about longer ambulance journey times in cases where someone has had a heart attack or very serious accident.

So what are the options for a single in-patient site?

The South Glasgow Trust looked at five different options.

1. A new Ambulatory Care Centre at the Victoria Infirmary and a completely new hospital for in-patient services on a new site reasonably convenient for everyone on the Southside.
2. A new Ambulatory Care Centre at the Victoria Infirmary and creating a completely modern in-patient hospital at the Southern General by demolishing old buildings and constructing new ones in two contracts over the next decade.

   These two options are explained more fully later.

3. In-patients at the Victoria Infirmary site with Ambulatory Care Centre at the Southern General.

   This was rejected because it would have made access to major Acciden tand Emergency services in the city unsuitable for patients from the West o of Greater Glasgow. (A brand new Accident and Emergency Department is already being built at the Royal Infirmary, in the North-East section of the motorway network. Having the second Accident and Emergency Department at the Victoria would denude the

West of Greater Glasgow. Having a third major Accident and Emergency Department at Gartnavel would frustrate the ability to have a single orthopaedic in-patient unit in North Glasgow).

In addition, the Victoria Infirmary site (11 acres) is too small to accommodate all of the Southside's in-patient services and ambulatory care for South-East Glasgow. This is still an insuperable problem even if a very large part of the Queen's Park Recreation site was available for a hospital – which it isn't.

4. All services at the Victoria Infirmary.

   Rejected for the same reasons. It would also deny to the residents of South-West Glasgow the ease of access to as many local services as possible that we want to provide as a matter of principle to everyone.

5. All services at the Southern General.

Rejected because it does not give any local access to services for residents of South-East Glasgow.

Child and Maternity Services

In looking at Options 1 and 2 the Trust explored whether it was possible to re-locate the Yorkhill Children's Hospital services to the Southside. This followed a suggestion made in earlier public debate in the Southside. It was found to be feasible and is included in the calculations later in this leaflet. Our Glasgow-wide consultation exercise seeks views on whether it would be a good idea to re-locate Yorkhill to the Southside. There are good clinical reasons for considering it and it would also help to ensure that maternity in-patient services remain securely in South Glasgow.

Our leaflet "Maternal and Child Health" says more about this suggestion.

Adult Mental Health Beds

Acute adult mental illness facilities for South-East Glasgow are currently located at Leverndale Hospital and for the South-West share the Southern General Hospital campus. All elderly mental health beds covering South Glasgow are at Leverndale Hospital. The Primary Care Trust would like to see all of these services provided on the same site as general hospital in-patient services. It provides better psychiatric support for the general hospital and reduces the isolation and stigma of mental illness.

In exploring options for the Southside's general acute hospital in-patients the South Glasgow Trust took into account the need for there to be enough space for mental illness beds but did not include the building costs in their calculations.

Option 1 – "A New Site Hospital"

The South Glasgow Trust appointed property agents to scan the Southside for suitable sites on which a new hospital could be built.

The site would need to be about 50 acres or more. There are very few sites of such a size available on the Southside.

The search identified three possible sites:

1. In the Pollok area a site of approximately 44.7 acres, incorporating the present Cowglen Hospital and the National Savings Bank (NSB), bounded by Boydstone Road, Barrhead Road, M77 motorway and Kennishead Wood. There is additional adjacent land to the South of Cowglen Hospital which would be needed to accommodate all the possible services.
2. An area of 73.6 acres incorporating the Pollok Playing Fields, currently leased to the NSB and land owned by the Pollok Estate.
3. An area of 80 acres at Darnley Mains adjacent to the M77 and next to the existing B & Q Warehouse.

Part of Site 1 is already owned by the Trust – Cowglen Hospital (16 acres). The remainder is owned by the NSB. The other land next to Cowglen Hospital is owned by a developer and is zoned for retail or commercial development. No conversations have taken place with the NSB and it is not known whether either they or the developer would be willing to sell. The cost of the land would be high due to its potential for retail development.

Site 2 is owned by Pollok Estate and is currently leased to NSB. However, it is understood that Glasgow City Council might have an interest in the site in order to increase the number of playing fields and recreation areas. It is currently zoned as "Green Belt".

Site 3 was not pursued as an option because its geographical location made it too inaccessible for most people living on the Southside and it was that much further away for Accident and Emergency\Trauma access from the West.

Of the three site options, Site 1 was considered the one most worth further detailed work.

A new hospital on the existing Cowglen Hospital site would mean closure, demolition and sale of the Victoria Infirmary, Mansionhouse Unit and the Southern General Hospital site (excluding 210 beds at the Shieldhall Road end of the site currently being built under Private Finance Initiative funding and to which the Trust is committed on a 30 year lease. The Trust would locate some of its in-patient rehabilitation and local South-West continuing care services within this new facility).

The cost of building a new in-patient hospital at the Cowglen site and an Ambulatory Care Centre at the Victoria Infirmary has been estimated by the Trust (assuming financing under Public Private Partnership):

In-patient hospital at Cowglen	£267,600,000
Ambulatory Care : Victoria Infirmary	27,115,000
Replacement of Yorkhill at Cowglen__	51,700,000
	£346,415,000

(These figures exclude equipment)

Additional Annual Running Costs £ 18,430,000

These figures do not include the cost of buying land from NSB or the owner of the field adjacent to Cowglen Hospital. Nor do they include any receipts from selling land at the Victoria Infirmary, Mansionhouse Unit, Southern General or Yorkhill – this could amount to a total of around £22 million which would help to off-set the cost of buying the extra land needed.

There are some significant **risks** with this option:

- it would be a hospital of around 1,400 beds, that would be completed in approximately 7 years time. We would be committing ourselves to that particular number of beds without any chance of adjusting the size of the hospital downwards if future trends in the use of beds shows a sharper decline than we currently expect.

Our leaflet on "The Number of Beds We Propose to Provide " explains the issues here.

- the land needed might not be available for sale or might be extremelyexpensive given its zoning for retail or commercial use.
- a single phase construction of a hospital this size is a scale not previously attempted in the UK as a single phase. The costs may therefore be higher to reflect the risk of cost over-runs on a project of this size.
- it is not known whether a development in this place with intensive traffic flows would create town planning or road infrastructure requirements that would add to the cost.

Option 2 - "Redeveloping the Southern General"

The Southern General occupies some 67 acres of land. Over the last ten years some £60 million of capital investment has been spent on providing new or substantially upgraded facilities.

£ 9 million - Spinal Unit

5 million - WESTMARC (artificial limb and wheelchair service)

2 million - Podiatry (foot care)

4 million - A & E\Out-patient Department

15 million - High quality refurbishment of ward areas.

11 million - Oral Maxillo-facial services and ENT.

12 million - Medicine for the Elderly (under Private Finance Initiative)

2 million - Physically Disabled Rehabilitation Unit

The site also has modern in-patient facilities for regional neurosciences and obstetrics and gynaecology. Both buildings date from the early 70s. So there is a significant basis around which a new hospital can be developed. In addition, its geographical location close to the modern urban motorway, M8, M77 and Clyde Tunnel, make it very accessible to ambulances using the Southside Hospital as one of Glasgow's two major Accident and Emergency hospitals.

A redevelopment of the existing Southern General Hospital site would mean closure, demolition and sale of the Victoria Infirmary and Mansionhouse Unit. The Trust would locate some of its rehabilitation in-patient services within the Ambulatory Care Centre at the Victoria Infirmary.

This option poses a three-part development of the Southern General site over a ten year period to provide a new Southside hospital based around the existing investment.

Part 1 - provision of a new surgical unit, medical receiving unit, theatres, Intensive Care, High Dependency and pharmacy facilities, continuing refurbishment of medical facilities.

Part 2 - provision of new Children's Hospital, Laboratories, staff facilities in dining room\kitchens etc.

Part 3 - provision of new medical, coronary care, out-patient and treatment facilities and diagnostic imaging.

Parts 1 and 2 would be organised as a single building contract. The cost of building – on an identical basis of comparison as Option 1 – is estimated to be:

New in-patient facilities at Southern General	£155,241,203
Ambulatory Care : Victoria Infirmary	34,870,000
Replacement of Yorkhill at Southern General	51,700,000

£241,811,203

(These figures exclude equipment)

Additional Annual Running Costs £ 11,060,000

This option requires very little in the way of new land acquisition – the Victoria Infirmary Ambulatory Care Centre would need a small parcel of land (around 4 acres) at the Queen's

Park Recreation ground to add to the Grange Road site already owned by the Trust.

What are the **risks** with this option?

- there is less risk of miscalculating future requirements for the number of beds because a fresh review of bed requirements can be made when planning the third part of the redevelopment at the Southern General.
- there is no risk of land not being available. The 67 acres at the Souther General is more than enough. Nor is there any risk of having to pay a premium price for land, which is the case with Option 1.
- a three part, two contract development reduces the risk of the capital cost over-runs that often afflict large building projects.
- it is not known what town planning issues might arise but the site has more flexibility in its local road access options (Moss Road, Shieldhall Road, Renfrew Road, Govan Road).
- there is a risk that the third part of the redevelopment might not proceed if government or Health Board policy changed after completion of the first contract.
- there is some risk of disruption to existing services on the Southern General site as buildings would be demolished and constructed in the centre of existing facilities.

Choosing between the two options

Both options include a new Ambulatory Care Centre providing locally accessible services for most services used by most patients. Both options also include 120 rehabilitation beds, the 'Southern General option' provides them at the Victoria Infirmary which will reduce the burden of visiting, especially for elderly people. The Cowglen option provides them at the Southern General since it involves using the PFI beds there to which the Trust is committed. Similarly both options include a "23 hour elective surgery" service at the Victoria Infirmary which will allow minimally invasive surgery and treatment to be given to those patients needing one overnight stay to aid their recovery.

The difference between the two options lies in:

a. accessibility.
b. speed of completion.
c. risks.
d. cost.

The Cowglen option would mean most people have to travel further than they do now for in-patient care. The Southern General option is more accessible to the North West for emergencies. Its access for people from the South-East is often quoted as problematic. Our leaflet on Accident and Emergency services explains why this is not the problem people might think it is in the case of 999 ambulance cases. For other patients and visitors needing to go to the Southern General we would provide an express shuttle bus service to and from the Victoria Infirmary. We will also negotiate with bus companies for better bus routes from the Castlemilk, Cathcart, Newton Mearns and Giffnock areas. We would be prepared to subsidise these until the routes are sufficiently established commercially. Negotiations cannot take place until decisions are made about which hospital services are where. In addition the 120 rehabilitation beds and 23 hour surgery beds will further reduce the need for people to travel from the South-East to the Southern General.

The Cowglen option would probably be completed four years earlier than the Southern General option.

The risks associated with the Cowglen option are greater than those of the Southern General option.

The key cost difference between the two options is in annual running costs. The Cowglen option would cost an extra £18.4 million per year, whereas the Southern General option would be an extra £11.1 million. In each case the costs would be payable for around 30 years although some tapering of costs usually occurs later in the PPP contract period. The difference of around £7.3 million per year for 30 years is massively significant. There are so many other services needing funding which GGNHSB could support with that £7.3 million per year – better primary care, shorter waiting times, better rehabilitation services, improved fertility services, more effective treatment for drug and alcohol misusers, better services for children, more district nurses. It is for this reason, above all else, that the Health Board thinks the Southern General option is in the better interests of all of those in Glasgow needing improved NHS services.

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Full Acute Services Strategy

MODERNISING GLASGOW'S ACUTE HOSPITAL SERVICES

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1. INTRODUCTION

1.1 This Consultation Paper is published under the terms of Scottish Office guidance published in 1975 which set out arrangements for statutory consultation. But much has changed since then and we want to use this opportunity to promote a wider and well-informed debate about Glasgow's hospitals. The aim is that by the autumn firm proposals will be put to the Minister for Health. Decisions then will give a green light to sorely needed modernisation of Glasgow's acute hospital services.

1.2 The formal consultation questions and a note about the consultation procedure are set out at the end of this paper.

1.3 But we want to emphasise the interactive nature of debate and consultation that we are promoting over the coming months. The proposals are extensively based on advice from NHS professional staff (doctors, nurses and others) and public debate that has already been running for two years. There are still aspects that need to be resolved through further debate. Above all, we hope that Glaswegians will feel that our approach to modernising Glasgow's hospital services is able to command their confidence and enthusiasm. We believe the approach is genuinely visionary but at the same time practical and capable of being translated into action.

By the end of the summer we hope that there will be some agreement about how to move forward.

2. WHAT ARE WE TRYING TO ACHIEVE?

2.1 Our aim is a hospital service which provides the most up-to-date treatment quickly, using advanced technologies and specialist skills in settings which are modern, friendly and convenient. Achieved within the next decade. Glaswegians have seen the modern facilities now available elsewhere and expect us to deliver a well designed service for them.

Too often for patients there are delays, postponements and trekking around hospital corridors, going to scattered departments in old or shabby buildings.

2.2 Almost all patient experience of acute hospital services does not involve the use of in-patient facilities. Our aim is to **keep local access** for at least 85% of these services – (the term used to describe them is "Ambulatory Care") – but to do so in facilities that are modern and provide the best possible experience for the patient.

2.3 In-patient care currently accounts for only **9%** of all patient episodes with the acute hospital service.

Meeting demand for in-patient services needs to balance:

a) the continuing trend in surgical specialties towards day case treatment rather than in-patient treatment. (Made possible by what are known as "minimally invasive technologies" – for example the use of fibre-optic probes which not only see inside the body but can remove growths, clear blockages etc. Laser technologies and robotics are increasing the scope for this approach).

b) the need to group both consultants and junior doctors into larger clinical teams so that they can better programme their work (including the need to cover emergencies without interfering with waiting list work and ambulatory care sessions). Many of the existing clinical teams are too small to avoid breaches of the EU Working Times Directive and the national agreement on junior doctors' working hours.

c) the growing evidence that specialists within the surgical disciplines often achieve better outcomes, especially if treatment needs the back-up of multi-disciplinary teams focused on particular conditions or disease-groups.

d) meeting the demands of the continuing increase in general medical admissions.

2.4 There is a strong degree of support among doctors in Glasgow for a pattern of hospital services which:

a) provides Ambulatory Care **just as locally accessible as it is now** but in facilities that are patient-friendly, well equipped with the necessary technologies and organised efficiently around what the patient needs.

b) concentrates in-patient services which are still reasonably accessible but which are in modern facilities, allow working hours regulations and educational standards to be met and, most importantly, provide greater assurance to patients that they will be in the hands of the specialist with the most appropriate knowledge and skills for their disease or injury.

2.5 Above all, the Glasgow NHS wants to see a thoroughly modern service pattern substantially in place within the first half of this decade.

One key to early progress is to make the best use of the modern facilities we already have. Where there are no suitable modern facilities, the priority is to secure capital investment to put them in place.

2.6 Glasgow's Health Board and NHS Trusts have been examining choices and the practicalities of how to move quickly. At the same time the public debate has continued in a wide range of settings – meetings with MSPs, Councils, Councillors, some community councils, local interest groups, large public meetings, and debate through the media. People value local access highly and are insistent that it is now right to invest in new facilities. But many also recognise that the resources available

are not limitless and that for many patients safe and effective care means specialist care. Our approach differs from most other UK cities. In recent years they have cut the number of hospital sites and concentrated all services into fewer very large hospitals – significantly reducing bed numbers at the same time. Our approach is cautious about bed numbers and retains local access for most things. But we also believe we can sustain it within the money we have and with the number of doctors and specialists who are available.

2.7 While keeping local access for most services, we also need to ensure that the service pattern makes sense on a Greater Glasgow basis too. In an ideal world it would be nice to be able to start with a totally blank sheet of paper but that's a luxury we do not have. We have looked hard at the shape of the road and transport system and how they relate to existing sites. We have been influenced by the major modern investment that exists at GRI and Gartnavel. In the South the NHS Trust has looked at what new sites might be acquired as an alternative to using the Victoria Infirmary and Southern General – would they be big enough for a brand new hospital and how well placed would they be for the population served?

2.8 The ideas we are now presenting combine local access for the vast majority of Services, with a north\east and south\west axis for the significant major accident and emergency services well located in relation to the strategic road routes that are important for ambulance services.

3. THE PATIENT'S EXPERIENCE

We've already said that what we propose is firmly rooted in seeking to transform the patient's experience. The touchstones are:

a) an altogether more user-friendly experience. Fast, responsive, "one-stop shop" wherever possible and in facilities that are attractive and good to use.

b) making as much as possible as local as possible. In broad terms around 85% of people's use of hospitals will continue to be just as local as it is now (out-patients, x-rays, day case treatment, rehabilitation services and minor injuries services).

c) making sure that where specialisation matters (and avoiding doctors being over-worked and over-stretched) we achieve strong clinical teams to create just that assurance of the best possible expertise.

d) making sure that the linkages between primary care (GPs) and hospitals are made as fast and informative as possible so that the GP's responsibilities for overseeing the patient as an individual are made easier. Changes in health care practice and technology will affect these linkages as time unfolds.

We have produced some leaflets which say more about these issues. We have tried to write them in plain English and as jargon-free as possible. These leaflets are:

- The Patient's Experience.
- Getting it right for patients : what it means for organising services.
- Cancer Services : Specialisation in action.

- Why Specialisation matters – and what we propose to do to make its benefits more available.
- Creating more responsive Accident and Emergency Services.
- Ambulatory Care : What is it?
- Minimally Invasive Technologies : Keyhole Surgery and the like.

4. SOME OF THE PLANNING BACKGROUND

4.1 In developing practical ideas about how to improve the patient's experience we have also had to take into account a **range of planning factors** .

Our leaflets "The overall planning challenge for Greater Glasgow" and "Some Recent Background History" set the general scene.

4.2 One major influence is the need to ensure that we get the organisation of **doctors' working hours** right. People will be familiar with the long history of junior doctors (those training to become specialists or GPs - often described as House Officers or Registrars) working ridiculously long hours. Things have improved in recent years but there is still more to be done. And it's not just a matter of working hours. Junior doctors are in training and the quality of their educational experience has increasing priority compared with their role as service workers. The quality of their training is crucial to the quality of service they will provide in the future. As a result Consultants are expected to do more of the hands on medical work and to exercise more continuing supervision. This is very much in the interests of patients!

But this is happening at a time when European Union working hours regulations are making a major impact.

Our leaflet "Impact of regulations on doctors' working hours" tells you more.

4.3 Although in-patient care is increasingly a less significant part of the hospital services, the question of whether there are **enough beds** continues to attract wide interest. And because wards require a lot of staff, the number of beds provided in any new hospital development has a major influence over our ability to afford it.

Our leaflet "The number of beds we propose to provide " sets out our approach to assessing this.

4.4 Glasgow is the home of a number of important **regional services** serving a population wider than just Greater Glasgow alone. There are three significant changes to regional services:

- moving the Beatson Oncology Centre (for cancer) from the Western Infirmary to Gartnavel on a phased process during the decade. New linear accelerators (which give radiotherapy treatment) on a steady programme of replacing the

existing old machines. Relocating beds in the middle to the end of the decade. (This move was approved by the Secretary of State in 1996 as part of wider proposals for West Glasgow).

- the idea to re-provide Yorkhill's Children's Hospital Services into the major hospital development on the Southside.
- the proposal to create a single cardiothoracic unit (for heart and chest surgery) in West Glasgow (by merging the two existing units at GRI and the Western Infirmary into one).

We have four leaflets which will help those with an interest in these issues to see what is proposed and why. They are:

- "Regional Services provided by Glasgow Hospitals"

- "Radiotherapy: Linear Accelerators – a Patient's Guide"

- "Maternal and Child Health"

- "Why centralise cardiothoracic surgery?"

4.5 An aspect of planning which rarely gets the attention it deserves is the need to support **teaching and research** . The presence in Glasgow of high quality teaching and research has many benefits:

a. a stimulus for continuous improvement of clinical practice.
b. recruitment and retention for the city of practitioners of high standing.
c. the best possible development of the next generation of health professionals.

Our leaflet "Why teaching and research matters" tells you more.

4.6 The pace of change in health care is accelerating. Whether we invest in modern facilities or not we need a positive approach to maintaining an **NHS workforce** that is well trained, motivated and adaptable. We have been working with trade unions on the Greater Glasgow Partnership Forum to get some clarity on how this rhetoric can be turned into reality.

Our leaflet "Staffing matters" sets out in more detail what some of issues are.

4.7 Our proposals mean the investment of a lot more **money** in Glasgow's acute services. Around £400 million in capital (new buildings and equipment) across the 10 year period. And more revenue (the running costs of new hospital buildings). The way in which the NHS capital and revenue system works is complicated. Unlike a private business the NHS cannot generate its own income - it has to operate within a cash limit determined by the Scottish Executive and Parliament. The acid test is whether our ambitions to improve our acute hospital service can be afforded within the cash limit we are given.

We believe the proposals can be afforded while at the same time leaving enough money available to improve other services outside the acute hospitals which make such an important investment in tackling the chronically poor state of health of many of Greater Glasgow's residents. Services for children, mentally ill people, those addicted to drugs and alcohol, people with chronic disabilities and the whole range of primary care (GPs and their teams).

Our leaflet "How the finance works" provides the detail.

The next sections describe our proposals for the Southside, North and East Glasgow and West Glasgow. There is also an important suggestion about Children's Hospital Services.

5. PROPOSALS FOR THE SOUTHSIDE

5.1 The 347,000 people of the Southside equate to an expected need for acute in-patient services by 2005 of just over 1,000 beds. The Southern General currently has 600 modern beds (although some of these are for regional services for a wider population – such as Neurosurgery). The Victoria infirmary's facilities are provided in old and unsatisfactory accommodation. There has been significant public support for the creation of a new hospital for the Southside to replace both the Victoria Infirmary and the Southern General. The Trust have examined this suggestion in great detail.

5.2 Comparing large capital projects is a complicated task since the costs and economics have to be looked at over a hospital 'life-time' period ranging from 30 years to 60 years depending on whether the scheme is paid for by the Government's capital programme for the NHS or through Public Private Partnership (using private sector capital). A totally new hospital, built on a new site in a single phase (with an Ambulatory Care Centre being built at the Victoria Infirmary site) would cost around £360 million and would take about 4 years building time. The total capital allocation for the whole of the NHS in Scotland amounts to around £165 million, although this is planned to rise to £200 million in about 2 to 3 years time. So this one project alone would consume between a half and two thirds of the whole of the country's capital programme for that 4 year period. This is unrealistic – so a Public Private Partnership (PPP) approach would be needed. The capital and running cost structure of PPP is different (for example it assumes a 30 year life and VAT is not payable on construction costs). The Trust have compared a PPP approach for two options:

a) a new hospital on a new site with a new Ambulatory Care Centre at the Victoria Infirmary.

b) a new Ambulatory Care Centre at the Victoria and a phased re-development of the Southern General to provide in-patient beds for the Southside.

5.3 Because PPP uses private capital, the cost for the NHS is felt in the form of annual running costs covering capital, interest and maintenance charges. Option (a) would have running costs of £20 million per year higher than the present annual cost (£165 million) of running Southside hospitals. Option (b)'s running costs would be £13 million per year higher than the present costs. The difference of £7 million matters. **Both** options produce an exciting new-style Victoria. **Both** options produce the same amount of modern in-patient facilities. although (b) takes 10 years from now to achieve it fully, it delivers a major set of improvements in the first half of the period. On the other hand (a) achieves it in around 6 years from now. That £7 million per year extra would be paying for a small difference in geographical location and 4 years faster completion for the final parts of the project (with the extra annual cost being paid at the higher level for the **30 years** life of the PPP agreement). There are many much needed hands on services for patients and local communities that £7 million a year could pay for. (See our leaflet on 'The Overall Planning Challenge for Glasgow').

5.4 Our conclusion is that the best way to get a modern hospital service in position for the Southside's population of 347,000 people is to:

a) build a state-of-the-art Ambulatory Care Centre at the Victoria Infirmary to open by 2004.

This will keep existing local access for some 85% of present patient visits with the Victoria Infirmary but in a vastly improved service setting. It would also include walk-in facilities for people with minor injuries\illnesses, a new locally accessible renal dialysis service, and 120 rehabilitation beds which would reduce the burden of visiting for relatives from the south-east of Glasgow. It would also provide day case surgery for the whole of the Southside.

b) build 355 new beds at the Southern General Hospital to open by 2005. The hospital already has 600 modern beds. This new build would give the hospital 955 modern beds. The 310 older beds which would remain in use have either already been refurbished or will be brought up to a very good standard by 2003. A second phase of development to replace them would be worked up with construction starting as soon as site space had been cleared (well before the end of the decade).

This would provide all the acute in-patient services for the Southside and regional\national services for neurosciences and spinal injuries. It would also have the major accident and emergency\trauma centre service on the Southside, readily accessible off the M8, M77 link and Clyde Tunnel.

It would have in-patient beds for:

- general medicine
- acute assessment of the elderly
- general surgery
- orthopaedics *

- gynaecology *
- urology *
- vascular services *
- clinical haematology *
- ENT (ear, nose and throat)*
- nephrology *
- dermatology *
- ophthalmology (although its needs for in-patient beds is
- expected to decline significantly) *
- maxillo-facial surgery (the only unit in the city)

[Note: * indicates one of two units in the city – one South, one North]

c) provide shuttle bus links between the Victoria Infirmary and the Southern General Hospital as part of a wider process of improving public transport links between east and west on the Southside.

6. MATERNITY AND CHILDREN'S HOSPITAL SERVICES

6.1 During the public debate in 1998 we were asked why no consideration had been given to including the re-provision of services provided by the Yorkhill NHS Trust at the new Southside Hospital campus. Yorkhill NHS Trust is the home of the Royal Hospital for Sick Children, the Queen Mother's Maternity Hospital, the West of Scotland Medical Genetics Service, the Headquarters of the Community Child Health Services for Greater Glasgow, 8 academic departments of the University of Glasgow and a major teaching and training hospital for health professionals caring for mothers and children. The development of a new children's hospital would allow GGNHSB to retain and improve upon all existing children's services provided by Yorkhill NHS Trust, develop new services in line with future patients' needs and ensure that both are provided by a modern, purpose-built hospital for mothers and children.

6.2 The Yorkhill site has relatively modern facilities (a new theatre suite opened in 1998) but the Queen Mother's Maternity Hospital has significant design limitations and has not worn particularly well as a building. The main building for the Royal Hospital for Sick Children is adequate for the foreseeable future although perhaps not particularly flexible to adapt to future changes in children's health care. In any event Yorkhill's replacement would become a pressing forward planning issue by the end of the decade.

6.3 There is a considerable weight of professional opinion that children's services should ideally be on the same site as adult and maternity services so as to make the mutual sharing and accessing of clinical expertise easier. There are also advantages in sharing, rather than duplicating, those hospital support services which are common to both adult and children's services. Examples elsewhere in the UK show how the crucial child –centred separate identity of a Children's Hospital can flourish within the same site as a larger general hospital.

6.4 The overall shape of services in Glasgow suggests that the **Southside** would be a potentially favourable location for a new Royal Hospital for Sick Children.

Relocating children's services to a site which provides adult and maternal health services for South Glasgow would result in a strong foundation for integrated child, adult and maternity services. Obviously if the new hospital goes ahead detailed consideration needs to be given to how all existing maternity services currently provided from the Queen Mother's Maternity Hospital and the maternity unit at the Southern General can be integrated with the new children's hospital and community services. There would be a period of 7 to 10 years before building was completed. The question of how to manage maternity services currently provided by the Queen Mother's and Southern General during that interim period will be the subject of a separate public consultation.

There are other benefits of siting a Children's Hospital alongside a Southside Adult Hospital:

a) Children's Neurosurgery, ENT and maxillo-facial surgery would be better integrated with other children's services than at present.

b) The Paediatric A & E services of Glasgow would be sited alongside one of Glasgow's two Trauma Units (compared with the lack of paediatric support at any of the Glasgow's adult A & E Departments at the present time).

c) It would greatly strengthen the research and academic environment in South Glasgow.

d) An exciting opportunity for the development of specialised adolescent services for Glasgow.

6.5 By contrast, although re-locating the Royal Hospital for Sick Children alongside adult oncology and adult cardiothoracic surgery in West Glasgow would have some benefits, it would do nothing to help with maternity and A & E service linkages. The oncology and cardiothoracic links are easier to sustain on a separate site (and involve fewer children) than is the case if maternity and A & E services are on separate sites from children's services.

A third alternative – re-location to the GRI – would further unbalance the maternity services as between north\east and south\west Glasgow and would achieve far fewer important service linkages with other adult services than would be the case with Southside location (or with West Glasgow adult services).

It would also be more difficult to achieve in site space\capital investment terms.

7. NORTH AND EAST GLASGOW

7.1 The current capital scheme under construction at the Glasgow Royal Infirmary will result in the GRI having 600 modern beds. The hospital will also have 500 old beds, 219 of which will be empty when the new scheme is complete. Stobhill Hospital has 297 acute beds – all of them in old buildings. The 340,000 people in

north and east Glasgow equate to an expected need for acute in-patient beds by 2005 of around 1,020. The question of how to meet those needs between the GRI and Stobhill has been a highly contentious matter. Taking as our guide the aim of:

- providing locally accessible Ambulatory Care.
- providing in-patient services in modern beds wherever possible.
- creating clinical teams large enough to meet the working hours and specialisation considerations.
- providing north of the river an Accident and Emergency\trauma centre service broadly equivalent to the quality of that proposed on the Southside.

we see the pattern for the north and east being very similar to that proposed for the Southside.

a) a state-of-the-art Ambulatory Care Centre at Stobhill to maintain existing local accessibility to such services (including the minor injury\illnesses patients who attend the Stobhill casualty) but in a vastly improved service environment. This will assure Stobhill's long term role as a major provider of health services.

b) a strong core of in-patient services at the GRI including:

- general medicine\elderly assessment.
- general surgery.
- orthopaedics (one of two in the city).
- maternity (one of two in the city).
- gynaecology (one of two in the city).
- plastic surgery\burns (providing a regional service).

There would also be out-patient services in modern facilities at GRI but we would expect a significant amount of day surgery for the east Glasgow population to be undertaken at Stobhill.

c) a major accident and emergency\trauma centre service in modern facilities at the GRI, readily accessible off the M8, M80, Springburn Road and the Clyde bridges in the east of the city.

7.2 The Health Board at its March 2000 meeting supported an Outline Business Case for a new Ambulatory Care Centre at Stobhill, recognising the strong local support for this service. We have asked the North Glasgow Trust to consult locally on issues of size, content, scope for future expansion and other issues identified in recent local public debate. By the time this wider consultation on Glasgow's acute hospital services reaches conclusions in the summer we shall know the outcome of that more local consultation about the detail of the Stobhill Ambulatory Care Centre.

7.3 We know the strength of feeling its local community has for Stobhill Hospital. The plan to modernise Glasgow's hospitals offers much of the certainty about the

future role of Stobhill which its community and staff have long wanted. In shaping this role we have to take into account the reality of the clinical and workforce influences that cannot be simply ignored or rejected. Over the next few months the North Glasgow Trust will lead a local debate about the issues so that by the autumn there can be full clarity about the long term role of Stobhill Hospital.

7.4 There is a fuller exploration of the issues in some of the back-up leaflets that we have produced to aid debate.

7.5 The proposal here would require a further capital investment of £30 m. for the Ambulatory Care Centre at Stobhill and £6 m. for fitting out the new orthopaedic floor at the GRI. (This would complement the £53 m. currently being spent on new facilities at the GRI).

8. WEST GLASGOW

8.1 The West Glasgow population of some 226,000 will need an acute general medical and general surgical in-patient service of 198 beds and 87 beds respectively.

8.2 There have been plans made before for health services in the west of Glasgow. These plans have focused on the relocation of the hospital services from the Western Infirmary to Gartnavel in order to end the arrangements whereby care for many patients was split across both the Western Infirmary and Gartnavel sites. Another objective has been to modernise the facilities at the Beatson Oncology Centre. Other elements of our Greater Glasgow Plan include:

- the modernisation of the Southside hospital services;
- ensuring Stobhill Hospital's future around its modern Ambulatory Care Centre; and
- using the modern developments already begun at Glasgow Royal Infirmary.

The Plan recognises that money for capital investment is not available in unlimited supply. This means that we have to make best use of existing modern facilities. These proposals have now been re-examined by the North Glasgow Trust in the context of the plan to Modernise Glasgow's Hospitals.

Gartnavel General has 543 modern beds and the Western Infirmary has 260 beds in relatively modern accommodation.

8.3 We believe the way forward is:

a) to use **Gartnavel General** as the in-patient centre for general medicine and general surgery for west Glasgow. It currently offers no walk-in service for minor injuries\illnesses – we propose to create a service of this type at Gartnavel giving much greater local accessibility for Clydebank, Drumchapel, Knightswood, Scotstoun, Yoker, Maryhill and their neighbouring areas. (People living in Hillhead and Partick would have the choice of going to Gartnavel or the Southern General (through the tunnel).

We would also need to improve emergency receiving and ambulatory care facilities at Gartnavel.

Our aim is to have these facilities in place by 2004\05 at the latest.

b) to use the **Western Infirmary** as the in-patient and out-patient centre for the Beatson Oncology Centre and a single cardiothoracic centre for the West of Scotland. These would use the Phase I block of modern facilities, requiring some capital investment to provide up-to-date imaging services.

We would vacate G Block.

Capital investment to make these various changes at both hospitals would be around £31.2 million.

8.4 This approach would make general acute services for West Glasgow more locally accessible for more people (core in-patient services, ambulatory care and minor injuries services) and provided in modern facilities at Gartnavel. It would allow regional services for cancer and cardiothoracic services to occupy modern facilities in a location readily accessible by public transport (exploiting the Partick bus\rail\underground interchanges). This improvement would be achievable by 2005. In the meantime there will need to be further planning for a subsequent integration of cardiothoracic services and the Beatson Oncology Centre onto a larger hospital campus. The programme of expanding and modernising linear accelerator capacity will force the pace of this decision-making since in-patient beds should not be separated from the linear accelerators their patients need.

Separate leaflets are available for different aspects of these proposals:

- Detailed analysis of the options for South Glasgow.
- Maternal and Child Health.
- Better access for West Glasgow residents.
- The GRI\Stobhill partnership.
- Why centralise cardiothoracic surgery?
- Radiotherapy: Linear Accelerators: A Patient's Guide

9. NOTE ON THE CONSULTATION PROCEDURE

9.1 We have summarised here an ambitious set of ideas for Glasgow's acute hospitals. Between April and the end of June 2000 we are organising a series of meetings with local interests throughout Greater Glasgow. Our Website (www.show.scot.nhs.uk/GGNHSB) also provides access to information and the opportunity to comment. We hope to generate an active period of debate that will help people to understand and influence what needs to be done to improve Glasgow's hospitals.

9.2 In July the Health Board will start to reflect on what has emerged from the debate, with a discussion at its public meeting on 15th August on what proposals should be put to the Minister for Health. Following that the Greater Glasgow Local Health Council (which represents the consumer voice in the NHS) and others will be able to comment on those proposals before the Health Board has a final discussion in public on 18th September. We hope that by then we will be able to send some firm proposals to the Minister in late September.

9.3 Once a Ministerial decision has been made the NHS Trusts in Glasgow can get on with organising the major building schemes needed to get the process of hospital modernisation going.

9.4 The key questions on which we are seeking views are:

a) should we seek to strengthen Accident and Emergency services by designating the GRI and the Southern General (or new Southside Hospital) as Trauma Centres with Consultant staffing to match while keeping local access for minor injuries at Stobhill and the Victoria Infirmary and providing such a service for the first time at Gartnavel General?

b) does our aim to maintain local access to out-patient clinics, x-ray, day case surgery and out-patient rehabilitation services at Victoria Infirmary, Southern General* (or new Southside Hospital), GRI, Stobhill and Gartnavel have widespread public support? (*We are proposing that most day case surgery for the whole of the Southside would be undertaken at the Victoria Infirmary and some day case surgery for east Glasgow would be done at Stobhill).

c) do the public agree that the Victoria Infirmary and Stobhill are the top priorities for the creation of new Ambulatory Care Centres?

d) in seeking to modernise the out-dated hospital facilities and deal with issues of specialisation and doctors hours in South Glasgow is our conclusion that a new Ambulatory Care Centre with rehabilitation beds at the Victoria Infirmary and a two phase redevelopment to concentrate Southside acute in-patients at the Southern General the most practicable option?

e) should we take the opportunity of creating a new Child and Maternal Health service based at the Southern General as an integral part of the first construction contract for the redevelopment of the Southern General campus?

f) in seeking to tackle the specialisation and doctors' hours issue in the North Glasgow Trust we are making firm proposals to concentrate in-patient gynaecology and orthopaedics at GRI in association respectively with the new facilities for maternity services and Accident and Emergency\Trauma. In each case there is strong medical advice in support of the change. Ambulatory care for these two services would also be provided at Stobhill and Gartnavel. Are there any persuasive and practicable alternatives to this solution?

g) in tackling the same issues of specialisation and doctors' hours in the North Glasgow Trust there is a need to decide what the in-patient base for several

specialties should be (with ambulatory care provided at GRI, Stobhill and Gartnavel). The specialties are urology, ophthalmology (eyes), ENT (ear, nose and throat), nephrology (kidneys) and vascular surgery (veins and arteries). The North Glasgow Trust will be leading an interactive debate about the possibilities and practicalities for these specialties so that by the late summer\early autumn a clear basis for future modern accommodation requirements can be established.

h) similarly the North Glasgow Trust will lead a debate about how medicine and surgery can work in partnership between GRI and Stobhill so that medium to long term clarity can be achieved.

i) the achievement of single site working for medicine and surgery for West Glasgow at Gartnavel was previously agreed in the 1996 consultation. This updated plan includes a proposal to create a single cardiothoracic unit in Glasgow, concentrated initially at the Western Infirmary in modern accommodation. This has benefits for the specialty but helps to create space at GRI for other use of modern accommodation there as part of the wider picture of modernisation. Are there any good grounds for not making this change?

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Modernising Glasgow's Acute Hospital Services

Return to Acute Services Main Index

Summary of Proposals

For PDF Version of this document, click here. See Advisory Leaflets for further information about PDF files.

MAKING GLASGOW'S HOSPITAL SERVICES FIT FOR THE FUTURE

Glasgow's acute hospital services have been in need of modernisation for a long time - and we must now take action. We at Greater Glasgow NHS Board and three Trust organisations: North Glasgow, South Glasgow and Yorkhill NHS Trusts have been asking doctors, nurses and other NHS staff for their views. We have also been debating ideas with the public. As a result, we have a number of ideas for getting hospital services in good shape for the 21st century.

We would now like your views on these options. So, over the next three months, we are holding a public consultation. In other words, we are asking you to take part in the debate about how we can improve Glasgow's hospital services.

This is your chance to have your say and so help build a health service of which you can be truly proud. At the end of this page, you will find ways of making sure your voice is heard. We want to come up with a plan that we can put to the Minister for Health in the autumn.

Contents:

WHAT ARE WE TRYING TO ACHIEVE FOR PATIENTS?

A Modern Service

Many of you have seen the modern facilities now available elsewhere and, quite rightly, expect such first class services in your own city. Too often, though, for patients there are delays, postponements and trekking around hospital corridors, going to scattered departments in old or shabby buildings.

Our aim is to provide a hospital service which offers the most up-to-date treatment quickly, using specialist skills in settings which are modern, friendly and convenient. We want to achieve this within the next ten years.

Local Access

These days, most patients (over 85%) do not need to stay overnight in hospital (so don't need in-patient care). More and more, patients can 'walk in and walk out' for their treatment in the same day (as out patients or day cases). **Our aim is to keep local access to these services - the term used to describe them is "Ambulatory Care" - but to do so in facilities that are modern and well-designed.**

The benefits of specialist care and team-working

There is growing evidence that specialists (especially within areas of surgical work) achieve the better results, especially if treatment needs to bring a whole team of different skills and knowledge together to treat a dangerous or difficult illness. Many of our existing clinical teams are too small to manage their workload effectively. Commonly they find that covering emergencies clashes with waiting list work or outpatient clinics. Many are at risk of not complying with the new legal limits on maximum working hours.

By bringing smaller teams together into larger teams we can make sure that working hours and educational standards are met, and, most importantly, that patients will be in the hands of specialists with the knowledge and skills most needed for their illness or injury.

Making sense across Glasgow as a whole

While keeping access local for most services, we also need to make sure that the pattern of services makes sense on a Greater Glasgow basis. We have looked hard at roads and transport and how convenient they are for people and ambulances travelling to different types of hospital services. We have also thought about how to make the best use of what modern facilities we already have. Where there are no suitable modern facilities we aim to provide them at a cost we can afford – without using up all the money we need to use to improve other health services in Glasgow.

See map showing acute hospitals and major road network.

We have produced some leaflets which say more about these issues. We have tried to write them in plain English and as jargon-free as possible. These leaflets are:

- The Patient's Experience.

- Getting it right for patients : what it means for organising services.
- Cancer Services : Specialisation in action.
- Why Specialisation matters – and what we propose to do to make its benefits more available.
- Creating more responsive Accident and Emergency Services.
- Ambulatory Care : What is it?
- 'Minimally Invasive Technologies': Keyhole Surgery and the like.

HOW WE CAME TO OUR PROPOSALS

Re-shaping hospital services is very complex and we had to consider many issues before we could present our choice of ways to improve the patient's experience of acute hospital services in Glasgow. You can find out more about these by requesting the leaflets shown:

- 'The overall planning challenge for Greater Glasgow' and 'Some Recent Background History' describe the practicalities of building hospital services in Glasgow
- 'Impact of regulations on doctor's working hours' gives details of the long hours being worked by doctors and the impact this has on their training and care of patients
- 'The number of beds we propose to provide' sets out how we have worked out the number of beds we can afford
- 'Regional Services provided by Glasgow Hospitals' gives details of the changes we suggest making to services provided to those living in Greater Glasgow and beyond
- 'Why teaching and research matters' outlines their importance in finding new treatments and attracting and keeping the best medical staff
- 'Staffing matters' stresses the need to have an NHS workforce that is well trained, motivated and flexible.
- 'How the finance works' gives details of how we can afford the cost of improvement and yet also leave enough money to improve other services outside the acute hospitals, such as the whole range of primary care (GPs and their teams).

CHANGES ACROSS GLASGOW

WHAT THE CHANGES WOULD MEAN FOR THE SOUTHSIDE

The Options

There has been a lot of public support for building a new hospital for the Southside to replace both the Victoria Infirmary and the Southern General.

A totally new hospital, built on a new site such as at Cowglen, in a single phase (with an Ambulatory Care Centre being built on the site of the Victoria Infirmary), would cost around £360 million and take about 6 years to complete. We have compared this with the cost of a new Ambulatory Care Centre at the Victoria and a rebuild of the Southern General to provide in-patient beds for the Southside – which would take 10 years to complete.

The mechanics of finding the money to pay for new hospital buildings are complicated but it boils down to our having to pay the equivalent of a "mortgage". We have produced a leaflet which explains the details in plain English. The bottom-line difference is that the brand new hospital option would cost us £7 million a year more than the option of redeveloping the Southern General. That £7 million per year extra would be paying for a small difference in geographical location and 4 years faster completion. But we would be paying that extra annual cost for around 30 years.

We believe that money could be better spent on many other services for patients and local communities. (See our leaflet on ‘The Overall Planning Challenge for Glasgow’).

Our Recommendation

In our opinion, the best way to get a modern hospital service for the Southside’s population of 347,000 people is to:

(i) build a state-of-the-art Ambulatory Care Centre at the Victoria Infirmary, to open by 2004.

This will provide much better facilities and keep existing local access for at least 85% of the Victoria Infirmary’s patients. It would include walk-in facilities for people with minor injuries or illnesses, a new locally accessible renal dialysis (kidneys) service, and 120 rehabilitation beds which would keep local access for some in-patients needing longer to recover (and easier for their relatives to visit). It would also provide day case surgery for the whole of the Southside.

(ii) build wards for 355 new beds at the Southern General Hospital to open by 2005. The hospital already has 600 modern beds. This would give the hospital 955 modern beds. The 310 older beds on the site would all have been refurbished by 2003 and then in a second phase of building starting well before the end of the decade.

This would provide all in-patient services for the Southside and regional\national services for neurosciences (brain) and spinal injuries. It would also mean better staffed major accident and emergency service, easily accessible off the M8, M77 link and Clyde Tunnel.

It would have in-patient beds for:

- general medicine- acute assessment of the elderly
- general surgery

- orthopaedics (bones and joints) *
- gynaecology (women's healthcare) *
- urology (urine and bladder) *
- vascular services (heart) *
- clinical haematology (blood) *
- ENT (Ear, Nose and Throat) *
- nephrology (kidneys) *
- Dermatology (skin) *
- Ophthalmology (eyes) *
- maxillo-facial surgery (face and neck reconstruction)

[* there will also be another unit in the North]

(iii) provide shuttle bus links between the Victoria Infirmary and the Southern General Hospital as part of a wider process of improving public transport links between east and west on the Southside.

WHAT THE CHANGES WOULD MEAN FOR MATERNITY AND CHILDREN'S HOSPITAL SERVICES

The Royal Hospital for Sick Children has relatively modern facilities (the theatre suite opened in 1998) but the Queen Mother's Maternity Hospital has design limitations and the building has not worn well. The main building for the Royal Hospital for Sick Children is adequate for the near future, although perhaps not particularly flexible to adapt to future changes in children's health care. By the end of the decade, we would need to start planning to replace facilities at Yorkhill, so it makes sense to include Yorkhill in our proposals now.

The Benefits of Sharing

Many medical experts believe it is best to have children's services on the same site as adult and maternity services. That way, they can share the expertise of medical teams and services which are common to both the treatment of adults and children. Separate children's hospitals, on the same sites as larger general hospitals, have worked very well in other parts of the UK.

The Location

The Southside would be the best location for the new Royal Hospital for Sick Children mainly because:

(a) Children's services would be more sensibly placed on the same site as a maternity unit serving South Glasgow.

(b) Children's neurosurgery, ENT and maxillo-facial surgery would be better integrated with other children's services. They are currently separate.

(c) It would provide strong paediatric support (for the treatment of children) to one of Glasgow's two accident and emergency units (compared with the lack of such support at any of Glasgow's adult A & E Departments at the present time).

Less favourable options

By contrast, although re-locating the Royal Hospital for Sick Children alongside adult oncology (cancer treatment) and adult cardiothoracic (lung and heart) surgery in West Glasgow would have some benefits, there would no links with maternity and A&E units.

A third alternative – re-location to the GRI – would unbalance maternity services between north-east and south-west Glasgow. There would be fewer links with other adult services than would be the case with a Southside location (or even with West Glasgow adult services).

WHAT THE CHANGES WOULD MEAN FOR NORTH AND EAST GLASGOW

The new facilities now being built at the Glasgow Royal Infirmary will result in the hospital having 600 modern beds. The hospital will also have 500 old beds, 219 of which will be empty when the new part is complete. Stobhill Hospital has 297 acute beds – all of them in old buildings. There are 340,000 people living in north and east Glasgow. We estimate that by 2005, we will need around 1020 acute in-patient beds for the north and east Glasgow population.

The Aim

Using the sites at the GRI and Stobhill, we aim to provide:

- locally accessible Ambulatory Care
- in-patient services in modern beds wherever possible
- clinical teams large enough to ensure specialist skills are available while working hours are reasonable
- a first class Accident and Emergency unit to match that proposed in south-west Glasgow.

Our Recommendation

We propose creating hospital services in the north and east, similar to those we suggested for the Southside. These services would include:

(a) keeping local access for the majority of patients by building a state-of-the-art Ambulatory Care Centre at Stobhill. This means Stobhill will have a long term role as a major provider of health services.

(b) In-patient services at the GRI including:

- general medicine\elderly assessment

- general surgery

- orthopaedics (one of two in the city)

- maternity (one of two in the city)

- gynaecology (one of two in the city)

- plastic surgery\burns (providing a regional service)

(There would also be out-patient services in modern facilities at GRI but we would expect most day cases from East Glasgow to be treated at Stobhill.)

(c) a major accident and emergency\trauma centre service in modern facilities at the GRI, easily accessible off the M8, M80, Springburn Road and the Clyde bridges in the east of the city.

The Future of Stobhill

We know that there are strong feelings about the role of Stobhill Hospital. The plan to modernise Glasgow's hospitals offers much of the certainty about the future role of Stobhill which its community and staff have long wanted. Over the next few months the North Glasgow Trust will lead a local debate about the issues so that by the autumn we will be clear about the about the long term role of Stobhill Hospital.

There is a fuller exploration of the specialisation and working hours issues in some of the back-up leaflets that we have produced to aid debate.

The Cost

An Ambulatory Care Centre at Stobhill would cost £30 million. £6 million will be needed to fit out a new orthopaedic department at the GRI. This would be in addition to the £53 million already committed for the new facilities at the GRI. The new facilities at the GRI will open in 2001.

WHAT THE CHANGES WOULD MEAN FOR WEST GLASGOW

The 226,000 people living in West Glasgow will need a total of 285 beds for acute general medical and surgical in-patients. A decision was taken four years ago, as part of the '1996 Acute Service Strategy', to close the Western Infirmary (which has 260 relatively new beds) and re- locate it at Gartnavel (which has 564 new beds). This decision was taken for two reasons:

(a) to modernise the facilities for the Beatson Oncology Centre (for the treatment of cancer).

(b) to put an end to the very unsatisfactory state of affairs where in-patient general medicine, surgery and orthopaedics were running at two sites. Staff were overstretched and many patients were transferred between hospitals at critical times in their care.

The North Glasgow Trust has been looking again at these issues to see how progress can be achieved in a way that we can afford.

Our priorities are to modernise the Southside hospital service and to secure Stobhill's future around its state-of-the-art locally accessible Ambulatory Care Centre. On this basis the starting point in West Glasgow is how to make best use of existing modern facilities.

Our Recommendation

We believe the way forward is:

(i) to use Gartnavel General as the in-patient centre for general medicine and general surgery for west Glasgow. At the moment, there is no walk-in service for minor injuries or illnesses. We propose creating a service of this type at Gartnavel, giving much greater accessibility for Clydebank, Drumchapel, Knightswood, Scotstoun, Yoker, Maryhill and their neighbouring areas. People living in Hillhead and Partick would have the choice of going to Gartnavel or the Southern General (through the tunnel).

We would also need to improve emergency services and ambulatory care facilities at Gartnavel.

Our aim is to have these facilities in place by 2004\05 at the latest.

(ii) to use the **Western Infirmary** as the in-patient and out-patient centre for the Beatson Oncology Centre (cancer treatment) and a single cardiothoracic centre (lung and heart surgery) for the West of Scotland. Some money would be needed to provide up-to-date specialist imaging equipment in the hospital's modern block. We would vacate G Block.

Capital investment to make these various changes at both hospitals would be around £31.2 million.

The Result

This approach would make general acute services for West Glasgow more locally accessible for more people (in-patient services, ambulatory care and minor injuries services) and provide modern facilities at Gartnavel.

It would provide more modern cancer and cardiothoracic (lung and heart surgery) for people living in Greater Glasgow and beyond, in a location which is easily reached by public transport (using the Partick bus, rail and underground links). We can achieve this by 2005.

Separate leaflets are available for different aspects of these proposals:

- Detailed analysis of the options for South Glasgow.
- Maternal and Child health.
- Better access for West Glasgow residents.
- The GRI\Stobhill partnership.
- Why centralise cardiothoracic surgery?
- Radiotherapy: Linear Accelerators – A Patient's Guide

MAKING YOUR OPINION COUNT

We have laid out ambitious and exciting ideas for the future of Glasgow's acute hospitals. It is now over to you to let us know how you feel about these proposals.

Getting Informed

This leaflet can only give you a broad picture. You can read up on any specific issue you are interested in by completing the leaflet request form below and sending it to the freepost address shown (no stamp needed).

Acute Services Review
Greater Glasgow NHS Board
FREEPOST (GW 707)
Glasgow G3 8BR

Or **FAX** the reply slip to:

0141-201-4426

Our web site www.show.scot.nhs.uk/GGNHSB also has up-to-date information, and copies of the advisory leaflets, just select acute services from the menu.

Getting Involved

From April until the end of June 2000, public meetings will be held for various groups to raise local issues. This will give you the chance to put your opinions or questions to representatives of the Greater Glasgow NHS Board or your local Hospital Trust. These meetings will be advertised locally.

You can also find details of the latest diary of public meetings from this web site (See under Acute Services).

Representatives from key community and healthcare groups will also be invited to attend briefings/workshops to work through the issues and give their verdict on the proposals. The results will be placed in local libraries and our web site.

As the whole debate unfolds we will write more leaflets to reflect particular questions and issues that have been raised.

Advisory Leaflets

To see the list of Advisory Leaflets currently available in both on-line and printed form, please click here.

Last modified: August 15, 2002

The Future of Glasgow's Hospital Services

Let's Plan It Together!

GREATER GLASGOW HEALTH BOARD

in partnership with the NHS Trusts in Glasgow

A51598597

Contents

Glasgow's acute hospital services have been in need of modernisation for a long time - *and we must now take action.*

We at Greater Glasgow Health Board and three Trust organisations: North Glasgow, South Glasgow and Yorkhill NHS Trusts, have been asking doctors, nurses and other NHS staff for their views. We have also been debating ideas with the public. As a result, we have a number of ideas for getting hospital services in good shape for the 21st century.

We would now like your views on these options. So, over the next three months, we are holding a public consultation. In other words, we are asking you to take part in the debate about how we can improve Glasgow's hospital services.

This is your chance to have your say and so help build a health service of which you can be truly proud. At the back of this booklet, you will find ways of making sure your voice is heard. We want to come up with a plan that we can put to the Minister for Health in the autumn.

What are we trying to achieve for patients?

A Modern Service

Many of you have seen the modern facilities now available elsewhere and, quite rightly, expect such first class services in your own city. Too often, though, for patients there are delays, postponements and trekking around hospital corridors, going to scattered departments in old or shabby buildings.

Our aim is to provide a hospital service which offers the most up-to-date treatment quickly, using specialist skills in settings which are modern, friendly and convenient. We want to achieve this within the next ten years.

Local Access

These days, most patients (over 85%) do not need to stay overnight in hospital (so don't need in-patient care). More and more, patients can 'walk in and walk out' for their treatment in the same day (as out-patients or day cases).

Our aim is to keep local access to these services - the term used to describe them is "Ambulatory Care" - but to do so in facilities that are modern and well-designed.

The benefits of specialist care and team-working

There is growing evidence that specialists (especially within areas of surgical work) achieve the better results, especially if treatment needs to bring a whole team of different skills and knowledge together to treat a dangerous or difficult illness. Many of our existing clinical teams are too small to manage their workload effectively. Commonly they find that covering emergencies clashes with waiting list work or out-patient clinics. Many are at risk of not complying with the new legal limits on maximum working hours.

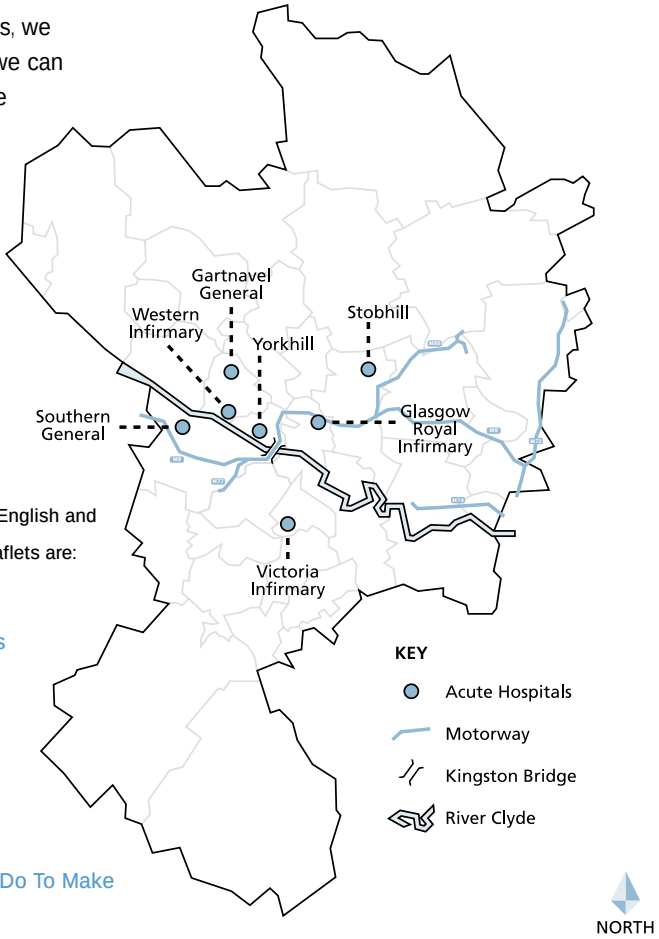
By bringing smaller teams together into larger teams we can make sure that working hours and educational standards are met and, most importantly, that patients will be in the hands of specialists with the knowledge and skills most needed for their illness or injury.

Making sense across Glasgow as a whole

While keeping access local for most services, we also need to make sure that the pattern of services makes sense on a Greater Glasgow basis. We have looked hard at roads and transport and how convenient they are for people and ambulances travelling to different types of hospital services. We have also thought about how to make the best use of what modern facilities we already have. Where there

Map showing acute hospitals and major road network

are no suitable modern facilities, we aim to provide them at a cost we can afford - without using up all the money we need to use to improve other health services in Glasgow.



We have produced some leaflets which say more about these issues. We have tried to write them in plain English and as jargon-free as possible. These leaflets are:

- The Patient's Experience
- Getting It Right For Patients - What It Means For Organising Services
- Cancer Services: Specialisation In Action
- Why Specialisation Matters - And What We Propose To Do To Make Its Benefits More Available
- Creating More Responsive Accident And Emergency Services
- Ambulatory Care: What Is It?
- Minimally Invasive Technologies: Keyhole Surgery And The Like

How we came to our proposals

Re-shaping hospital services is very complex and we had to consider many issues before we could present our choice of ways to improve the patient's experience of acute hospital services in Glasgow.

You can find out more about these by requesting the leaflets below:

- 'The Overall Planning Challenge For Greater Glasgow' and 'Some Recent Background History' describe the practicalities of building hospital services in Glasgow
- 'Impact Of Regulations On Doctors' Working Hours' gives details of the long hours being worked by doctors and the impact this has on their training and care of patients
- 'The Number Of Beds We Propose To Provide' explains how we have worked out the number of beds we can afford
- 'Regional Services Provided By Glasgow Hospitals' gives details of the changes we suggest making to services provided to those living in Greater Glasgow and beyond
- 'Why Teaching And Research Matters' outlines their importance in finding new treatments and attracting and keeping the best medical staff
- 'Staffing Matters' stresses the need to have an NHS workforce that is well trained, motivated and flexible
- 'How The Finance Works' gives details of how we can afford the cost of improvement and yet also leave enough money to improve other services outside the acute hospitals, such as the whole range of primary care (GPs and their teams)

What the changes would mean for the Southside

The Options

There has been a lot of public support for building a new hospital for the Southside to replace both the Victoria Infirmary and the Southern General. A totally new hospital, built on a new site such as at Cowglen, in a single phase (with an Ambulatory Care Centre being built on the site of the Victoria Infirmary), would cost around £360 million and take about 6 years to complete. We have compared this with the cost of a new Ambulatory Care Centre at the Victoria and a rebuild of the Southern General to provide in-patient beds for the Southside - which would take 10 years to complete.

The mechanics of finding the money to pay for new hospital buildings are complicated but it boils down to our having to pay the equivalent of a "mortgage". We have produced a leaflet which explains the details in plain English. The bottom-line difference is that the brand new hospital option would cost us £7 million a year more than the option of redeveloping the Southern General. That £7 million per year extra would be paying for a small difference in geographical location and 4 years faster completion. But we would be paying that extra annual cost for around 30 years.

We believe that money could be better spent on many other services for patients and local communities. (See our leaflet on 'The Overall Planning Challenge For Glasgow'.)

Our Recommendation

In our opinion, the best way to get a modern hospital service for the Southside's population of 347,000 is to:

(i) build a state-of-the-art Ambulatory Care Centre at the Victoria Infirmary, to open by 2004. This will provide much better facilities and keep existing local access for at least 85% of the Victoria Infirmary's patients. It would include walk-in facilities for people with minor injuries or illnesses, a new locally accessible renal dialysis (kidneys) service, and 120 rehabilitation beds which would keep local access for some in-patients needing longer to recover (and easier for their relatives to visit). It would also provide day case surgery for the whole of the Southside.

(ii) build wards for 355 new beds at the Southern General Hospital to open by 2005. The hospital already has 600 modern beds.

This would give the hospital 955 modern beds. The 310 older beds on the site would all have been refurbished by 2003 and a second phase of building would replace these well before the end of the decade.

This would provide all in-patient services for the Southside and regional/national services for neurosciences (brain) and spinal injuries. It would also mean a better staffed major accident and emergency service, easily accessible off the M8, M77 link and Clyde Tunnel.

It would have in-patient beds for:

- *general medicine*
- *acute assessment of the elderly*
- *general surgery*
- *orthopaedics (bones and joints)**
- *gynaecology (women's healthcare)**
- *urology (urine and bladder)**
- *vascular services (heart)**
- *clinical haematology (blood)**
- *ENT (Ear, Nose and Throat)**
- *nephrology (kidneys)**
- *dermatology (skin)**
- *ophthalmology (eyes)**
- *maxillo-facial surgery (face and neck reconstruction)*

* *there will also be another unit in the North*

(iii) provide shuttle bus links between the Victoria Infirmary and the Southern General Hospital as part of a wider process of improving public transport links between east and west on the Southside.

What the changes would mean for maternity and children's hospital services

The Royal Hospital for Sick Children has relatively modern facilities (the theatre suite opened in 1998) but the Queen Mother's Maternity Hospital has design limitations and the building has not worn well. The main building for the Royal Hospital for Sick Children is adequate for the near future, although perhaps not particularly flexible to adapt to future changes in children's health care. By the end of the decade, we would need to start planning to replace facilities at Yorkhill, so it makes sense to include Yorkhill in our proposals now.

The Benefits of Sharing

Many medical experts believe it is best to have children's services on the same site as adult and maternity services. That way, they can share the expertise of medical teams and services which are common to both the treatment of adults and children. Separate children's hospitals, on the same sites as larger general hospitals, have worked very well in other parts of the UK.

The Location

The Southside would be the best location for the new Royal Hospital for Sick Children, mainly because:

(a) children's services would be more sensibly placed on the same site as a maternity unit serving South Glasgow.

(b) children's neurosurgery, ENT and maxillo-facial surgery would be better integrated with other children's services. They are currently separate.

(c) it would provide strong paediatric support (for the treatment of children) to one of Glasgow's two accident and emergency units (compared with the lack of such support at any of Glasgow's adult A&E Departments at the present time).

Less favourable options

By contrast, although re-locating the Royal Hospital for Sick Children alongside adult oncology (cancer treatment) and adult cardiothoracic (lung and heart) surgery in West Glasgow would have some benefits, there would no links with maternity and A&E units.

A third alternative - re-location to the GRI - would unbalance maternity services between North-East and South-West Glasgow. There would be fewer links with other adult services than would be the case with a Southside location (or even with West Glasgow adult services).

What the changes would mean for North and East Glasgow

The new facilities now being built at the Glasgow Royal Infirmary will result in the hospital having 600 modern beds. The hospital will also have 500 old beds, 219 of which will be empty when the new part is complete. Stobhill Hospital has 297 acute beds - all of them in old buildings. There are 340,000 people living in North and East Glasgow. We estimate that by 2005, we will need around 1020 acute in-patient beds for the North and East Glasgow population.

The Aim

Using the sites at the GRI and Stobhill, we aim to provide:

- locally accessible Ambulatory Care
- in-patient services in modern beds wherever possible
- clinical teams large enough to ensure specialist skills are available while working hours are reasonable
- a first class Accident and Emergency unit to match that proposed in South-West Glasgow.

Our Recommendation

We propose creating hospital services in the North and East, similar to those we suggested for the Southside. These services would include:

(i) keeping local access for the majority of patients by building a state-of-the-art Ambulatory Care Centre at Stobhill. This means Stobhill will have a long term role as a major provider of health services.

(ii) in-patient services at the GRI including:

- *general medicine/ elderly assessment*
- *general surgery*
- *orthopaedics**
- *maternity**
- *gynaecology**
- *plastic surgery/burns (providing a regional service)*

(There would also be out-patient services in modern facilities at GRI but we would expect most day cases from East Glasgow to be treated at Stobhill).

* *there will also be another unit in the South*

(iii) a major accident and emergency/ trauma centre service in modern facilities at the GRI, easily accessible off the M8, M80, Springburn Road and the Clyde bridges in the East of the city.

The Future of Stobhill

We know that there are strong feelings about the role of Stobhill Hospital. The plan to modernise Glasgow's hospitals offers much of the certainty about the future role of Stobhill which its community and staff have long wanted. Over the next few months the North Glasgow Trust will lead a local debate about the issues so that by the autumn we will be clear about the long-term role of Stobhill Hospital.

There is a fuller exploration of the specialisation and working hours issues in some of the back-up leaflets that we have produced to aid debate.

The Cost

An Ambulatory Care Centre at Stobhill would cost £30 million. £6 million will be needed to fit out a new orthopaedic department at the GRI. This would be in addition to the £53 million already committed for the new facilities at the GRI. The new facilities at the GRI will open in 2001.

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The 226,000 people living in West Glasgow will need a total of 285 beds for acute general medical and surgical in-patients. A decision was taken four years ago, as part of the '1996 Acute Services Strategy', to close the Western Infirmary (which has 260 relatively new beds) and re-locate it at Gartnavel (which has 564 new beds).

This decision was taken for two reasons:

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Capital investment to make these changes at both hospitals would be around £31.2 million.

The Result

This approach would make general acute services for West Glasgow more locally accessible for more people (in-patient services, ambulatory care and minor injuries services) and provide modern facilities at Gartnavel.
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Separate leaflets are available for different aspects of these proposals:

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Our web site - www.show.scot.nhs.uk/gghb - has up-to-date information, and copies of the advisory leaflets. Just select ***acute services*** from the menu.

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Leaflet request form

Getting Informed

This leaflet can only give you a broad picture. You can read up on any specific issue you are interested in by completing this leaflet request form. Tick the box ✓ next to the leaflets you want, provide your name and address in the space provided and send it to the Freepost address below (no stamp needed).

Acute Services Review
Greater Glasgow Health Board
FREEPOST (GW 707)
Glasgow G3 8BR

- ❑ 1. The Patient's Experience
- ❑ 2. Getting It Right For Patients: What It Means For Organising Services
- ❑ 3. Cancer Services : Specialisation In Action
- ❑ 4. Why Specialisation Matters - And What We Propose To Do To Make Its Benefits More Available
- ❑ 5. Creating More Responsive Accident And Emergency Services
- ❑ 6. Ambulatory Care : What Is It?
- ❑ 7. Minimally Invasive Technologies: Keyhole Surgery And The Like
- ❑ 8. The Overall Planning Challenge For Greater Glasgow - Acute Hospitals In A Wider Context
- ❑ 9. Some Recent Background History
- ❑ 10. Impact Of Regulations On Doctors' Working Hours
- ❑ 11. The Number Of Beds We Propose To Provide
- ❑ 12. Regional Services Provided By Glasgow Hospitals
- ❑ 13. Why Teaching And Research Matters
- ❑ 14. Staffing Matters
- ❑ 15. How The Finance Works
- ❑ 16. Detailed Analysis Of The Options For South Glasgow
- ❑ 17. Maternal And Child Health
- ❑ 18. Better Access For West Glasgow Residents
- ❑ 19. The GRI\Stobhill Partnership
- ❑ 20. Why Centralise Cardiothoracic Surgery?
- ❑ 21. Radiotherapy: Linear Accelerators - A Patient's Guide

Name: _____

Address: _____

_____

_____

Postcode: _____

You can also send it by fax on 0141 201 4426.

Alternatively, you can call us on Freephone 0800 85 85 85.

Greater Glasgow Health Board

Dalian House

350 St Vincent Street

Glasgow G3 8YZ

Tel: 0141 201 4444 Fax: 0141 201 4401

Textphone: 0141 201 4400

Web site: www.show.scot.nhs.uk/gghb

GREATER GLASGOW
HEALTH BOARD

in partnership with
the NHS Trusts
in Glasgow

A51598597

MODERNISING GLASGOW'S ACUTE HOSPITAL SERVICES - CONSULTATION

Meeting of the Board Tuesday, 21 March 2000		Board Paper No. 00/

CHIEF EXECUTIVE

Recommendation:

The Board is asked to approve for consultation to 30th June 2000 the attached Consultation Paper, Summary Leaflet and the 21 specific leaflets as its consultation package which presents proposals to Modernise Glasgow's Acute Hospital Services.

Background

The Board, in February 2000, considered proposals for a process of public debate and consultation on Modernising Glasgow's Acute Hospital Services. The Board approved the proposals which emphasised the interactive nature of the consultation we are proposing from now until 30th June 2000.

Consultation Paper

In addition to the attached Consultation Paper there will be a 'Summary of our Proposals' (also attached) which we intend to deliver to every household in our area in early April. There will also be 21 specific leaflets (click here for details) drawn up on those issues we think the public and staff will have most interest in. These leaflets and the 'Summary' are written in plain English, jargon-free and well presented so that issues are clear.

This portfolio of information – the Consultation Document, Summary of Proposals and the 21 specific leaflets – will constitute the substantive formal proposition for statutory requirements on consultation and will be provided to our usual recipients of NHS Consultation papers.

The Summary (attached) and range of leaflets will each have information on how to get any other leaflet or/and further information. The 21 specific leaflets are at various stages of preparedness, but will be completed and will be made available to Members shortly, in time for the formal consultation to commence.

Website

The Board's Acute Services at website (www.show.scot.nhs/GGNHSB) will be launched on 3rd April and will contain new pages on Modernising Glasgow's Acute

Hospital Services with up-to-date information on leaflets, new issues and the programme of meetings.

Telephone Enquiry Line

We will be setting up a Telephone Enquiry Line where people can obtain the Consultation Paper, the Summary, and detailed Leaflets, or additional information. Callers will also be able to have their more detailed comments dealt with by Health Board or Trust personnel depending on the issues raised.

Programme of Events/Meetings

Four initial briefings/presentations to launch our proposals have been arranged as follows:

1. 2.00 p.m., Tuesday, 21st March at the Lecture Theatre – North Glasgow Acute Trust Headquarters, Stobhill for:

NHS Board Members/Trustees

Local Health Council

Glasgow Alliance

Healthy City Partners

Ambulance Service

MSPs

Media

2. 3.00 p.m., Wednesday, 22nd March at the Lecture Theatre - North Glasgow Acute Trust Headquarters, Stobhill for:

Greater Glasgow Partnership Forum Members

Professional Advisory Committee Members

3. Date and venue to be confirmed:

Councillors and officials from the 6 Local Authorities in the Board's area

Social Inclusion Partners

Community Councils

4. Date and venue to be confirmed:

Representatives from the 3 Universities

Local Health Care Co-ops

Local Medical Committee

Royal College

Voluntary Organisations

We will be arranging a list of public meetings which will commence in April on a geographic basis throughout our area and publicising these in local communities. Details of dates and venues will be made available in posters etc. to Libraries, GP premises etc. and on our website.

We are giving consideration to Round Table Discussions and Workshops and would hope to set these up in mid-May.

Posters and displays will be produced for public places and hospital entrances informing people of how they can get a hold of information on our plans.

Separate briefings have been set up for MSPs over the next fortnight.

Trusts have already started briefing their staff on our plans and the impact they may have on our services.

Timescale

21st March	Board approves materials to be used for consultation.
1st April – 30th June	Formal Consultation process – early April distribution of Consultation Information, delivery of Summary Leaflets to all households and web page launched.
April – June	Programme of meetings and events take place.
July 2000	Board analysis of the outcome of discussion and consultation, undertaken with Trusts and Local Health Council.
15th August	Board consider report on outcomes.
16th August	Board conclusions discussed with Local Health Council and others for comments.
18th September	Board reviews conclusions in light of Local Health Council comments.
Late September	Proposals sent to Minister for approval.

Conclusion

The Board is asked to approve for consultation to 30th June the attached Consultation Paper, Summary Leaflet and the 21 specific leaflets as its proposals to Modernise Glasgow's Acute Hospital Services.

Return to top of page

Issue 1 April 14, 2000	Greater Glasgow NHS Board IN Partnership with the NHS Trusts in GLASGOW

Modernising Glasgow's Acute Hospital Services

Let the Consultation Begin…..

Planning hospital services to meet the needs of the future is not an easy task. Medicine, surgery and their technologies are now changing fast. Assumptions need to be made on the likely state of play five years from now and beyond.

In Greater Glasgow we are faced with trying to provide modern medicine and surgery in buildings which are often out-dated and dilapidated. Everyone involved in providing and using these health services agree that this is not the way we want to continue. But to consider upgrading, refurbishing and building new hospital facilities on the scale we have in Greater Glasgow is a mammoth task .

It's a task that we in the health service do not want to tackle alone. That is why this acute hospital services review is being developed with a key emphasis on **genuine** public involvement in assessing the options and coming to workable conclusions on the best way forward.

Attracting and maintaining high quality staff to manage and run those services is also crucial to the success of the review.

We recognise that with a task as great and diverse as this it is impossible to please all the people all the time. But what we will achieve, through working in partnership with local people, is a package of hospital services which will be much better placed to deliver fast, effective and efficient services.

Our aim…..

…... is to offer the safest and most up-to-date treatment quickly, using specialist skills in settings which are modern, friendly and convenient. We want to achieve this within the next ten years. Many people have seen the modern facilities available elsewhere and, quite rightly, expect such first class services in their own city. Too often patients suffer because of delays, postponements and trekking around hospital corridors, going to scattered services in old or shabby buildings, we want to consign this experience to the past.

What Hospitals are involved?

Southern General

Victoria Infirmary

Glasgow Royal Infirmary

Stobhill Hospital

Royal Hospital for Sick

Children (Yorkhill)

Queen Mother's Maternity Hospital

Gartnavel General Hospital

Western Infirmary

What's Been Done So Far……

February 15 – Paper to GGNHSB outlining the process of consultation on the review

March 21 – Health Board approved the consultation paper, summary leaflet and 21 issues specific l leaflets for formal consultation beginning on April 3

March 21-31 – Printing and proof reading for over half a million leaflets

Late March/ – MSPs, Councillors, Glasgow Alliance, Social Work, Housing Partners and many others Early April invited to the various presentations launching the proposals

April 3 – Telephone information line 0800 85 85 85 goes live. 100 calls received in the first week.

April 3-12 – 403, 000 summary leaflets delivered throughout Greater Glasgow households

April 10 – 2,500 consultees receive a set of the full consultation package

from April 11 – first of 28 public meetings arranged across Glasgow to inform and discuss the proposals. Click here for a list of the scheduled meetings.

Four Main Issues Raised So Far…….

1. Yorkhill

Concern has arisen that Yorkhill' s unique identity and world class status could be undermined. It's not surprising that people's reactions dwell more on threats than opportunities. We care as much as anybody else about Yorkhill's excellence in its regional and national specialist services. We played an influential part in the recent decisions about keeping children's heart surgery in Glasgow.

We think that the Yorkhill proposal creates three opportunities:

to **improve** services for children where they are currently not as child-centred as we would like them to be – neurosurgery, ENT and accident services for children.

better links with adult services – particularly for Yorkhill Trust's maternity services, where being on the same site as intensive care, general medicine and gynaecology will provide a safer service for mums. It will also enable us to offer a much better service for adolescents, who at the moment end up as uncomfortable residents in children's wards or on adult wards.

to give Yorkhill's services completely up-to-date facilities. By the end of this decade most of Yorkhill's services will be in buildings coming on 50 years old. (We don't think there's enough space on the Yorkhill site to rebuild there. Even if it were possible, staying put would fail on the other two aims.)

If Yorkhill's services did re-locate to the Southside:

they would remain as distinct, child-centred and **complete** as they are now (but stronger in neurosurgery, ENT and accidents) – that's a promise.

equipment bought for children by charitable donations would still be dedicated to children – that's a promise.

Ronald McDonald House would be re-provided on the new site – that's a promise.

maternity services in Glasgow would benefit too, by being stronger based and with a wider range of links to Yorkhill's specialist services for babies – that's a fact.

If we couldn't make these promises, we wouldn't even be suggesting this proposal in the first place.

One MSP expressed concern about the impact on the local community - jobs, local shops and a belief that the proposal is about land values. On jobs, remember that clinical services will be the same as they are now, so the same jobs for nurses, physiotherapists, speech therapists and all the other clinical staff. And the new facilities at the Southern General would need cleaners, porters and ward clerks.

Govan underground station is only 2 stops away from Kelvinhall.

Local shops may experience some change, but Glasgow's West End shops' loss would be Govan local shops' gain.

As for the value of the Yorkhill land, the fact of the matter is that sales proceeds would go towards the £52 million cost of replacement children's hospital. A new hospital on cheaper land we already own made affordable by selling a 40 to 50 year old hospital on expensive land benefits children and taxpayers alike – any NHS management which did not consider such a possibility would be failing in its duty to the Parliament.

2. South Glasgow

As expected, there's a lot of discussion but there seems, at this early stage, to be more acceptance that the Southside does need a single site hospital for its in-patient and Accident services. The question is where it should be. There have also been voices saying that in addition there should be two "community hospitals" (presumably one at the Victoria and one at the Southern General if the new hospital were elsewhere). It is not clear what is meant by a "community hospital". GGNHSB's proposal that at the Victoria there should be an Ambulatory Care Centre doing 85% or more of what the current Victoria provides for patients plus 120 rehabilitation beds may be pretty close to what people describe as a "community hospital".

The big issue around whether the single site in-patient centre should be at Southern General or somewhere else (eg Cowglen) is, of course, at the very heart of the consultation exercise. The judgement about what to do needs to take account of ease of access, comparative suitability of families and cost. GGNHSB has been quite open in saying that for it, cost is critical. Redevelopment at the Southern General will involve GGNHSB paying £11 million per year more for acute hospital services in South Glasgow. The "Cowglen option" would cost an extra £18 million per year – a difference of £7 million per year. That's an awful lot of money just for bricks and mortar being in place A rather than place B – it's enough to pay for at least 325 extra nurses or to provide or improve a whole range of other currently over-stretched or inadequate services. One MSP asked us what it would take for GGNHSB to change its mind – we think the question might reasonably be asked the other way, "What does the Cowglen option have that justifies its enormous (other missed) opportunities cost?"

3. Access

People are concerned about access – from South-East Glasgow to the Southern General; from the Clydebank area to the Southern General are two examples. GGNHSB is due to meet Strathclyde Passenger Transport Executive on 13th April and will report on the discussions in our next Newsletter.

4. Stobhill

Our next Newsletter will reflect more fully on some of the issues that are arising in debate so far. But the April announcement of GGNHSB support for the new Ambulatory Care Centre at Stobhill has been well received and will assure, way into the future, that around 90% of present contacts with Stobhill will be at Stobhill, including the well-regarded Casualty service). It's also worth drawing attention to the fact that what the Health Board is saying about general medicine and general surgery at Stobhill is to pose questions for serious and thoughtful debate – it isn't making a particular proposition.

Send your comments on the consultation:-

in writing to:
John Hamilton, Head of Corporate Services
Greater Glasgow NHS Board,
Dalian House

350 St Vincent Street
Glasgow, G3 8YZ

by E-mail to: [redacted]

Summary and Topic Specific Leaflets

Erratum – please note the following amendments in the printed leaflets:-

Summary Leaflet – The Future Of Glasgow's Hospital Services

pages 13 & 15 – Please note that the correct title of leaflet 16. Is Detailed Analysis Of The Options For South Glasgow (and not North as shown)

Leaflet 19 – The GRI/Stobhill Partnership

page 6, column 2, line 7 – Should read: Stobhill has 401 acute beds (not 297 as shown)

Page 7, table, line 1 – Should read: General Medicine Number of beds 222 (not 79 as shown)

Snippets

Q – "Will GPs and patients be able to exercise choice about where to go? For example could people in Castlemilk go to Hairmyres of they prefer? Or people in Rutherglen or Gorbals to the GRI instead of the Victoria or Southern?

A – Yes

Q – "Isn't Ambulatory Care an untested idea?"

A – No. We do lots of ambulatory care already. It's out-patients, day case surgery, diagnostic tests, out-patient rehabilitation and minor injuries – but it would be done in a building specially designed to be more patient friendly and efficient.

Q – "Will GGNHSB have a tough time getting its proposals accepted?"

A – We think there is plenty in the proposals that most people will support – new Ambulatory Care Centre at the Victoria and Stobhill, unified medicine and surgery at Gartnavel are three examples. And we hope that over the next few months people will get a fuller understanding of some of the other issues and recognise that some genuine choices are open to responsible and reasoned debate.

And Finally…….

……...We are encouraged by the interest that has already been raised on our proposals to modernise Glasgow's hospital services.

The discussion and debate has begun, through many channels including the programme of public meetings set out on the back page. We would encourage people to come along and hear the proposals and pose any questions directly to the team of doctors and staff at the various venues.

There has also been encouraging interest from the Members of the Scottish Parliament. To date the following MSPs have attending briefings/meetings on the proposals:- Des McNulty, Janis Hughes, Cathy Craigie, Fiona McLeod, Margaret Curran, Mike Watson, Johan Lamont, Dorothy Grace-Elder, Paul Martin, Sandra White, Robert Brown, John Young, Nicola Sturgeon, Margaret Jamieson, Bill Aitken, Ken McIntosh, Kenny Gibson, Elaine Smith, Sam Galbraith, and Ross Finney.

This dialogue is key to the success of this project. We need, over the coming months, to listen, hear and consider different viewpoints and analysis – before we begin the task of formulating conclusions on the best way to structure the provision of hospital services in Glasgow.

Once a set of conclusions is developed, we will be entering into a further phase of consultation before a conclusive plan is put to the full Health Board. This is planned for September but we are currently considering a request to give this phase a bit more time.

The Newsletter will be updated every fortnight throughout the consultation period. The next edition will be available from April 28, 2000.

If you have any issues you'd like us to cover in the Newsletter, please send them to Elaine McKean, Press Officer, GGNHSB, Dalian House, 350 St Vincent Street, Glasgow, G3, 8YZ. Or alternatively you can fax on 0141 201 4426 or e-mail elaine.mckean[redacted]

Public Involvement – We Need to Hear Your Views

PROGRAMME OF PUBLIC MEETINGS

Your chance to hear the Board's proposals and debate and influence the issues which concern you

Click here for Public Meetings schedule.

The format of the public meetings will be that doctors and managers will present the Health Board's proposals and then there will be an opportunity to debate and influence the issues that concern you.

Additional meetings will be put in place as required. For up-to-date information of meetings taking place contact our information line on 0800 85 85 85 or visit our website at www.show.scot.nhs.uk/GGNHSB.

For extra copies of the newsletter, contact Elaine McKean : [redacted]

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MODERNISING GLASGOW'S ACUTE HOSPITAL SERVICES: UPDATE

Meeting of the Board	Board
Tuesday, 18 April 2000	Paper No. 00/

CHIEF EXECUTIVE

Recommendation

The Board is asked to note the up-to-date position with regard to consulting on the plans to Modernise Glasgow's Acute Hospital Services.

Background

The Board, at its meeting on 21st March 2000, approved the documentation for consultation to 30th June 2000 on the plans to Modernise Glasgow's Acute Hospital Services.

The Consultation Paper, Summary Leaflet and the 21 specific leaflets have been issued to our consultees and made available to those who request them.

Website

The Board's website www.show.scot.nhs.uk/GGNHSB was fully launched on 3rd April and has all the aforementioned documentation. It also has the updated list of public meetings and the site will be updated continually to take account of issues raised.

Telephone Enquiry Line

The telephone enquiry line (**0800 85 85 85**) was launched on 3rd April and a steady flow of calls are being received – mainly requesting specific leaflets or the full consultation paper.

Summary Leaflet

The Summary Leaflet has now been delivered to all households in the Board's area.

Launch

There have been four briefings/presentations to launch our proposals – all held at the Lecture Theatre, North Glasgow University Hospitals NHS Trust Offices, Stobhill Hospital.

MSPs Briefings

The following MSPs have attended the various different briefings which have been offered:-

Des McNulty
Sam Galbraith
Ross Finnie
Fiona McLeod
Mike Watson
Johan Lamont
Cathy Craigie
Margaret Curran
Janice Hughes
Dorothy Grace-Elder
Paul Martin
Sandra White
Robert Brown
John Young
Nicola Sturgeon
Margaret Jamieson
Bill Aitken
Lyndsay McIntosh
Ken McIntosh

Public Meetings

Attached is the current list of public meetings which have been arranged by the Trusts – adverts have appeared in the key local papers and two national papers. The Programme of Meetings was also enclosed with the consultation pack sent to consultees. The Board will be arranging separate meetings with the Local Health Council, Glasgow City Council, East Dunbartonshire Council, and Strathclyde Passenger Transport Executive.

Newsletter

We plan to issue a fortnightly newsletter during the consultation period – the first edition will be issued with the "To Follow" papers. It covers the main issues raised with us in various forms already. Its distribution will include MSPs, Local Health Council, Local Authorities, Trusts, Local Health Care Co-operatives and consultees.

General

Plans are being considered to hold a Citizens Jury and Round-Table Workshops.

Conclusion

The Board is asked to note the up-to-date position with regard to the consultation on Modernising Glasgow's Acute Hospital Services.

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MODERNISING GLASGOW'S ACUTE HOSPITAL SERVICES

Access and Public Transport

We expected access to be an issue that people wanted to discuss arising from the changes in hospital services that we are proposing. Interestingly, we are hearing a lot of concern about access to the existing pattern of service. In other words public transport is a source of concern regardless of whether hospital services change or not.

GGNHSB had an encouraging first meeting with the Strathclyde Passenger Transport Executive (SPTE) on April 13th. The SPTE explained that they have varying influence over the different modes of transport available in and around the city. The SPTE control and run the underground services, specify services and fares for the railway services but with de-regulated buses they only have limited powers or funding to subsidise some services. Some £3million is spent in Strathclyde subsidising routes, mainly evening or weekends or filling gaps in the network.

The discussions picked up on the concerns we have been receiving from people trying to travel by public transport to Glasgow hospitals either as a patient or to visit friends and relatives.

Bus Services

To run a shuttle bus between the Southern General and the Victoria Infirmary between say 9.30am and the early evening on weekdays would cost in the region of £70,000 per year. If the shuttle system required more buses to run a continuous loop, the cost would multiply. We also discussed a possible shuttle bus service between Partick and the Southern General.

There is clearly a lack of available information about the best way of using public transport to get to various hospitals. What's more bus routes and bus times are prone to change - making leaflets very difficult to keep up to date. Nevertheless, we need to help people make informed choices about the best way of getting from various parts of Glasgow to the individual hospitals. We have agreed with SPTE that we should do some work to find ways of routinely providing patients and relatives with good advice about the quickest and easiest public transport routes.

The dial-a-bus service was discussed, but under the tight criteria to access the service there is not a lot of scope for further development. However we did agree to give further thought to finding better opportunities for transport for people who are relatively immobile.

Station Upgrades

Hyndland and Partick stations are earmarked for upgrade in the near future to make them more user friendly, particularly for people with restricted mobility. The upgrade at Hyndland may also require some improvements in the Gartnavel Hospital grounds themselves to make sure that there is good disabled access on the hospital sites.

Detailed Planning for the Future

Once we are clear what our future service plans for hospitals are, we will need to commission a series of detailed access surveys which will help us to work up proposals to present to bus companies for changes in bus routes. The surveys will allow estimates to be made of future expectations of different modes of traffic to the various hospital sites for staff, patients and visitors. Alongside proposals for changes in bus routes, we will also need to make each hospital campus more bus-friendly, making it more attractive to take the bus rather than using private cars.

Some people might think this sort of detailed work should have been done already. However such surveys are laborious and expensive and there is no point in spending money on them until we have a clear picture of what the preferred pattern of service is based on patient care considerations. It is also important to emphasise that the pattern we propose involves no change in access patterns for the vast majority of the existing hundreds of thousands of journeys.

More Time for Consultation

Several individuals and organisations have requested a longer period of consultation than the 3 months originally identified. UNISON in particular are seeking a 6-months extension to December, 2000.

The general principles underlying the proposals had been widely discussed in Glasgow over the last two years (issues for specialisation; securing the best outcomes in patient care; doctors' hours; the significance of ambulatory care). In addition the basic choice in the Southside had been clearly signalled in last year's Health Improvement Programme – what was new in the current consultation was a straightforward question of making a judgement about opportunity costs and access.

In the case of North Glasgow we recognise that the consultation asks questions and therefore there would need to be further consultation beyond the summer once the Health Board had gauged responses to those questions. Thus by the end of June (or shortly thereafter – we won't be rigid about that deadline) we hope people will have expressed a view about:

a) overall principles – flagged in the two preceding Health Improvement Programmes.

b) the site choice on the Southside.

c) how to sort out split site working in West Glasgow.

d) the various questions posed for North-East Glasgow.

We would then hope that at its August meeting the Health Board could express tentative conclusions on these four points and then test them through further consultation – hopefully quickly on the first three but probably taking several months on the latter.

We are striking a balance between not excessively prolonging uncertainty, (a factor felt to be important for South and West Glasgow), while providing good scope for debate where choices for the way forward are much less clearly delineated (North-East Glasgow).

Telephone Inquiry Line 0800 85 85 85

Since becoming operational on April 3rd, the telephone inquiry line has taken 154 calls for further information on the consultation. Over 4000 leaflets have been distributed on request, and many people have accessed the consultation package via the Health Board's website.

Public Meetings Update

Attendance at the public meetings has been variable. The quality of questions and the level of interest from those attending, whether it is 4 or 40, has been very encouraging. As we stated at the beginning, this is a genuine consultation process. There have been some helpful suggestions about how the meetings could be best organised in order to promote effective debate about issues in a systematic way.

Throughout the meetings, a common theme has been the transportation issues which have been touched on earlier in the Newsletter. Some of the other concerns raised include:-

Q **How do you identify which patients need A&E treatment from those requiring to be treated at a casualty department?**

A If patients are in ambulances, organised by a GP or by 999, they will automatically be taken to the right hospital. The vast majority of patients who make their own way to hospital will be suitable for minor injuries/casualty treatment. The small minority who aren't will be stabilised and transferred by ambulance. Experience elsewhere shows that the arrangement works well.

Q **Ambulance response times have been criticised lately – could patients die as a result of additional transferral times to the major trauma centres?**

A Two factors are important in dealing with major injuries, firstly, the length of time to be first stabilised by a paramedic at the scene and secondly, who the patient sees when they reach the A&E department. Currently not all seriously injured patients are seen by senior medical staff. By consolidating the major trauma services to two sites, more patients will have vital access to senior consultant staff on arrival at A&E. A few

minutes extra in an ambulance is highly unlikely to make a critical difference to outcome.

In recent years there has been a decrease in the numbers of major accidents through a reduction in the injuries sustained in road traffic accidents, largely due to people wearing seatbelts and traffic calming measures. There has also been a reduction in the numbers of heavy industry accidents. This has resulted in A&E treating fewer patients with multiple injuries.

The proposals for trauma in the consultation document will take effect over a 5-year period so there is time for the ambulance services to be expanded. The Scottish Executive have recognised that there is a need for more ambulances and paramedical staff and are allocating additional funding for this.

We need to be careful not to confuse A&E with medical and surgical emergency referrals arranged by GPs. Such referrals will go to Gartnavel as well as to the GRI and the Southside in-patient centre. The question of medical and surgical receiving services at Stobhill is an issue that is being debated as part of this consultation.

Q **Is this consultation just about cutting beds?**

A No! It's about combining the best quality pattern of in-patient care with continuing local access for ambulatory care, all provided in up-to-date facilities. At present there are about 3,500 beds in Glasgow. After all the changes there will be about 3,200. That is a 300 bed reduction over 10 years which is small compared with past trends in the NHS. What's more the reduction is wholly in the surgical specialties, reflecting the continuing trend towards day surgery, minimal intervention techniques and shorter lengths of stay in surgery. No reductions in acute medical beds are proposed.

Q **What about in-patient beds at Stobhill?**

A With the proposed Ambulatory Care Centre at Stobhill, 85% of patients will continue to receive their care and treatment locally, on an out-patient and day case basis. So, for the vast majority of patients the only change is a much better organised service in modern facilities.

The North Glasgow Trust is organising debate and consultation on the whole question of in-patient beds at Stobhill. The Royal Infirmary and Stobhill have been working in partnership in many different ways in recent years. However, the impact of specialisation, reduced in-patient lengths of stay in hospital, the switch from in-patient diagnosis and treatment to ambulatory care and the effect of working hours regulations have brought us to the point of needing to explore, during this consultation, the in-patient services at Stobhill. This is what the North Trust are now doing. (Further information is contained within Leaflet 19 - The GRI / Stobhill Partnership).

Q Does the HCI have a place in the future plans?

A It's interesting that the issue has been raised at a public meeting. HCI has, from time to time, been used by NHS patients for radiotherapy treatment. This is primarily due to a gap between the rising demand for the service and the time it takes to increase the existing capacity. The number of linear accelerators is being increased, but this takes time. The question of whether West Glasgow general hospital in-patient services should be based at Gartnavel or at HCI has been raised by various people over the past few years. Our proposals reflect the presumption that Gartnavel is in the best interest of patients and taxpayers but we have always been open to debate on this issue if people feel it should be re-examined.

The Evening Times have run some features over the last few weeks on:

The People's Jury, April 7th
Yorkhill, April 19th
Ambulatory Care, April 28th

Similar features on the Southside proposals and Accident and Emergency services are to be published soon.

Greater Glasgow NHS Board
in partnership with
THE NHS trusts in Glasgow

MODERNISING GLASGOW'S ACUTE HOSPITAL SERVICES

PROGRAMME OF PUBLIC MEETINGS

Your chance to hear the Board's proposals and debate and influence the issues which concern you.

Date	Place	Time
Thursday 11 May	Roystonhill Recreation Centre	7.00 pm-9.00 pm
Friday 12 May	Cooper Institute, 86 Clarkston Road	7.00 pm-9.00 pm
Tuesday 16 May	Brunswick Centre	7.00 pm-9.00 pm
Wednesday 17 May	Clarkston Hall	7.00 pm-9.00 pm
Wednesday 17 May	Drumchapel Community Centre, Drumchapel	7.00 pm-9.00 pm

Thursday 18 May	Scotstoun Primary School, Scotstoun	7.00 pm-9.00 pm
Monday 22 May	Edinbarnet Primary School, Faifley	7.00 pm-9.00 pm
Monday 22 May	McLeod Hall, Pearce Institute, Govan	7.00 pm-9.00 pm
Wednesday 24 May	Blue Vale Community Centre, Dennistoun/Carntyne	7.00 pm-9.00 pm
Wednesday 24 May	Trinity High School, Glenside Drive, Rutherglen	7.00 pm-9.00 pm
Thursday 25 May	Dental Hospital, Sauchiehall Street	7.00 pm-9.00 pm
Tuesday 30 May	Blairdrum Community Centre, Knightswood	7.00 pm-9.00 pm
Wednesday 31 May	Garrowhill Primary School, Baillieston	7.00 pm-9.00 pm
Thursday 1 June	Dalmuir Community Education Centre	7.00 pm-9.00 pm
Monday 12 June	Castlemilk Community Centre, Castlemilk	7.00 pm-9.00 pm
Monday 19 June	Mosspark Labour Hall, Mosspark	7.00 pm-9.00 pm

1st Issue detailed a meeting on May 11th at the Brunswick Centre; please note that the meeting is not now taking place. However a meeting is scheduled for May 16th.

Public meetings are for everyone, come along talk to doctors and NHS staff and hear and ask question about Greater Glasgow NHS Board's proposals for new and better services. This is your chance to be heard.

Details of the Health Board's proposals can be obtained by contacting the telephone inquiry line on **0800 85 85 85** or visit our page on this site.

Send your comments on the consultation:-

in writing to:

John Hamilton, Head of Corporate Services
Greater Glasgow NHS Board,
Dalian House
350 St Vincent Street
Glasgow, G3 8YZ

by E-mail to:

[redacted]

If you have any issues you'd like us to cover in the Newsletter, or for extra copies, please contact Elaine McKean, Press Officer, GGNHSB, Dalian House, 350 St Vincent Street, Glasgow, G3, 8YZ. Or alternatively you can fax on 0141 201 4426 or e-mail elaine.mckean[redacted]

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YORKHILL NHS TRUST

Acute Services Strategy – Feedback from Public Meetings

Place/Time	Presenters	Numbers attended
Yorkhill and Kelvingrove Community Council H.Q. Tuesday 16 May 2000	Mr Graham Haddock Mr Jonathan Best Councillor Malcolm Green	Approximately 50

Comments/Questions
Does the land belong to Yorkhill Trust? Yes, the land belongs to Yorkhill NHS Trust. University has no ownership.
Emergency on North side of river – how will ambulances access the South side? Point about transport is major but children come from across the city.
Statement – The sewerage Odour is abnoxious
Where did the proposal come from to consider a South-side option? Proposal came from Health Board following a general consultation meeting on the South side where it arose from a member of the public.
Is theSouth side option solely influenced by Private Public Partnership? Capital money will have to come from private investment. Public investment could not sustain the size of resource required. Another major influence could be the Maternity Services – number of delivery units.
If the decision has been made to transfer what happens to land? Asset realised and goes towards new build. .
Statement. . If new state of the art hospital in South side – same builders may cause poor standards of building.
Statement: Transport is such a major issue. Reassured that access to services is Yorkhill's top priority. Personal experience of Govan underground is that it is not suitable for prams, buggies. Personal experience demonstrated how difficult access to Southern General Hospital is.
Acknowledge this. Glasgow Health Board is discussing all aspects of transport with Passenger Transport Executive.
Statement - Health Board has restructured itself for second time in three years. This leads to low moral . Yorkhill should be protected from 7-10 years of being prepared to face change.
Comment : *Shared mother and child facilities – Concern about adult facilities being offered to children. An example of X-ray.*

Greater Glasgow NHS Board

Meeting of the Board	Board
Tuesday, 20th June 2000	Paper No. 00/72

CHIEF EXECUTIVE

MODERNISING GLASGOW'S ACUTE HOSPITAL SERVICES - UPDATE

Recommendation

The Board is asked to note the up-to-date position with regard to the consultation process on the plans to Modernise Glasgow's Acute Hospital Services.

1. Background

The Board at its meeting on 21st March 2000 approved the documentation for consultation on the plans to Modernise Glasgow's Acute Hospital Services. At its May meeting the Board agreed to extend the consultation period from 30th June to 8th September 2000 and this has been communicated to all consultees, highlighted in letters responding to comments received on the consultation process and included within the Board's website.

2. Responses

Since the consultation document was launched there have been about 65 to 70 responses – some seeking further information or commenting specifically on some of the statements contained within the leaflets. The Chief Executive and Head of Board Administration have been working towards ensuring that every response received is replied to and thereafter included in the database for inclusion in the paper to the Board in September on the Outcome of Consultation.

3. Main Themes

The main themes in the comments received to date have related to the Board's proposals for the Southside – it is becoming clear that there seems to be a fairly widespread acceptance of the need to create a single in-patient hospital service for the Southside to integrate the two separate existing services; Yorkhill – whether this should be retained on its existing site or follow the Board's proposal to re-locate it in the Southside; the ACAD proposals for Stobhill and the Victoria Infirmary and specific issues around the services provided; Trauma (A&E) – including the services to be provided from the Minor Injuries Unit and,

lastly, the transport issues which have also highlighted dissatisfaction with the current pattern.

4. **Public Meetings**

Up to 35 public meetings have now been held across the Greater Glasgow NHS Board area and organised by the North Trust, South Trust and Yorkhill Trust. Attendance at these meetings has been variable (a handful to up to 200). The majority of meetings have had a good to healthy attendance and the debate has been informed and rigorous. At the time of writing this paper the following meetings remain:

Thursday, 15th June	Cranhill Parish Church	7.00-9.00 pm
Monday, 19th June	Mosspark Labour Hall, Mosspark	7.00-9.00 pm
Monday, 19th June	Clydebank Town Hall, Dumbarton Road	1.00-2.30 pm (organised by the Yorkhill NHS Trust)

Detailed below are two public meetings which the Local Health Council have arranged:

Tuesday, 20th June	Quality Central Hotel, Gordon Street, Glasgow	7.00-9.00 pm
Monday, 26th June	Holyrood Secondary School, Dixon Road, Glasgow	7.00-9.00 pm

Each public meeting will be written up and presented to the Board at its September meeting as it forms part of the outcome of the consultation process. Officers from the Health Board and Trusts are now considering proposals to hold up to three Round Table Workshops during the course of August and details of these will be communicated at a later date.

5. **Summary Leaflet**

At the May Board meeting there was an update on the meetings between the Head of Board Administration and the distributor of the summary leaflets to all households within the Greater Glasgow NHS Board area.

As reported at the last meeting, the Press Officer of the Health Board contacted staff within the Board, Trusts, Hospitals, Clinics and Health Centres to see if they had received the summary leaflet at their home address. This information, detailed by postcode area, was collated and

tabulated and presented to a representative of Scotmail as further evidence of our growing concern at the distribution arrangements. As a result of that meeting Scotmail were asked to survey the particular areas within the Board's area where high levels of non-delivery were highlighted by our staff. The survey was undertaken over four days by Scotmail and further tested by a senior management representative of the organisation re-visiting specific previously surveyed areas. The outcome of that survey, which was undertaken some six weeks after the delivery of the summary leaflet, indicated that up to 75% of people recalled receiving the leaflet, up to 16% couldn't remember and 8% indicated they had not received it. Each person spoken to as part of the survey was asked to sign for the reply and the detailed signing sheets have been made available to the Head of Board Administration.

As the perception at public meetings and other anecdotal evidence that the distribution arrangements have not all been what the Board would have wished, Scotmail have been asked, not only to present the information formally to the Head of Board Administration, but also to give an indication of a possible reduction in the charge or consider submitting an alternative proposal to the Board.

In light of the concerns that have been expressed to us about the distribution arrangements we have ensured that all those attending any of our public meetings have been given a copy of the summary leaflet and we have also sent 30 copies to each GP practice, dental surgery, pharmacist and optician within the Board's area for their waiting areas. We have also provided additional copies at hospital entrances, out-patient departments, some in-patient departments and also libraries. We have tried to ensure as best as possible that our proposals have been accessible and available to as many members of the public as possible. It is also available on our website and available, on request, via our Freepost address, or contacting the Health Board itself.

6. **Advisory Leaflets**

The 21 specific advisory leaflets continue to be requested by members of the public and others and the three most requested leaflets have been the Detailed Options for the Southside, the Planning Challenge and Regional Services.

7. **Telephone Line**

The Telephone Enquiry Line set up on 0800 85 85 85 peaked at about 70 calls per day, however, recently has dropped to just a couple of calls per day. Therefore the line has been suspended for the time being and the message which callers receive is that they can contact the Head of Board Administration for any information or write to the Board at its Freepost address if information/documentation is required.

8. **Website**

The website continues to be accessed regularly with over 580 hits in the last four weeks.

Further update will be provided to the July Board meeting and should include a copy of the 3rd Newsletter.

THE FUTURE OF GLASGOW'S HOSPITAL SERVICES

REPORT ON FIRST PHASE OF CONSULTATION

1. INTRODUCTION

1. In April, 2000 Greater Glasgow NHS Board (GGNHSB) embarked on a formal consultation about how best to reshape Glasgow's hospital services. We had five aims:

    a. modern facilities for a better patient experience.
    b. creating larger specialist teams of doctors in order to assure more continuous availability of specialists and to tackle new requirements governing the working hours of senior and junior (trainee) doctors.
    c. maintaining local access for as much as possible.
    d. creating a pattern of hospital services that made sense across Glasgow as a whole.
    e. levering in major capital investment in a way that was affordable.

2. A comprehensive range of 22 leaflets was published setting out the proposals, background information and detail. Annex 1 lists them. Cross-references to them are made in the text of this paper. A large number of public and staff meetings were held. Similarly there were discussions with the City Council, other local authorities whose populations use Glasgow hospitals, the Local Health Council, Glasgow University, neighbouring Health Boards, MSPs, the Scottish Ambulance Service, Strathclyde Passenger Transport Executive and other interested parties. Press coverage was extensive. Annex 2 to this paper itemises the consultation activity in detail.
3. This report describes the nature of responses we have received, reflects on their implications and suggests what response the Health Board might now make.
4. This response to consultation should itself be the subject of further consultation throughout October and November with the Health Board finally reviewing the position at its meeting on 19th December, 2000.

2. THE NATURE OF THE DEBATE

1. Although a small minority of those who responded regarded the issues as simple ("just replace the existing hospitals in situ"), the great majority recognised that the issues are complicated and that decisions affecting one part of the Glasgow hospital system have disconcerting repercussions elsewhere in the system (uncannily like a Rubik's Cube). In particular trying to reconcile:

    - clinician advice about concentrating teams/facilities versus public preferences about access.
    - operational linkages between different specialties.
    - hospital planning considerations with wider traffic and transport issues.
    - the need to invest more money in acute hospital services versus the imperative of building up primary care, community health services, children's services, addiction services, mental health services and other services aimed to tackle fundamental inequalities in health.
    - timing\phasing and financial flows.

continues to be a difficult challenge.

2. As might be expected the debate has been vigorous. Some of it has explicitly taken the form of sectional campaigning rather debating the inter-relationship of issues and the difficult trade-offs involved in making choices. On the other hand some of the responses we have received demonstrate a considerable investment of time and effort to understand the issues and to develop a coherent analysis. We are especially grateful to those individuals and organisations because they have contributed greatly to the testing of ideas and propositions.
3. It is striking just how uneven the pattern of response has been; confirming that those living in circumstances of deprivation are often those least likely to take part in a debate of this type. Yet their needs must always be in the forefront of our minds. In particular, issues of access and cost of public transport fares are highly significant for them. Later in this paper we reflect on how the consultation process has helped us to focus our minds on these needs. Sections 5 and 6 explore the issues.
4. One intrinsic difficulty in a debate at this stage of strategic planning is that many commentators feel frustrated at the lack of convincing operational detail underpinning some of the proposals. But such detail can only come with the costly and time-consuming work that is part of the next stage of the planning process – the development of Outline Business Cases. There is a Catch-22 here. Some people will only be convinced if they see the detail but the detail cannot be provided until the fundamental strategic direction has been agreed. Ironically, many of the comments we received ignored factual detail that we had provided in the consultation leaflets (for example on the numbers and different types of patients currently flowing into Accident and Emergency Departments and how they could be managed in future). It was also clear that many people were expressing concerns about things we were **not** proposing anyway (for example, many people attending out-patient clinics at the Victoria were concerned about having to go to the Southern General – but that was not what we were proposing at all). Similarly some campaigners described the Southern General option as a proposal for "refurbishing it" whereas the option essentially results in demolition of all the old buildings and their replacement by brand new buildings.
5. Much of the debate has focused on issues common across Glasgow as a whole (such as public transport; traffic impact; the role of stand-alone Ambulatory Care Centres; bed numbers etc). The debate about the Southside proposals has been intense. There has been less about the pattern in North Glasgow, probably because the documents published in April posed questions rather than made definitive suggestions (in North-East Glasgow at least).
6. Annexe 3 describes the range, subject matter, source and weight of responses that we received.
7. Public decision-making can never be based on popularity\unpopularity alone. The Scottish Parliament, taxpayers, professional regulatory bodies and the like expect other criteria to be taken into account, such as:

    a. value for money.
    b. management of risk.
    c. opportunity cost and wider implications for other areas of public policy.
    d. affordability.
    e. meeting basic quality standards for service organisation and delivery.
    f. how these factors inter-relate with each other.

    In analysing the responses to consultation we have sought to cross reference them to this framework for decision-making.

8. In the time since the end of the first phase of the consultation period we have not been able to absorb all the details but believe this paper does capture the key issues. If there are other substantive issues relevant to the strategic decisions that need to be taken in December we hope they will be identified over the next few weeks.

3. THE THEME OF CONSOLIDATING IN-PATIENT SERVICES

1. In our proposals we argued that **creating larger specialist teams** would greatly increase our ability to ensure that patients most needing treatment and care by specialist teams would get it regardless of the impact of annual leave, study leave, sick leave, and rostered time off. Although published evidence that specialist teams secure the best outcomes for patients is not extensive, where it does exist it is compelling, and intuitively most of us would prefer to

be seen by someone specialising in our particular condition, especially if we are seriously ill. Leaflets 3 and 4 explained the issues.

2. In addition larger clinical teams make it easier to fulfil the new limitations on senior and junior **doctors' working hour commitments**. Indeed without such consolidation it will be virtually impossible in most specialties to meet the now very stringent limitations, bearing in mind the national shortage in the supply of doctors, the need not to dilute the skills of doctors and the punitive costs incurred if junior doctors' hours are not significantly reduced. Leaflet 10 explained the issues in detail but has now been overtaken by a national agreement on junior doctors' hours and pay which makes much of the present pattern of rotas in Glasgow unacceptable, unsustainable and unaffordable.

Currently North Glasgow Trust has 626 junior doctors with a cost of £23.6 million.

If rotas remain unchanged, by 2002 the new pay agreement means the cost will be £31.8 million.

3. Achievement of the shorter working hours for junior doctors requires a significant **reduction in the number of emergency cover rosters** in the city. A relatively small specialty such as gynaecology, for example, cannot sustain five emergency rotas for a mere 126 beds in the city (its present bed complement). ENT cannot sustain three rotas for its 59 beds. Other specialties face similar challenges.

4. These realities led us to suggest that:

    a. the single site New Western Infirmary at Gartnavel, formally approved by the then Secretary of State in 1996, should be confirmed. (Leaflet 18)
    b. a single in-patient centre for the Southside should be created. (Leaflet 16)
    c. the long term continuation of in-patient beds at Stobhill was unlikely to be sustainable. (Leaflet 19)

5. In a later section in this paper we discuss the practical implications of achieving the single-site hospital at **Gartnavel** previously approved in 1996. Support for this move remains almost universal among the responses we have received.
6. The proposition that there should be a **single Southside in-patient centre** was strongly endorsed by the Area Medical Committee (representing GPs and hospital doctors), the Local Health Council, most local MSPs, and most members of the public who responded (2,876 out of 3,416 = 84%). The issues of controversy are where such a hospital should be located and whether it should be complemented by a stand alone Ambulatory Care Centre at the Victoria Infirmary site.
7. As far as **North-East Glasgow** is concerned, in our original consultation we suggested (in leaflet 19) that the future of orthopaedics, gynaecology, ophthalmology, urology, and ENT as in-patient specialties at Stobhill was unsustainable given their already small bed numbers and the pressure on doctors' emergency rotas. We suggested that the question of whether there should be a single general surgical service for the 340,000 people of North and East Glasgow should be debated – we implied that there should be such a service. Finally we asked whether general medicine could be sustained alone on the Stobhill site if general surgery had no in-patient presence there. We report in more detail later in this paper what response we got to these suggestions. Although there has not been a large volume of response to these questions, the North Glasgow Trust itself and the medical advisory machinery are advising us that we should aim to create a single in-patient centre for North and East Glasgow at the GRI – the question of when and how this can be completed in practice is explored later in this paper.

4. AMBULATORY CARE

1. In our proposals we observed that 85% to 90% or more of the patient encounters with the acute hospital services was now on a "walk-in, walk-out, same day" basis. These include out-patient clinics; diagnostic tests such as x-ray or ECG; out-patient physiotherapy, speech

therapy and the like; day surgery and minor injury attendance at Accident and Emergency Departments. The jargon term for this type of work is "Ambulatory Care". Leaflets 6 and 7 explained the background.

2. We confirmed that the GRI, Gartnavel and the Southside in-patient centre would provide ambulatory care services on site to complement their in-patient work. This has been welcomed by all of those commenting on this aspect of our proposals.
3. We also suggested that in order to meet the public's wish to preserve as much local access to hospital services as possible, we should build new purpose-designed Ambulatory Care Centres at both Stobhill and the Victoria Infirmary. We demonstrated how such units would provide around 90% of the hospital services currently used by local people at those sites. (See leaflets 16 and 19)
4. The suggestion that there should be **"stand-alone" Ambulatory Care Centres** at Stobhill and the Victoria Infirmary has attracted opposition on several grounds:

    a. the concept of Ambulatory Care Centres is said by some to be "untried".
    b. more particularly some clinicians have expressed concern that patient safety might be compromised if day surgery or interventional radiology are undertaken on a site with no in-patient beds or intensive care back up if complications arise. Some MSPs, the Local Health Council, Area Medical Committee and members of the public have picked up on this issue and are adding their voices to the issue.
    c. some clinicians argue that doing some of their ambulatory care work on one site and their in-patient working on another constitutes "split-site working" which they regard as inefficient and undesirable.
    d. some clinicians fear that the stand-alone Ambulatory Care Centres might result in inefficient duplication or triplication of expensive radiological, endoscopic and laboratory equipment.

5. **Are Ambulatory Care Centres "untried"?**

No. Ambulatory Care is what we already do now. Around 90% of hospital work is ambulatory care. An Ambulatory Care Centre is simply a purpose-designed setting that allows ambulatory care to be undertaken more efficiently, in a pleasant environment, providing greater scope for a "one-stop" experience of diagnosis and treatment for more patients. Our present hospitals have developed so haphazardly that they defeat the aim of organising the patient's experience efficiently and as pleasantly as possible. For us not to seek to provide facilities that are organised around the needs of the patient, exploiting new equipment and technologies and giving staff teams a more satisfying holistic relationship with patients is unthinkable. Nor do the design challenges take us into uncharted territory.

Our present "tried and tested" models of organisation are frankly too often a mess. They include services and equipment that fail to insulate the interests of elective patients against the dominating needs of emergency patients. They result in delays. They entail multiple visits when one or two would suffice. They entail long treks around confusing corridors and between different buildings.

Purpose-built Ambulatory Care Centres solve these problems. They enable investment to be made in facilities and services that will transform the patients' experience for the better.

6. **Are day surgery and interventional radiology unsafe without back-up of in-patient services?**

The scarcity of stand-alone Ambulatory Care Centres in the UK, the lack of published data on complication rates, and to-day's more exposed medico-legal position of doctors have caused some doctors to express this anxiety.

There is a stand-alone Ambulatory Care day surgery service at Bexhill in Sussex which has operational links to the Conquest Hospital in Hastings (around 7 miles away). It has undertaken 14,000 day cases, of which only 71 (0.5%) have required transfer to Hastings.

Admissions are usually for the side effects of anaesthesia or pain medication and are usually confined to nausea and vomiting. Annex 4 provides a report compiled following a visit to the Unit.

Data provided by Stobhill shows that in 1998\99 out of 12,045 day cases 105 (0.87%) were subsequently admitted to an in-patient bed. The reasons included:

20 "social reasons"
24 experienced post-operative nausea and vomiting (usually due to analgesia). 7 were classified as "under recovered". 2 were kept in for "observation". 14 were described as "unfit". 7 were experiencing pain. 2 had vision problems.
1 needed to be intubated. 8 were described as having a medical, heart or blood pressure problems.
6 were bleeding. 1 had their operation abandoned.
13 needed further investigation or surgery.

What is not clear is whether any of these could have been avoided through improved routines for screening for suitability for selection for day surgery in the first place. Nor is it clear how many of them required intervention by doctors as opposed to routine post-operative observation and care by nurses on an extended day basis. (The Stobhill Day Surgery Unit closes at 7.00 p.m.)

Similarly it is not clear how many of them were so unwell or serious that transport by ambulance to another hospital would have been considered if there had been no on-site beds (i.e. the Bexhill\Hastings arrangement).

However, given the number of admissions at Stobhill for social reasons or because a bit more time was needed to recover from analgesia it is likely that a stand-alone Ambulatory Surgery service at Stobhill with recovery beds open later into the evening (or overnight, as in the proposal for the Victoria Infirmary Ambulatory Care Centre) would entail only a similar transfer rate to in-patient beds as is experienced at Bexhill (0.5% of 12,045 cases would be 60 transfers – just over one case a week and a rate of transfer 58 times less than experienced by West Glasgow patients in their current use of West Glasgow hospitals' split-site working).

Clinical audit data from the Victoria Infirmary indicates that in the last six years no day surgery patients have needed to be transferred into Intensive Care. In the UK many surgeons, who also work in the NHS, undertake significant in-patient surgery in private hospitals with no on-site intensive care facilities.

In the USA there are around 1,300 free-standing Ambulatory Care Centres which are neither based on hospital sites nor merely what the Americans call "office-based" (i.e. undertaking very minor procedures in a doctor's consulting rooms). The great majority of these undertake endoscopies and day surgery in ENT, gastroenterology, ophthalmology, urology, orthopaedics and general surgery. Many are twenty to thirty minutes away from the link in-patient hospital (source: Ambulatory Systems Development Consulting – Website http://www.asdconsulting.com). It is clear that such centres are seen as a rapidly growing part of the American healthcare scene (ibid). The Federated Ambulatory Surgery Association (FASA) in the USA reports a high level of patient satisfaction. A survey undertaken by the US Department of Health of 837 patients who had cataract extraction with intraocular lens implant, upper gastrointestinal endoscopy, colonoscopy or bunion-removal showed that patients preferred out-patient surgery to in-patient stays, 98% expressed satisfaction with the

service and post-operative care was not a problem for most patients (see www.fasa.org/aschistory.html). FASA also report that only 9.6% of surgery centres offered 23 hour post-surgical recovery care.

GGNHSB understands why clinicians feel cautious in to-day's climate but we do not think the concept of day surgery in stand-alone Ambulatory Care Centres should be discarded, particularly since it is so widespread in the USA, a country with the highest level of medical litigation and extensive accreditation regimes. We have now made a contact in the USA and will arrange for clinicians and other interested parties to visit some hospitals to examine issues of risk management at first hand.

7. **"Split-site Working"**

"Split-site working" is understandably an emotive term. In Glasgow it has gained particular resonance from the wholly unsatisfactory patterns of care and working arrangements experienced in West Glasgow where many patients have to be transferred between the Western and Gartnavel in mid-episode of care and where staff also find themselves shuttling backwards and forwards between the two sites.

The creation of the New Western Infirmary at Gartnavel, with its own on-site Ambulatory Care Service will mean that physicians and surgeons based there will not experience "split-site working " (although some specialists based at Gartnavel may very well do clinics or provide expert advice\support at other hospitals elsewhere in Glasgow or further afield as part of a Managed Clinical Network).

However, the contention that stand-alone Ambulatory Care Centres at Stobhill and the Victoria Infirmary would cause "split-site working" needs closer examination.

a. **For patients attending the Victoria or Stobhill Ambulatory Care Centre only a tiny proportion might find themselves transferred to the Southside in-patient centre or GRI respectively (e.g. those experiencing problems after day surgery – see above – or those who attend an out-patient clinic but are then assessed as needing immediate in-patient admission – relatively few in number). A level of transfers such as this is nothing like the volume and seriousness experienced currently by West Glasgow hospitals' patients. (The Ambulance Service carries 3,500 patients per year between the West Glasgow Hospitals).**
b. **Patient Records will need to transfer between hospital sites if a patient is, say, attending the Ambulatory Care Centre but later has to be admitted as an in-patient to , say, the Southside in-patient centre either electively or as an emergency. By the time the new pattern of service is implemented the NHS in Scotland will surely be well down the path of electronic records and any remaining logistics involving paper records ought to be amenable to good organisation.**
c. **Staff movement between sites is inefficient and disruptive if it has to take place erratically or several times during a working day. However, the creation of larger clinical teams will mean that for most staff their work can be more adequately planned on a weekly or monthly basis and the designation of teammembers to concentrate on emergency cover on a programmed basis will free other team members from the clashes between emergency and elective work which is currently such a blight. Thus if a consultant is programmed to spend a day at, say, the Stobhill Ambulatory Care Centre we would not expect him or her to be called back to the GRI to deal with an emergency.**

Having a programme of work which takes staff to different hospitals on different days can rightly be regarded as "multi-site working" but that does not entail the disruptions caused by the "split-site working" as typified by the current Western\Gartnavel arrangement.

d. **<u>Duplication of equipment</u> is theoretically a possibility in any situation but one that can only be addressed at a later stage of planning. The essence of an improved service for patients requires smartly scheduled access to equipment. The Ambulatory Care Centre model will be dealing with the vast majority of patients and each Centre will have equipment to meet its needs. It is the concentration of in-patient work onto fewer sites which will reduce the risks of duplication of equipment for what they need. We have already made the point that because Ambulatory Care Centres insulate their patients from the pressures of urgency associated with in-patients, they experience fewer delays, cancellations and costs (to the NHS and to its patients) which such inefficiency causes.**

The NHS has experienced at least two decades of seriously inadequate investment in new equipment. There are encouraging signs that the problem is now being addressed, driven by a governmental determination that the experience of patients must be transformed for the better.

8. **<u>So how does all this affect GGNHSB's view on stand-alone Ambulatory Care Centres?</u>**

Our commitment to them reflects our desire that patients should have as much local access to as many services as possible. The concept of stand-alone Ambulatory Care Centres would, in particular, protect this aspect of service quality for the current users of service at Stobhill and the Victoria Infirmary – areas where issues of local access are particularly important to local people, judging from the comments received during the consultation.

We do not think the concept of day surgery at these Centres should be discarded. GGNHSB would not wish to put in place arrangements which cannot be managed safely. We will organise further work and enquiry to look at risk management arrangements in the USA which is a highly litigious society and takes risk management very seriously.

We do not think the "day surgery tail" should wag the "Ambulatory Care dog". For the two hospitals the <u>total</u> amount of day surgery amounts to only around 5% or less of the expected Ambulatory Care Centre workload. We certainly do not think the provision of Ambulatory Care Centres for the two sites should be lost even if, as a result of more tightly defined selection of suitable patients, slightly less day surgery were done than we previously estimated.

We think the convenience of local access for patients for most services is more important than eliminating a pattern of multi-site working for staff, especially since that multi-site working should be well programmed. Both the proposed stand-alone Ambulatory Care Centres would be located in, or close to, populations with high levels of socio-economic deprivation, for whom ease of access is very important.

<u>5. ACCIDENT AND EMERGENCY AND RELATED SERVICES</u>

1. In our original proposal we suggested that there should be two Accident and Emergency (A & E) Centres (one at the GRI and one at the Southern General or Cowglen) supported by locally accessible Minor Injuries Units at the Victoria, Stobhill and Gartnavel. We also said that medical and surgical emergency referrals by GPs should be received at the GRI, Southside in-patient centre and Gartnavel, being taken directly into the care of medical and surgical receiving teams which should be at the 'front door' of the hospital. In this way seriously ill or injured patients would have the best possible chance of being seen by appropriate consultants as quickly as possible, overcoming delays and bottlenecks too often experienced at present. Leaflet 5 explained our thinking and included relevant data based on two one week surveys undertaken in A & E Departments in 1998

and 1999. It also referred to data about Nurse Practitioners published by "The Lancet" and to the Audit Commission Report of 1996 on Accident and Emergency Services.

2. The Scottish Trauma Audit Group (STAG) Report published in February, 2000 reinforces the need for change. This audit reviewed all trauma patients who:

a) are admitted for three days or more.
or b) die at any time during their stay.
or c) are managed in an intensive care unit.

(It excludes elderly people with isolated fracture of neck of femur or the pelvis, and children under 13).

In a one year period (1\7\98 to 30\6\99) 1,202 Glasgow A & E patients were recorded meeting the audit criteria. (Data from the GRI was not available for a period of 3 months within that period) 81% arrived by ambulance. 30% arrived between 9 a.m. and 5 p.m. on weekdays, 70% arrived in the evening, during the night or at weekends. 50% (600 patients) were deemed to have moderate injuries, 17% (204 patients) had serious injuries. 20% of those with serious injuries (40 patients) died.

In terms of meeting national standards, performance in Glasgow A & E Departments was:

	Performance (%)			
Standard	Western	GRI	VI	SGH
(i) 20% of all STAG patients should be managed by an A & E Consultant	9	17	27 (3)	34 (3)
(ii) 40% of all seriously injured patients should be managed by an A & E Consultant	21	29	52 (3)	62 (3)
(iii) 90% of seriously injured patients should be seen within 10 minutes of arriving at A & E	79	57	78	74
iv) 100% of seriously injured patients should be seen within1 hour of arriving at A & E	96	79	85	92
v) Less than 15% of seriously injured patients should be managed by an SHO	10 (3)	30	22	14 (3)
Standards met (3)	1	None	2	3

(There are two other national standards concerned with Patient Report Forms and the management of seriously injured patients in resuscitation rooms which Glasgow hospitals either meet or exceed or, in a couple of cases, fall short by 1 or 2 percentage points only).

It is important to emphasise here that Glasgow hospitals are far from unique in their difficulties in meeting standards. Hospitals elsewhere struggle to meet them too. Indeed only 8 hospitals in Scotland met standard (iv) and 7 standard (v). The key issue for Glasgow however, is that we emphatically do need to improve our performance. This is a point made by the A & E Consultants themselves. Their response to our proposals emphasises the importance of investing more in A & E Services but concentrating A & E consultants (and other staffing) resources onto fewer sites and extending the hours of consultant coverage.

3. **The proposition that there should be a single A & E Department on the Southside is emphatically supported by the A & E Sub-Committee itself, by the Trust and the Area Medical Committee and is consistent with the proposal for a single in-patient centre for South Glasgow. The Local Health Council accepts the logic of having one Accident and Emergency Department situated in South Glasgow although it believes it should be based in a new centrally located Southside Hospital.**
4. **The clinical responses regarding the position in North Glasgow are best summed up by the A & E Sub-Committee which feels there should be a "maximum of three adult A & E Departments in Glasgow" but there are "concerns about reducing the number to two (one South, one North) in the short to medium term". These concerns centre on the capacity of the GRI to absorb the workload that would flow there.**

   In relation to these concerns it is interesting that some respondents have questioned the timescale for the proposals and suggested that, with a longer timescale, they could support them.

   > **"It is our firm belief that in the long term (approximately 10 years) we should move to one Accident and Emergency Service in the North of the city. However, in the short to medium term .... there should be two fully staffed and resourced Accident and Emergency Departments."**
   >
   > **(A & E Consultants, North Glasgow)**

Yet the concern about the capacity of the GRI A & E Department is not one of timing but of implementation. We refer elsewhere to the work we will do to make sure that our proposals for the role of the GRI A & E Department are soundly-based and practical. The comment made by the A & E Consultants centres on the fact that existing facilities, and indeed the current new build under construction does not provide for the future pattern of services now being proposed. This is true. We shall change the facilities and review the design to make sure that they do. Like many of the comments on the proposals, the concern being expressed appears to be less about the broad direction of the proposals than with proper and thorough implementation.

5. **There were two other key dimensions to GGNHSB's proposals for A & E services. One was that for those sites without an A & E Department (Stobhill, Victoria and Gartnavel) there should be Minor Injuries Units staffed by Nurse Practitioners working to protocols devised by A & E Consultants and supervised by them. The second was that GP emergency referrals should be dealt with at the 'front door' of the hospitals (in an Emergency Receiving Centre) by consultant and junior staff teams in medicine and surgery.**

   Both of these arrangements would have the effect of significantly reducing the burden on A & E Departments and their staff, allowing them to concentrate on the work that will most benefit from their skills.

6. **The A & E Sub-Committee unanimously supports the development of nurse practitioners and envisages them treating and discharging patients with minor injuries. It goes on to say "the development of stand alone minor injuries units is highly controversial. There is a majority view that given adequate resources and support minor injury units could be made to work". It then goes on to talk about the importance of not introducing them "before 'parent units' have developed the clinical strategies required".**

   In our consultation (leaflet 5) we gave some indications of the number of cases likely to be suitable for treatment in Minor Injuries Units. For example sprains, superficial injuries or cuts, abscesses and foreign bodies in the eye alone amounted to a quarter of all attendances at A & E and are equivalent to 76,000 attendances a year.

GGNHSB believes that nurse practitioner minor injuries units, working to clinical protocols and supervised by A & E Consultants should indeed be a significant part of our future service pattern for all the reasons set out in leaflet 5. Such units at Stobhill and Gartnavel would significantly reduce the pressure of patient flows that would otherwise affect an A & E Department at the GRI.

Indeed postcode analysis confirms that for many patients currently attending the Western A & E Department, Gartnavel with its Minor Injuries Unit and the Southern General would be much more accessible than the GRI.

7. **The point we made about medical and surgical emergency receiving has not attracted much comment. The A & E Sub-Committee acknowledges that the model proposed by GGNHSB "is current practice elsewhere" and "patients who have been assessed as stable by their GP and referred for in-patient assessment can be safely admitted via receiving units" (i.e. not "processed" by the A & E Department). They go on to remark about a lack of enthusiasm for this on the part of physicians.**

   The Victoria Infirmary Support Force report remarked on the importance of consultant physicians and surgeons and their teams being rostered as dedicated for emergency receiving, unencumbered by other commitments and able to deal with the patient at the 'front door'. GGNHSB firmly believes that such an arrangement is emphatically in the best interests of patients who are, after all, deemed by their GP to be seriously ill or to need urgent specialist attention. It is, surely, the standard of care and attention that most of us would expect for ourselves.

8. **We do not therefore believe that the impact of Gartnavel not having an A & E Department (but having a minor injuries services and medical and surgical receiving) would have the 'flooding effect' on the GRI that some fear. Similarly the presence of a minor injuries unit at the Victoria would reduce the tendency for self-referrals from South-East Glasgow to drain into the GRI rather than going to the Southside in-patient centre\A & E.**

9. **However, the points raised by the A & E Sub-Committee about the GRI:**

   a. **being sure that the new GRI A & E Department is big enough;**
   b. **modelling how the GRI would cope with peaks and troughs in admission rates;**
   c. **traffic access;**

need to be worked through so that there can be confidence about these practical issues. We consider however, that these are consequential issues to be overcome by careful planning rather than fundamental strategic objections. We return to this point later in this section.

10. **During consultation comments were made about impact on the ambulance service.**

Currently the Ambulance Service is not meeting national (ORCON) standards which specify that for 50% of calls an ambulance should be on scene in 7 minutes (95% in 14 minutes). Figures produced by the Ambulance Service at the time the National Audit Office Report on the Scottish Ambulance Service was debated by the Audit Committee of the Scottish Parliament indicated that in September, 1999 the performance levels were:

Station	% in 7 minutes	% in 14 minutes
Central	33	89
South	34	92
East	37	94
West	26	91
Cowglen	23	90
Clydebank	37	91

Kirkintilloch *	45	95

*** Kirkintilloch is covered by a different ORCON standard since it is defined as a "Medium Population Density Area". Its standard is 50% within 8 minutes, 95% within 18 minutes.**

For the year 1999\2000 as a whole the average response time in Glasgow was 9.8 minutes (Source: Scottish Ambulance Service Annual Report for 1999\2000).

11. **Between April, 1999 and March, 2000, the Accident and Emergency demand for Greater Glasgow was:**

	Emergency Calls	Urgent Calls
GRI	19,223	5,340
Southern General	7,519	3,859
Victoria Infirmary	12,196	3,877
Western Infirmary	15,304	4,893
Stobhill	6,899	3,150
Others (Yorkhill, Maternity Units, Gartnavel etc)	9,090	4,679
	70,231	25,798

(Source: Scottish Ambulance Service)

"Emergency Calls" are 999 calls. "Urgent Calls" are made by GPs seeking urgent admission of their patients. However, GPs sometimes use 999 if they feel their patient's condition requires an immediate response from an ambulance.

(There were also 5,397 'Planned Journeys' – usually inter-hospital transfers, which would be significantly reduced by our proposals, thereby releasing some capacity. These reductions would arise due to the imminent transfer of plastics\burns services from Canniesburn to the GRI, the need for fewer transfers of head injury cases to the neurosciences unit at the Southern General\Southside Hospital – since more would go direct there in the first place – and the end of split-site working between the Western Infirmary and Gartnavel).

12. **The average daily shift coverage in Glasgow is shown in Annex 5. Illustrative peak time provision is 30 ambulances at 1400 hours, 32 at 1500 hours, 29 at 1600 hours, 24 at 2300 hours. The current average service time (receipt of call to the vehicle being clear for its next call) is 53.4 minutes per case.**
13. **There are currently approximately 200 A & E emergency crew staff in Greater Glasgow. More money is being invested in recruiting another 20 staff for emergency ambulance services for Glasgow which, together with improved operating arrangements, are planned to enable ORCON standards to be reached by 2002. In addition money is now being invested to ensure that every emergency vehicle has a trained para-medic on its crew by 2004 (Currently 28% of emergency crew staff are trained para-medics. The target is to achieve 55% - 60% of the workforce).**
14. **There is no doubt that having just two Accident and Emergency units in Glasgow will increase average ambulance service times to and from the two A & E units. However, the crucial measure of effective healthcare response is the time taken to reach the patient in the first place (the response time), not the subsequent running time in the ambulance nor the time taken to return to its local deployment position. In order to ensure that response times are not compromised, it will be necessary to invest in additional emergency ambulances. This is achievable within the timescale in which we envisage changes being made (i.e. the**

middle of the decade) and will be based on detailed modelling to be undertaken with the Ambulance Service during the next stages of planning. As a yardstick it should be noted that a 10% increase in ambulance crew staffing would cost around £500,000 per year.

15. **We recognise that many people still feel anxious about longer running times from scene\home to the nearest A & E. The following data supplied by the Scottish Ambulance Service puts this into context:**

From	To	Running time from location to hospital (minutes)
Easterhouse	GRI	14
Easterhouse	Stobhill	17
Kirkintilloch	Stobhill	21
Kirkintilloch	GRI	28
Anniesland	Western	11
Anniesland	Southern General	8
Anniesland	Gartnavel General	4
Duntocher	Western	26
Duntocher	Southern General	24
Mearns Castle	Victoria	22
Mearns Castle	Southern General	26
Castlemilk	Victoria	8
Castlemilk	Southern General	23
Govanhill	Victoria	6
Govanhill	Southern General	16
Govanhill	Cowglen	13

(Source: Scottish Ambulance Service. All times compiled between 10 a.m. – 12 noon on a routine weekday, except Duntocher, taken during rush hour). Test vehicles observed speed limits and traffic lights.

This data can also be put alongside a larger range of journey time data provided in Annex 7.

16. **What this data indicates is that running times of 20 to 26 minutes would be the worst case current experience of many ambulance-borne patients. In life or death circumstances, under blue light driving conditions, running times would be shorter than this. The pattern we proposed improves running times for patients coming from the north-west (if they were going to the Southern General rather than the Western Infirmary). The difference for such patients if there were an A & E unit at Gartnavel would only be advantageous by around 4 minutes, but running times from the North-West to Southern General remain better than they currently are to the Western Infirmary. For people in the Partick area who currently go to the Western, ambulance running time would be faster to the Southern General than to Gartnavel.**

Is emergency access through the Tunnel a problem?

Letter from Calum Kerr, Manager, West Central Division, Scottish Ambulance Service, 4 Maitland Street, Glasgow printed in The Herald on 11th August, 2000.

I have read a number of letters relating to problems which will be experienced by our Accident and Emergency crews while transporting patients to and from the proposed Accident and Emergency Department at Glasgow's Southern General Hospital, via the Clyde Tunnel.

We have raised the issue with the Tunnel Master. We are assured that one bore of the Tunnel will constantly be available for use. If the traffic lights are in operation, an approaching A & E unit would utilise a combination of hard shoulder and its run-off\slip-road areas to move to the front of the queue.

In addition to the CITRAC and NADICS signpost system, the Tunnel Operational staff will notify Ambulance Control of any possible delays, at the same time that the police are informed.

The Scottish Ambulance Service is discussing various implications of the proposals within the Acute

Services Review with Greater Glasgow NHS Board as an on-going basis.

17. For the Southside population if they were taken to the Southern General rather than to the Victoria Infirmary, ambulance running time would lengthen.

For example current journey times in non-blue light conditions are as follows:

	Minutes	
	SGH	Victoria
Shawlands	13.1	6.4
Cathcart	19.7	4.3
Clarkston	20.0	10.6
Giffnock	17.0	10.0
Gorbals	23.2	12.9
Castlemilk	23.0	8.4
Rutherglen	29.8	12.8
Govanhill	19.5	6.5

(These times are taken from Travel Time Study commissioned by the Glasgow Health Forum (South-East). However, the ambulance service has indicated that for some of these areas it would take 999 patients to the GRI rather than to the Southern General. The longer running times remain within the current experience of many GGNHSB residents (for example 21\28 minutes Kirkintilloch to Stobhill\GRI, 26 minutes Duntocher to Western Infirmary, 17 minutes Cambuslang to Victoria, 15 minutes Eaglesham to Victoria) and there is no evidence of adverse outcomes for such journeys. The key issue is response time to scene and then application of the ambulance crew's skills to stabilise the patient for their journey to hospital.

18. Some of the responses to consultation have quoted cases where people had had heart attacks and believed that survival would have been compromised by a longer ambulance running time. We addressed this issue specifically on page 6 of leaflet 5. Since then a study published in "Heart" by researchers from Glasgow University confirmed that there is a major problem of people having heart attacks putting off dialling 999 because they do not think they are ill enough. One fifth of 313 heart attack survivors had sought medical help within an hour but a fifth also delayed more than four hours and 12% waited 24 hours.

There is a major health education challenge here for the NHS – we must help people to recognise the signs of an incipient heart attack.

GGNHSB has recently published a loose-leaf booklet ("My Heart Book") which will be given to people diagnosed with angina (2,500 people are diagnosed with angina each year in Glasgow). It includes a wealth of practical advice in plain English, including what to do in an emergency.

19. **Other responses have raised the Ibrox football traffic issue but have not identified any new perspectives that we had not already addressed on pages 6 and 7 of leaflet 5.**
20. **A few people raised the implications for Major Disaster planning of having only two A & E Departments in the city rather than the present four. Major Disaster response basically involves:**
    a. **dispatching a medical and nursing team to the site to deal with site triage and unavoidable on-site treatment.**
    b. **spreading casualties among several hospitals so that the impact of numbers can be more readily absorbed (rather than over-burdening a single hospital).**
    c. **clearing space in out-patient areas so that assessment and treatment is not just concentrated in an A & E Department alone.**

In the event of a large Major Disaster we would expect all three Glasgow in-patient sites to play a part in the response and further back-up would be available from Paisley, Vale of Leven and Hairmyres. This is a normal arrangement in Major Disaster Planning.

21. **We need at this point in the analysis to return to the fundamental question of whether Glasgow should have two A & E units or three. In considering this we need to bear in mind that:**
    a. **the Minor Injuries component of the total service pattern will absorb a significant percentage of the current workload of existing A & E Departments.**
    b. **the presence of medical and surgical emergency receiving teams at the 'front door' of the hospital will deal with another significant proportion of the present workload of existing Accident and Emergency Departments.**
    c. **the key improvement we wish to make is for the A & E patients with moderate to serious injuries where prompt and direct management by A & E Consultants should be the gold standard of performance. There were around 800 of these recorded in the CRAG audit although the actual number is likely to be rather higher because for a part of the year of the audit data was not supplied from the GRI.**
    d. **in our leaflet on Doctors' Working Hours (leaflet 10) we showed a pattern of extended cover achievable with a team of five Consultants. The A & E Sub-Committee indicate that "a total of no less than 15 Consultants are required to manage the adult workload of the city " but go on to say "significant levels of out-of-hours cover cannot be provided with rotas of less than six Consultants".**

        We currently have 10 A & E consultants based on four sites.

22. **The key issue is of size and volume of the workload at the GRI. Annex 6 provides a model for estimating what this might be. Current total attendances at Glasgow A & E units (including Stobhill but excluding Yorkhill) total around 283,000 a year but many of these are GP referrals which should in future be dealt with by the emergency receiving teams of the specialties concerned.**

	GP referrals	% of total A & E Attendances
Victoria Infirmary	8,320	12
Southern General	6,136	15
Western Infirmary	12,012	22

GRI	8,892	13
Stobhill	8,944	20

(Source: Data extrapolated from 1998 one week survey)

A large number of children also attend adult A & E Departments. The Board is currently seeking views on whether all such children should be diverted to the Yorkhill A & E Department (or to primary care). Annex 6 provides a model for considering possible range of attendances in a two-site A & E model. In it children have been excluded on the assumption that they will be diverted to Yorkhill\primary care. One of the points arising in the debate is what to do about children who turn up to adult hospitals regardless of what "policy" might say. If the outcome of that debate is that some properly organised facility should be provided we would not want it at the GRI to be located within the large adult A & E Department itself. We would wish to see a separate facility elsewhere on the GRI site capable of dealing with any "walk-in, walk-out" children who did arrive at the GRI. We are currently working with Yorkhill to determine how its staffing and facilities could be strengthened so that it could deal with all ambulance-borne cases.

Of the other attendances a very large number will be minor injuries and will continue to go to the units at Stobhill, the Victoria and Gartnavel. At the Southside Hospital and GRI they would be triaged into separate minor injuries areas staffed by nurse practitioners. The 1998 one week survey showed that 25% of all attendances were for four common minor conditions (sprains, superficial injuries or cuts, abscesses and foreign body in the eye). These alone equated to around 76,000 attendances in a full year. The 1996 Audit Commission Report put cuts, bruises, grazes and sprains at 32% of all attendances. Definitive estimates for the future cannot be made until we have worked with A & E consultants to agree treatment protocols for conditions treatable in Minor Injuries Units but Annex 6 shows a model for gauging how the flows might change. It will require further refinement for the next stages of detailed planning but for the purposes of determining strategic direction it provides a sufficiently robust sensitivity analysis.

It suggests that depending on what assumptions are made about patients suitable for Minor Injuries treatment (a range of 33% of non-999 cases to 40% and 60% has been modelled) and how patients currently using the Victoria, Stobhill and Western might flow differently in future, the number of cases to be managed at the GRI ranges as follows:

	Scenarios				
	1	2	3	4	5
a. Minor Injuries Facility	12,300	14,900	22,300	12,300	22,300
b. Main A & E Facility	82,366	75,996	57,884	101,443	71,068
	94,666	90,896	80,184	113,743	93,368

The difference between the maximum and minimum on line (a) is 10,000 (27 patients a day). The difference between the maximum and minimum on line (b) is 43,559 (119 patients a day) but is accentuated by the extreme conservatism about Minor Injuries treatment rates in Scenario 4 (and hence the number of such cases treated at other hospitals) and its highly improbable assumption about in-flows from West Glasgow and parts of the South. We believe that the most likely outcome is between Scenarios 2 and 3.

23. **The new A & E Department at the GRI is being built for a capacity of 70,000 attendances. The Trust have confirmed that capacity can be increased to 90,000 by reorganisation within the design's contingency space and changes to operational policies. At the other end of the spectrum, the Trust have estimated that if capacity had to be expanded to accommodate up to 120,000 attendances it would entail re-examining the use of adjacent ground floor space**

by the plastic surgery out-patient services and relocating some of them. If the whole of the ground floor space (which would require total relocation of Plastic Surgery Out-patients, prosthetics and laser) were devoted to A & E\Minor Injuries it would provide 2,573 square metres, which would be enough to accommodate around 150,000 attendances. There is therefore a practical solution available which can be costed over the next two months.

24. **One "reality check" on this issue of sizing is to consider whether there are similar A & E Departments elsewhere:**

    a. **Edinburgh will have 1 A & E Department serving a population of over 440,000 in the city alone. It will be located on the extreme south-eastern edge of the city. Approximate number of attendances currently at the Edinburgh Royal Infirmary is 94,000.**
    b. **In England there are larger A & E Departments (of over 100,000 attendances and up to 130,000) in Leicester, Liverpool, London and Nottingham. There are also around 50 departments with over 75,000 attendances a year, many of which serve geographical areas at least as large as North Glasgow and South Glasgow. In Leicester, where the A & E is in the city centre, a current review is suggesting the creation of a number of Minor Injuries Units in the catchment area to improve accessibility and to reduce the pressure that large numbers of minor injuries\illnesses are having on the A & E Department at the Leicester Royal Infirmary.**

Experience suggests that what is crucial to the smooth running of these units is the quality of the leadership, strong consultant presence on the floor of the A & E, effective clinical triage and streaming of patients at the front door, adequate staff in support of the consultants and well designed sufficient space. These must be our ambition for Glasgow and in the next stages of detailed planning GGNHSB commits itself to investing in these requirements. We should also consider what scope there might be for establishing a minor injuries service in the East End as part of a programme to improve the accessibility of a wider range of healthcare needed for this area. We will need to discuss with local GPs and with A & E Consultants whether this should be seen as part of an extended primary care service or organisationally as part of the Glasgow-wide A & E\Minor Injuries Unit network. Such provision would further reduce the pressure placed on the GRI A & E Department.

25. **The other key consideration is staffing numbers and especially consultant numbers. The A & E Sub-Committee suggests no less than 6 consultants per site if a significant level of out-of-hours cover is to be provided. Our own leaflet 10 suggested no less than 5.**

    The difference between having two A & E units and three is therefore significant. Two units would require a maximum of 10 consultants (GGNHSB leaflet) and 12 consultants (A & E Sub-Committee). For three A & E units the comparable figures would be 15 or 18. This difference of 5 or 6 consultants equates to a gross employers' cost of around £400,000 per year in salaries alone. The cost of this service improvement is significant when put alongside other uses to which such money could be put.
26. **Nor can it be said that this extra cost of consultants with a three centre model would eliminate increased cost in ambulance services. A significant part of any extra ambulance cost arises from moving from two A & E Departments to one on the Southside – a proposal with which the vast majority of respondents agree.**
27. **Other cost differences between a two or three A & E solution can be summarised as follows:**

    a. **Senior House Officers (junior doctors) – three rotas rather than two.**
    b. **Nurse Practitioners – in overall terms probably no different except .....**
    c. **..... three units more expensive than two in staffing up for the quiet hours between 2 a.m. and 7 a.m.**
    d. **a three unit configuration would entail building a new unit at Gartnavel larger than what is needed for Minor Injuries and Emergency Receiving alone (although this may be balanced if there is a need under a two centre option, to enlarge capacity at the GRI).**

e. **three unit configuration means an impact on out-of-hours cover in other specialties in three hospitals whereas two site configuration means higher intensity but only in two sites rather than three. This is particularly significant for orthopaedics.**

Overall these factors add to the premium cost of a three centre model and thus further make the two centre model more cost effective.

28. So what conclusions do we draw from this analysis of the issues that have been raised?

a. **Firstly that Minor Injuries Units, staffed by nurse practitioners, working to protocols devised by A & E consultants, and supervised by them, have a valuable part to play in any future pattern because:**

• they will help to maximise local accessibility of services.

• they can provide good quality, responsive treatment with safe procedures for managing risk.

• they will stream less serious work away from the more serious cases, to the mutual benefit of both. Faster response for both and with different clinical skills being focused on what they are most suited for.

• they will reduce the volume of people attending the A & E Departments themselves.

b. **Secondly that we should continue to plan to concentrate A & E \Trauma Services into two units rather than three, because a three centre configuration is less cost effective in terms of the benefits in improved patient care that we are determined to achieve and resources. This is a very real consideration bearing in mind the many other improvements we want to see in acute hospital service provision which will also cost significant amounts of extra money. We are willing to invest to achieve two "gold standard" A & E units but resourcing three at that level is not a choice we regard as a priority.**

c. **Thirdly that with the GRI being one of the two units, the other would be better placed at the Southern General than either Gartnavel (there would be no unit in the south, and Gartnavel has minimal time advantage over the Southern General for the north-west population) or Cowglen (poorer access from the north-west, only marginal advantage in ambulance running time for patients from many parts of the south, worse running times for Southside patients living in Govan, Drumoyne, Hillington, Cardonald and parts of Renfrew).**

d. **Fourthly, however, that the issues raised by the A & E Sub-Committee about the capacity of the new GRI unit should be explored during the next two months before any final conclusion is reached.**

e. **Detailed planning would pick up the issues of strengthening the resources of the ambulance service so that the impact of overall longer service times could be absorbed without detriment to response times.**

f. **We should look more closely at the needs of those Social Inclusion Partnership communities most distant from the proposed pattern of A & E \ Minor Injuries Units. We must aim to improve access to service for the large numbers of people (including children) with very minor conditions for whom the skills of extended primary care teams (with or without minor injuries service nurse practitioner support) are most appropriate. This may require us to invest more money in places such as the East End, Drumchapel, Clydebank, Castlemilk, Rutherglen\Cambuslang and Kirkintilloch.**

Assuming that the fourth point can be satisfactorily resolved the pattern would therefore be:

• major A & E Departments at the GRI and the Southside hospital.

• Minor Injuries Units at GRI, Southside Hospital, Gartnavel, Stobhill, Victoria Infirmary.

We would also commence work to plan development of more accessible local healthcare provision, including for minor conditions, for the East End, Rutherglen, Cambuslang, Castlemilk, Drumchapel and Clydebank and Kirkintilloch.

. ACCESS, PUBLIC TRANSPORT AND TRAFFIC IMPACT

1. These issues were the foundation of more comment in the consultation than anything else.
2. GGNHSB's proposal to have stand-alone **Ambulatory Care Centres and associated Minor Injuries Units** at the Victoria Infirmary and at Stobhill was intended precisely to address the issue of local accessibility. In all the debate, virtually nobody has acknowledged this feature and its significance. It is, therefore worth repeating:

	(a)	(b)	(c)	
	Present total patient encounters\ episodes per year	Future	Number affected by change of service location	%
Victoria Infirmary	393,000	316,500	76,500	19.5
Stobhill	324,747	287,537	37,210	11.5

These figures were derived from the 1998\99 Blue Book. Column (a) shows all in-patients, day surgery cases, out-patients (consultant clinics, physio and other therapies, hearing aids, out-patient, diagnostic services), A & E attendances and day patients. Column (b) assumes day surgery cases, out-patients, day patients and estimated adult attendances at the local Minor Injuries Unit at the rate of 60% - see Scenarios 5 and 6 in Annex 6. Of the other 40% of A & E attendances who go to main A & E Departments at GRI or Southern General / Cowglen, many of those will 'walk-in, walk-out' on the same day.

Of the numbers in column (c), approximately 40% at the Victoria (around 30,500) are in-patients. At Stobhill the figure is around 75% (28,000 in-patients). Many of these will be emergency admissions, taken to hospital by ambulance. For them, ease of access for themselves is not an issue.

Our proposals therefore offer state-of-the art modern facilities at the Victoria Infirmary and Stobhill with no change in accessibility for a massive number of over 700,000 attendances. The number of patients from these two hospitals affected by change adds up to around 114,000 by contrast. This is not to dismiss the issue of access but it does need to be put in context.

3. **The impact of our proposals in West Glasgow has attracted relatively little comment other than in relation to Accident and Emergency services (see Section 5) and orthopaedics . In fact, with the exception of the population clustered immediately around the Western Infirmary the transfer of services to Gartnavel (or to the Southern General if that becomes the chosen option for South Glasgow) makes access to hospital services easier for most of the West Glasgow catchment population.**
4. **What has come out loud and clear from the consultation is that public transport access, road congestion and car parking are seen as problems here and now. Even if we were not proposing change in hospital configuration these are issues that would need to be addressed. The concerns that have been identified are as follows:**

	Action needed
a) Car parking at GRI	Implement multi-story car park as required by planning consent for the Maternity\Plastic Surgery\Emergency Receiving Scheme currently under construction.
b) Traffic congestion at Townhead (affecting GRI)	Mostly outside the influence of the NHS, but re-orientation of more of GRI's services along Alexandra Parade will mean that the problems of Castle Street are not added to. Completion of the M74 in the strategic planning period would take pressure off the M8.
c) On-site access for A & E at GRI	Detailed planning issue that the Trust must resolve. There is scope to do so.
d) Bus routes to GRI from East Glasgow	These are seen as poor at some times of the day. The Trust need to explore this issue with the bus companies. GGNHSB also needs to explore whether the creation of a more locally accessible healthcare facility in the East End offering a range of diagnostic and therapy services and a Minor Injuries Unit is feasible. This would improve access to services for this population and reduce some of the traffic pressure local to the GRI.
e) Car parking at Gartnavel	The Trust acknowledges this needs to be addressed in the next stages of site development planning. This issue emphasises the importance of not overloading the Gartnavel site with services transferred from elsewhere.
f) Access from Hyndland Station to Gartnavel	Strathclyde Passenger Transport Executive intend to make the station easier to use for people with restricted mobility. The Trust need to review access from the station to the hospital for such people and improve where necessary.
g) Making Gartnavel site more attractive for bus routes to come on site	Trust to consider at the next stage of planning. Strathclyde PTE can offer advice as to what is needed.
h) Traffic densities at Gartnavel.	Identified as an issue to be addressed in finalising the whole site development plan (including mental health services). The Trust need to work with the City Council and local residents in addressing this. Access onto the Great Western Road will be a central focus of this work.
i) Car parking at Southern General	An issue often quoted by opponents of the Southern General Hospital option. Yet the hospital, like Stobhill, currently has the best parking provision of any hospital in Glasgow and there are as many anecdotes about

	absolute ease of parking as there are difficulties. It is possible that the issue is one of needing improved sign-posting on site and advance information for patients and visitors – people may currently be experiencing localised difficulty on site and not realising that there is plenty of space elsewhere. For the future, if the hospital is the site of the new Southside Hospital, it would have plenty of space for car parking.
j) Congestion through the Clyde Tunnel affecting road access to the Southern General	Liaison between tunnel management and the ambulance services ensures that this is not a problem for emergency ambulance access. At most times traffic flows smoothly, with the tunnel being no more prone to blockage or congestion than surface roads in the conurbation. When traffic is congested driver\passenger perceptions of delay often feel much greater than the actuality measured in minutes of delay.
k) Bus access onto the Southern General site	Some buses already go onto the Southern General site. The Trust need to explore with Strathclyde PTE and the bus companies the scope for an increase in routing through the site, especially where it can result in people not having to use the unpopular pedestrian underpass at Drumoyne.
l) Bus routes to the Southern General	This issue is considered more fully below.
m) Car parking at the Victoria Infirmary	There is virtually none available at present. Redevelopment of the site owned by the Trust to build an Ambulatory Care Centre will include car parking – a significant improvement on the present position.

a. Some responses to the consultation have complained that our proposals have not been underpinned by detailed Traffic Impact Analysis. This will certainly need to be done at the next stage of detailed planning and discussed with City Council planners. However, such analyses are costly to undertake and we did not feel that expense could be justified until there was clarity about strategic service direction.

b. However, there are some observations that can be made on this issue at this stage:

- **a. predictions of future traffic levels and their relationship to road capacity are fraught with uncertainties depending on:**
  - **b. what improvements are made in public transport (now an explicit UK government priority).**
  - **c. increases in car ownership.**
  - **d. economic, retail, leisure and housing developments (such as Braehead, Pacific Quay, Drumchapel New Neighbourhood, Clyde Port Authority granaries).**
  - **e. investment in new roads (e.g. M74 extension; Glasgow Southern Orbital).**
- **f. by proposing Ambulatory Care Centres at Stobhill and the Victoria Infirmary we are creating less change in current traffic patterns than would be the case if we adopted the three hospitals option preferred by the Area Medical Committee for example (GRI, Gartnavel and Southside).**
- **g. moving the Southern General's in-patient and A & E services to the Victoria Infirmary would have a significantly adverse traffic impact in an area where there is little spare capacity on the existing road network and little opportunity to substantially improve it.**

h. **the prospect of increased traffic impact at Gartnavel is unavoidable unless we continue its present split-site working with the Western (clinically unacceptable) or closed it altogether, redistributing its services onto other sites altogether. We say more about this in Section 7.**
i. **much has been made of traffic impact in concentrating more in-patient services at the Southern General but it has more local manoeuvrability in choice of road access than most other hospitals:**

Gartnavel	Great Western Road only. (Access off Crow Road is not supported by City Planners or local residents).
GRI	Castle Street from the east and south Wishart Street from the south Alexandra Parade from the east and north.
Victoria	The Langside Road, Battlefield Road, Grange Road tight triangle at the junction of busy east / west, north\south through routes.
Stobhill	Stobhill Road (narrow residential street), Belmont Road from Balgrayhill Road, back entrance of Balornock Road
Southern General	Served by a "box of roads" giving flexible local choices (Govan Road, Renfrew Road, Shieldhall Road, Hardgate Road, Moss Road). Beyond that there are other choices of approach involving Edmiston Road into Shieldhall Road, M8 into Moss Road, Berryknowes Road from Paisley Road to Moss Road. These choices offer opportunities for spreading traffic impact.

7. **One of the most valuable contributions to debate in the consultation period was a "Southside Hospital Travel Time Study" commissioned from Mr. A.W. Drewette, a Consulting Traffic and Transportation Engineer by the Health Forum (South East). This is attached at Annex 7. Mr. Drewette's study contains much useful information. Unfortunately the brief he was given limits the full value of his study because several relevant factors were omitted:**

   a. **the significance of patient access southwards for some residents in the west of Glasgow north of the river (e.g. for A & E, maternity, gynaecology, orthopaedic services).**
   b. **the options of access to GRI or Hairmyres for people in Rutherglen and Cambuslang.**
   c. **non-GGNHSB residents in Renfrewshire who use the Southern General.**

8. **Nevertheless Mr. Drewette's report is helpful because it demonstrates the application of accepted strategic transport models. Mr. Drewette is also scrupulous to point out that his modelling would be affected by future changes in public transport, car usage and road capacity.**
9. **In the debate about access to Cowglen versus Southern General, Mr. Drewette's report (his Table 1) is very helpful in providing insights at the individual patient\visitor level.**

   It demonstrates how accessible the Victoria Infirmary site is to such a large proportion of the Southside population by both car and public transport. However, as we explain later in Section 11, we do not regard the creation of a new Southside Hospital on the Victoria Infirmary campus as a viable option.

10. **We therefore need to examine Mr. Drewette's Table 1 to see what light it casts on the significance of access to the choice between Southern General and Cowglen.**
11. **Taking public transport we need to consider first the needs of in-patients. Many of them will have been taken to hospital by ambulance.**

For example, over 10,000 of the Victoria Infirmary's 29,000 in-patient admissions were in general medicine and the majority of them will have been taken by ambulance. This is corroborated by the one week survey of A & E attendances in 1998 which suggest that on an annual basis around 8,320 GP referrals are conveyed to the Victoria Infirmary by A & E\urgent ambulance. The total number of A & E\urgent ambulance journeys to the hospital in 1999\2000 was just over 16,000 (Ambulance Service data). Not all of these would have been admitted as in-patients but a large proportion would have. If, say, of the hospital's 29,000 in-patients just under half were conveyed by ambulance, the other 15,000 to 17,000 would have come in by other means. With family, friends and neighbours rallying round in a time of need, and with a not insignificant proportion of the population able to afford taxis, it is difficult to see how in-patients using public transport to go to the Victoria Infirmary would be more than about 20 to 25 people a day (7,300 to 9,000 people a year).

12. **The larger need arises from patients' visitors. Mr. Drewette's report suggests that each patient might have 5 sets of visitors per day (3 sets travelling by car or taxi, 2 sets travelling by public transport). We have no separate survey data to confirm or vary this assumption. Arguably as an average it might be on the high side but is certainly helpful for modelling purposes. Mr. Drewette's analysis of the travel implications of this pattern is flawed slightly since he assumes 100% bed occupancy whereas 80% to 85% is probably a more realistic average figure.**

Mr. Drewette converts his calculations into assessments of additional traffic vehicle kilometres travelled and total person hours spent on public transport per day. Without seeing the detail underneath the calculations it is not possible to gain a picture of what his global figures mean in terms of individual people's experience. However, taking his own assumptions about visiting rates, public transport users, bed numbers (but corrected to an 85% occupancy) and add a further assumption of 2 visitors per set of visitors, we can estimate that if the beds at the Victoria were re-located (to the Southern General or to Cowglen) the number of visitors using public transport would be:

	2	sets of visitors using public transport
X	2	visitors per set
X	2	2 journeys per visit (i.e. there and back)
X	485	(85% occupancy of 570 beds)
	3,880	visitor journeys per day by public transport, principally from people living in the current Victoria Infirmary catchment area.

(If one felt that Mr. Drewette's estimate were too high and that each patient might get only one visitation per day using public transport, with an average of one and a half visitors per visitation, the figure would be:

	1	visitation per day
X	1.5	visitors per day
X	2	2 journeys each (there and back)
X	485	beds occupied
	1,455	visitor journeys by public transport per day.

This demonstrates that the global totals are very susceptible to only very slight changes in assumptions about number of visitations, numbers of visitors and mode of transport.

It is also the case that Mr. Drewette's analysis does not take into account the easing of patients' visitors' travel times resulting from our proposal to provide 120 rehabilitation beds at the Victoria Infirmary site. This would benefit precisely those people who have been expressing the most personal concern about this issue.

13. **So, what are the implications of the choice between Cowglen and Southern General in terms of public transport access? Mr. Drewette's Table A shows the following profile of respective advantage in public transport times at off-peak (when most patient visitors will be travelling):**

Cowglen advantageous compared with Southern General by: (minutes)

Mansewood	34.9
Thornliebank	29.0
Shawlands	28.8
Rouken Glen	21.9
Priesthill	21.8
Crookfur	21.8
Croftfoot	20.0
Govanhill	19.2
Pollokshields	13.3
Pollok	13.2
Cambuslang	12.3
Eaglesham	9.8
Burnside	9.4
Giffnock	8.6
Crookston	8.2
Mosspark	6.8
Castlemilk	6.7
Carmunnock	6.7 *
Oatlands	5.8
Rutherglen	5.6 *
Busby	4.5
Craigton	Equal *
Cathcart	2.1 SGH advantage over Cowglen
Hillington	2.9
Clarkston	3.6
Gorbals	5.5
Netherlee	7.1
Toryglen	8.3

Kirkhill (Newton Mearns)	8.3
Cardonald	8.4
Ibrox	14.7
Kingston	15.8
Drumoyne	23.6
Govan	26.9

*** For these places SGH is advantageous during peak hour travel by public transport.**

This analysis shows us that for 19 of the 34 places the difference in public transport time is 10 minutes per journey or less. Moreover in commissioning Mr. Drewette's report the Health Forum (South-East) omitted to ask him to include Renfrew and Dean Park in his analysis nor any flows from north of the river or further afield (where access via the Underground and shuttle bus link from Govan station to the Southern General would be relevant).

14. **It is worth taking a sideways look at the travel times by car columns in Mr. Drewette's Table 1. They suggest, for example, that the slow public transport access from places like Mansewood, parts of Pollok, Pollokshields, Shawlands and Thornliebank is not caused intrinsically by distance or road travel time but by bus frequencies and\or routing. Most if not all of these problems should be amenable to negotiation with the bus companies or by the development of dedicated shuttle bus routes to which we have already committed ourselves.**

At an individual public transport user level therefore we do not consider that the public transport issue is a differentiator between the Southern General and Cowglen.

- **For 19 of the 34 places the difference is 10 minutes per journey or less.**
- **In both cases public transport would need to be improved.**
- **In both cases most of the more onerous differences can be resolved by the development of express shuttle buses.**
- **In both cases, the 120 rehabilitation beds and the Ambulatory Care Centre at the Victoria Infirmary means that public transport access for the vast majority of people, especially the elderly, is no different from what it is now.**

15. **We must turn now to the question of road access and travel times by car (or taxi). Again Mr. Drewette's Table 1 is a helpful source of information. It shows, for example, that the Victoria Infirmary has the shortest travel times by car for 17 of the 34 places, while Cowglen has the shortest travel time for 10 places and Southern General 6. Crookston is equidistant in travel time to both Cowglen and the Southern General.**

In understanding travel time as a differentiator between options for the future we need to look at the pattern of advantage between the Southern General and Cowglen. At off-peak times (which is when most patient visitors will be travelling) the profile is as follows:

<u>Cowglen advantageous compared with Southern General by</u>: (minutes)

Thornliebank	10.3
Mansewood	9.8
Giffnock	9.8
Netherlee	9.7
Cathcart	9.6
Croftfoot	9.5
Burnside	9.5
Rutherglen	8.5
Rouken Glen	8.4
Eaglesham	8.4
Clarkston	8.4
Carmunnock	8.4
Busby	8.4
Castlemilk	8.3
Kirkhill (Newton Mearns)	8.3
Crookfur	8.1
Priesthill	7.5
Toryglen	6.5
Shawlands	6.3
Cambuslang	5.7
Pollok	5.3
Govanhill	4.5
Oatlands	3.7
Mosspark	3.1
Pollokshields	2.4
Gorbals	1.8
Kingston	1.5
Crookston	Equal
Craigton	0.8 SGH advantage over Cowglen
Cardonald	1.9
Ibrox	2.3
Hillington	3.1
Govan	3.7
Drumoyne	4.0

Cowglen clearly has the balance of advantage. At what point might such differences become truly decisive at an individual driver\passenger level? At less than five minutes? At eight minutes? The maximum travel time given by Mr. Drewette in his Table A is 30 minutes from Burnside and from Cambuslang to the Southern General. (From each of these two places the alternative travel time to Cowglen is 20.6 minutes and 23.9 minutes respectively).

> **Thus the debate about the impact of access time for car\taxi users is contained within an envelope of 30 minutes of maximum actual travel time where the difference between the two options is six minutes or less for 15 of the 34 places. for another 12 of the 34 places, the difference is less than 9 minutes.**

16. **The question of what significance to place on individuals' feelings about differences in travel times, whether by public transport or by car\taxi is fraught with subjectivity. For some people an extra ten minutes is onerous; others regard it as inconsequential. Mr. Drewette's Report quite correctly seeks to address this issue by converting it into an economic analysis (see Section 7 of his report).**

As we have pointed out Mr. Drewette's analysis has some important drawbacks. It is based on 100% occupancy rather than 80-85%; it is highly susceptible to variations in the number of visitations to patients and the number of visitors per visitation; it will be influenced by the pattern of origin of journeys, which will not be of equal density or mode of transport from all 34 places, it ignores patient (and visitor flows) from Renfrew and from north of the river and it ignores the significance of maintaining 120 rehabilitation beds at the Victoria Infirmary site.

16. **However, the analysis is still helpful in giving some sense of how wider economic considerations might look alongside the differences in cost to the NHS. Mr. Drewette suggests that the comparison of the two options would be (as discounted costs over 30 years):**

	£M	£M
	SGH option	Cowglen Option
Additional travel time costs	72.0	32.1
Additional vehicle operating costs	5.9	1.2
Additional accident costs	7.6	1.6
	85.5	34.9

This needs to be seen against the difference in costs to the NHS. Compared with the present cost of hospital services in the Southside we estimated (see leaflet 16) that the Southern General option would cost us £11 million a year more whereas the Cowglen option would cost around £18 million a year more.

If that difference is discounted over 30 years at 6% in exactly the same way as Mr. Drewette's calculation the additional service cost of the Southern General over 30 years would be £151.4 million whilst that of Cowglen would be £247.7 million. Putting Mr. Drewette's transport-related 30 year cost alongside the equivalent 30 year calculation for NHS cost results in the following:

	Net Present Value at 6% over 30 years	
	Southern General	Cowglen
	£m	£m
Transport	85.5	34.9

Change in hospital running costs	151.4	247.7
TOTAL	236.9	282.6

The Southern General Hospital has a net economic advantage (when measured on transport and hospital running costs) of £45.7 million. This advantage would be even greater when the flaws in Mr. Drewette's analysis are taken into account (see earlier in this paragraph).

17. There is one final issue concerning access which has emerged from the consultation period. It concerns access to services for six areas each of which has not only significant problems of deprivation, social exclusion and poor health status but also difficulties with access to hospital services already – the East End, Rutherglen, Cambuslang, Castlemilk, Drumchapel and Clydebank and Kirkintilloch.

In each case there are already problems of access to services, including limitations in public transport (frequencies, routing and the cost of journeys involving more than one bus or bus\train combinations). Although GGNHSB cannot resolve all the problems of public transport in the Glasgow conurbation we can alleviate the access problem in three ways:

a. firstly by subsidising or stimulating some hospital shuttle buses from key points.
b. secondly by exploring scope to increase Community Transport Schemes. We understand that in London the Camden Community Transport Scheme has one hundred vehicles and one hundred and fifty staff, providing non-emergency patient transport to Barts, the Royal Free, Chase Farm Hospital and Enfield Community Trust. There are already community transport schemes in Greater Glasgow but they are usually localised, sometimes specialising on particular specialist purposes. There may be scope in Greater Glasgow to strengthen the capacity of community transport.
c. secondly by strengthening local health services. This is most likely through working with Local Health Care Co-operatives and the Primary Care Trust to extend the range and quality of local primary care. Although these would not result in services on the scale proposed for the Ambulatory Care Centres at Stobhill and the Victoria Infirmary they would make a significant contribution to achieving easier local access to a wider range of healthcare and reduce pressure on waiting times elsewhere in the Glasgow NHS. GGNHSB commits itself to exploring these potentials with LHCCs, NHS Trusts, Social Inclusion Partnerships and local authorities.

We think it is highly likely that this work will also be relevant to other Social Inclusion Partnership areas such as Gorbals, Glasgow North and Pollok and we intend to explore the issues with them in the light of what we learn from discussion with the other SIPs.

. POPULATION CHANGE, CROSS-BOUNDARY FLOWS AND WIDER PLANNING CHOICES

1. Some commentators have said that they regard future population changes as an important issue which we had not adequately addressed.

2. There are several features to consider:

    b. overall change in population numbers and age structures.
    c. changes in flows of patients across Health Board boundaries.

3. The GGNHSB population profile for the future is expected to decline although the rate of decline is susceptible to two relatively new factors:

    a. a concerted effort by the Glasgow Alliance to reduce decline through the creation of New Neighbourhoods (at Drumchapel and Ruchill) and a continuing improvement in housing and infrastructure.
    b. the expectation that Glasgow will be home for several thousand asylum seekers.

The Government population prediction used by the Arbuthnott Report in its calculations of funding used a 1994-based population projection which showed Greater Glasgow having a population of 893,000 in the year 2000, declining to 852,000 by 2010, a decline of 41,000 (or 4.6%). One might expect that due to the new factors referred to earlier the rate of decline might be rather slower.

4. Age structure has a particular impact on planning services for children, adolescents and the elderly, although in Greater Glasgow as much attention has to be given to its locally distinctive health status and patterns of illness. The impact of deprivation and social inclusion worsens many adults' health much earlier in their lives than elsewhere.

5. The impact of the scale of expected population change is marginal at the level of our strategic planning. It does not affect:

    - how many hospitals there should be.
    - how many Accident and Emergency Departments there should be.
    - the concept of Ambulatory Care Centres.

    It will affect the number of beds provided, and that will need to be picked up by Trusts at the next stage of Outline Business Case planning. Even so, population change is only one factor in determining bed numbers – as we see in the next section of this paper.

6. As far as changes in flows of patients are concerned, we are already aware that Lanarkshire Health Board wish to see some changes affecting their residents. Discussions with Lanarkshire Health Board and the acute hospital Trusts concerned are still underway but it is anticipated that over a three year period from 2001\2 there will be fewer patients coming to Glasgow hospitals from the Cumbernauld, Wishaw, East Kilbride, Hamilton and Monklands areas. These changes have been translated into estimated numbers of cases.

7. In advance of definitive agreement being reached we cannot be precise about impact, but it might help to illustrate the impact by reference to a range of specialties affected. The numbers that follow are illustrative only:

In year one 2,200 fewer cases to North Glasgow, 1,100 fewer to South.
In year two 3,400 fewer cases to North Glasgow.
In year three 2,400 fewer cases to North Glasgow.

8. The impact on bed requirements depends on the mix between in-patient cases and day cases (which is not yet clear). If this followed the normal current ratio of cases to in-patient (1 : 3), then 1,100 fewer patients in South Glasgow might equate to 275 day cases, 825 in-patients. If those in-patients had average lengths of stay of as much as 5 days (which is relatively high), that equates to 4,125 bed days or around 13 beds at 85% occupancy. Clearly the potential impact is higher in North Glasgow, where a similar illustrative calculation results in an impact of some 96 beds (at a 5 day average length of stay). Clearly if the ratio of day cases to in-patient care is different or length of stay were less than 5 days – which is likely – then the impact on bed numbers is likely to be less than this.

9. What is more problematic is the loss of income from Lanarkshire. Because the bed numbers impact will be scattered in small numbers between different specialties and different hospitals it will be difficult for the Trusts to reduce their costs. This means prices to GGNHSB (mostly) and other Health Boards are likely to rise. The withdrawal of income is estimated at:

    2001\2 £2.2 million

    2002\3 £2.9 million

    2003\4 £3.9 million

    and the impact has to be factored into GGNHSB's financial planning.

10. Argyll and Clyde Health Board rightly draw attention to a more complex set of inter-relationships between their hospital services and those in Glasgow. For example, they point to the fact that a "modern healthcare facility (Royal Alexandra Hospital, Paisley) already exists a short distance from the Southern General and ..... this could present significant opportunity for improved working and modernisation across boundaries".

    The Chief Executive of GGNHSB has used several opportunities provided by Argyll and Clyde in the last two years to share thinking from within Greater Glasgow with a range of stakeholders in Argyll and Clyde. The Health Board response reflects the questions that have been raised on those occasions and provides a useful agenda for some further discussion both within the next two months and in the more detailed planning processes that lie beyond.

11. The dilemma of how to regard the potential roles of nearby hospitals such as the Royal Alexandra, Paisley; the Vale of Leven and Hairmyres has hovered uneasily through the process of reflection during the last two years. At one extreme one could say that South Glasgow does not need any new hospitals at all and that patients could argue either travel north of the river or outwards to the Royal Alexandra or Hairmyres. Both hospitals are modern and could be expanded if necessary. Yet this is not a strategy which Greater Glasgow NHS Board felt it could promote with any prospect of success even if it were minded to (which it was not).

12. We think the more fruitful line of approach is through encouraging collaboration between clinical teams, using the Managed Clinical Network approach as a model. It is highly likely that problems such as single-handed specialists, or gaps in specialist services, or conforming to to-day's requirements on doctors' working hours, would look very different when viewed from the perspective of having larger clinical teams, telemedicine links, electronic records and joint clinical policies. We think this is the way forward; not hospital closures nor the loss of particular clinical specialties from their local access.

8. BED NUMBERS

1. In our original consultation material we went to some lengths to explain why "bed numbers" has been such a source of hot debate for so many years and why trying to predict requirements for the future is difficult. We referred to trends that might continue to reduce beds (decline in population, new clinical techniques etc) and trends that might increase them (more elderly people in the population, for example).
2. We wished to be cautious in our approach – using the phased approach to the implementing the strategy during the decade to take stock of bed requirements half way through the programme of change.
3. We published two different projections for bed requirements. One showed the position if demand in general medicine continued to grow (at a rate of 5% by 2005) while requirement for beds in other specialties remained unchanged in that period due to continuing reduction in length of stay and increases in day surgery. The other assumed 2% growth in all specialties by 2005.
4. Regrettably the calculations we had done for us made an error in the way they calculated the average length of stay of remaining in-patients after applying the assumption that all current zero, one and two day stay in-patients would in future be treated on a day case basis.
5. Some of the assumptions in the model were also queried:

    a. our model assumed 85% occupancy; clinicians feel 80% makes it easier to manage peaks in demand.
    b. the assumption that all zero, one and two day stay in-patients would in future be day cases was felt by clinicians to be over-ambitious.
    c. the variant that assumed no increase in demand impacting on bed requirements in surgery was queried, although no statistically argued alternative hypothesis was put forward.

6. Clearly we would wish to correct the statistical error but a meaningful agreed bed model cannot be finalised until there has been further discussion with clinicians about:

    a. legitimate scope for increased rates of day surgery (we are below national case-mix adjusted benchmarks in a number of specialties).
    b. an analytical approach to verifying different bed occupancy rates against their capacity to absorb peaks in demand in large or small pools of beds.
    c. bed requirements to deal with medical emergency admissions (for the immediate future we shall be increasing medical bed numbers this winter – 2000\1).

1. As an example of the range within which this work now needs to be done, the Table below shows:

    a. the current number of beds in the North Glasgow Trust.
    b. the (arithmetically flawed) number suggested by ISD.
    c. figures suggested in recent discussions with North Glasgow clinicians.

Specialty	Current beds	ISD	Trust Clinical
ENT	32	8	24
General Surgery	373	263	350
Ophthalmology	22	6	16
Urology	82	41	79
ITU	17	17	17
Cardiology	103	66	95
Clinical Haematology	26	24	27
Communicable Disease	32	24	20
Dermatology	20	6	18
Gastroenterology		8	3
General Medicine (inc. Resp\Haem)	417	504	513
Homoeopathy	15	15	15
Nephrology	61	62	73
Respiratory Medicine	90	69	89
Rheumatology	39	38	33
A & E	22	0	0
Orthopaedics	172	122	158
Plastics	76	42	70
Burns	22	15	15
Oncology	141	130	130
Gynaecology	75	32	30
Cardiothoracic	94	94	94
Geriatric Assessment	194	194	194
TOTAL	2125	1792	2051

8. **In part the relevance of this work becomes clear at the Outline Business Case stage of planning. At our present stage of strategic planning, the significance impacts on overall**

affordability. Other factors impact on affordability too, such as the capital charges of new buildings or the speed with which we procure new buildings. Work is in hand to refine these affordability profiles during the next few weeks.

9. THE FINANCIAL POSITION AND AFFORDABILITY

1. In our original consultation we made the point that GGNHSB was willing to invest significantly more revenue into acute services in order to pay the higher capital changes for modern buildings replacing heavily depreciated old buildings. For the Southside alone we were willing to invest an extra £11 million per year for new buildings that would offer a greatly improved patient experience. We also envisaged increased revenue costs in North Glasgow but not on the same scale (see leaflet 15).

2. In considering options for the Southside we estimated that the Cowglen option would cost an extra £18.4 million in revenue per year (see leaflet 16). The difference between this and the option of replacing the old Southern General Hospital buildings is around £7.3 million. We expressed the opinion that this opportunity cost of £7.3 million was too high a price to pay for having bricks and mortar in place A rather than place B. We pointed out that £7.3 million would pay for better primary care, shorter waiting times, better rehabilitation services, more effective treatment for addictions, better services for children, more district nurses. £7.3 million would pay for around 350 front-line health care staff (nurses, physios etc). We felt using money these ways would be significantly more in the interest of people's health and quality of service.

3. It was disappointing that the responses to the consultation have almost universally ignored this fundamental issue of choice which has a real impact on what care can be provided for vulnerable people.

The majority of responses have had the tone of demanding that the extra cost of the Cowglen option be met and if necessary GGNHSB should demand that the Scottish Executive simply provide the extra money. This displays a lack of recognition that Health Board revenue funding is essentially formula-driven.

4. One major development since the consultation began has been the UK Chancellor's March budget and his announcement of significant additional funding for the NHS. We have reviewed the financial prospects for this decade in the light of that announcement. We have also taken stock of known financial pressures and the implications of the government's challenge to the NHS that extra funding must secure a transformation in the NHS's responsiveness and quality – drastically shorter waiting times, for example.

5. The money allocated to Health Boards is shared between them on a formula basis. The Arbuthnott Report published in 1999 has been subject to consultation and has recently published revised proposals. These are currently being considered by the Minister. The Arbuthnott revised proposals include an illustrative projection of what GGNHSB's allocations might be over the period up to and including 2003\4. In developing a financial framework we have used that illustration but must await Ministerial announcements before we can confirm the framework.

6. Our financial framework allows some sense to be made of what money is likely to be available for particular types of service development. The model has several features:

    a. its baseline is the current position for 2000\1. It does not yet include any of the "Tobacco Tax" money (£26 million nationally) that the Minister has earmarked for a "Public Health Fund". Some of it is being used for national projects but around £13 million is flowing through to Health Boards. GGNHSB's share varies year from year but is around £2.5 million per year – to be used on local public health initiatives, over half of which will have been specified nationally by the Minister. Nor does this baseline include any

additional money that might possibly be allocated to GGNHSB later in 2000\1 as a first step in moving us towards our new Arbuthnott target.

b. its baseline includes GMS cash limited funds, ACT Research funding, GP out of hours, HIV\AIDS, and distinction awards funding which were not included in the baseline given in the most recent Arbuthnott Report "illustration".

c. the model incorporates a comparison of current spending with the service programme component originally developed by Arbuthnott in building up the new national formula in his review group's first report. Since we do not yet know what revisions have been made to the Arbuthnott formula following the national exercise of consultation and further work this comparison is subject to revision. However, what it shows is this:

Programme area	Current spending 2000\1 £m	Current GGNHSB Spending (%)	Target population in Arbuthnott Formula (%)	Comment
Acute services	347.6	56.77%	53.43%	GGNHSB currently spending more on acute services than the Arbuthnott share suggests.
Mental Health	81.1	13.57%	17.38%	GGNHSB spending below what Arbuthnott share suggests.
Community Health Services	80.2	13.10%	9.96%	GGNHSB spending above what Arbuthnott share suggests, but this element of the Arbuthnott formula was the one subject to the most adverse criticism (i.e. in underestimating the Community Health Service needs and costs elements within the formula).
Maternity Services	27.6	4.51%	4.67%	No increase\decrease indicated, but present spending in Glasgow on maternity services is unbalanced between hospital delivery services and pre and post-natal care, with the balance threatening to worsen unless we reduce from three delivery units to two in line with falling birth numbers.
Learning Disabilities	38.7	6.32%	6.38%	No increase\decrease indicated on a formula basis. Existing JCCP agreements see fundamental re-shaping of services (including resource transfer to local authorities) as part of the plans to close Lennox Castle, RSNH and similar hospitals in Lanarkshire.

Geriatric Long Stay	35.0	5.72%	8.18%	Issues of definition arise here. The Arbuthnott category "geriatric long stay" cannot be seen in isolation from the pattern of complementary services for the elderly in acute hospitals and community health services. Glasgow currently has a relatively high level of hospital continuing care provision for the elderly.

It should be noted that the Arbuthnott formula does not have a separate programme element for children. In terms of using these comparisons to guide future investment choices in service delivery it makes sense to form three aggregations:

	2000\1 spend £m	**Current GGNHSB proportion**	**Arbuthnott**	**Difference £m**
• Acute services	347.6	56.77%	53.43 %	-20.5
• Mental health	83.1	13.57%	17.38 %	+23.3
• Other programmes	181.5	29.66%	29.19%	- 2.8
	612.2	100.00%	100.00%	0

Such an aggregation will allow flexibility in the 'Other Programmes' category in developing primary care community health responses to children, elderly people, people with physical or learning disabilities, problems of addiction and building capacity for healthy living in deprived communities. These areas of need would mainly be met from the 'Other Services' category. The cost of children's hospital services is currently reflected in the Acute Services category and would therefore access some development money through it. Similarly some (but not all) elements of addiction services are reflected in the cost of Mental Health Services.

d. the model provides for the funding of pay and price inflation at a level above the GDP deflator, which reflects the experience of recent years. Thus in 2001\2 the GGNHSB allocation is expected to increase by £49.4 million, of which £18 million will be earmarked to cover the costs of inflation in hospital and community services and £12.2 million for inflation in the 'unified budget' which includes GP prescribing. In 2002\3 the model also provides for the increase in NHS employers' superannuation contributions which falls due that year (at a recurrent cost of £5.8 million).

e. although the Comprehensive Spending Review announced by the Chancellor runs only to 2003\4 we have assumed that 2004\5 would have a similar profile.

The model ignores some year on year movements in the Joint Community Care Plan (JCCP) financial envelope. Principally in 2002\3 the JCCP shows a recurrent "surplus" of £1.7 million which restores transitional funding invested by GGNHSB in earlier years of the JCCP.

TABLE A

	2000\1 £m	2001\2 £m	2002\3 £m	2003\4 £m	2004\5 £m
INCOME					
1. GGNHSB income base	776.8	827.8	877.2	929.4	978.5
2. Increase over previous year	51.0	49.4	52.2	49.1	48.9
3. Total Income	827.8	877.2	929.4	978.5	1027.4
4. Expenditure base	784.9	827.	877.2	929.4	978.5
5. Unified budget inflation (GP prescribing etc)	11.2	12.2	13.4	14.7	16.0
6. Provision for inflation in Trusts	17.4	18.0	24.4	19.7	20.4
7. Available for service development ¬	14.3	19.2 ®	14.4	14.7	12.5
8. Total Application of funds ¯	827.8	877.2	929.4	978.5	1027.4

- **The model assumes that line 7 investments are recurrently committed each year and become part of the following year's expenditure base in line 4.**
- **Includes £5.8 million for increase in NHS employers' superannuation contributions.**
- **Approximately £3 million of this £19.2 million is required for the balance to full year effect of developments started part way through 2000\1.**
- **Of the £827.8 million spending in 2000\1 approximately £200 million is spent on GP Prescribing and General Medical Services cash-limited services (GP services). The remaining £627 million is spent on acute hospital, mental health services and the other programmes defined in paragraph 9.6 (c) above.**

7. **Line 7 in this model is the money available to meet the great array of competing service priorities already identified in previous Health Improvement Programmes or still to be developed in response to the National Plan for the NHS in Scotland which is expected to be published later this autumn.**

8. **The question is how best to deploy the resources available in line 7 to meet the number of requirements:**

   a. **whatever requirements emerge from the National Plan for the NHS in Scotland. Reduction in waiting times and improved cancer services are likely to be main features and will almost certainly entail a significant increase in the number of doctors, nurses, radiographers, physiotherapists and other professions supplementary to medicine. To give a sense of orders of magnitude, 25 to 30 extra consultants would cost around £1.5 million to £2.0 million in salary costs alone. Each incremental increase of 50 more nurses, physiotherapists, radiographers etc., would cost around £1.25 million to £1.5 million. Extra linear accelerators for treating cancer will be expensive to maintain.**
   b. **implementation of the GGNHSB's existing plans for the Mental Health Framework, including services for Mentally Disordered Offenders.**
   c. **improving services for the management of chronic disease such as epilepsy, diabetes, multiple sclerosis, chronic fatigue syndrome, the effects of head injury, and so on.**
   d. **strengthening the range and quality of primary care.**

e. **investing in public health measures, service improvements and community development aimed at tackling inequalities in health and the problems associated with socio-economic deprivation, especially among children, people with addictions and those experiencing homelessness and social exclusion.**
f. **providing a wider range of locally accessible health care in communities such as the East End, Rutherglen, Cambuslang, Castlemilk, Drumchapel and Clydebank.**
g. **the extra cost arising from replacing old hospital buildings with new buildings.**

9. **Experience demonstrates that if money for some of these services is not ring-fenced, cost pressures within acute hospital services tends to consume any available cash. Table B shows two different approaches to ring-fencing money for development during the planning period to 2004\5. One approach assumes that line 7 in Table A is distributed on the basis of current share of spending; the second shows a distribution based on the Arbuthnott formula proportions.**

TABLE B - USING MONEY FOR SERVICE DEVELOPMENT

Option 1 – based on current spending share.

	2001\2 £m	2002\3 £m	2003\4 £m	2004\5 £m
a) Acute 56.77%	10.9	8.2	8.3	7.1
b) Mental health 13.57%	2.6	2.0	2.0	1.7
c) Other programme 29.66%	5.7	4.2	4.4	3.7
	19.2	14.4	14.7	12.5

Option 2 – based on Arbuthnott formula proportions

	2001\2	2002\3	2003\4	2004\5
	£m	£m	£m	£m
a) Acute 53.43%	10.3	7.7	7.9	6.7
b) Mental health 17.38%	3.3	2.5	2.5	2.2
c) Other programme 29.19%	5.6	4.2	4.3	3.6
	19.2	14.4	14.7	12.5

10. **When this framework is put alongside the service requirements identified in paragraph 9.8 above it looks adequate in addressing issues for mental health and other programmes as measured by the aspirations set out in 2000\1 Health Improvement Programme but taking into account also the Board's commitment to see significant improvements in primary care and child health above levels signalled in the Health Improvement Programme.**

11. **The framework is under pressure in relation to acute services especially in 2001\2 where there are major extra costs associated with junior doctors' hours, the Working Times Directive and loss of Trust income (£2million gross) to reflect reductions in the inflow of patients to Glasgow hospitals from Lanarkshire Health Board. In addition North Glasgow Trust still has an unresolved deficit of around £10 million that needs to be addressed, possibly involving extra income from GGNHSB.**

Beyond 2001\2 however the money available for acute services would allow only some relatively modest service developments. In both 2002\3 and 2003\4 further significant income reductions are expected in respect of continuing reductions in Lanarkshire cross-boundary flow (£2.9 million and 3.9 million respectively).

12. As far as choices about meeting the cost of new hospital buildings is concerned we were expecting the major revenue costs of a new Southside hospital to fall due at the beginning of the 2006\7 (if Cowglen) or in 2005\6 (if new build at the Southern General). The profile we gave in leaflet 15 was:

TABLE C

	Net increase in cost £ million				
	(a)	(b)	(c)	(d)	(e)
	2001\2	2002\3	2003\4	2004\5	2005\6
• GRI maternity, plastic surgery and emergency receiving	1.7				
• Gartnavel : new linear accelerators	1.2				
• Stobhill Ambulatory Care Centre		1.1			
• GRI – new orthopaedics unit			0.3		
• West Glasgow – new buildings				3.0	(5.0)
• Victoria Ambulatory Care				3.0	
• Southern General new build				6.0 *	
	2.9	1.1	0.3	12.0	(5.0)

*** Money reserved in 2004\5 to be available in 2005\6.**

The balance of the Southern General option revenue cost would fall to be met in the period between 2006\7 and 2010.

13. The consultation period has highlighted the importance of moving faster in centralising the Beatson Oncology Centre at Gartnavel and so we would expect the requirement in column (d) to be higher.

14. If the Cowglen option were pursued, the increased revenue cost of £18.4 million would fall due to be met sometime towards the end of the decade, if town planning problems could be overcome that is.

15. The projection given in Table B, when put alongside the revenue requirements for new buildings illustrated in Table C shows how the cost of new buildings would in 2004\5 or 2005\6 (depending on when the money needed to be deployed) consume virtually the whole of the year's development monies for acute services altogether. The Cowglen option revenue cost would, by itself, require more than the total of development monies available for acute services development. It would

consume money otherwise earmarked for mental health and the other programmes (primary care, child health, community health etc).

16. **Furthermore we need to bear in mind that the levels of real term growth in NHS spending for the four year period 2000\1 to 2003\4 are at an all-time historic high, far surpassing anything we have seen sustained at that level since 1948. There can be no guarantee that this unusually high level will be continued in 2004\5 and beyond. If growth fell back to its more historically usual levels the total amount of money available for all types of service improvements (after provision for inflation), would more typically be around £10 million per year.**

17. **There is, therefore, a very real risk that the Cowglen option would be unaffordable within the GGNHSB formula allocation from the Scottish Executive. Indeed even the Southern General option will require careful financial stewardship if its additional revenue costs are to be met.**

0. DECISION-MAKING AND RISK

1. Earlier in this review we described the complexity of the overall decision process in reconfiguring hospital services for Glasgow. Decisions or judgements affecting one factor or one part of the Glasgow hospital system have repercussions elsewhere. We likened it to a Rubik's Cube.
2. We emphasised too that a coherent and realistic set of decisions of this type cannot be based merely on the weight of sentiment or popularity alone. There are other tests to be passed, applied variously by the Scottish Parliament, the Scottish Executive, the statutory Auditors and professional regulatory bodies. They include:
    a. ensuring that what is proposed meets good **quality standards** for service organisation and delivery.
    b. ensuring that the decision offers the best possible sy**nergy with other aspects of public policy** and **avoids conflict with those other policies**. The most relevant policies are:

        - protecting the environment.
        - minimising traffic impact.
        - promoting employment opportunity.
        - promoting ease of access to services for people who lack mobility for physical or economic reasons.
        - promoting opportunities for health gain.

    c. achieving **best value** for the taxpayers' money.
    d. **managing risk** so that major overspends, delays or fruitless payments are avoided.
    e. demonstrating that the decision does not create unacceptable **opportunity costs** adversely damaging the achievement of other needs and priorities.
    f. ensuring that the decision is **affordable** within the resources allocated by the Scottish Executive.
    g. seeking the **best possible fit** with all of these factors.

3. Our proposals have been designed to give the best possible fit across all of these factors. For example, if we had proposed just a three hospital site option with no Ambulatory Care facilities at Stobhill and the Victoria we might have satisfied criterion (a) but the sheer scale of the new investment required would have enhanced risk under criteria (d), (e) and (f) and compromised the traffic impact and accessibility elements under criterion (b) to a significant degree.

   Similarly a proposal to quit the GRI and build a brand new hospital at Stobhill would have raised

extremely searching questions about criteria (c) and (d) [in terms of waste of the new capital investment currently under construction at the GRI].

4. In particular our proposals aim to achieve a transformation of service quality and environment for patients. They maximise the amount of modern (25 years old or less) facilities in use for hospital services in Glasgow, at the same time preserving local accessibility for most services while adopting a model of service organisation and delivery which meets modern quality standards. We seek to achieve this in a way which represents value for money, is affordable and leaves scope to greatly increase the numbers of doctors, nurses and other health care staff providing treatment and care for patients. While we have a responsibility to minimise the risk of cost overruns and fruitless payments, our priority is to minimise the risk of lengthy further delay.
5. Elsewhere in this paper we apply this framework to the various contentious elements of the decision-set we need to make. It is important that our partners in this important debate for the future of Glasgow's hospital services recognise the obligation we have to scan across all of these criteria. It would be wonderful simply to be able to make the popular decisions and be greeted with public acclaim but sadly they do not automatically meet the testing expectations of the Parliament and other judges of the quality of our decision-making and stewardship.

11. SOUTH GLASGOW SERVICES

1. This element of the proposals has attracted significantly more comment than any other. There have been hundreds of letters from members of the public, responses from Community Councils, comments from local authorities, professional advisory committees and the Local Health Council. Local MSPs have maintained a close interest throughout the period of consultation.

2. If decision-making were a matter of weighing the sheer volume of comment it would point unequivocally to overwhelming support for the concept of a single in-patient hospital on the Southside. But beyond that there is mixed opinion as to whether it should be at the Victoria/Queen's Park Recreation site or Cowglen.

   Up until 31st August there was a desire for it to be built at Cowglen (103 responses): however, in the last few days of the consultation period the volume shifted for it to be located at the Victoria or Queen's Park Recreation site (171 responses).

   In addition the lack of response from people from the south-west of Glasgow does not mean that the option of the Southern General would have no support.

3. **The concept of a single in-patient hospital for the Southside** appears to have attracted support for a number of reasons:

   a. frustration at the appalling quality of most of the buildings in the Southside hospitals, particularly at the Victoria Infirmary where there has been a lack of investment in upgrading or replacing existing facilities over the last 10 to 15 years. The Southern General has been better served by its management in that period. However, it too is burdened by a legacy of Victorian buildings which cannot add up to a hospital designed efficiently around the needs of patients, no matter how well individual ward upgradings and link corridor schemes have been undertaken.

   b. recognition of the importance of creating larger specialist teams.

   c. a concern that the current fragmented pattern will continue to cast the Southside in a less favourable position compared with the bigger groupings and more recent investment that can be seen – albeit incompletely and unbalanced – in North Glasgow. This can undermine staff recruitment attractiveness and has also retarded specialist service development in South Glasgow.

4. **GGNHSB believes that failure to deliver on this consensus would be highly damaging to the quality of hospital services in South Glasgow.**

5. The issues of controversy concern the question of **location**.

6. As is said in paragraph 11.2 some respondents have argued that a new Southside hospital should be located **at or alongside the existing Victoria Infirmary site**, (171 respondents). It is timely to remind ourselves why **this has not been seen by GGNHSB to be a viable option**:

    a. **In a "two A & E for Greater Glasgow" configuration**, with one of those two being at the GRI, **the Victoria Infirmary is not an acceptable site** because the whole of West Glasgow, north and south of the river, would have to look to the East for access. A North\East and South\West axis for A & E services provides the most balanced position, particularly if the two units are close to the strategic road corridors (M8, M77, Clyde Expressway, Clyde Tunnel).

    b. **the site is too small**. The acreage already owned by the Trust is only some 11 acres (including the Grange Road School site).

    c. the suggestion made by some respondents that a larger site could be made available by the Trust acquiring the whole of the **Queens Park Recreation site does not seem to us to be viable**:

        i) it would still only offer 34.2 acres (compared with 67 acres at the Southern General and 73.6 acres at Cowglen)

        ii) it would not be large enough to accommodate **acute mental illness** beds for South Glasgow nor a relocated **Royal Hospital for Sick Children** if that were transferred.

        iii) advice from town planners confirms that the acquisition of Queens Park Recreation site would require a change of use of land currently designated as Open Space. We are advised that areas designated as Open Space are "key elements in the green-space network of the city and .... there will be a strong presumption against loss of designated open space, whether in public or private ownership" and that the Open Space Land Use Policy requires that such areas "should remain primarily as open space and that development will only be permitted which relates to open space\recreation purposes" (letter from City Council Development Control dated 22nd August, 2000). It would require specific public consultation, the formal overturning of its own Land Use Policy by the City Council as town planning authority, and the agreement of Sport Scotland.

        It is likely that a formal public enquiry would be held. The complex town planning process would take between one to two years. It would also be necessary for the Trust to meet the cost of providing replacement playing fields in the vicinity. Given the size of site involved it is far from clear whether such alternative space is available (it would already have been identified by Scottish Enterprise – Glasgow if it were since they are very anxious to find large sites for industrial development in South Glasgow and are finding it difficult to identify any).

        The existing Queens Park Recreation site is used as overflow car parking for matches at Hampden Park – its loss for that purpose would also pose problems in finding acceptable alternatives.

This option would almost certainly add two years to the process of securing a new hospital for the Southside, thus prolonging the present problem of improvement blight experienced by the Southside's hospital service.

Acquisition and re-provision would clearly add to the cost and delay of any hospital development. It is more likely however, that the option would fail to overcome the planning barriers.

d. The Victoria is located in a "highly developed area where there is little spare capacity on the existing road network and little opportunity to substantially improve it". (Source : Travel Time Study commissioned by the Glasgow Health Forum (South-East)). It hardly seems likely that the **traffic impact** of bringing the Southern General's in-patient work into the area would be viewed favourably, nor would they be physically easy to resolve. This issue adds to the town planning complexity already described earlier.

e. A new Southside Hospital at the Victoria Infirmary campus would have to be phased since a quarter of the total 34.2 acres (if Queens Park Recreation were available) is already occupied by the existing hospital which would have to remain in use while new facilities were built on the adjacent site. A two phase development would therefore be unavoidable. Added to the town planning delays, this means that the Victoria Infirmary option would be much slower to deliver than the Southern General option.

7. These reasons continue to be compelling.

8. In leaflet 16 we set out the **differences between the other two alternatives** (Cowglen and the Southern General). We said that the differences centred on:

    a. accessibility.
    b. speed of completion.
    c. risks.
    d. cost.

During the consultation period three other factors have been raised:

    a. wider implications for other areas of public policy.
    b. traffic impact.
    c. the environmental impact of the Shieldhall Sewage works.

9. It is important to revisit each of these in turn in the light of consultation. However, before doing so it is necessary to **revisit the position on Ambulatory Care**.

10. An **Ambulatory Care Centre** at the Victoria Infirmary campus would provide local access for at least 85% to 90% of all patient contacts that currently use the Victoria Infirmary. (Details given in leaflet 16). Many of the letters of concern we have received have been from people who currently go to ambulatory care services at the Victoria and who have gained the impression that in future they would have to go to the Southern General. There is no basis for such anxiety.

Such patients would continue to go to the Victoria Infirmary as they do now:

- around 275,000 out-patients No change [1]

- around 5,000 day patients No change

- around 9,000 day surgery cases No change [2]

(1 - "out-patients" also includes visits to x-rays, physio, speech therapy, hearing aids etc.)

(2 - assumes the issues around complication rates are satisfactorily resolved)

Of around 75,000 A & E attendances, between a minimum of around 14,900 would go to the Minor Injuries Unit at the Victoria, more likely a figure of 27,000 would go there. (Annex 6 explains this range) Around 14,000 children attend the Victoria A & E Department each year; an expert Paediatric A & E Review Group has recommended that all such children should go to the Yorkhill A & E or else attend local primary care services.

In addition the proposal to provide 120 rehabilitation beds in a new building next to the Ambulatory Care Centre would help local people needing to visit a patient who needs more extensive time in hospital to recover.

Thus for over 310,000 patients concerns about access to a new Southside Hospital at Cowglen or to the Southern General do not arise.

As Section 4 of this paper sets out GGNHSB sees no reason to depart from its original view that stand-alone Ambulatory Care Centres have a major part to play in the future pattern of service.

11. Section 6 of this paper explores the issues of **accessibility** which attracted a large amount of comment in the consultation.

    We suspect that much of the concern was from people who did not appreciate the significance of providing an Ambulatory Care Centre and 120 rehabilitation beds at the Victoria Infirmary (see above). Certainly many of the letters specifically referred to difficulties in attending out-patient clinics – which we are not proposing to move from the Victoria Infirmary campus. Others quoted the concerns of elderly people visiting their partners or friends during lengthy spells in hospital – the 120 rehabilitation beds are aimed to meet precisely the needs of such people.

    For **in-patients** we suggest, in section 6, that the number relying on public transport to get from the present Victoria Infirmary catchment area to either Cowglen or Southern General (i.e. those not taken to hospital by ambulance, by taxi or by car driven by family, friends or neighbours) is unlikely to exceed 20 to 25 people a day. This would involve a public transport journey averaging 57.1 minutes (if Cowglen) or 62.4 minutes (if Southern General) if off-peak or 60.3 minutes and 64.7 minutes respectively if at peak hour – an average difference of between 4 and 6 minutes.

    In the case of **patients' visitors** we have drawn on a useful analysis commissioned by the Health Forum (South-East) – see Annex 7. We analyse the position in some detail in section 6. We concluded that:

    a. at an individual public transport user level, **public transport** is **not a differentiator** between the Southern General and Cowglen because:

        - for 19 of the 34 places examined in Annex 7, the difference is 10 minutes per journey or less.
        - in both cases public transport would need to be improved.
        - in both cases most of the more onerous differences can be resolved by the development of express shuttle buses.

    b. for **car users** the difference is contained within a **10 minute margin either way** and on a personal level the significance of this will be subjective.

c. the **economic advantage** of Cowglen over the Southern General option in terms of travel times and costs was more than outweighed by the economic advantage to the NHS and taxpayers of the Southern General option over Cowglen.

d. the significance of the 120 rehabilitation beds at the Victoria Infirmary site had been overlooked by many respondents but would significantly remove differences in public transport access for many patients' visitors, especially the elderly.

A further issue that was raised during the consultation concerned the **speed** with which a new hospital for the Southside could be achieved. Many of those who commented on this issue preferred the **Cowglen** option because it assumed a **single phase construction** completed in approximately 7 years time (i.e. 2007). By contrast the Southern General option would involve a first phase of new building (not upgrading) complete by the same time scale and with a second phase of new building following demolition of old buildings elsewhere on the site freed up by the availability of the new hospital blocks.

The two phase approach was principally determined by the need to create potential site space for the relocation of the Royal Hospital for Sick Children (if that was decided). The Trust has reviewed the way in which site space could be released for new building and there **might be scope for a single phase provision of a Southside hospital at the Southern General site**. This needs further consideration both in terms of practicality and the profile of revenue funding requirements which the Trust would be able to examine reliably at Outline Business Case stage.

12. A major differentiator in the choice between the two principle options has been **cost**. In our original consultation material we highlighted that the **Cowglen option** would cost an extra **£18.4 million per year** more than the present cost of hospital services in South Glasgow compared with an extra **£11.1 million per year for the Southern General option**. We felt that the difference of £7.3 million was too high both in terms of absolute affordability and as an opportunity cost (i.e. taking into account that the £7.3 million could otherwise be spent on doctors, nurses and other healthcare staff providing extra healthcare for patients).

The responses to consultation were not impressed by this argument. However, the significance of this issue is now greater because the revision of bed numbers (see Section 8) means that the running costs of a new Southside Hospital (whether at Southern General or Cowglen) will be higher than we estimated in our original consultation period.

In Section 8 of this paper we revisit the issues of financial affordability in the light of the consultation responses the revision in bed numbers and new developments in NHS funding. Section 8 includes a new financial model for the period up to 2004\5 but also looks at the prospects for 2005\6 and beyond.

Its conclusion is that there is a very real risk that in 2006\7 the Cowglen option revenue requirement would be unaffordable within the GGNHSB formula allocation from the Scottish Executive. Indeed even the Southern General option with its higher number of beds will require careful financial stewardship over the next few years if its additional revenue costs are to be met.

13. **Cowglen - site issues.**

At the start of the consultation we said two potential sites had been identified in the Cowglen area.

a. a 44.7 acre site incorporating the present Cowglen Hospital and the National Savings Bank. Adjacent land owned by Retail Property Holdings Ltd would have created just enough additional space to build a hospital.
b. a 73.6 acre site incorporating the Pollok Playing Fields and owned by the Pollok Estate.

Early in the consultation period the South Glasgow NHS Trust met representatives of the National Savings Bank (NSB) and, at the latter's request, recognised that the NSB site was not for sale. Siemens, who run the operation on behalf of NSB, have recently won another contract which will further increase employment on this site. Building a hospital on the site would not create new jobs in South Glasgow (since NHS jobs would simply be transferring from the Southern General and Victoria to Cowglen) but would involve displacement of the NSB and all the hundreds of jobs it provides.

This leaves the Pollok Playing Fields site as the only potential location large enough in the Cowglen area.

14. **Cowglen : New Hospital on the Green Belt for Pollok?**

The Greater Pollok Social Inclusion Partnership has written to point out that this site has been identified as an alternative site for the reprovision of playing fields at South Pollok which were lost when the M77 was built. The Greater Pollok Partnership wrote that they "would not support construction of a new hospital which encroached onto Broompark Farm without the full support of the local community. The provision of these playing fields is a requirement under the National Planning Guidance following the loss of the former facilities at South Pollok".

It is also the case that this site, which is designated as Green Belt Open Ground and as a Conservation Area is subject to a Conservation Agreement between Nether Pollok Ltd (now Pollok and Corrour Ltd) and the National Trust for Scotland. Use of the site would therefore require the agreement of the National Trust, the Trustees of Pollok Park and the City Council as local planning authority. The City Council's Pollok Park Local Plan aims to "promote and maintain it as a high quality countryside area within which leisure and cultural pursuits can be undertaken without detriment to the countryside environment. In these circumstances ..... serious doubts as to the viability of any proposal to develop a new hospital on this site" (City Council Development Control letter dated 22nd August, 2000).

Any planning application to build on designated Green Belt needs to demonstrate very special circumstances which include demonstrating that:

- there is nowhere else that the proposed development could go.
- the development could not be reasonably undertaken on another site.
- the development would not materially diminish the openness of the Green Belt.
- there are substantial benefits for the community.

Even if, contrary to its own Local Plan and policies, the City Council approved a planning submission that approval would still need to be referred to the Scottish Executive who might decide to 'call it in' and then to hold a public enquiry. It seems inconceivable that there would be no "green\conservation" interest groups that would not be opposing loss of Green Belt in the sensitive Pollok Estate. The odds on a public enquiry must be very high and the certainty of a successful outcome very low. The process would take a minimum of one to two years. It would also be unfortunate, to say the least, for a Health Board committed to promoting physical exercise as a major contributor to good health maintenance to be dismissive of recreational space close to an area of significant health and social deprivation. Likewise for a Health Board to seek to convert a Green Belt Conservation Area into a high density concentration of buildings, car parking and yet more traffic is also out of tune with what is expected in responsible corporate decision-making.

15. Are there any **other sites in a central location** in the Southside? In their response the Local Health Council urge GGNHSB "to pursue a longer term strategy which is more radical and will lead to the development of a much needed new hospital on a more centrally located site in South Glasgow". We understand this ambition, and who could not be tempted by its challenge? However, in starting its work on the proposals last year the South Glasgow Trust and its property advisers were unable to locate any such sites of adequate size other than those at Cowglen, Darnley and the Southern General.

At a meeting of the Glasgow Alliance Management Board on 25th August Scottish Enterprise – Glasgow gave a presentation on its programme to secure an adequate supply of good quality, well located, serviced sites in order to attract employment opportunities into Glasgow.

Among their criteria for success are:

- approximately 50 acres or more.
- high quality environment.
- motorway connections.
- access to facilities.
- scope to achieve unified public ownership.

They reported that the city is running out of the first class sites now needed to attract major inward location of new industrial\business opportunities. Such sites usually take two or three years to assemble and make ready for business occupation. They were aware of our initial interest in the Cowglen NSB site and were intending to work in partnership with the owners to help bring the Savings Bank building into full business use thereby increasing employment opportunity in the area. The only other site identifiable in the city south of the river was Darnley Mains. Scottish Enterprise – Glasgow were concerned that use of prime vacant sites for a new Southside Hospital would possibly deny the city a major new net extra employment opportunity in one of the very parts of the city where such opportunities are both needed (adjacent to Pollok) and most difficult to create. It was also pointed out that although an NHS development in such a site large enough for a new hospital would in due course release the Southern General site for industrial development that opportunity would not be ready for use until the end of the decade whereas the need to attract net additional employment existed here and now.

The sense of the Glasgow Alliance Management Board meeting was that the creation of net extra employment opportunity for the Southside should not be overlooked when decisions are to be made about Southside Hospital configuration (which offers no net increase in employment). Three issues therefore arise in addressing the Health Council's challenge:

a. what alternative sites are there?
b. if there were alternative sites how should we weigh employment opportunity against those considerations of public feeling about the Southern General site explored elsewhere in this paper?
c. how long are we prepared to wait in order to identify a site and resolve tortuous planning issues (or find that we cannot resolve them) when we already own a site (Southern General) which is certainly large enough and has fewer town planning problems associated with it?

16. Some responses to consultation rightly draw attention to the **traffic impact** of options for the Southside. In section 6 we analyse this issue in overall terms. There will certainly need to be a traffic impact analysis as part of the next stages of planning, involving liaison with the City Council in its planning, roads and traffic management roles. The salient points emerging from our considerations of comments made so far are as follows:

    a. **<u>any</u> reconfiguration** of hospital services in Glasgow **will change traffic patterns** one way or another.
    b. our creation of a stand-alone **Ambulatory Care Centre** at the **Victoria Infirmary keeps overall traffic change to a minimum**. It will however reduce traffic around the congested area of Battlefield Road\Langside Avenue\Prospecthill.
    c. conversely our judgement not to locate a single hospital for the whole of the Southside at the Victoria Infirmary site avoids what would almost certainly be a quite unacceptable increase in local traffic and reduction in local environmental amenity.
    d. the **Cowglen** option would clearly be better than the Southern General in involving a more manageable **traffic impact** but, as we identified in 11.13

and 11.14 above there are serious other problems involved with the acquisition and use of sites at Cowglen.

e. the whole issue of **traffic impact at the Southern General** would need to be examined alongside issues of existing road capacity, scope for improved public transport to reduce extra traffic, neighbouring developments at Braehead, Pacific Quay, Meadowside Granary and Yorkhill and any road or bridge developments associated with them.

17. A large number of consultation responses cited the smell from **Shieldhall Sewage Works**, adjacent to the Southern General as a significant reason why a single-site Southside hospital should not be located there. GGNHSB has raised the issue with West of Scotland Water who replied that they were very conscious of the potential impact that the Shieldhall facility can have on neighbouring properties. They went on:

"Consequently, three years ago this Authority developed an outline plan to reduce odours from this site. This plan is based on reliable measurement of odour nuisance to locate the principal sources of complaint and , therefore, to find innovative and cost effective solutions.

Measurement of odour levels has been undertaken at Shieldhall continuously since 1997. The information collected is utilised by site personnel on a daily basis to monitor and improve operational performance. A site specific odour dispersion model has been developed by a specialist consultant and is used to help identify the problem locations and determine priority investment.

The Authority has invested in excess of £1 million at Shieldhall during the past 18 months addressing odour issues.

In addition, the underlisted investment is planned:

Financial year 2000\1

- Physical covering of high risk channels and pump wells.
- Consultant investigation to optimise the operation of the site to mitigate odour generation.
- Review of odour model to incorporate new measurement techniques identified in the latest European CEN Standard.

Financial year 2001\2

- Discontinue the use of the Interim Sludge Treatment Centre.
- Reduce the quantities of sludge delivered to Shieldhall for processing.
- Improve\upgrade odour abatement plant on site.

When this programme of work is completed, all of the presently identified significant sources of odour will be largely abated. Thereafter, there will be a further programme of measurement to ensure that there will be no outstanding odour generators.

The operation of this site does generate odours. However, West of Scotland Water is endeavouring to ensure that at the boundary with our neighbours, there is no cause for complaint as a result of site operations. In this regard, we have established day-to-day liaison with representatives of the local community, Barr and Stroud and your hospital to assist in identifying sources of complaint and speedy advice of difficulties."

Clearly it is not possible for us to predict the precise success of these measures but we are confident that West of Scotland Water recognise the importance of the issue and are demonstrating a significant commitment to tackling it. Because they are monitoring complaints and linking them to specific site operations and weather conditions it will be possible to assess with some precision the effect of their current investment when it is completed by Spring, 2002.

Some consultation responses raised concern about the risk of airborne infection from the Sewage Works. Public health monitoring shows no pattern of disease in the area which could be attributed to the Sewage Works nor is there any experience elsewhere of disease being transmitted from a sewage works to neighbouring communities by an airborne route.

The issue of the Shieldhall Sewage Works is not, in our view, a factor that should influence the decision about future strategic configuration of hospitals, particularly since by the time change occurs West of Scotland Water's investment programme will have been undertaken and its effectiveness monitored. If an odour nuisance remains it will be necessary to press for further measures by West of Scotland Water.

18. In leaflet 16 we identified a number of **risks** associated with the two main options on the Southside. They concerned:

    a. site availability.
    b. site acquisition cost.
    c. degree of flexibility in relating ultimate bed numbers to clinical experience and need over time.
    d. relationship of building contract size to degree of risk of cost-overruns.
    e. traffic impact issues.
    f. the risk, with two or three phase developments, of hiatus between phases.
    g. on-site disruption during building works.

19. In terms of differentiating between the Southside option, the risk profile is as follows:

	Southern General	Cowglen	Victoria (incl. Queen's ParkRecreation)
a) Site availability	Nil risk. Already fully owned by Trust	High risk. Competing public policy considerations and long town planning process delays. Successful outcome cannot be guaranteed.	High risk. Competing public policy considerations. Long town planning process delays. Successful outcome cannot be guaranteed.
b) Site acquisition cost	Nil risk. Already fully owned by Trust.	Medium risk. Costs of reprovision\relocation of playing field space (but where?) likely to arise.	Medium to high risk. Cost of providing alternative playing field space arises, so amount of land to be paid for is almost twice the area needed for the hospital itself.
c) Flexibility on future bed numbers	Good flexibility unless we seek to achieve a single phase exercise.	Low flexibility because single phase project.	Good flexibility because it would have to be a two phase project.

d) Risk of cost overrun magnified by sheer scale of building contract	High, especially if a single phase approach is sought and if PPP not used.	Medium if PPP used.	High because of site complications and phasing.
e) Traffic impact	Medium, depending on other nearby retail and leisure developments.	Low, although any expansion of other retail\ commercial activity around junction 2 of the M77 may raise this risk.	High, due to existing lack of local road capacity.
f) Phasing hiatus	High, unless single phase approach is feasible.	Nil risk.	High.
g) Building work disruption on site	Medium. Site layout makes demolition and new building on a zoned basis possible without excessive disruption of other zones.	Nil risk.	Low risk. Disruption would be to the local neighbourhood rather than to the Victoria Infirmary itself.

Of these (a) is critical – no site, no hospital. Risk (b) is also a first order risk, since it will magnify cost differences between options to a significant degree. Risk (c) is not a significant differentiator. In our view the risks at (a) and (b) outweigh the risks at (e), (f), and (g). If risk (d) becomes high for the Southern General option because a single phase approach is adopted, then risk (f) becomes a nil risk for the Southern General.

20. **Taking Stock**

Taking into account all the perspectives raised and explored during the consultation process how does GGNHSB view the position now?

a. Firstly we wish to re-affirm our ambition that the Southside should have a pattern of hospital services that stand comparison with those available north of the river. This means:

- a coherent range of general acute services offering state-of-the-art ambulatory and in-patient care, with specialties and sub-specialties viably staffed and assuring the local population reliable access to specialist teams at all times.
- the presence of regional services which add richness to the clinical life of a hospital.
- co-location of acute mental illness services with general acute services so as to reduce the stigma of mental illness and to provide clinical links where they are needed (e.g. in relation to overdose patients and emergency patients with physical and mental illness).

- thoroughly modern facilities helping to make the patient experience as good as it can be.

b. Secondly, we do believe a stand-alone Ambulatory Care Centre, including a Minor Injuries Service and 120 rehabilitation beds, located at the Victoria Infirmary will provide the best possible local access to as many services for as many people as possible.

c. Thirdly, we continue to subscribe to a pattern of two Accident and Emergency Services for Greater Glasgow (supported by a network of more local Minor Injuries Units) which is best positioned on a north\east and south\west axis.

d. Fourthly, we are anxious that the strategic planning blight which has afflicted South Glasgow for at least two decades should be brought to an end. We wish to see an early start to replacing the Southside's obsolete hospital buildings.

Ending the blight requires a decision on siting to be made within the next few months. If decisions become dependent on the most lengthy town planning processes, including public enquiry and the decision-making timescales that flow from a public enquiry, then the planning blight afflicting the Southside hospital service will remain rigidly unresolved for up to three years or more.

During that period of blight no resources could be committed to planning the new Southside Hospital in any meaningful detail, which in turn means that building would be unlikely to start until 2005 or 2006. The Southern General option is the only one which avoids this prospect of blight.

21. The Board has reviewed its decision matrix for the Southside which is as follows:

	Victoria + Queens Park Recreation	**SGH (+ACAD at Victoria**	**Cowglen (+ACAD at Victoria)**
Site Issues			
1. Site size	34.2 acres.	67 acres (SGH) + 5.5 acres (Victoria).	73.6 acres (Cowglen) + 5.5 acres (Victoria).
2. Site availability	Highly uncertain.	Already owned.	Highly uncertain.
3. Site acquisition problems and cost	Highly uncertain. Need to include cost of reproviding playing fields and re-routing main sewer on Grange Road. Would enable sale of SGH site (?£7.5 million).	Nil (apart from 4 acres next to Annan Street). Would enable sale of part of Victoria site (? £6m) + Mansionhouse (? £2 million).	Highly uncertain. Would enable sale of SGH, part of Victoria site and Mansionhouse (? £15.5 m in total).
4. Building work disruption	Low risk to hospital. Significant impact on local neighbourhood.	Medium risk but minimised by zoned nature of site and order of demolitions. Less intrusive	Nil risk.

		impact on local neighbourhood.	
5. Environmental impact\issues	High. Removes local playing fields and open space. Heavier traffic in residential\ recreational\shopping area with congested roads already.	Minimal. No loss of public amenity space. No change in use of site. Modern buildings replace muddle of older buildings on site. Options available for resolving traffic impact. Sewage works nuisance being addressed by West of Scotland Water.	High. Loss of open space. Traffic impact unlikely to be a major problem.
Accessibility			
6. Number of patients affected by change of location.	All SGH patients = 450,000	VI in-patients + A & E less MIU = 75,000	VI in-patients + A & E less MIU + All SGH = 525,000
7. Number of patient unaffected by change in accessibility	All VI patients = 375,000	VI ACAD\MIU = 300,000 SGH = 450,000 750,000	VI ACAD\MIU = 300,000
8. Public transport	Best. Current off-peak average journey of 34 minutes (based on Mr. Drewette's work).	53 minutes average journey.	48 minutes average journey time.
9. Car\taxi access	Best. Average off-peak journey of 11 minutes.	Average of 17 minutes.	Average of 12 minutes.
Town Planning Risk			
10. Ease\difficulty of of town planning (also see factor 5)	Very difficult. Likely to take several years. Prospect of successful outcome is highly uncertain.	Easiest of the three options. Unlikely to take years. Prospect of successful outcome is very good.	Very difficult. Likely to take several years. Prospect of successful outcome is highly uncertain.
Conflict with Policy Considerations (see also factor 5)			

□ Impact on employment opportunities in South Glasgow	Exports jobs from Govan to Langside\Queens Park area.	Exports jobs from Langside\ Queens Park to Govan.	Exports jobs from Govan, Langside\Queens Park to Pollok.
□ A & E Services for Glasgow	Will require 3 major A & E Departments in Glasgow.	Consistent with 2 A & E Department configuration.	Will require 3 A & E Department configuration.
• Possible relocation of Children's Hospital	Not possible. Site too small.	Achievable.	Achievable.
□ Co-location with Mental illness services	Not possible. Site too small.	Achievable.	Achievable.
<u>Cost</u>			
□ Capital cost (leaflet 16). <u>Excl.</u> Yorkhill relocation and site acquisition\disposal	Not costed but would be no less than Cowglen option, certainly much more than SGH option.	£190 million.	£295 million
□ Annual running costs (leaflet 16)	Not costed but would be similar to Cowglen option.	£11.1 million.	£18.4 million.
□ Risk of capital cost overrun	High.	High.	Medium (if PPP)
• Is there a big 'sunk cost' penalty of walking away from recent significant capital investment?	Yes. £41 million spent on new build at SGH in last 10 years (<u>excluding</u> refurbishment of old buildings).	No. Capital spending at Victoria has been refurbishment only.	Yes. £33 million at SGH.
<u>Other risks</u>			

□ Flexibility in provision of most appropriate bed numbers	Good flexibility.	Good unless done in single phase.	Low flexibility.
□ Risk of delayed start and planning blight.	Very high.	Low.	Very high.
□ Risk of phasing hiatus (e.g. non-completion of a second phase)	High. Two phases unavoidable.	High unless single phase approach is feasible.	Nil risk.

22. This analysis indicates that the **Southern General option** is significantly the **best in terms of**:

Factor

2 Site availability.

3 Site acquisition.

5 Environmental impact.

6\7 Access disruption to the smallest number of people.

10 Lowest town planning risk.

12 Fit with GGNHSB policies on A & E.

15 Value for money in capital investment terms.

16 Affordability **and** least adverse opportunity cost for other health care services.

18 Least 'sunk cost' penalty.

20 Minimum risk of further delay and planning blight.

On some **other factors** there is **little difference** between it and the Cowglen option.

1 Site size (both are large enough).

11 Employment.

13 Scope to re-locate Children's Hospital services (no difference).

14 Fit with GGNHSB policy on mental health services (no difference).

19 Flexibility on bed numbers (possibly some advantage to SGH).

For factor 17 (risk of capital cost overrun) is difficult to judge since it depends on whether the SGH scheme is phased or not (higher risk), or subject to Public Private Partnership (lower risk) or not.

In four factors Cowglen has an advantage:

4 Site disruption during building work.

21 Lower risk of phasing hiatus (although this would not be the case if the feasibility of a single phase approach at SGH proves to be possible.)

8 Public transport (but both involve the need to improve it. Current time differences between them are within a narrow band. We do not see this as a significant differentiator).

9 Car\taxi access (depending on how differences of 10 minutes or less are viewed).

But factors 8 and 9 need to be seen in the context of the Cowglen option causing access disruption to the largest number of patients (factors 6\7).

23. The **Victoria Infirmary\Queens Park Recreation Site option** falls, in our view, due to the significance of its position in relation to:

    - too small a site (factor 1) to address factors 14 and 13 (mental health and children.
    - its inevitable delay (factor 20).
    - its adverse environmental impact (factor 5).
    - its adverse impact on job opportunity in Govan (factor 11).
    - its cost disadvantages shared with the Cowglen option (factors 15 and 16).
    - its exposure to phasing hiatus (factor 21).
    - its much higher access disruption score (factors 6\7).
    - its lack of fit with GGNHSB policy on A & E provision (factor 12).

    We do not see these as being outweighed by its advantages in relation to factors 4 (building work disruption), 8 and 9 (public transport and road access – many residents in the present Southern General catchment area would feel as much dismayed by their perception of increased travel difficulty to the Victoria as do many of those from the Victoria Infirmary catchment area who complained about this issue during the consultation period), 19 (flexibility on bed numbers).

24. **Our conclusion therefore is to re-state our preference for the option of locating the Southside in-patient hospital at the Southern General, with an Ambulatory Care Centre (including Minor Injuries Unit) and 120 rehabilitation beds at the Victoria Infirmary campus.**

25. Is this unambitious? We think not.

    a. it meets a vision of clinical services significantly stronger than the present pattern and on a footing that will no longer compare adversely with other parts of the city.
    b. it retains as much local access as possible.
    c. it provides the Southside totally with all-modern buildings within which a high quality patient experience can be provided by well organised and supported teams of staff.
    d. it is the solution capable of the fastest delivery.

26. Does this mean we have not taken notice of what has emerged from the consultation process? No, it does not. We have:

- reviewed the arguments about Ambulatory Care and minor injuries in more depth and identified how to examine some detailed issues more fully in the next stages of planning.
- revised the estimates of future bed numbers.
- examined the public transport analyses carefully and now have a much clearer understanding of what we need to do to improve public transport (which applies as much to the Cowglen option as it does to the Southern General option).
- recognised the need to explore more fully the scope for extended primary care services in Castlemilk, Rutherglen\Cambuslang, Pollok and Gorbals.
- re-opened the issue of a possible single phase approach at the Southern General site.
- understood more fully the town planning and alternative land use issues associated with Cowglen.
- checked West of Scotland Water's plan for Shieldhall Sewage Works.

27. We have also thought hard about how to deal with a number of pressing clinical service issues that need to be addressed in the period between now and the completion of the major capital investment later in the decade:

    a. an urgent need to ensure that the Victoria Infirmary has stronger capacity to deal with the rising tide of medical emergency admissions during the next few years.
    b. concentrating haemato-oncology (cancer of the blood and lymphatic systems) services.
    c. concentrating gynaecology in-patient services.
    d. concentrating breast cancer surgery.
    e. concentrating in-patient vascular surgery services.

28. The biggest single clinical pressure at the Victoria Infirmary for years has been its lack of capacity to deal satisfactorily with **medical emergency admissions**. In part that was due to inadequate staffing (mainly medical and nursing) and a need for improved organisation. The Trust has been addressing these issues in the last 12 months, with significant additional financial support from GGNHSB. However, the problem will remain intractable for as long as there are too few medical beds. At present medical patients continue to "board out" in the wards of other specialties, principally general surgery. This makes it more difficult to manage the patients efficiently and it also causes significant disruption to general surgery, making it more difficult to improve waiting list performance.

    Unfortunately the Victoria Infirmary does not have any vacant wards which can simply be staffed and re-opened.

    In order to tackle the problem, and put the hospital onto a sound footing for the remaining years of its acute in-patient role, we suggest the following sequence of changes should take place:

    a. It is already the case that when in-patient ENT moves to newly created accommodation at the Southern General in 2001 (a move already agreed following earlier consultation), an adult ENT ward of 24 beds will become vacant at the Victoria Infirmary.
    b. It is proposed also that in-patient gynaecology should be concentrated at the Southern General Hospital by the autumn of 2001. The benefits and implications of this are explained more fully below. This transfer from the Victoria Infirmary will free up ward 12A (25 beds).
    c. It is already the case that within the Victoria Infirmary general medicine bed complement 12 beds are allocated (in a 12 bed ward) for haemato- oncology. However, it is often the case that 3 or 4 haemato-oncology patients are also placed in another 11 bed general medical ward across the corridor.

Our proposal aims to produce a significant improvement in the Victoria general medicine capacity, simultaneously provide some small easement for general medicine capacity at the Southern General and improve quality of service for Southside haemato-oncology patients.

The current haemato-oncology ward at the Victoria Infirmary has single rooms with positive and negative ventilation systems to reduce risks of infection in patients whose treatment may make them vulnerable to infection. The ward across the corridor does not have this and haemato-oncology patients are placed alongside other patients with a range of general medical conditions. Haemato-oncology in-patients at the Southern General Hospital currently use 5 beds within a general medical ward. The proposal is to convert the ward adjacent to the existing haemato-oncology ward at the Victoria Infirmary so that an integrated unit for the whole of the Southside with suitable facilities and environment can be dedicated to this patient group. The cost of conversion would be around £200,000. This would affect 124 in-patient haemato-oncology admissions per year that currently go to the Southern General who would in future go to the Victoria for in-patient and day case care (375 attendances per year). Their routine out-patient consultation would continue at the Southern General.

This conversion would allow the concentration of haemato-oncology staff expertise in the Southside and would allow better cover for staff absences.

This manoeuvre would free up 5 extra beds for general medicine at the Southern General but would reduce the Victoria's designated general medical bed complement by 11 beds (slightly less in terms of current availability for general medicine), but

d) ..... general medicine's bed complement would be increased by allocating to it the wards vacated by gynaecology (25 beds) and adult ENT (24 beds). There would thus be an extra 38 beds for the designated general medicine bed complement. GGNHSB would provide the revenue necessary for this expansion. This should provide significant easement of the Victoria Infirmary's difficulties in absorbing general medical workload and should significantly reduce the level of patients boarding out in general surgical wards. Waiting list performance will also benefit therefore.

We believe these changes would provide enormous benefit to the Victoria Infirmary and its busiest acute services.

29. As already indicated, this manoeuvre depends on a ward being vacated by **gynaecology**. What is the rationale for this and what are its implications?

Firstly **the clinical logic** flows from the advice of the Area Sub-Committee in Obstetrics and Gynaecology which favours co-location of gynaecology with obstetrics (maternity services) and urology. As is the case with other surgical specialties there are also trends towards the development of sub-specialisation within gynaecology which are particularly difficult to accommodate at a time when legal and regulatory constraints on doctors' working hours (senior and junior doctors) are tightening. As specialisation continues so does the importance of ensuring as much continuity and strength in depth among the dedicated nursing team (and other staff) for gynaecology, many of whom also develop specialist knowledge and skills.

The Glasgow-wide proposal for gynaecology envisages in-patient gynaecologybeing located at the Glasgow Royal Infirmary and the single in-patient hospital for the Southside. Ambulatory Care would continue to be provided at the Victoria Infirmary, Stobhill and Gartnavel (as well as at GRI and the Southside hospital), although the Gynaecologists share the caution of some other surgeons about day-surgery in stand-alone centres (an issue discussed earlier in this paper).

There are strong reasons for proceeding with the concentration of in-patient gynaecology on the Southside at the earliest opportunity:

a. It allows the benefits of a larger clinical team (specialisation and better staffing cover) to be secured without waiting several years.
b. It allows use to be made of currently idle ward space at the Southern General.
c. It creates sorely needed space to expand general medicine at the Victoria Infirmary.
d. It allows in-patient gynaecology services to be relocated from West Glasgow at an early opportunity, thereby freeing up room for manoeuvre to facilitate the highly desirable service changes that would release West Glasgow acute services from their present wholly unsatisfactory pattern of split-site services for in-patients during their episode of care.
e. It will save about £300,000 a year, mostly as a result of a reduction in junior doctors' rota commitments and from more efficient use of beds. GGNHSB is currently underwriting that excess cost and no longer having to do so will allow that £300,000 to be spend on expanding general medicine capacity at the Victoria Infirmary.

30. The impact of these changes for patients would be as follows:

	Out-patient Attendances	Day Cases	In-patient episodes	TOTAL
Southern General	9,361	985	1,909	
Victoria Infirmary	9,746	1,296	2,390	
Western\Gartnavel	10,587	1,367	1,668	
No change	29,694	3,648	1,909	**35,251**
Change	Nil	Nil	4,058	**4,058**

The total bed days in hospital for the 4,058 patients affected by change (based on data in the 1998\99 Blue Book) is 9,450, an average of 2.3 days per patient.

These figures assume that the patient population currently attending the West Glasgow hospitals would in future have their in-patient stays at the Southern General. GPs would be able to refer their patients to the GRI\Stobhill service if they wished for clinical or other reasons.

31. **How** could the concentration of gynaecology in-patient services be achieved?

There is currently one 25 bed gynaecology ward at the Victoria Infirmary and one 25 bed gynaecology ward at the Southern General (located in the Maternity Block). There is also a vacant 25 bed ward in the Southern General Maternity Block.

The Trust would propose to upgrade the existing and vacant wards (Wards 40 and 49) in the Maternity Block at a cost of £1.2 million (£600,000 per ward). The service would also need to be supported by a triple theatre suite by the time gynaecology from West Glasgow joined the concentrated service. A site exists adjacent to the gynaecology wards in which to locate this.

If capital funding is available, this work could be started in the Spring of 2001, allowing gynaecology to vacate its ward at the Victoria Infirmary by the Autumn of 2001, it time for general medicine to occupy it before the winter of 2001\2.

The detail of the scheme to create a triple theatre capacity to accommodate the current West Glasgow in-patient workload would depend on whether the Southern General or Yorkhill was the location of the second

of only two maternity delivery services in Glasgow (an issue subject to separate consultation – see Section 15).

Whatever the outcome of that, there is site space in which the necessary theatre capacity could be created.

If the need to expedite changes to split-site working for medicine and surgery between the Western and Gartnavel pointed to the desirability of transferring in-patient gynaecology from there to the Southern General in late 2001\2, theatre time would need to be accommodated. According to the 1998\99 Blue Book the number of operating theatre hours is as follows:

	Day cases	In-patient cases	Total needed
	(Hours per year)	(Hours per year)	at SGH
	(Hours per year)	(Hours per year)	
Victoria	Stays at Victoria	1,912	1,912
SGH	394	1,336	1,730
West Glasgow	Stays in West Glasgow	1,334	1,334
			4,976

4,976 hours equate to 103 theatre hours per week over a 48 week work year, which for 3 theatres equates to 34 hours per week each (7 hours per day).

The two upgraded wards would provide space for 50 beds. The transfer of in-patient Gynaecology from the Victoria Infirmary would see one of the two wards working on a day a week basis and one on a 5 day a week basis. When the West Glasgow service moved both wards would work on a 7 day a week basis.

	VI	SGH	Western\ Gartnavel
a) In-patient episodes	2,390	1,909	1,668
b) Average length of stay (days)	2.0	2.8	2.8
c) Beds days per year (a x b)	4,780	5,345	4,670
d) Victoria and Southern General combined	10,125		
(bed days)			
e) All combined (bed days)	14,795		

First phase (Victoria and Southern General combined)

25 beds @ 7 days per week x 85% occupancy = 7,756 bed days

25 beds @ 5 days per week x 85% occupancy = 5,525 bed days

13,281

Second phase (West Glasgow service included

50 beds @ 7 days per week x 85% occupancy = 15,512 bed days

This analysis demonstrates that the configuration provides sufficient capacity.

32. As far as **staffing implications** are concerned there would be a reduction in the number of Senior House Officer posts in gynaecology, but with the reduced number working in a pattern consistent with the new national agreement on working hours and pay.

The interim arrangement of one ward working 7 days a week and the other 5 days would require fewer nurses than at present but this will be more than compensated by the increase in general medical beds at the Victoria Infirmary. In overall terms the net change in capacity is created by re-opening the closed Ward 49 and increasing theatre capacity at the Southern General. There will be no fewer overall jobs in nursing, professions allied to medicine, ancillary or administrative\clerical at the Victoria and slightly more overall at the Southern General.

33. The impending transfer of ENT in-patient services to the Southern General creates an opportunity to achieve a significant **early improvement in the breast surgery service** by **concentrating its in-patient element at the Victoria Infirmary**.

Currently there is a breast unit staffed by two consultant surgeons and their teams with high quality accommodation at the Victoria Infirmary – single rooms in a dedicated ward with its own team focused on a specific group of patients needing great sensitivity at a difficult and worrying time. At the Southern General one consultant surgeon specialises in breast surgery and the in-patients are managed within the general surgical bed complement.

The existing children's ENT ward at the Victoria is located next to the Breast Unit. It is proposed that in the summer of 2001 it be converted (approximate cost £200,000) to the standard of the Breast Unit. Together the two wards would form an integrated Breast Unit to provide the in-patient care for the Southside breast service.

It would:

a. create a 3 consultant team, giving better absence cover.
b. strengthen the multi-disciplinary specialist breast care team.
c. create a ward environment purpose-designed for all Southside breast surgery patients needing in-patient treatment.
d. create a bed complement protected from emergency admission pressures, thereby reducing the risk of late cancellation of booked admissions.
e. use a dedicated elective theatre, also protected from emergency admission pressures.
f. create the capacity at the Southern General to allow a similar strengthening of the in-patient vascular surgery service (see below).

Out-patient clinics and day case surgery would continue to be undertaken a both the Victoria Infirmary and the Southern General.

The number of patients affected would be around 100 per year which in future would go to the specialist unit at the Victoria Infirmary rather than to the Southern General.

There would be no net change in staffing, although some change in the base hospital of a small number of staff would occur.

34. The creation of a single in-patient Breast Unit at the Victoria Infirmary would create the capacity at the Southern General simultaneously (i.e. in the second half of 2001) to form **a single integrated vascular surgery service** whose in-patient work would be **based at the Southern General** (out-patients and day cases still provided at the Victoria Infirmary).

The key features of this service would be:

a. the creation of a 3 consultant team (compared with the current pattern of 2 at the Southern General and 1 at the Victoria Infirmary).
b. a dedicated in-patient area for vascular surgery created at the Southern General, with a trained dedicated nursing team.

c. more in-patients would be in closer proximity to the specialist Vascular Laboratory (mainly using ultrasound imaging) located at the Southern General (there is currently no dedicated equivalent at the Victoria).
d. the Southside vascular service would be better placed to play a leading role in the South Clyde Vascular Network currently being developed with vascular service clinicians in hospitals in Argyll and Clyde.

Emergency vascular surgery could still be undertaken when necessary at the Victoria Infirmary by the surgeons going to the patient rather than vice versa. This is already the arrangement in Glasgow, where vascular surgeons work as a specialist network to cover out-of-hours emergencies.

The number of in-patients affected would be around 240 per year who would be treated at the Southern General rather than at the Victoria Infirmary.

There would be no significant impact on staff other than possibly a change of hospital base for a small number.

NORTH GLASGOW SERVICES - CONTEXT

Sections 12 and 13 of this paper address a great deal of detail about proposals for change that have been developed during the consultation debate. We asked the North Glasgow Trust to develop specific proposals and that is what they have now done.

It is important not to let the detail obscure the fact that there is a strong degree of consensus within the Glasgow NHS about some major directions and principles:

- there should be two in-patient centres in North Glasgow.
- one of these should be the Glasgow Royal Infirmary, utilising its substantial stock of modern accommodation.
- the other should be achieved by expanding Gartnavel to allow the closure of the Western Infirmary (approved in 1996) to proceed.
- the Board's prognostications about the transfer of the smaller specialties away from Stobhill have been confirmed and the eventual transfer of general surgery and hence general medicine from Stobhill to the GRI (and Gartnavel) has been advocated and accepted (subject to the necessary facilities being fully fit-for-purpose).

The areas of disagreement during debate have concerned:

- the pattern of A & E services.
- GGNHSB's wish to locate an Ambulatory Care Centre at Stobhill.
- GGNHSB's wish to have a single orthopaedics in-patient centre in North Glasgow at the GRI
- speed with which the Beatson Oncology Centre services should transfer.

12. THE GRI \ STOBHILL PARTNERSHIP

1. Leaflet 19 described the way in which the partnership between these two hospitals has been evolving and what its further direction was likely to be. The proposal to create an Ambulatory Care Centre at Stobhill was seen as a fundamental guarantor that Stobhill would have a long term future as a busy hospital, ensuring that 90% of local people's present contacts with the hospital would continue to be as local and accessible at Stobhill as they are now.

We identified that the future of in-patient services, especially in the smaller specialties of orthopaedics, gynaecology, ophthalmology, ENT and urology, was unlikely to be sustainable in the light of increasing specialisation, restrictions on doctors' working hours, and continuing reductions in already small bed

numbers as lengths of stay reduce and day surgery increases. We concluded that general surgery would likely face similar pressures causing it to need to integrate onto one in-patient site at the GRI to provide a service for a population of 340,000 people. We asked whether people felt general medicine would be sustainable in the absence of general surgery.

2. Responses from clinicians have confirmed both our analysis of the smaller specialties and our prognostications about the future of general surgery and general medicine. The Stobhill Medical Staff Association wrote:

"The concept of a 3 acute hospital solution to Glasgow is recognised as being the best way forward but only in our view with 3 genuinely new built hospitals in modern facilities".

The Medical Staff Association's reservations are not about concept but about modernity of buildings and timescales. They went on to write:

> "it was felt unanimously that acute medicine and surgery could not exist without each other, partly because of implications of associated anaesthetic back-up and intensive care unit. The meeting unanimously rejected any plans that would involve maintaining medicine in the Stobhill site without surgery".

3. General medicine and general surgery are seen as complementary in the arrangements for acute receiving. A patient might be referred with a vague diagnosis. If medical tests did not reveal a condition treatable by a physician, there could be a need for the patient to referred to a surgeon for investigation. Equally patients admitted for surgical treatment might also need medical care.

   If there were no general surgery on site, then there would be no in-patient operations, thus reducing the activity in intensive care. This level would be so small that any intensive care unit would not be considered suitable for training of doctors and would have difficulty attracting staff. The unit could not function. This would leave general medicine on site without intensive care which would be clinically undesirable.

   These interactions between acute in-patient services are rather "internal" but they serve to demonstrate that the two specialties, general medicine and general surgery, need to work together for as long as a site operates as an acute receiving site. Therefore, for as long as Stobhill remains an acute in-patient site they should both be there.

4. The model that there should be three in-patient sites for Glasgow – two in the North and one in the South – has been the subject of debate off and on in Glasgow for years. If there is agreement that there should be a single General Surgery service in the North and East, leaflet 19 made clear this would necessarily have its in-patient base at the GRI in support of the major Accident and Emergency service. This can only be achieved, however, when the GRI can provide suitable facilities for both in-patient general medicine and general surgery for North and East Glasgow, allowing those specialties to move together from Stobhill. Until that can be achieved they should remain at Stobhill.
5. In its response the North Glasgow Trust is quite clear on these points and it is worth quoting this part of their response in full:

> "The debate in the North, especially in the North East, has concentrated on the future of in-patient facilities at Stobhill. The Trust has been explicit in its discussion at meetings that the outcome of the proposals will be the transfer of all in-patient services from Stobhill, principally to Glasgow Royal Infirmary but some to Gartnavel. The Trust wishes to register that it supports this move. The Trust recognises two points. Firstly, much of the detail of the distribution of specialties needs to be worked out with clinicians and this work is in progress. Secondly, many of the Stobhill's community expressed regret at what they perceive as a loss of service. They expressed favourable views of the service provided by Stobhill over the years. The Trust is well aware of the high esteem in which Stobhill is held by its community which reflects on the staff who have worked there.

> In the debate with many of the Stobhill catchment area and with its staff the Trust has been clear that the outcome of these proposals inevitably means that there will be no in-patient facilities at Stobhill within seven years. This fact needs to be the subject of wider and explicit consultation. The Trust takes the view that the proposals set out in the Acute Services Review not only provide clarity about the future of Stobhill but do so in a way which means that that future can be a pioneering and innovative one for the future of health care".

GGNHSB notes the point about consultation. We would hope that the principle of consolidation of in-patient medicine and surgery principally to the GRI but probably with some GPs deciding to make referrals to Gartnavel, can be agreed and approved at the conclusion of this current consultation process. However, we recognise that the public and staff must feel confident that the precise timing and circumstances of such a move are satisfactory. The key requirements are that a satisfactory standard of accommodation and access to diagnostic, theatre and other support services can be provided at the GRI (and Gartnavel). The Trust estimates that it will be able to offer this "within seven years". We do not expect it to be feasible in much less than seven years unless there are unforeseen changes in circumstances.

We therefore propose that the transfer of general medicine and general surgery be approved in principle but that there be further local consultation in due course to confirm that the implementation arrangements meet the tests of adequacy.

6. In the meantime general medicine and general surgery will remain together at Stobhill Hospital. For much of their remaining time there they would be operating in tandem with the new Ambulatory Care Centre on site. This will help the local population to develop confidence in the significance, quality and accessibility of the Ambulatory Care Centre as a major and enduring feature of Stobhill's long term future as a busy hospital site.
7. We note the view held by some doctors that Stobhill should close altogether. For example, The Area Medical Committee's comments appear to imply this, supporting "early closure of Stobhill General Hospital ..... when accommodation fit for the purpose is provided for Stobhill's patients at the remaining site".

   We do not subscribe to this view. Our objective is that as many services should be as locally accessible as possible. By locating an Ambulatory Care Centre at Stobhill, the Health Board and the Trust will be able to achieve around 90% of all patient contacts remaining local.

8. During consultation debate about the plans for the **GRI** often focused on **shortcomings of this site**. These criticisms have sometimes been expressed so forcefully that it would be possible to overlook the fact that the GRI has been a busy hospital providing a service to the people of Greater Glasgow – and beyond – for decades.

The debate also overlooks the fact that it is not possible to plan in a vacuum. We need to take account of recent developments and those in progress. In the North and East commentators often asked why the consolidation of in-patient facilities should take place on the GRI and not Stobhill where people saw more room for expansion. At public meetings the North Glasgow Trust explained that Glasgow Royal Infirmary would have to form a major component of any future plan for acute services. Two major developments costing a total of £60 million will be completed there within the next two years. There can be no question that this level of investment of public money could be written off. We cannot plan to leave these developments before they are even opened.

The Trust also pointed out that the impact of the completion of this investment on the GRI site will be considerable and will address some of the criticism directed at the hospital. The existing A & E Department will be demolished, opening up the site. There will be a new site road system. Space will be created for a multi-story car park. Importantly, a nucleus of relatively new buildings will be created around the Alexandra Parade end of the GRI site. Further development here enables services to be moved out of the old buildings on the site. All clinical activity would then take place in buildings the oldest of which would be twenty-five years old.

9. A conclusion that the GRI will be the in-patient site for general surgery and general medicine for the North and East of Glasgow within seven years means that the planning for **other in-patient**

specialties currently at Stobhill needs to be pursued in detail. This requires decisions to be made now, so that the resources for detailed planning can now be committed. A great deal of discussion has taken place on the future distribution of these services. In some cases, those discussions go back years but have never reached a conclusion.

A major synchronised planning of logistics is required of North Glasgow to ensure that the transfer of specialties takes place in an organised manner, when space is available elsewhere, when capital is available and, quite simply when it makes sense to implement the change in order to bring about the benefits for patients. All of this has to be achieved while maintaining the service.

Not all of the changes can take place at once. Therefore, although we consider that the bulk of general medicine and general surgery in-patient services will remain at Stobhill for some seven years, faster progress can and should be made with other specialties, especially those with smaller numbers of beds. The way that the benefits of consolidation, larger clinical teams, better infrastructure and medical cover can be secured across the North Glasgow Trust is described in the next few paragraphs. In each case it is essential to remember that out-patient and day case patients will continue to access their own local hospitals at Stobhill, the GRI and West Glasgow.

10. The consolidation of the **orthopaedics** in-patient service for the North and East at Glasgow Royal Infirmary has been the subject of discussion for nearly ten years. Agreement was reached by clinical staff many years ago on the need to achieve it. Actual implementation has always been hindered by operational and management problems. The orthopaedic clinicians of the North and East have co-operated across the two sites by arranging to carry out in-patient planned surgery at both the GRI and Stobhill with all trauma (accident and emergencies) treated at the GRI. These clinicians are also unanimously in favour of the single in-patient unit for orthopaedics in North Glasgow. They see it as necessary to improve the service. Specifically consolidation will enable them:

    a. to develop departments with expertise in the various sub-specialties (hands, knees, shoulders, hip replacement, trauma and so on).
    b. to work more closely with related disciplines such as rheumatology and plastic surgery.
    c. to provide the best training opportunities for junior doctors, nurses and para-medical staff.

There is an opportunity to bring about the long delayed move of in-patient orthopaedics from Stobhill to the GRI very early in 2001. Adequate ward and theatre capacity has been identified within Glasgow Royal Infirmary which would enable this move to take place but also increase day care capacity, thereby reducing waiting times. It would entail the transfer of 17 orthopaedic beds at Stobhill. The number of in-patient cases at Stobhill in 1998\99 was 806 (compared with 90 day cases and 8,395 out-patient attendances which would remain at Stobhill). The average length of stay for Stobhill orthopaedic in-patients was 5.4 days.

Staff have been fully involved in the planning for this move.

11. In the case of **gynaecology** there is general agreement that Gynaecology and Obstetrics should be on the same site wherever possible. Many of the clinicians work in both specialities and there are clinical links between the two specialties.

The North Glasgow Trust has identified a location in the Queen Elizabeth Building at the GRI which would be suitable for gynaecology. The location needs some capital investment to convert it to clinical use and once this is complete, in-patient gynaecology would be in modern, fit-for-purpose accommodation, 30 beds and the necessary theatre capacity It will also be close to the Obstetrics Department which is opening in 2001.

As the alternative location and the capital to make the necessary changes have been identified, there is no good reason to delay the move of in-patient gynaecology from Stobhill. The service and its patients will benefit from a move to new accommodation. The Stobhill Gynaecology service currently has 1989 admissions per year which would be affected by the transfer to the GRI. The move of gynaecology in-patients does not adversely impact on the specialties which will be remaining at Stobhill for the medium term. There is a need to conclude some discussion about where best to locate the in-patient gynaecological

oncology service which is a regional component of the present Stobhill service. That discussion will continue during October\November, 2000.

GGNHSB hopes that there can be agreement to this transfer early in 2001, so that the transfer can be implemented by 2002. Planning for this transfer has been less advanced than for orthopaedics but staff will be closely involved in planning for implementation.

12. An **Ophthalmology** specialty review group set up by the North Glasgow Trust advised in early 2000 that all out-patient services should be maintained on the sites they are at present. They also proposed that there should be one adult in-patient site for Ophthalmology for the whole of Glasgow. The review group did not at that stage identify a site for this.

    The review group felt that consolidation would open the way for increasing sub-specialisation and also allow the introduction of different models of care which would ensure a wider spread of expertise. This could speed access for patients to someone suitably qualified to treat their condition, whether this be an optometrist or a nurse practitioner as well as a member of medical staff. This sub-specialisation would see these different models adopted for the glaucoma, corneal and diabetic eye services. It would allow city-wide medical cover to be provided. GGNHSB believes that the key to achieving these ambitions is to encourage greater collaboration among the North and South Glasgow clinical teams, to monitor the progress of these new service models and let the future disposition of in-patient facilities be driven by the pace of change in clinical practice.

    In the meantime there is a pressing practical reason for the transfer of in-patient Ophthalmology from Stobhill. In practice, there are only two designated in-patient beds for Ophthalmology at Stobhill (although sometimes three beds are in use). These are located in the Orthopaedics ward. Once Orthopaedics moves then these two beds would have to be transferred in any case. Transfer at that stage (early 2001) to join the other in-patient service in North Glasgow, at Gartnavel, makes sense. It would improve out of hours cover for Ophthalmology for North Glasgow as a whole because of the single-site presence of SHOs working a rota which complied with regulations.

This change would affect some 570 in-patient cases treated per year at Stobhill, with an average length of stay of 1.4 days. There is capacity at Gartnavel where there are 24 ophthalmology beds (equivalent to a potential capacity of 7,400 bed days per year at 85% occupancy) and two in-patient theatres. In 1998\99 there were 1,891 in-patients at Gartnavel with and average length of stay of 2.2 day (equates to 4,160 bed days). The annual theatre hours requirement was 3,200 hours, which equates to around 67 hours per week. The current Stobhill workload would require some 8,000 bed days and 700 theatre hours (equates to around 15 hours per week). There will need to be discussion to fine tune use of total theatre capacity between day case and in-patient theatres. The patients would also have the benefit of care from trained specialist nursing and junior medical staff in a more sustainable way than can be achieved with two beds located on an orthopaedic ward remote from the main ophthalmology centre.

The day case work (over 1,100) and out-patients (over 9,000 attendances per year) would continue at Stobhill.

13. A specialty review for **urology** was also set up by the North Glasgow Trust and has reported. The review group examined a range of options for the number of sites and also the distribution of services at each of the sites. There is agreement that out-patient services should remain dispersed at all the sites in North Glasgow. While the preferred option for the in-patient service was for this to be on one site, there remains further work to be done to identify the site for this and to reach agreement on the interaction with day surgery services.

It is clear, however, that as with other smaller specialties currently at Stobhill, the North Glasgow Trust will seek to transfer in-patient Urology to link it principally to the GRI in-patient Urology service. This will affect a total of 1,593 in-patient cases per year, using 20 beds (16 beds in ward 6 plus 4 beds in the Gynaecology Ward which are used for female Urology patients only).

Although it is not yet clear whether this should be a transitional stage to a single in-patient Urology service in North Glasgow, it is clear that there are benefits in terms of sub-specialisation and junior doctors' rostering of out-of-hours cover which mean that within the next three years in-patient Urology in North

Glasgow will only be provided from the GRI and Gartnavel and not at Stobhill. The practical logistics of achieving the transfer of the in-patient service from Stobhill can only be worked out as part of the wider jigsaw of achieving change across the North Glasgow Trust but GGNHSB hopes that there can be agreement to the principle of transferring the service from Stobhill into capacity to be provided at GRI and Gartnavel.

14. **ENT** is the only other small specialty (i.e. in terms of bed numbers) at Stobhill (it has 6 designated beds although at times when other beds are available move patients are admitted) . Again it has been the subject of a specialty review in North Glasgow. This review considered the possibility of one in-patient ENT centre for the whole of Greater Glasgow but decided at this stage that it was more practicable to have one service for the North and one for the South. The North Trust will be planning to achieve this consolidation by the transfer of the in-patient service currently provided from 6 ENT beds at Stobhill to Gartnavel when the opportunity arises during the other changes being planned between Stobhill and Gartnavel. The implications of this transfer on beds and theatre capacity need to be worked through but this can be achieved in 2001\2. It would affect 1,050 in-patient cases per year with an average length of stay of 2.5 days.
15. Although the implementation jigsaw for change across the whole of the North Glasgow Trust is quite complex and not yet clear (because the major elements involving the transfer of services from the Western Infirmary to Gartnavel require large scale capital investment), the **pathway to change involving Stobhill's acute in-patient services is much clearer**:

    by or in 2001

• In-patient orthopaedics to the GRI (facilities now available).

• In-patient ophthalmology to Gartnavel (using existing Tennant Institute facilities).

by or in 2002

• In-patient gynaecology to the GRI (capital available to convert accommodation in the Queen Elizabeth Building. Future of gynaecological oncology requires further discussion).

• In-patient ENT to Gartnavel (still requires detailed planning but only 6 beds and around 945 theatre hours per year at approximately 20 hours per week to be accommodated as part of wider jigsaw of change at Gartnavel).

by or in 2003

• In-patient Urology to GRI and (requires a detailed and practicable Gartnavel plan to be developed)

by 2007\8

• In-patient general medicine and (when robust and funded plans have general surgery to GRI (some been developed to meet the tests of to Gartnavel) adequacy)

16. Before moving on to consider the position for services in West Glasgow we wish to re-state here that one of the issues emerging from the consultation has been the concern expressed by people in the **East End** about their sense of being **too remote from many services**. During one meeting, for example, a man argued that in addition to the Glasgow Royal Infirmary there should be a new District General Hospital built on the site of the former Belvidere Hospital. Many more people pointed to the cost of public transport to the GRI or to the difficulty of using two different buses if they had to go to Stobhill.

    While it is not feasible to produce a proliferation of new District General Hospitals located in Glasgow's more outlying areas and estates, we can and should seek to extend the role and capacity of primary care so that fewer people have to travel to hospitals or Ambulatory Care Centres in the first place. It should be possible to provide more local access to physiotherapy and other advice and treatment from nurse practitioners and professions supplementary to medicine. It should also be possible to provide better support to primary care in managing many chronic diseases.

Similarly an enhanced "nurse treatment room" service on a "turn up and be treated" basis would reduce pressure on GPs themselves and give patients an alternative to going to the GRI when they feel they need that sort of service.

GGNHSB commits itself to working with LHCCs and the Social Inclusion Partnership to explore these possibilities for the East End of Glasgow.

NORTH GLASGOW SERVICES - CONTEXT

Sections 12 and 13 of this paper address a great deal of detail about proposals for change that have been developed during the consultation debate. We asked the North Glasgow Trust to develop specific proposals and that is what they have now done.

It is important not to let the detail obscure the fact that there is a strong degree of consensus within the Glasgow NHS about some major directions and principles:

- there should be two in-patient centres in North Glasgow.
- one of these should be the Glasgow Royal Infirmary, utilising its substantial stock of modern accommodation.
- the other should be achieved by expanding Gartnavel to allow the closure of the Western Infirmary (approved in 1996) to proceed.
- the Board's prognostications about the transfer of the smaller specialties away from Stobhill have been confirmed and the eventual transfer of general surgery and hence general medicine from Stobhill to the GRI (and Gartnavel) has been advocated and accepted (subject to the necessary facilities being fully fit-for-purpose).

The areas of disagreement during debate have concerned:

- the pattern of A & E services.
- GGNHSB's wish to locate an Ambulatory Care Centre at Stobhill.
- GGNHSB's wish to have a single orthopaedics in-patient centre in North Glasgow at the GRI
- speed with which the Beatson Oncology Centre services should transfer.

13. SERVICES IN WEST GLASGOW

A single site service

In leaflet 18, Better Access for West Glasgow Residents, we described the long-standing plan to transfer services from the Western Infirmary to Gartnavel. We made clear that this remained an essential objective. There has been little disagreement with the view that there *should* be a single in-patient site for West Glasgow for general medicine and general surgery and their sub-specialties. This will end the arrangements which see patients being shuttled backwards and forwards between the two sites during a single stay in hospital, often on more than one occasion. No one has disagreed with the need to achieve this.

1. **Gartnavel** will become the **in-patient site for West Glasgow for general medicine and general surgery**. For the first time it will be an acute receiving hospital with the ability to treat medical and surgical emergencies referred by GPs.

   Gartnavel will also for the first time be able to treat people who have minor injuries which previously would be treated in an A & E Department at the Western Infirmary. The addition of acute receiving and minor injuries unit to Gartnavel brings both these services into a

location more widely accessible to the population of West Glasgow than the existing Western Infirmary. Gartnavel will also become the acute in-patient centre for specialties such as Ophthalmology and ENT. These developments will build on the other developments which have taken place at Gartnavel and which are described in leaflet 18:

- The Brownlee Centre which opened in June, 1998.

- The new Homoeopathic Hospital building.

- A new Ophthalmology Department.

- A new Out-patient Radiotherapy Unit.

- The new Scottish National Blood Transfusion Service facility.

2. Earlier in this paper we describe the debate there has been about **Accident and Emergency Services**. We recognise that the majority of medical and public opinion in West Glasgow would wish there to be an Accident and Emergency Service at Gartnavel. However, our analysis in Section 5 of this paper sets out why **we believe that the need for 'gold standard' A &E services to deal with moderately to seriously injured patients can be met by two centres in Glasgow rather than three and why the Southern General is the best strategic location for the second such unit if the GRI is the other**.

   We go on in Section 5 to analyse the range of numbers of patients we would expect to use a Minor Injuries Unit at Gartnavel. Based on the detail provided in Annex 6 our expectations would be as follows:

Current level of attendance at Western Infirmary = 55,000 per year. Of these, 1,200 are children whom we would expect in future to go to Yorkhill or to be treated by primary care. Another 12,000 are GP referrals. We would expect these to go to Gartnavel. Some 8,600 are adult 999 ambulance cases. We would expect most of these to go to the Southern General (the balance to GRI). We would expect between 13,300 and 19,900 to go to the Minor Injuries Unit at Gartnavel. Of the others we predict that no more than 6,600 would go to GRI (probably significantly fewer than this). The larger number would go to the Southern General. So, of the present 55,000 attendances at the Western Infirmary our prediction for the future is that they would go instead to: Gartnavel 25,300 to 31,900 Yorkhill or primary care 1,200 GRI or Southern General 21,900 to 28,500

3. During consultation, people have raised anxieties about where they would be taken if they had a **heart attack**. The advice of the Accident and Emergency Sub-Committee on this issue is:

   "It is recognised that (GP referred emergency) patients who have been assessed as stable by their GP and referred for in-patient assessment can be safely admitted via (medical and surgical) receiving units and that this is the current practice elsewhere. All un-assessed 999 self-referral patients, together with physiologically unstable patients and those that deteriorate in transit should be admitted and assessed by A & E staff in a fully equipped department medical and surgical receiving at hospitals without full A & E services should be limited to GP-referred stable patients".

   GGNHSB has asked the A & E Sub-Committee to explain their advice more fully since others have said that they would expect patients with "obvious heart attack symptoms" to be

taken to the medical receiving unit at Gartnavel. Their reply will be published when it is received.

4. In this context it is worth reminding ourselves what the **travel time differences** are.

   The road pattern is such that anyone travelling from west of Anniesland will currently approach the Western Infirmary from there, either along the Great Western Road, cutting through to the Western Infirmary at some point or along the Clydeside Expressway or Dumbarton Road. Those coming from the Maryhill area or beyond will use Bearsden Road to Anniesland Cross or Clevedon Road or Maryhill Road, then cutting across Great Western Road at some point.

   - From Anniesland Cross it takes around 11 minutes to drive to the Western Infirmary.
   - From Anniesland Cross to Gartnavel is 4 minutes.
   - From Anniesland Cross to Southern General is 8 minutes.

   Thus although Gartnavel provides the shortest time, the Southern General provides a 3 minute improvement compared with present experience of going to the Western Infirmary.

   For people currently living close to the Western Infirmary, for whom the present ambulance journey may be only 5 minutes or less, the future journey time to the Southern General would be around 10 minutes (measured from the Partick end of Byres Road) which is still significantly less than experienced by many patients in Greater Glasgow being taken to the present pattern of A & E Departments.

   All of these times were measured in normal driving conditions, not in blue light conditions.

5. The other major area of debate during consultation has been the issue of whether there should be a separate **orthopaedic service** at Gartnavel or whether there should be a single orthopaedic service for the whole of the North Glasgow Trust with its in- patient facilities located at the GRI.

   In our consultation proposals we indicated our preference for a single North Glasgow service with all of its in-patient services at the GRI, but undertaking out-patient and day case surgery work at all three sites (GRI, Gartnavel and Stobhill).

   The Area Medical Committee in saying that it was "unable to support the withdrawal of in-patient orthopaedic services from the Gartnavel site" did so because it was "unconvinced that the change from five A & E sites to two can be safely managed in the current climate" and the presence of on-site orthopaedics is essential to the viability of an A & E service.

   The Orthopaedic Sub-Committee itself did not submit a response to the consultation, almost certainly because opinion within it is divided. The orthopaedic surgeons at the GRI, Stobhill and Southside favour a "two orthopaedic unit" configuration for Glasgow. Those in West Glasgow advocate a "three unit" configuration.

6. The **arguments in favour of a single trauma and orthopaedic unit** in North Glasgow as described by the orthopaedic surgeons from the GRI and Stobhill are:

   a. it allows departments to be developed with expertise in the various sub-specialty areas of orthopaedics, including upper limb surgery, hand surgery, spinal surgery, lower limb surgery, complex trauma surgery and bone tumour surgery.
   b. it provides the best possible training environment for junior doctors, nurses and paramedical staff.
   c. it provides the most robust platform from which to co-operate with related disciplines, notably rheumatology, plastic surgery and oncology.

d. it provides the strongest possible basis for a University department of orthopaedics.
e. it complies most easily with the requirement to reduce junior doctors' hours.

7. The **arguments against**, advanced by the West Glasgow orthopaedic surgeons are a mixture of comment about the overall principles of our proposals:

    - the "split-site working" argument.
    - the risk management issue relating to day surgery in stand-alone Ambulatory Care Centres.
    - opposition to Minor Injuries Units staffed by nurse practitioners.
    - doubts about the capacity of the GRI A & E Department to cope.
    - a lack of detail in the GGNHSB proposals about how we should tackle the "blocked beds" issue.

    and points specific to orthopaedics:

    - a worsening of access for West Glasgow orthopaedic patients.
    - access for visitors to elderly patients with hip fractures.
    - the need for on-site orthopaedic support for patients of the Beatson Oncology Centre whose cancer involves the bones or who experience pathological fractures.
    - a single North Glasgow service of 18 or more consultants would be too large to run efficiently "particularly since doctors could be working between three hospitals (Gartnavel, GRI and Stobhill)".
    - synergies between orthopaedics and other specialties have been overlooked.
    - there is no evidence that a single unit will improve the quality of care.

8. It is important to look closely at the arguments for and against. The issues around **stand-alone Ambulatory Care Centres, Minor Injuries Units and the capacity of the GRI A & E Department** are addressed earlier in this paper (see paragraphs 4.6, 5.6 and 5.22\23 respectively).

9. The issue of '**blocked beds'** is undoubtedly important and is being addressed in conjunction with colleagues in Social Work services. Glasgow has many fewer 'blocked beds' to-day than it did two years ago and we intend to achieve further reductions. The consultation exercise about the reconfiguration of acute services cannot include every angle and cross-connection with other strategies – those wanting to be assured about such issues need to look at the Health Improvement Programme.

10. The question of **"split-site working"** is discussed in paragraph 4.7 of this paper but also needs to be seen in the context of how a larger unit might be organised.

The West Glasgow orthopaedic service has a potential complement of eight consultant orthopaedic surgeons, the GRI\Stobhill service would have nine when fully staffed. (The South Glasgow orthopaedic service will have twelve consultants).

The creation of larger teams provides scope to organise clinical commitments more confidently against the disruption caused by leave and other absence than is feasible in a smaller unit. It also provides more scope to cover trauma adequately by pairing consultants in a "buddy" system with improved continuity of patient care and more flexible receiving duties. At the same time this should maximise the amount of time available for clinics and elective operating.

In leaflet 10 (on Doctors' Working Hours) we gave an illustration of how this could work in practice.

The advice of general and orthopaedic surgeons is that single in-patient surgical and orthopaedic units on the Southside could each comfortably manage their emergency workload with single emergency teams in each specialty.

Every day on both sites in the South, we currently have 2 emergency orthopaedic teams, that is theatre nurses, anaesthetists and surgeons available to perform emergency operations. The reduction to a single emergency team would free up that resource to perform elective work and reduce our waiting list for elective procedures in orthopaedics. This would free up enough time to do, for example, 500 extra hip replacements in a year.

If we illustrated this point in terms of hours, an example might be as follows:

If each hospital has consultant emergency presence in the hospital from, say, 9 a.m. to 7 p.m. each day then the difference in requirement for consultant surgeon time is as set out below. It is expressed in very simple terms but it serves to illustrate the point:

9 a.m. to 7 p.m. dedicated time for emergency work = 3,650 hours per year.

So, 2 orthopaedic units with emergency cover require 7,300 hours a year whereas a single team\unit could do the same job using only 3,650 hours. Moving from 2 to 1 releases 3,650 hours a year to be used to reduce non-emergency waiting times without any adverse effect on ability to deal properly with emergencies. An individual consultant complying with EU working hours regulations can work 2,016 hours per year. So 3,650 hours is equivalent of nearly two consultants' clinical working time

There are many different ways of organising work programmes. An illustration of how moving from two separate orthopaedic services in South Glasgow to one could be expected to lead to significant benefits has been produced during the consultation period:

Possible Activity Gains from One-site Model

Assume 12 consultants, of whom 8 will have a trauma commitment and 4 will not. Each surgeon will work 26 fixed sessions per month, of which a basic 20 will be as follows:

TRAUMA SURGEONS
4 ortho clinics 8 elective theatres 4 fracture clinics 4 trauma theatres

ELECTIVE SURGEONS
8 ortho clinics 12 elective theatres

The balance of 6 sessions\consultant\month will comprise Day Surgery sessions, elective theatre sessions and special interest clinic sessions in proportions designed to fit each consultant's individual practice.

This will generate a total of 72 sessions, which assuming an equal split will lead to:24 day surgery sessions 24 elective theatres 24 special interest clinics

Assume each surgeon is available for 10 months (40 weeks).
Assume 16 patients are seen at each New OP clinic and half the Ortho clinics are for new patients.
Assume 12 patients are seen at each Special Interest clinic.

In one year 5,120 patients will be seen at New OP clinics and 2,880 patients will be seen at the Special Interest clinics. This makes a total of 8,000 New OPs per year.

The total number of elective theatre sessions will be 1,360 per year.

This compares with current practice (where each surgeon does 8 elective theatres per month and 4 new patient clinics per month) as follows:

	Status quo	new model
New OPs per year	7,680	8,000
Elective theatre sessions per year	960	1,360

It is understood that the British Orthopaedic Association advocates 12 new patients per clinic in Teaching Hospitals (as opposed to 16 in this illustration) but the difference in productivity potential between status quo and new model remains significant even if applying a lower rate of new patients per clinic.

It is difficult to see why similar gains could not be achieved in patient activity (with all its benefits for reducing waiting times) in North Glasgow. This would need to take account of the larger trauma commitment from combining the workload for the entire North Trust. It is estimated that when combined with the increasing number of hip fractures in the elderly and pathological fractures from the Beatson Oncology Centre, this would require two Consultant teams working in two theatres, at least during the normal working day. Only one Consultant would be required for overnight cover but at junior staff level there would be a need for duplication to provide cover to both the elective and trauma wards as well as providing orthopaedic support to the A & E Department. For these reasons the move from two orthopaedic units to one would not result in a significant saving in junior staff on-call rotas.

What it does do is provide an opportunity of creating a large team of at least 16 consultants with better cover for absences due to leave and more flexible work programmes.

It is this efficiency which generates so many opportunities to strengthen sub-specialisation, increase patient numbers, reduce waiting times and increase the richness of training and research opportunities for staff by providing the basis for a University Department of Orthopaedics.

11. What of the issues of **access for patients?** The current activity profile of the West

    Glasgow service is:

	Per year	
Out-patient attendances	21,807	Would be at Gartnavel
Day case surgery cases	723	Would still be at Gartnavel
In-patient admissions	3,619	Most of the trauma cases would go to the Southern General. Elective cases would be undertaken at GRI.

    Most trauma patients are ambulance borne and for them access is not an issue. For elective patients the issues become those of car parking and public transport access at the GRI , which we addressed in paragraph 6.4 of this paper. The number of patients affected is very similar to the numbers of patients who have to travel to a single centre in the city already for some services, such as neurosurgery (3,250 per year), plastic surgery (3,500), paediatric surgery (4,700) – certainly not as convenient as having a service on one's local doorstep but not an unusual experience when the benefits for patient care lead to some centralisation. In the case of orthopaedics the benefit to patient care derives from more robust continuity in sub-specialisation service provision and significant reduction in waiting times caused by the more efficient management of trauma demand.

12. In the case of **elderly patients and their elderly visitors** there is an issue which needs to be addressed regardless of where hospitals are located and that concerns the speed and effectiveness of rehabilitation services and discharge planning. We acknowledge the need to devote effort and resources to improve NHS (and local authority) performance in this area. Elsewhere in this paper we have examined the predicaments of visitors (see paragraph 6.12). Most West Glasgow trauma admissions would go to the Southern General which has adequate car parking space, is more accessible to more parts of West Glasgow than is the

Western Infirmary and whose public transport links can be greatly improved by our proposal to sponsor a regular shuttle bus link to the Partick Station rail\bus interchange.

13. The issue of **synergy with other specialties** is difficult to get right in Glasgow since its size and the unavoidable need for some specialties (such as neurosurgery, plastic surgery and maxillo-facial surgery) to be highly concentrated onto single sites means that perfection is unattainable. (Clearly at the GRI there would be excellent synergy between orthopaedics, A & E services and plastic surgery). In the case of Gartnavel the key necessary **synergy is with cancer services.**

For the Orthopaedic Oncology service there is a need to provide out-patient clinics, diagnostic imaging with CT and MRI and a biopsy service in close proximity to the main Beatson Oncology Centre. This leaves a difficult decision on where to site the in-patient services for the small number of patients requiring major tumour surgery. On balance the expert opinion from the specialists in orthopaedic oncology would prefer this to be with the major orthopaedic service because of the need to utilise specialised theatre facilities, equipment and instrumentation. These would be expensive to duplicate for a relatively small, but demanding, workload. It would also provide the additional advantage of easy access and collaboration with the Plastic Surgeons at GRI. However, this would create an additional need for the patients with pathological fractures from cancer deposits in bone to be transferred from the Beatson Centre to GRI for their surgery. The current estimates are that there would be 2 – 3 patients each week with this problem.

14. The final issue concerns the **rostering of junior doctors in orthopaedics**. The cost of paying for four emergency rotas when two would be quite adequate is not insignificant given the now punitive cost of junior doctors' out of hours working. In the case of orthopaedics in North Glasgow the current cost of 31 junior doctors is £1.2 million per year. If the present rota pattern continues unchanged, by 2002 the cost will have increased by £890,000 (i.e. almost doubled). It is urgent that the number of rotas is not sustained at this level, since we would be paying hundreds of thousands of pounds unnecessarily for no benefit to patients.

Our conclusion therefore is to maintain the proposition that there should be one single orthopaedic team for North Glasgow with its in-patient service located at the GRI, undertaking out-patient and day case work at all three hospitals (GRI, Gartnavel and Stobhill).

15. In leaflet 18 and in leaflet 21, Radiotherapy : Linear Accelerators – A Patient's Guide, we proposed that the **Beatson Oncology Centre** should remain on the Western Infirmary site while the general medicine and general surgery services were transferred to Gartnavel. We saw this as a temporary measure, lasting no more than ten years. Most responses have urged us to accelerate this process. In its response the North Glasgow Trust sums up the position thus:

"Discussion within the Trust had raised doubts that the Trust can sustain the delivery of cancer services over two sites for as long as ten years. These doubts have been reinforced by the action taken by the Trust to address the lengthening waiting lists for radiotherapy treatment. This led the Trust to accelerate the programme for the introduction of the three new linear accelerators at Gartnavel. These will now come into operation by December, 2001, eight months earlier than originally achievable.

Previously the more gradual commissioning programme for these machines would have meant they would have provided out-patient treatment to compliment the in-patient service provided from the Beatson Oncology Centre located at the Western Infirmary. The accelerated programme will mean that the provision of in-patient radiotherapy will be possible at Gartnavel earlier than planned. It would be provided from two sites, Gartnavel (from the new machines) and the Western Infirmary (from the existing machines).

The Trust does not believe that the provision of in-patient radiotherapy services from two sites is sustainable. Therefore, the Trust believes that the total service will need to be relocated to be close to the new machines sooner than originally planned. This would also satisfy the need for cancer services to be located close to surgery".

We agree with these arguments.

The Trust is now accelerating its planning and the development of an Outline Business Case for the transfer of these services from the Western Infirmary to Gartnavel General Hospital. The Trust plans to achieve this within the next five years. The Beatson Oncology Centre will be relocated within that time with all its services then provided from Gartnavel.

16. This change of plan has an impact on one other element of the proposals. This relates to the **centralisation of Cardiothoracic Surgery**. Leaflet 20 "Why Centralise Cardiothoracic Surgery?" explained the reasons for the plan to bring together in one unit the services currently provided at the GRI and at the Western Infirmary. The objective of centralisation has not been questioned during the consultation. The proposal has been generally welcomed.

    The proposal to locate the centre on the Western Infirmary site was made because it was already the location of one of the two elements of the service. It also ensured that, together with the continued presence of the Beatson Oncology Centre, greatest use was made of the relatively modern buildings at the Western Infirmary. Finally, it freed space in the GRI for other moves in the complex series of specialty transfer across North Glasgow.

    As the Beatson Oncology Centre is now to be transferred earlier than planned at first, there is a question of whether the Western Infirmary site can sustain only one service, the Cardiothoracic Centre, for up to 10 years. The North Glasgow Trust has yet to work through the implications of this with the clinicians and others. There **might be a need to relocate this service earlier than originally suggested**.

    Notwithstanding the timing of the move to Gartnavel, however, we propose to plan for a single Cardiothoracic Centre in North Glasgow. This will still be in two stages with an initial consolidation to the Western Phase 1 building and subsequent relocation to Gartnavel. The question of how long that subsequent relocation will take will be addressed during the next two months.

17. What of the position of **other specialties at Gartnavel?** We have already indicated in Section 12 that we propose to designate Gartnavel as the in-patient centre for the North Glasgow **Ophthalmology and ENT** services (with out-patient and day case work at all three hospitals).

18. **Gynaecology** currently based in West Glasgow faces the same clinical logic referred to earlier in relation to the Southside and North and East Glasgow which favours co-location with both obstetrics and urology. It also faces the same issues of declining bed numbers and inefficient rostering requirements for junior doctors. Co-location with obstetric services is not possible at Gartnavel. Creating a larger single site location for in-patient gynaecology at the GRI would require more space than is available there.

The debate sponsored by the North Glasgow Trust has confirmed an already emerging view that the most sensible way forward would be to co-locate the current West Glasgow gynaecology service with the single gynaecology service being proposed for South Glasgow (see paragraphs 11.30 to 11.33 for details).

The outcome of consultation on the choice of whether to locate Glasgow's second maternity delivery unit at the Southern General or at Yorkhill cannot be anticipated. If the outcome is to choose the Southern General than co-location of gynaecology with both obstetrics and urology would be achieved. If the outcome is to choose Yorkhill, the obstetrics and gynaecology team supporting its operation would be separated from the Southern General by a relatively short journey through the Clyde Tunnel (approximately 10 minutes).

The issue of timing is set out in paragraph 11.32. Synchronised transfer of the West Glasgow and Victoria Infirmary in-patient gynaecology services to the Southern General in the Autumn of 2001 would avoid

gynaecology having to make a double move (from the Western Infirmary to Gartnavel and then to the Southern General).

We therefore propose that in-patient gynaecology should transfer from the Western Infirmary to the Southern General as soon as the necessary upgraded ward and theatre capacity has been provided (hopefully by the Autumn of 2001). Out-patient and day case work will continue to be done in West Glasgow.

14. OTHER SPECIALTIES

1. The position on some other specialties needs further discussion.
2. During consultation, the dermatologists have produced a document which proposes **a unified Dermatology service for Glasgow**. The proposal combines a well developed vision of local ambulatory care at all hospital sites with a single in-patient unit (they propose 24 beds). The proposal is attached at Annex 8.

   Dermatology is currently located at both the Southern General and the Western Infirmary. Clearly with the closure of the Western Infirmary some relocation is unavoidable. The questions is "to where?".

   GGNHSB would want to encourage the dermatologists towards the achievement of their vision of excellence and accessibility.

   We therefore endorse the principle of a single in-patient centre for Greater Glasgow and will now explore what the preferred location should be. As part of that process we seek views on the thinking set out in Annex 8.

3. Some months ago we requested advice on the organisation of **Nephrology** services (for kidney patients). In leaflet 4 we had indicated that we proposed one in-patient centre at the Southern General and one in North Glasgow. This reflected earlier advice from nephrologists that there should be two units in Glasgow and GGNHSB's own desire to see a nephrology service established in South Glasgow.

   We are not sure whether professional opinion on this issue has shifted in the intervening months. Our view is that the major A & E centres proposed for the GRI and the Southern General should have on-site nephrology services in support. We are open to persuasion that Gartnavel and its mix of services may also need on-site nephrology services in support.

   We wish to receive definitive advice on the pattern of provision for nephrology based on the disposition of other specialties now becoming clear through the present consultation exercise.

4. The position of **urology in North Glasgow** was discussed in paragraph 12.13 in relation to the transfer of in-patient urology services from Stobhill to the GRI and Gartnavel. The North Glasgow Trust has indicated that it is not yet clear whether such a transfer would be a transitional step towards a single in-patient service in North Glasgow or not. If there is a proposal to establish a single North Glasgow in-patient service it will be subject to separate consultation in due course.

   In the meantime GGNHSB confirms its proposal to transfer in-patient urology from Stobhill to the GRI and Gartnavel as soon as appropriate capacity and support services can be provided (see paragraph 12.13).

5. The significance of **mental health services** has been raised in connection with several aspects of the consultation. There is of course a well developed Mental Health Framework and Implementation Plan which is currently being put in place throughout Glasgow as new facilities (e.g. the new wards at Stobhill) and revenue money become available. It was itself subject to extensive consultation during 1998 and 1999.

The three areas of significance in relation to acute services configuration are:

a. the need for "liaison psychiatry".
b. the replacement of Leverndale Hospital in South Glasgow.
c. the future of Stobhill Hospital.

6. **"Liaison psychiatry"** recognises the connection between physical and psychiatric ill health. The Primary Care Trust's Psychiatric Medical Advisory Committee wrote

> "Improving the psychological health of medical\surgical in-patients and out-patients improves the quality of life, ... reducing bed occupancy, investigation and procedural costs ..... Each provider unit should provide facilities, both in medical wards and Accident and Emergency Departments which is sufficiently private, safe and properly furnished for interviewing patients concerning psychological, sexual problems and assessment of suicide risk".

In Glasgow there is a high level of need in relation to patients with drug and alcohol addictions and others who have committed deliberate self-harm.

We shall need, in the detailed next stages of planning, to ensure that liaison psychiatry is available whenever it is needed on all acute hospital sites.

7. The Primary Care Trust is planning the re-location of mental health services from their isolation at Leverndale and reprovision of existing mental illness beds at the Southern General currently provided in very old and unsuitable buildings. Their preferred option is to **co-locate acute mental health services on the Southside's acute hospital site**. This would:

a. help to make the provision of liaison psychiatry more efficient.
b. help to reduce the stigma of mental illness which is perpetuated by the existence of stand-alone "mental hospitals".

This service improvement goal is relevant to the choice of location for the Southside acute services in-patient hospital. Environment and design are important in good mental health care. High rise development is not appropriate and adequate dedicated recreation space is important. The requirements are therefore quite "land hungry". The need could not be met at the Victoria Infirmary\Queens Park Recreation site. The Trust's preference is for the Southern General site and space has been earmarked on the Coila Park site within the campus which neither interferes with the space needed to rebuild the Southern General nor add to the risk of site disruption during construction.

8. Some commentators have raised questions about the position of **mental health services at Stobhill** if there are no general acute in-patient services there. Such a change in Stobhill's role would not undermine the clinical effectiveness of the mental health services in any way. The fact that the Stobhill campus would still be an extremely busy general acute services site (with over 300,000 patient attendances per year) would mean that its atmosphere would be dominated by that activity rather than by the presence of a relatively small number of mental health wards. Most importantly the risk of mental illness being stigmatised would be reduced by Stobhill's multi-purpose healthcare role.

   The presence of mental health services on the campus would help to provide liaison psychiatry support needed for Stobhill's Ambulatory Care Centre.
9. The issue of clinical support specialties such as **laboratory services** and **imaging** (x-ray, ultrasound, MRI) was not addressed in our original consultation material. Work is underway to develop an investment plan for imaging services in Glasgow and will be reported in our next Health Improvement Programme. In the case of laboratory services we recognise that capital investment is needed to modernise facilities, harness new technologies, create flexibility between disciplines and provide a platform for further new scientific development. We wish to work with the Trusts and laboratory medicine staff to consider what the most effective investment strategy would comprise.

15. MATERNAL AND CHILD HEALTH

1. In leaflet 17 ‘Maternal and Child Health’ we described the suggestion that had been made about the possibility of re-locating Yorkhill Trust’s hospital services into brand new facilities. This would at the same time facilitate an on-site link with adult services which does not currently exist and strengthen the child-centred focus on some children’s hospital services not currently provided by Yorkhill.
2. We acknowledged that the suggestion had not been developed in any planning detail but felt, in the spirit of early consultation on issues, that we should stimulate discussion about it.
3. The responses to consultation have not been studied in any depth since they only emerged at the last moment in the consultation period. We can summarise their gist but not get very far in any evaluation of them.
4. The Yorkhill Trust conducted extensive consultation themselves with a wide range of staff, family \ parent support groups and others with an interest in the health, development and healthcare of children. They report that over 100 written responses were received but have not shared those with GGNHSB. Instead the Trust Board has referred to the inevitability that a wide range of comments were received but has distilled a number of recurring themes emerging from their consultation exercise:

    - accessibility.
    - importance of retaining a child centred focus.
    - access to local amenities\environment for patients and families.
    - integration between child and maternity services.
    - concern that financial imperatives should not drive a decision.
    - the need to avoid planning blight.
    - the perception of charitable organisations possibly being adversely affected by location within a predominantly adult campus.

5. GGNHSB itself received very few letters from the general public on this issue. Some thought the idea of re-location was worth exploring, some opposed it.
6. The trust developed 10 Key Principles which they feel should guide the continued development of Child and Maternal Services. These are shown at Annex 9.

The Trust’s commentary (also shown in Annex 9) on how the principles would be met by the choice between re-locating children’s services or leaving them at the present Yorkhill campus needs fuller analysis. For example:

a. In Principle 1 (access), no reference is made to what the differences in travel might be in measurable terms nor is the significance of over 21,000 children attending adult A & E services at the Victoria and Southern General considered. The analysis given on access also excludes consideration of access for longer stay children and their parents\visitors.
b. Principle 7 (advocacy for children) seems to be about Yorkhill’s status as a separate Trust rather than about the difference that location might make to this Principle.
c. There appears to be no recognition of the possibility that Principle 10 (a child and family focus) might be diminished depending on how location influenced the degree of achievement on Principles 4 (links with maternity services) and 5 (links with adult medicine).
d. The analysis of Principle 5 (links with adult medicine) appears to be limited to the benefit it might have for children whose later care as adults would be served by the host adult acute hospital site. It is highly likely that the benefits of links with adult medicine will be greater than that, especially for older children and adolescents and for maternity patients.

7. The Trust also commissioned W.S. Atkins to provide an estate development plan for the Yorkhill site. The report has only just been received by GGNHSB and needs examination. However, it appears to have several main messages:

    a. the existing Queen Mother’s Maternity Hospital building is in "very poor physical and functional condition. Even with an investment of over £15 million, an upgrade would not address some of the fundamental functional problems that were inherent due to the building’s structure. ..... the constraints inherent in the existing structure and difficulty of site access do not lend themselves to the provision of 21st century maternity services. In addition construction work would be logistically extremely difficult, due to site access and especially if a clinical service had to be retained throughout".

b. there is site space to provide a new Ambulatory Care Centre at Yorkhill if the present Queen Mother's building is demolished.
c. the existing Royal Hospital for Sick Children's main block is in reasonably good condition. Physical and functional upgrading costing around £25 million would take it into the next 30 years.
d. the report does not appear to address whether and how the existing Main Block could eventually be replaced on site while continuing to provide its services. The suggested site development plan does appear to offer only what would in future be the hospital's main car park as a site but that would be immediately adjacent to the existing block (and therefore very disruptive during construction) and when completed would result in a less good functional relationship with the proposed Ambulatory Care Centre.
e. the cost of building a new maternity unit at the Yorkhill site would be £13.3 million (excluding VAT and equipment) on one of two suggested site development options or £14 million on the other.
f. the cost of redeveloping the Royal Hospital for Sick Children and give it its "30 year lease of life" would be some £23.5 million on one option or £28 million on the other. The second option is the most ambitious. The difference between the two is essentially that the second provides a brand new Ambulatory Care Centre while the first does not.

This is a useful piece of work which now needs closer examination.

9. By comparison the South Glasgow Trust had estimated that it would need to spend around £51.7 million (excluding equipment) in order to include Yorkhill's services at either Cowglen or at the Southern General campus.

This option too needs closer examination over the next few weeks. In particular its adequacy in terms of site space, internal functionality and service linkages needs to be tested.

10. The Yorkhill Trust's conclusion, following its consultation process, and its consideration of the 10 Key Principles and the W.S. Atkins Report was that it should remain on its present site, with progressive redevelopment of child and maternal hospital facilities on the site.

A number of other commentators took this view.

11. A different view was taken by the Area Medical Committee. It supported the provision of Maternity services at the GRI and on the South Glasgow site. With regard to children's services it said:

"there is strong and unanimous support for the longer term continuation of Glasgow's children's hospital, the Royal Hospital for Sick Children, providing services to children and maintaining its own unique ethos. The Committee supports the principle that there are advantages to the Glasgow children's hospital and regional referral centre for children being co-located with an adult general hospital on a shared campus. The Committee is ..... sensitive to the concerns of those who are unconvinced that the possible benefits outweigh the perceived dangers of the loss of facilities specially designed for the needs of children. Our children's hospital must not become 'just another department' in an acute Trust".

Within the medical advisory machinery those supporting this view included the Area Anaesthetics, GP and Obstetrics and Gynaecology Sub-Committees. The Paediatric Sub-Committee rehearsed the pros and cons in an even-handed way and concluded that it did "not see the need to move RHSC from its present site at Yorkhill. Until it is clear what alterations are being offered it supports the view that Paediatric and neo-natal services should continue to expand and develop on this site".

11. The Local Health Council felt more information about choices and benefits should be developed. It felt there was merit in exploring the matter further but that GGNHSB should not commit itself at this stage to a policy to transfer Yorkhill's services.
12. The issue needs to be seen alongside the future disposition of maternity services. In 1999 GGNHSB consulted on a recommendation from the Maternity Services Liaison Committee that in the light of falling numbers of births and the imminent surplus capacity in Glasgow once the new GRI Maternity Unit had opened, we should reduce the number of delivery units from 3 to 2. In other words GRI plus the Southern General or GRI plus Yorkhill.

The Maternity Services Liaison Committee has done further work on the factors that should affect this choice and GGNHSB expects to receive some suggestions in the next month or so. We shall then conduct public consultation as to what choice we should take.

13. Where does this leave the issue of Yorkhill's services for children? We need to examine the analysis of issues produced by the Yorkhill Trust, the W.S. Atkins Report and the issues of space, functionality and linkages of other options. We shall encourage those analyses to be conducted openly and on a shared basis, during the next two months.

If, by December 2000, GGNHSB felt that there was a justifiable case for considering the transfer of children's services from Yorkhill to brand new facilities elsewhere we would develop a fully worked up consultation paper for widespread consideration early in 2001.

16. FUTURE OF GLASGOW DENTAL HOSPITAL AND SCHOOL

1. In its response, the North Glasgow Trust has drawn to our attention the separate consideration which they have been giving to the future of the Glasgow Dental Hospital and School. Representatives from Dental Hospital and School staff, Glasgow University, Greater Glasgow Health Council, Postgraduate Education, and the Chief Dental Officer have been involved in discussion.

2. The status quo is not an option. The services provided at present from the Glasgow Dental Hospital and School will almost certainly have to move from their present site in Sauchiehall Street. Structural problems in this building have been identified. An option appraisal has indicated that any solution to these structural problems raises major affordability and practical operational problems.

The objectives of the review of the Dental Hospital and School needed to address clinical and educational issues:	
Clinical	**Educational**
How to improve patient service by: a. reconfiguring clinics to gain more effective care. b. increasing chair efficiency through multi-use clinics. c. redesigning A & E Dental services and introducing one stop services. d. introducing new technology (e.g. teledentistry). e. developing local referral services. f. reconfiguring production laboratories.	i) How to accommodate the additional BDS year taking place in clinics. ii) How to increase outreach for fifth year students. iii) how to introduce a screening clinic to ensure the suitability of referrals to student clinics.

3. The review produced a short list of six options.

    1. Do minimum (repairs only) on current site.
    2. Repair, refurbish and reconfigure the tower block, decanting from the old block.
    3. Two possible sites for relocation at the Western Infirmary.
    4. Share of the New Build planned at Gartnavel.
    5. New Build at Stobhill.
    6. Share of the New Build planned at Southern General\Southside.

4. A workshop was held to identify the criteria for assessing these options. A further workshop involving staff, staff representatives, representatives from the Health Board, health Council and

Chief Dental Officer was held to assess them. Some of the options were deemed unsatisfactory by those involved in the workshop.

1. Do minimum on current site	Both these options incur high costs, severe disruption, absence of real functional and structuralimprovement and high maintenance costs.
2. Refurbish current site	
3. Relocation at the Western	The uncertainty surrounding the long-term future of Infirmary this site rules this out.
6. New Build in the South	A transfer to a different organisation at the same time as relocating the service adds avoidable complexity. The alternatives offer greater potential for patient benefit by enabling interaction with Oncology and Cardiology.

5. This left relocation to Gartnavel or Stobhill. Further work needs to be done on developing these options. In the meantime GGNHSB and the Trust would welcome feedback on the issues. In due course a formal consultation process will need to be pursued.

7. SUMMARY OF PROPOSED DECISIONS AND FURTHER WORK AFTER DECEMBER, 2000

1. Some of the issues and propositions emerging from the consultation require decision at the end of the consultation process. Others are issues which would be addressed during subsequent detailed planning and the development of Outline Business Cases. In this section we set out which issues would be pursued in which way.
2. Issues which we believe will require Health Board decision in December, 2000 are as follows:

    a. that there should be a single in-patient hospital on the Southside of Glasgow (a South Glasgow University Hospital).

    b. that this will entail transferring in-patient services from the Victoria Infirmary to the new South Glasgow University Hospital.
    c. that the Southern General campus should be the site for the South Glasgow University Hospital subject to confirmation in the option appraisal to be conducted as part of the Outline Business Case process.
    d. that in implementing the 1996 Ministerial agreement to close the Western Infirmary and transfer services to Gartnavel, GGNHSB will be commissioning a Minor Injuries service there, while Accident and Emergency Services would be provided at the GRI and South Glasgow University Hospital.

    e. confirming also that the role of Gartnavel will comprise:

        - medical and surgical receiving.
        - the single North Glasgow in-patient centre for ophthalmology and ENT.the Beatson Oncology Centre.
        - the Regional Cardiothoracic Centre.
        - local Ambulatory Care services.
        - a Minor Injuries Unit.

    f. the early implementation of the following transfers of in-patient services:

        - centralise in-patient gynaecology from Victoria and Gartnavel to SGH in 2001.

        - centralise Southside in-patient haemato-oncology at Victoria in 2001.

- centralise Southside in-patient breast surgery at Victoria in 2001.
- centralise Southside in-patient vascular surgery at SGH in 2001.
- transfer in-patient orthopaedics from Stobhill to GRI in 2001.
- transfer in-patient gynaecology from Stobhill to GRI by or in 2002.
- transfer in-patient orthopaedics from Western\Gartnavel to GRI when facilities are available.
- transfer in-patient ENT and Ophthalmology from Stobhill to Gartnavel in 2001\2.
- transfer in-patient urology from Stobhill to GRI and Gartnavel by or in 2003.
- transfer of in-patient cardiothoracic services from GRI to the Western Infirmary as an intermediate step to transferring the whole service to Gartnavel. To be achieved as soon as space becomes available at the Western Infirmary.

g. agreement in principle to transfer general medicine and general surgery from Stobhill to the GRI (some to Gartnavel) within seven years but to require further local consultation in due course to confirm that the implementation arrangements meet the tests of adequacy.

3. A number of issues would be pursued through the next stages of detailed local planning and preparation of Outline Business Cases. They include:
   a. continuing planning for the Ambulatory Care Centres at Stobhill and the Victoria Infirmary.
   b. seeking a faster move to Gartnavel for the Beatson Oncology Centre.
   c. discussions with Strathclyde Passenger Transport Executive, bus companies and other interests to secure improvements in public transport and related issues.
   d. discussions with SIPS, LHCCs and others about strengthening extended primary care services in those parts of the Greater Glasgow area most distant from hospital facilities (Clydebank, East End\Easterhouse, Rutherglen, Cambuslang, Castlemilk, Drumchapel and Kirkintilloch).
   e. continuing examination of the planning issues concerning future major investment in Children's Hospital services and the future of the Dental Hospital and School, leading in due course to preparation of formal consultation material.
4. Work to commence consultation about the future of maternity services is well advanced and will be published soon.
5. The strategy agreed by the Health Board in December, 2000 will be submitted to the Scottish Executive for consideration, including endorsement of Health Board decisions as appropriate.

ANNEX 1

LIST OF CONSULTATION LEAFLETS

Leaflet No.	Title	No. actually sent out
Summary	The Future of Glasgow's Hospitals – Let's Plan it Together!	426,750
1	The Patient's Experience	2,074
2	Getting It Right For Patients: What it Means for Organising Services	2,096
3	Cancer Services: Specialisation in Action	2,023
4	Why Specialisation Matters – And What We Propose To Do To Make Its Benefits More Available	2,054

5	Creating More Responsive Accident And Emergency Services	2,087
6	Ambulatory Care : What Is It?	2,108
7	Minimally Invasive Technologies: Keyhole Surgery And The Like	2,013
8	The Overall Planning Challenge for Greater Glasgow – Acute Hospitals In A Wider Context	2,154
9	Some Recent Background History	2,060
10	Impact of Regulations On Doctors' Working Hours	2,023
11	The Number Of Beds We Propose to Provide	2,058
12	Regional Services Provided By Glasgow Hospitals	2,116
13	Why Teaching And Research Matters	2,005
14	Staffing Matters	2,052
15	How The Finance Works	2,047
16	Detailed Analysis Of The Options For South Glasgow	2,169
17	Maternal And Child Health	1,999
18	Better Access for West Glasgow Residents	2,070
19	The GRI\Stobhill Partnership	2,072
20	Why Centralise Cardiothoracic Surgery?	1,995
21	Radiotherapy: Linear Accelerators – A Patient's Guide	1,992

Annex 2

The Process of Consultation on Greater Glasgow NHS Board's

Proposals to Modernise Glasgow's Acute Hospital Services

Background

1. Planning

1.1 The Health Board sought advice from the Public Relations Consultancy Shandwick on the most effective methods to use to engage effectively with its population. Shandwick were contracted to work for the Board and the Trusts from December 1999 – March 2000. Their remit was :-

> to describe a participative consultation process with the public and interested bodies which is informed and coherent, for the Board to seek views on its proposals for the future provision of acute health care in Glasgow.

1.2 Shandwick assisted in the drafting of the leaflets, identifying appropriate design and print production houses and liasing on behalf of the Chief Executive with the media stratregy.

2. Consultation Launch

2.1 Greater Glasgow NHS Board agreed at its meeting on March 21st to launch a consultation proposal to modernise Glasgow's acute hospital services. The consultation document comprised:

- the consultation paper - Modernising Glasgow's Acute Hospital Services;
- a summary leaflet entitled The Future of Glasgow's Hospital Services: Let's Plan it Together; and
- 21 topic specific leaflets on a range of issues and geographical information of interest to the public and staff in the health service.

2.2 The materials were issued week beginning April 10th to our consultee list and others who requested the consultation package, *see Appendix 1 and 1a*. The period of consultation was initially set for June 30th. Following representations from a number of organisations, the Health Board announced on May 15th that the consultation period would be extended until September 8th, 2000.

2.3 A series of presentations were arranged with key partners of the Health Service, local Councillors and MP/MSPs, on the proposals and the long term benefits for the provision and delivery of health services in Glasgow. These took place on March 21st, 22nd, 28th and 31st. Representatives from all the Trusts and the Health Board took part in presenting the proposals and details of those invited to attend (and those presenting) are contained within *Appendix 2.*

2.4 Extensive staff briefings in each Trust were also arranged to co-incide with the March Board meeting to inform staff immediately of the consultation. This included scheduling meetings to ensure that staff on shifts also received the information at the earliest opportunity.

2.5 Meetings were arranged, through Shandwick, for the Chief Executive to meet with the key media editors to inform them of the basis for the consultation. Chris Spry met with the Herald, Evening Times, Daily Record, STV and BBC. The Evening Times commented that on an issue this big the embargo would not hold and in those circumstances they could not afford to be left 'standing at the post'. We sought to achieve the best result we could from the expected breaking of the embargo. The Evening Times were asked to check their material with us before publishing and this they agreed to do. The Evening Times ran a detailed analysis of the proposals on March 15th.

2.6 Following extensive interest, the Evening Times worked closely with the Board on a series of articles which identified the key issues raised by its readers and carried an official response on each issue. The Chief Executive also took part in a People's Jury on April 6th, organised by the Times to debate the key issues emerging from the Board's proposals.

3. <u>Summary Leaflet</u>

3.1 To ensure that as many people as possible who were interested in contributing in this debate had a clear understanding and easy access to the proposals, the Board decided to distribute the leaflet to every household in the GGNHSB area.

3.2 500,000 leaflets were printed comprising of 423,000 for the door-to-door distribution and the balance being distributed through hospital out-patient departments and clinics, GPs, Dentists, Opticians and Community Pharmacists, available at all the public meetings and from the key public outlets where the consultation documentation was available (libraries etc).

3.3 Scotmail on behalf of GGNHSB carried out the door-to-door distribution. Initial internal evidence suggested that the distribution of the leaflet had not been as comprehensive as we would have liked. This was also tested at the public meetings which indicated that a large proportion of people had not received the leaflet through their door. At the end of May, Scotmail were asked by the Board to survey postcode areas G3, G11, G12, G14, G32, G33, G44, G53, G61, G62, G64, and G81. The Health Board also requested that Scotmail survey geographical area G76 where reports that a high number of copies had not been received. The overall findings showed a 76% success rate in the distribution of the material by

Scotmail (the areas surveyed had been chosen by Board officers following a survey of NHS staff and the survey included the householder signing for whether they recalled receiving the Summary Leaflet or not).

3.4 A number of minor errors occurred in some leaflets and the Board sought to correct these immediately. The Summary Leaflet referred to Leaflet 16 detailing options for the North – it should have said South, and Leaflet 19 – GRI/Stobhill Partnership contained errors in the bed numbers at Stobhill. Once these errors were identified, erratum slips were incorporated into the affected leaflets. More recently the basis for the figures in leaflet 11 – The Number of Beds We Propose To Provide has also been shown to have errors due to a fundamental assumption wrongly made on the calculation of bed numbers by ISD. A re-calculation has been carried out and is attached to the main covering paper.

4. Topic Specific Leaflets

4.1 The scale of the consultation resulted in the key issues being explained individually within a series of topic/geographical specific leaflets. There were 21 leaflets cover the following:-

1. The Patient's Experience
2. Getting it Right for Patients: What it Means for Organising Services
3. Cancer Services: Specialisation in Action
4. Why Specialisation Matters – And What we Propose to do to Make its Benefits More Available
5. Creating More Responsive Accident and Emergency Services
6. Ambulatory Care – What Is It?
7. Minimally Invasive Technologies: Keyhole Surgery and the Like
8. The Overall Planning Challenge for Greater Glasgow – Acute Hospitals in a Wider Context
9. Some Recent Background History
10. Impact of Regulations on Doctors' Working Hours
11. The Number of Beds we Propose to Provide
12. Regional Services Provided by Glasgow Hospitals
13. Why Teaching and Research Matters
14. Staffing Matters
15. How the Finance Works
16. Detailed Analysis of the Options for South Glasgow
17. Maternal and Child Health
18. Better Access for West Glasgow Residents
19. The GRI/Stobhill Partnership
20. Why Centralise Cardiothoracic Surgery?
21. Radiotherapy: Linear Accelerators – A Patient's Guide

4.2 Over 3,000 copies of each leaflet were produced for distribution to the public. Annex 1 of the main covering paper shows the distribution of each leaflet.

The leaflets could be requested via the telephone enquiry line, website, writing to the Board's Freepost address or by contacting the Board via letter, fax or telephone.

5. Events Schedule/Public Meetings

5.1 The consultation process included many formal and informal opportunities to explain and discuss the implications of the proposals for individual specialities and within the context of Greater Glasgow as a whole.

52. Greater Glasgow NHS Board, the North Glasgow Trust, the South Glasgow Trust and Yorkhill Trust undertook a range of meetings, some on a geographical basis and some with interested groups and organisations. Details of these meetings is attached as an Events Schedule covering March – August at *Appendix 3.*

The attendance at the 44 public meetings (4 launches and other open meetings) was mixed – some with good attendances and some disappointing attendances.

Also attached is the detail of the place, date and lead officers for each public meeting and the questions raised and answers given – this includes the public meetings held by North Glasgow, South Glasgow and Yorkhill NHS Trusts.

There is no distillation of the issues raised, however, the points discussed have been fed into the process and considered by the Board and Trusts as the strategy has emerged to its next stage.

Issues for the future centre around how to engage the public more on issues of such importance and a greater concentration of engagement with Social Inclusion Partnerships. These and other lessons learned will be discussed with the Trusts in order to improve our communications with the public in the future.

6. Newsletter

6.1 The Board issued a newsletter to further publicise the consultation and its main aims and issues. The first newsletter was issued on April 14th with a follow up on May 9th which picked up on some of the key issues arising from the Board's proposals in particular the issue of transport and the Chief Executive's meeting with Strathclyde Passenger Transport Executive.

6.2 The newsletters were issued to our consultee list, available through our website, placed in libraries and available on request.

7. Telephone Inquiry Line

7.1 Network Scotland were contracted to provide a telephone inquiry line for members of the public who required further information or literature about the proposals. The inquiry line operated as a freephone number (0800 85 85 85) and began on April 3rd. The service was available during the hours of 9.00am – 6.00 pm weekdays and from 10.00 am – 2.00 pm on Saturdays. Out of these hours callers could leave a message on an answering machine facility.

7.2 The number of callers was such that the service continued until May 24th. Within that period there was approximately 190 calls from people looking for leaflets, details of the public meetings or other specific information on the consultation.

7.3 Network Scotland also distributed copies of the leaflets. Over 2550 copies of the leaflets were requested and dispatched.

7.4 From May 24th, due to the low number of calls to the line, a message was left on the freephone number directing callers to the Health Board and indicating that further information or leaflets could be accessed using the Board's Freepost address.

8. Website (www.show.scot.nhs.uk/GGNHSB)

8.1 The Board's website has provided an easy route for people far and wide to access the detail of our proposals. This is the first time we have put our proposals for consultation on our main website and we have been told that some individuals were pleased to be able to access the documentation electronically. All the consultation documents, together with the final versions of the 21 leaflets, are available both in PDF format and HTML. The Acute Hospital Services section of the website was launched on March 17th.

8.2 Throughout the process the website has been updated regularly with details of the public meetings, the newsletter and copies of subsequent related Board papers. We also built in a facility to request leaflets and receive comments on our proposals through the web; the e-mail address being [redacted]. A number of comments were received this way.

We introduced a hit counter on the site in May: there have been over 1830 visitors to the Acute Services section of the Board's website since then.

9. Advertising

9.1 A series of advertisements were placed in the Glasgow papers to publicise the series of public meetings. Adverts appeared in the Kirkintilloch Herald on April 12th and in the Herald, Evening Times, The Glaswegian, East End Independent, The Reformer, Clydebank Post, and The Extra on April 13th.

9.2 Posters were produced and distributed to the Trusts to publicise their local meetings within the hospitals and in local community settings.

10. A backdrop visual based on the Summary Leaflet was produced for the Board and Trusts' public meetings.

10. Response

Up until the last few days of August Board officers have been trying to answer in full responses received from the public and others, as well as enquiries and requests for additional information.

In the last 2 weeks, efforts have been concentrated upon analysing the responses to consultation received and putting the themes raised into a Board paper and summarising the responses received for the September Board meeting. Over 3,100 responses have been received as at 13th September 2000.

Appendix 1

Modernising Glasgow's Acute Hospital Services Consultation Documentation – Initial List of Recipients – April 3rd, 2000

Advisory Committees (Bulk supplies to Secretary with one copy to Chairman)

Area Dental Committee	(16 copies)
Area Paramedical Committee	(16 copies)
Area Medical Committee	(51 copies)
Area Nursing and Midwifery Committee	(21 copies)
Area Optometric Committee	(10 copies)
Area Pharmaceutical Committee	(21 copies)
Principal University of Strathclyde	(5 copies)
University of Glasgow	(50 copies)
Principal Glasgow Caledonian University	(10 copies)
North Glasgow University Hospitals NHS Trust	(50 copies)
South Glasgow University Hospitals NHS Trust	(50 copies)
Yorkhill NHS Trust	
Greater Glasgow Primary Care NHS Trust	(30 copies)
	(10 copies)

Joint Professional Organisation	(2 copies to the Secretary + 1 copy each Member)
British Dental Association	

British Orthoptic Society

British Dietetic Association

Royal College of Midwifery

Hospital Physicists Association

Association of Clinical Biochemists

British Medical Association

Royal College of Nursing

JTUC (2 copies to Secretary + 1 copy to each Member)

AEEU

GMBATU/APEX (2 Members)

MSF

UCATT

TGWU

UNISON (3 Members)+

- Scottish Health Visitors Association

- British Association of Occupational Therapists

Chartered Society of Physiotherapists

Society of Radiograhpers

Community and District Nursing Association

Chair – Partnership Forum (Mr S MacLennan)

Main Public Libraries in GG Area

Mitchell (1 copy in English, Chinese, Punjabi and Urdu plus 1 copy of audio tape)

Giffnock

Mearns

Rutherglen

Clydebank

Bishopbriggs

Milngavie

Rest of Public Libraries in GG Area (1 copy in English, Chinese, Punjabi and Urdu plus 1 copy of audio tape)

Local Health Council (32 copies) (Plus 2 copies in Chinese, Punjabi and Urdu plus 2 copies of audio tape)

(including copies for Local Health Forums)

Other Organisations/Professional Bodies

Scottish Asian Action Committee

Scottish Chinese Co-ordinating Committee

Strathclyde Community Relations Council

The Director of Social Work, Committee of Social Responsibility

One Plus

Bangladesh Association Glasgow

Indian Association of Strathclyde

Pakistan Muslim Welfare Society

East Pollokshields Project

Mr W G Alston,

Strathkelvin Health Forum

Glasgow Jewish Representative Council

National Federation of the Blind (West of Scotland Branch) (To receive audio tapes only – not printed version (2 copies)

Link - Glasgow Association for Mental Health

Castlemilk Youth Complex

Greater Pollok Health Group

Integrate

Soroptimist International (Glasgow West)

National Schizophrenic Fellowship

Glasgow Council for Voluntary Services

Archdiocese of Glasgow

Scottish Association for Mental Health

Soroptimist International (Glasgow West)

Glasgow Nursing Homes Association

Carntyne Clinic

c/o Soroptimists International

Nuffield Centre for Community Care Studies

(For consultations to do with Community Care only)

Royal College of Midwives (Scottish Branch)

Strathkelvin Health Forum

Glasgow Hospitals Auxiliary Association

Department of Nursing Studies, University of Glasgow

Mr A Tough, Health Board Archivist, University of Glasgow

Royal Pharmaceutical General Council (Scotland)

Royal College of Physicians and Surgeons of Glasgow

Glasgow City Council Social Work Department **(3 copies plus 2 audio tape)**

Glasgow and West of Scotland Society for the Blind **(1 copy plus audio tape)**

Multi-Cultural Elderly Care Centre **(1 copy in English, Chinese, Urdu and Punjabi)**

Glasgow Occupational Therapy Managers Group

Community and District Nursing Association

Scottish Association for Mental Health

SAMH North

SAMH South & East

SAMH Central

SAMH Glasgow & Ayrshire

Midwives Information & Resource Service (MIDIRS) **(For consultations appropriate to Midwives)**

Scottish Head Injury Forum

Professor of Primary Care

Marie Curie Centre (Huntershill)

All Scottish MSPs (129) **(1 copy each)**

Scottish Ambulance Service NHS Trust

All Scottish Health Boards (14) **(3 copies each**)

Unitary Authorities with Residents within Greater Glasgow **(10 copies unless indicated),**

City of Glasgow Council (20 copies)

North Lanarkshire Council

East Renfrewshire Council

South Lanarkshire Council

East Dunbartonshire Council

West Dunbartonshire Council

General Medical Practices within Greater Glasgow (220)

General Dental Practices within Greater Glasgow (195)

General Pharmaceutical Practices within Greater Glasgow (213)

General Optometric Practices within Greater Glasgow (135)

Local Medical Committee (1)

Community Councils (130)

Copies for Internal Circulation (one each unless otherwise shown):-

Non-Executive Board Members

Chief Executive

Director of Finance (4)

Director for Commissioning (5)

Director of Public Health (12)

Director of Health Promotion (2)

Nursing Adviser

Pharmaceutical Policy Adviser

Consultant in Dental Public Health

Head of Corporate Services (5)

Public Relations Manager

Chief Executive's Office

Secretariat Officer

Women's Health Co-ordinator (Sue Laughlin)

Assistant Director for Commissioning (South Sector)

Assistant Director for Commissioning (North)

Greater Glasgow Health Service Librarians = (8)

Spare (100)

Appendix 1a

Additional recipients of Modernising Glasgow's Acute Hospital Services Consultation Documentation

Royal College of Physicians and Surgeons of Glasgow

Dr Alison Mack

Mr David Thompson

Mr D McGugan

Ms Susan G Watters

Ms Helen Drumond

Mr Alberto Lanniello

Liaison VAT Consultancy

Mr Chris Johnston

Mrs J Tottern

Ms Kerin Wells

Councillor Brian McKenney

Mr Robert P French

Mr Frank Harvey

Rev E Hope

Mr Blair Robertson

Father S Dunn

Ms Sheila Scott

Mr Adrian Lucas

Strathclyde Passenger Transport Executive

Mrs Lorna Howieson

Councillor Butler

Dr Green

Councillor McKenna

Professor S B Kaye

Mr Liam Purdie

Mr Ian Davidson

Ms Christine McNeill

Mr John A McLintock

Councillor Tony Devine

Mr John Jolly

Ms Marie Burns

Ms Lesley Garrick

Ms Shona Mackie

Mrs Glenda Kelly

Mrs Ann Campbell

The Right Hon Alex Mosson

Dr Malcolm Reid

Ms Carmel Sheriff

Dr Ian Gordon

Mrs Zoe Van Zwanenberg

Mrs D McNicol

Dr Hugh McNeill

Ms Alison Wood

Mrs Margaret Hinds

Ms M McAuley

Mr Calum Kerr

Mr D Hankins

Appendix 2

Consultation Launch – Lecture Theatre, North Glasgow Trust Headquarters, Stobhill Hospital

	Invited Attendees	**Presenters**
21.3.00	Chairmen, Executive Directors and Trustees of NHS Boards in Glasgow Greater Glasgow Health Council MSPs Jim Devine Media Glasgow Alliance Healthy City Partners Ambulance Service	Mr Chris Spry - Chief Exec.,GGNHSB Dr Tim Parke –Chairman, A&E Sub-committee Mr Ian Sother – Clinical Director, Orthopaedics, North Glasgow Trust Prof. Tim Cooke – Chairman of Surgical Division, North Glasgow Trust Dr Brian Cowan – Medical Director, South Glasgow Trust Dr Morgan Jamieson – Medical Director, Yorkhill Trust
22.3.00	Greater Glasgow Partnership Forum Professional Advisory Committees	Mr Chris Spry - Chief Executive, GGNHSB Miss Maggie Boyle – Chief Executive, North Glasgow Trust Mr Robert Calderwood – Chief Executive, South Glasgow Trust Mr Jonathan Best – Chief Executive, Yorkhill Trust
28.3.00	Chief Executives, Directors of Social Work and Councillors of Glasgow City, East	Mr Chris Spry - Chief Executive, GGNHSB

	Dunbartonshire, West Dunbartonshire, South Lanarkshire, North Lanarkshire and East Renfrewshire Councils Dean and Heads of Nursing etc at Glasgow, Strathclyde and Caledonian Universities Social Inclusion Partnerships Secretaries of Community Councils	Dr Tim Parke – Chairman, A&E Sub-committee Mr Ian Sother – Clinical Director, Orthopaedics, North Glasgow Trust Dr Brian Cowan – Medical Director, South Glasgow Trust Dr Angus Ford – Clinical Director, Yorkhill Trust
31.3.00	Chairman and General Managers of Local Health Care Co-operatives Local Medical Committee Royal Colleges Charities – Hospices, Marie Curie, Macmillan Ethnic Minorities Advisory Group	Mr Chris Spry – Chief Executive, GGNHSB Miss Maggie Boyle - Chief Executive, North Glasgow Trust Mr Robert Calderwood - Chief Executive, South Glasgow Trust Mr Jonathan Best - Chief Executive, Yorkhill Trust Dr Tim Parke - Chairman, A&E Sub-committee Dr Brian Cowan - Medical Director, South Glasgow Trust

Appendix 3

Greater Glasgow NHS Board Meetings

Date	**Invited to Attend**	**Introductions**	**Nos.**
9.3.00	Herald Daily Record Evening Times	Chris Spry	
14.3.00	STV	Chris Spry	
15.3.00	BBC	Chris Spry	
24.3.00	Greater Glasgow MSPs	Chris Spry/Prof. Hamblen	

31.3.00 3.4.00			
17.5.00	Greater Glasgow Health Council	Chris Spry	
22.5.00	MSPs	Chris Spry	*
30.5.00	Executive Directors, Ayrshire & Arran Health Board	Chris Spry	
1.6.00	Greater Glasgow Primary Care Trust	Chris Spry	
9.6.00	GP/Consultants, Royal Alexandria, Paisley	Chris Spry	
21.6.00	GP/Consultants, Vale of Leven	Chris Spry	
22.6.00	East Dunbartonshire Council	Chris Spry	
23.6.00	Scottish Ambulance Service	Chris Spry	
23.6.00	Glasgow City Council	Chris Spry	
3.7.00	Stakeholders – Paisley	Chris Spry	
14.8.00	Stakeholders – Dumbarton	Chris Spry	
28.8.00	Deaf Connections	Chris Spry	25

*cancelled due to lack of interest

North Glasgow University Hospitals NHS Trust Meetings

Date	**Invited to Attend or Venue**	**Introductions**	**Nos.**
11.4.00	Lenzie Public Hall	Maggie Boyle	20
12.4.00	Woodside Hall	Margaret Smith	3*
13.4.00	Bellrock Community Centre	Maggie Boyle	3*
17.4.00	Partick Burgh Hall	Alan Boyter	39
18.4.00	Kirkintilloch Town Hall	Maggie Boyle	47
19.4.00	Ruchazie Community Centre	Maggie Boyle	3*
20.4.00	Milngavie Town Hall	Maggie Boyle	43
25.4.00	Clydebank Town Hall	Maggie Boyle	37
26.4.00	Westerton Hall	Maggie Boyle	38
27.4.00	Provanhill Neighbourhood Centre	Maggie Boyle	3*
2.5.00	Campsie Memorial Hall	Alan Boyter	9
3.5.00	Springfield Centre	Bill Anderson	2
4.5.00	Auchinairn Public Hall	Brian Steven	14
8.5.00	Broomhill	Maggie Boyle	???
9.5.00	Shettleston Hall	Brian Steven	4
10.5.00	Bishopbriggs War Memorial Hall	Maggie Boyle	22

11.5.00	Roystonhill Recreation Centre	Maggie Boyle	1*
16.5.00	Brunswick Centre, Springburn	Maggie Boyle	22
17.5.00	Drumchapel Community Centre	Maggie Boyle	5
18.5.00	Scotstoun Primary School	Brian Steven	100
22.5.00	Edinbarnet Primary School	Maggie Boyle	2*
24.5.00	Blue Vale Community Centre	Maggie Boyle	4
25.5.00	Dental Hospital	Alan Boyter	0*
30.5.00	Blairdrum Community Centre	Brian Steven	
31.5.00	Garrowhill Primary School	Alan Boyter	
1.6.00	Dalmuir Community Education Centre	Maggie Boyle	
12.6.00	Faifley Regeneration Centre		
15.6.00	Cranhill Parish Church	Maggie Boyle	

South Glasgow University Hospitals NHS Trust Meetings

Date	Invited to Attend or Venue	Introductions	Nos.
2.5.00	Bellarmine High School		
5.5.00	Langside Hall		
12.5.00	Cooper Institute		
17.5.00	Clarkston Hall		
22.5.00	McLeod Hall		
24.5.00	Trinity High School		
12.6.00	Castlemilk Community Centre		
19.6.00	Mosspark Labour Hall		

Yorkhill NHS Trust Meetings

Date	Venue	Introductions	No.s
17.4.00	Shettleston Hall	Jonathan Best	
26.4.00	Possilpark Health Centre		
27.4.00	Partick Burgh Hall		
2.5.00	Langside Hall		
3.5.00	Family Support Groups		
10.5.00	Family Support Groups		
11.5.00	Local Councillors		
12.5.00	MSPs/MPs		
13.5.00	MSPs/MPs		

ANNEX 6

A & E SERVICES
A MODEL FOR GAUGING FUTURE FLOWS

The absence of sophisticated data collection systems in A & E Departments makes it difficult to assess future figures. The model below is based on a one week survey of A & E attendances in 1998. There is some mismatch between survey data and the way the Ambulance Service classifies between Urgent Calls and Emergency Calls. All 'Urgent Calls' will be from GPs but some 999 calls will also be for very urgent GP referrals. Column (b) extrapolates from the one week survey and column (c) nets (b) off from the total of annual Emergency Calls and Urgent Calls recorded by the Ambulance Service.

Table A

	(a)	(b)	(c)	(d)	(e)
Hospital	Total A & E Attendances	Of which Children =	GP referrals =	999 Ambulance Cases (adults)	Net Total (a – (b+c+d)
1. Victoria	75,000	14,000	8,320	7,644	45,036
2. Western	55,000	1,200	12,012	8,632	33,156
3. Stobhill	45,000	9,800	8,944	845	25,411
4. GRI	68,000	7,000	8,892	14,891	37,217
5. Southern General	40,000	7,400	6,136	5,034	21,430
6. TOTAL	283,000	39,400	44,304	37,046	162,250

Column (a) includes children who attend adult A & E Departments. Most children presenting at the Western A & E Department are directly referred to the Yorkhill A & E Department. A specialist review group on children's A & E services in Glasgow recently advised that all children should attend the Yorkhill A & E Department (which is receiving additional staffing) and should not be seen in adult A & E Departments. It also estimated that around 10,000 of all current children attending A & E Departments (Yorkhill included) had injuries or illnesses that could be managed within primary care. As the data in column (d) in Table B implies, that might be an underestimate. 10,000 children between 220 GP practices implies about one child per practice per week. Even if it were as high as 30,000 that would still equate to around 3 children per practice per week.

Based on the 1998 one-week survey the approximate number of children currently attending each adult A & E Department would be:

TABLE B

	(a)	(b)	(c)	(d)
	In one week Survey	Extrapolated to one year	Number in column (a)arriving by ambulance	Extrapolated to one year

Victoria	268	14,000	12	624
Western	24	1,200	1	52
Stobhill	188	9,800	5	260
GRI	135	7,000	15	780
Southern General	143	7,400	3	156
		39,400		1,872

The figure in column (b) is slightly higher than that identified by the Paediatric A & E Review Group but is broadly reconcilable with their figures (they suggested a range of 32,000 to 37,000) which were themselves approximations. The low figure in column (d) suggests that the number of children who could in future be treated closer to their homes if primary care were organised and resourced to provide a "walk-in" service is potentially quite high.

In interpreting scenarios in the model, the impact of the vast majority of children being seen in Yorkhill's A & E Department (or more likely, in an extended primary care service) is netted off. This is shown in column (b) in Table A.

Scenario 1 – Conservative about Minor Injuries (cuts, sprains, grazes and bruises and virtually

nothing else. See Exhibit 2 of 1996 Audit Commission Report on A & E Services) with flows based on Ambulance Service view of catchments

i) Assume that figures in column (c) go to separate Emergency Receiving Units at GRI,

Gartnavel and Southside Hospital.

- **ii. Assume only 33% of column (e) is treated in Minor Injuries Units.**
- **iii. Assume that this is what gets treated at Victoria, Stobhill and Gartnavel Minor Injuries Units (i.e. 33% of 1(e), 3(e) and 2(e).**
- **iv. Assume that for 1(d), 65% goes to GRI, 35% to Southside Hospital.**
- **v. Assume that for the balance of 1(e), 62% goes to GRI, 38% to Southside Hospital.**
- **vi. Assume that for 2(d), 7% goes to GRI, 93% to Southside Hospital.**
- **vii. Assume that for 2(e), 2% goes to GRI, 98% to Southside Hospital.**
- **viii. Assume that for 3(d) and the balance of 3(e) 100% goes to GRI.**

The percentages in (iv) to (vii) reflect ambulance service advice as to where they would take patients in future. Those new "catchments" are then applied to data from the one week survey which showed ambulance arrivals for each hospital by originating postcode and non-ambulance arrivals by originating postcode.

This scenario would see:

Minor Injuries Cases

Victoria	14,900
Gartnavel	10,900
Stobhill	**8,400**
	34,200

	(f)	(g)	(h)
	Current adult A & E attendances (GRI and SGH) less GP referrals	Flows from other	Total

		Hospital areas (excl. GP referrals)	
Southside	26,464	43,966	70,430
GRI	52,108	42,558	94,666

Of the figures in column (h), a minimum of 12,300 (GRI) and 7,100 (Southside) would be treated in the hospital's Minor Injuries Unit (assuming 33% of Table A, column (e) is 'minor injuries').

In addition to a conservative assumption about self-referral and\or triage into minor injuries units, this model also pessimistically assumes that patients choosing to go under their own travel arrangements to GRI or Southside who would formerly have gone to the Victoria, Western or Stobhill do not turn out to be treatable in a Minor Injuries Unit. This is a highly pessimistic assumption. If 10% of those accounted for by assumptions (v) and (vii) above turned out to be suitable for treatment in a Minor Injuries Unit, the total treated in the GRI and Southside Hospital's Minor Injuries Units would be:

GRI 12,300 + 4,300 = 16,600

Southside 7,100 + 4,400 = 11,500

Scenario 2 – As before but a modest increase in suitability for Minor Injuries treatment

Same as 1, except assume that 40% of column (e) in Table A is treated in Minor Injuries Units.

This scenario would see

Minor Injuries Cases

Victoria	18,000
Gartnavel	13,300
Stobhill	10,200
	41,500

	(f) Current adult A & E attendances (GRI and SGH) less GP referrals	(g) Flows from other hospital areas (excl. GP referrals)	(h) Total
Southside	26,464	40,436	66,900
GRI	52,108	38,788	90,896

Of the figures in column (h), a minimum of 14,900 (GRI) and 8,600 (Southside) would be treated in the hospital's Minor Injuries Unit (assuming 40% of Table 1, column (e) is 'minor injuries').

Like Scenario 1, this model is also pessimistic about patients "diverting" from other hospital catchment areas and travelling under their own arrangements being suitable for Minor Injuries treatment. 10% of those patients would equate to around 3,200 at GRI and 3,000 at Southside Hospital being suitable for Minor Injuries treatment.

Scenario 3 – As before but with 60% of patients suitable for treatment in Minor Injuries Units

Minor Injuries Cases

Victoria	27,000
Gartnavel	19,900
Stobhill	15,200
	62,100

	(f) Current adult A & E attendances (GRI and SGH) less GP referrals	(g) Flows from other hospital areas (excl. GP referrals)	(h) Total
Southside	26,464	30,548	57,012
GRI	52,108	28,076	80,184

Under column (h), a minimum of 22,300 (GRI) and 12,900 (Southside) would be treated in the hospital's Minor Injuries Unit (assuming 60% of column (e) is 'minor injuries'). If 10% of those diverting from other hospitals were also Minor Injuries, the total treated in the GRI and Southside's Minor Injuries Units would be:

GRI 22,300 + 2,500 = 24,800

Southside 12,900 + 2,000 = 14,900

Scenario 4 – Same Minor Injuries treatment rate as Scenario 1 (33%)

but more patients going to GRI

Assume that flow from Western Infirmary is not in 90 : 10 Southside : GRI ratio range seen in Scenarios 1 to 3, but 50 : 50 Southside : GRI.

Also assume that flow from Victoria Infirmary is not in the 35 : 65 Southside : GRI ratio range seen in Scenarios 1 to 3, but 25 : 75 Southside : GRI.

This is a combination of assumptions that is different from the ambulance service view of how they would carry their patients (equating to around 10% of current total A & E attendances at the Victoria and 16% of current attendances at the Western). It also assumes that all patients currently living east of Anniesland and at Bearsden\Milngavie would. All go to GRI. Likewise it assumes that not only do all patients from Govanhill, Rutherglen, Cambuslang, Toryglen, Cathcart, Castlemilk and Gorbals but half of those from Pollokshaws, Newlands, Giffnock, Clarkston and Newton Mearns also go to the GRI rather than to, for the purposes of illustration, Southern General. It is improbable that so many people from these places would actually make that choice. Nevertheless the scenario is useful in showing the upper limits of probability of burden on the GRI.

Minor Injuries Cases

Victoria 14,900

Gartnavel 10,900

Stobhill 8,400

34,200

	(f)	(g)	(h)

	Current adult A & E attendances (GRI and SGH) less GP referrals	Flows from other hospital areas (excl. GP referrals)	Total
Southside	26,464	24,889	51,353
GRI	52,108	61,635	113,743

Scenario 5 – As Scenario 4 (i.e. upper limits of probability of flows to GRI)

but with high level of Minor Injuries Unit treatment (60%)

Minor Injuries Cases

Victoria 27,000

Gartnavel 19,900

Stobhill 15,200

62,100

-

	(f) Current adult A & E attendances (GRI and SGH) less GP referrals	(g) Flows from other hospital areas (excl. GP referrals)	(h) Total
Southside	26,464	17,364	43,828
GRI	52,108	41,260	93,368

Summary of locations of Treatment

	Scenarios				
	1	2	3	4	5
Victoria - Minor Injuries Unit	14,900	18,000	27,000	14,900	27,000
Gartnavel - Minor Injuries Unit	10,900	13,300	19,900	10,900	19,900
Stobhill - Minor Injuries Unit	8,400	10,200	15,200	8,400	15,200
GRI - Main A & E	82,366	75,996	57,884	101,443	71,068
- Minor Injuries Unit	12,300	14,900	22,300	12,300	22,300
Southside - Main A & E	63,330	58,300	44,112	44,253	30,928
- Minor Injuries Unit	7,100	8,600	12,900	7,100	12,900
	199,296	199,296	199,296	199,296	199,296

Medical and surgical emergency receiving (GP referrals) will be managed at GRI, Southside and Gartnavel by the medical and surgical receiving teams. The position of children (39,400 currently treated at adult A & E Departments) depends on the development of services at Yorkhill and in primary care but since the number of children arriving by ambulance is around 5%, this suggests that if parents continue to take their child to the nearest hospital regardless of advice, the impact is likely to fall on local Minor Injuries Units and not on GRI or the Southside Hospital's main A & E Departments.

Conclusions

Of these Scenarios we would regard something between Scenarios 2 and 3 to represent the highest probability of how people behave in practice in terms of self-referral judgements and travel.

The key issues in debate concerned the capacity of the GRI A & E Department. What will be needed is:

Scenario

2 3

Minor Injuries 14,900 22,300

Main A & E 75,996 57,884

Total 90,896 80,184

In addition the hospital would have to provide space for the reception of medical and surgical emergency admissions referred by GPs. Further discussion is needed about the probabilities of having to manage children but we would expect anyway a separate space to be provided for children, with staff trained to care for children.

ANNEX 10

ACUTE HOSPITAL SERVICES - HOW IT LOOKS TO US NOW

1. We've learned a lot during the consultation

Literally hundreds of documents, letters and meetings – with public groups, staff, MSPs, Councils, the Local Health Council – have given us a strong sense of what people want and what issues cause them problems (like public transport difficulties). A lot of detailed contributions have been received. They've helped us to

think hard about how we should go about modernising Glasgow's hospital service and how it should connect with other parts of the health care system.

As in all debates the headlines concentrate on areas of disagreement but underneath all that everyone's agreed on one thing – we've got to make change happen. We can't stay locked in a pattern of run down hospitals, and services that are fragmented or overstretched.

It's not possible to meet everyone's expectations. There are too many contradictions to reconcile but the way that debate has tested ideas and raised new suggestions has been great.

Myth

"Nothing's changed as a result of consultation"

Wrong! There are some hugely important changes. And we go forward with so much better understanding than we had before. Read on!

2. What's new as a result of consultation?

A lot!

- promise of a faster plan to get the Beatson Regional Cancer Service onto a single site at Gartnavel.

- a clearer set of proposals about how to provide stronger specialist teams and tackle the doctors' working hours issue north of the river.

- recognition that we need to expand fast access to a wider range of healthcare in areas most distant from hospitals (East End, Easterhouse, Drumchapel, Clydebank, Rutherglen, Cambuslang, Castlemilk and Kirkintilloch).
- confirmation that people really do want a new Southside Hospital – and as soon as possible. We weren't sure of that before consultation began.

- a fuller understanding of what needs to be done to improve public transport access to all hospitals.

That sounds OK – but what about other issues?

Actually nothing has been untouched by what we learnt during the consultation exercise. There are some difficult choices to make. We've likened the challenge of bringing Glasgow's hospital service into the 21st Century to a Rubik's Cube. Change one part of the puzzle and you find it's put something else out of shape in another part of the system. There are some parts of our original proposals which look very much the same as they did before but they've been tested under the fire of vigorous debate and we still feel confident about them. They include judgements that:

- the Southern General campus is the right place for a new South Glasgow University Hospital (SGUH).

- a pattern of two Accident and Emergency Departments (GRI and SGUH) supported by locally accessible Minor Injuries Centres at the Victoria, Stobhill and Gartnavel is in the best interests of the different types of patients and is workable.

3. For the vast majority of people, they will still go to the same hospital as they do now

And in future, those hospitals will be modern and efficient for the patient.

• "I have to go to the chest clinic every month, where will I go in future?"

To exactly the same hospital as you do now.

• "I'm attending physio sessions following an accident, where will I go?"

To exactly the same hospital as you do now.

• "I've sprained my ankle, where can I get it dealt with?"

At your local hospital – the GRI, Stobhill, Gartnavel, Victoria or new South Glasgow University Hospital. Go wherever is most convenient.

• "My GP's referred me for an x-ray, where will I go?"

To the same hospital as you do now, unless it's a very specialised examination (but it's already the case that not every hospital meets all local needs for specialist x-rays).

• "I've had an earache for several days, where will I get that dealt with?"

You should go to your GP who is very locally accessible. Accident and Emergency Departments aren't intended for that sort of problem.

For 85% to 90% of what patients go to hospital for, they will still go to the same place.

4. We're aiming to spend a lot of extra money to bring Glasgow's hospitals up to date

- A South Glasgow University Hospital. A new Ambulatory Care Hospital at the Victoria Infirmary.
- A new Ambulatory Care Hospital at Stobhill.
- New wards, Accident and Emergency Department and Maternity Hospital at the GRI.
- New departments at Gartnavel to make it a complete hospital at last.

By 2010 virtually all the old buildings will have gone, replaced by new state-of-the-art facilities. As well as spending a lot of money to build them, we'll also be spending a lot of extra money to run them.

Myth

"The plans as just about saving money"

Wrong! We will spend millions of pounds more.

5. The new pattern will mean shorter waiting times

There are 4 reasons why:

- Ambulatory Care Centres\Hospitals will protect their patients from playing second fiddle to in-patients in accessing equipment, facilities and staff time, which is what happens now in to-day's higgledy-piggledy hospitals.
- Larger consultant teams will make it easier to prevent the disruptions that currently lead to cancellation – unexpected absence of a consultant; doctors having to cover emergencies while doing something else at the same time.
- Larger pools of beds will make it easier to cope with peaks of demand – so, fewer cancellations.
- One-stop clinics mean fewer return visits, so more time to see new patients.

6. Public Opinion favours a new South Glasgow Hospital on a new site

So they do. People also told us they were fed up with decades of hospital planning blight. So are we. The consultation process has flushed out more information about sites. A new hospital needs more than 50 acres. Scottish Enterprise-Glasgow is also looking for sites this size. They couldn't find any that we hadn't already identified. Many people favoured Cowglen but the National Savings Bank site is not for sale and the other site at Cowglen is Green Belt. Horrendous town planning problems. Years of delay if we pursued it. Little prospect of success at the end of it. No site, no new hospital.

7. The Southern General site is big enough and ready now

And that's why we should go for it. The tunnel makes it an excellent second site for Accident and Emergency to match the GRI – very accessible for ambulances from West Glasgow as well as from most of the Southside.

In 10 years the South Glasgow University Hospital will be an all modern campus.

Myths galore

- **"You're just tarting up the Southern"**

  Wrong! It'll be all new build.

- **"It's on the edge of its catchment area"**

  Wrong. It's central for its A & E role for the west side of Glasgow north and

  south of the river. Ambulatory care services – 90% of all patient experiences – will still be provided at the Victoria , as central for those patients as ever. For those in-patients who do have further to travel the trade-off is safer, more consistent specialist care for the most serious illnesses.

- **"The Vicky is going to close"**

  Wrong! There will be a large new-style hospital built there, its focus on Ambulatory Care. If you currently go to a clinic at the Vicky, you'll still go to a clinic at the Vicky.

- **"You're ignoring travel problems"**

  No. We pledge ourselves to improving public transport, including some express shuttle bus routes. For most people travel will be improved. Whatever site is used for a new hospital, public transport would have to be improved.

8. The Queens Park Recreation\Victoria suggestion as a site for a single Southside Hospital won't wash

Some people have suggested that this site could be readily made available as a site for a new South Glasgow hospital. We strongly disagree:

- the site isn't big enough. as designated Open Space, it would take years of town planning process before we even knew if it was actually available.
- the traffic impact in the locality would worsen an already congested local road system.

- its delay and uncertainty would prolong the blight that everyone wants to end. it's in the wrong place to complement the GRI as part of our two "gold standard Accident and Emergency" strategy.

But we do think the location is an excellent place for an Ambulatory Care Hospital which will meet most people's needs for hospital services in a very locally accessible way.

9. What about Ambulatory Care Centres?

This has been an interesting debate. All sorts of different agendas. The bottom line is that Ambulatory Care is what we do already. – out-patients, routine diagnostics, physio, other therapies and day surgery. New multi-million Ambulatory Care Hospitals are simply about doing it better from the patients' point of view – fewer visits, fewer reception desks to negotiate, fewer corridors to trek, fewer delays. All in a thoroughly modern environment.

Everyone likes the idea. Some people have raised a question about a tiny part of their role the day surgery bit amounts to around 5% of what an Ambulatory Care Hospital would do. Some of those who oppose Ambulatory Care Hospitals for the Victoria and Stobhill just don't want to have to spend time working away from what they see as their 'base' (GRI, Gartnavel or the South Glasgow Hospital). We want these Ambulatory Care Hospitals at Stobhill and Victoria because they'll provide most of what people currently use these hospitals for. We can't let a 5% tail wag the whole dog – which is about local access to services, which is what everyone says they want.

Complication rates in day surgery?

Are very low and are usually slowness to recover from anaesthetic.

Myth

They're just glorified Health Centres

Hardly! These places are big and complex. They do almost everything that conventional hospitals do – but an easier experience for patients.

10. The proposals secure the long term future of Stobhill

The new Ambulatory Care Hospital for Stobhill will be big, busy and built to serve the population who currently use Stobhill. It will be the guarantee that most of what people use Stobhill for, they will continue to use.

For the in-patient experiences, people will be referred to GRI or Gartnavel (or to Southside, as already happens for some conditions). Longer travel, yes, but the benefits will come from the ability of clinical teams to provide their expertise in a much more sustained and responsive way in an era where the notion of "working all hours doctors" is no longer acceptable.

11. The new pattern of Accident and Emergency Departments will save lives

Yes – a bold statement but clinical audit shows too many seriously injured patients not being seen by a consultant. We intend to invest in two "gold standard" A & E Departments. There aren't enough of the seriously injured to justify three gold standard departments – instead we want well organised Minor Injuries

Units at each hospital – GRI, Stobhill, Gartnavel, Victoria and South Glasgow – to provide fast service for the "walking wounded". Fewer delays for them because they won't be competing for attention with the more seriously injured cases.

12. The Ambulance Service will be up to the job

It's already investing in extra crews and getting a paramedic on every 999 vehicle. We shall invest more on top to match the new pattern of Accident and Emergency Departments.

It's speed of response to the scene of incident that saves lives. Subsequent journeys of no more than 25 to 30 minutes to the nearest Accident and Emergency Department are not unusual in the UK. In many areas of Glasgow the journey times will be much less. The current average journey time from scene to hospital is about 10 minutes – it will not change much. For people in West Glasgow, the ambulance time to the South Glasgow Hospital site will be around 3 minutes shorter than the current journey time to the Western.

13. We've got a better handle on public transport access problems than we've ever had

The consultation has confronted us with the problems that many patients have in getting to the present pattern of hospitals. Whatever change is made for the future pattern, something has to be done to improve public transport. This is not a problem that the NHS alone can solve but we will do our bit, including commissioning some express shuttle buses, working with Strathclyde Passenger Transport Executive to get better information about bus routes.

14. We've flagged up some more work that needs to be done on:

- bed numbers
- Yorkhill
- Dental Hospital
- expanding the new Accident and Emergency Department at the GRI

Beds

A lot of people were worried abut there being fewer surgical beds in future (we had proposed there should be more medical beds). We've agreed to review what we expect future average lengths of stay and trends in day surgery to be. And how the new concentrations of beds will deal with peaks of demand. We'll publish the results of that work as soon as we can. Our aim is to ensure that there will be enough beds. We will be opening extra medical beds at the GRI (27) this year and 38 at the Victoria if gynaecology transfers to the Southern General next year. There will also be extra medical beds for the winter at Gartnavel, Stobhill and, this winter, the Mansionhouse Unit.

Yorkhill

The Trust have produced some useful work on choices for the future which we will be exploring with them and others. If a proposal to build a new Children's Hospital does emerge we will consult on it. Already it is clear that some people favour a move, others don't.

The Dental Hospital

One of the new issues that has emerged during the consultation period. People want to know its future, bearing in mind the building is not in good condition. We've published a note on progress so far.

GRI Accident and Emergency Department

The new Department will need more space. There is space available. The Trust will plan the details.

Greater Glasgow NHS Board
Acute Services

THE FUTURE OF GLASGOW'S HOSPITAL SERVICES

REPORT ON FIRST PHASE OF CONSULTATION

11. SOUTH GLASGOW SERVICES

1. This element of the proposals has attracted significantly more comment than any other. There have been hundreds of letters from members of the public, responses from Community Councils, comments from local authorities, professional advisory committees and the Local Health Council. Local MSPs have maintained a close interest throughout the period of consultation.

2. If decision-making were a matter of weighing the sheer volume of comment it would point unequivocally to overwhelming support for the concept of a single in-patient hospital on the Southside. But beyond that there is mixed opinion as to whether it should be at the Victoria/Queen's Park Recreation site or Cowglen.

   Up until 31st August there was a desire for it to be built at Cowglen (103 responses): however, in the last few days of the consultation period the volume shifted for it to be located at the Victoria or Queen's Park Recreation site (171 responses).

   In addition the lack of response from people from the south-west of Glasgow does not mean that the option of the Southern General would have no support.

3. **The concept of a single in-patient hospital for the Southside** appears to have attracted support for a number of reasons:

   a. frustration at the appalling quality of most of the buildings in the Southside hospitals, particularly at the Victoria Infirmary where there has been a lack of investment in upgrading or replacing existing facilities over the last 10 to 15 years. The Southern General has been better served by its management in that period. However, it too is burdened by a legacy of Victorian buildings which cannot add up to a hospital designed efficiently around the needs of patients, no matter how well individual ward upgradings and link corridor schemes have been undertaken.

   b. recognition of the importance of creating larger specialist teams.

c. a concern that the current fragmented pattern will continue to cast the Southside in a less favourable position compared with the bigger groupings and more recent investment that can be seen – albeit incompletely and unbalanced – in North Glasgow. This can undermine staff recruitment attractiveness and has also retarded specialist service development in South Glasgow.

4. **GGNHSB believes that failure to deliver on this consensus would be highly damaging to the quality of hospital services in South Glasgow.**

5. The issues of controversy concern the question of **location**.

6. As is said in paragraph 11.2 some respondents have argued that a new Southside hospital should be located **at or alongside the existing Victoria Infirmary site**, (171 respondents). It is timely to remind ourselves why **this has not been seen by GGNHSB to be a viable option**:

    a. **In a "two A & E for Greater Glasgow" configuration**, with one of those two being at the GRI, **the Victoria Infirmary is not an acceptable site** because the whole of West Glasgow, north and south of the river, would have to look to the East for access. A North\East and South\West axis for A & E services provides the most balanced position, particularly if the two units are close to the strategic road corridors (M8, M77, Clyde Expressway, Clyde Tunnel).

    b. **the site is too small**. The acreage already owned by the Trust is only some 11 acres (including the Grange Road School site).

    c. the suggestion made by some respondents that a larger site could be made available by the Trust acquiring the whole of the **Queens Park Recreation site does not seem to us to be viable**:

        i) it would still only offer 34.2 acres (compared with 67 acres at the Southern General and 73.6 acres at Cowglen)

        ii) it would not be large enough to accommodate **acute mental illness** beds for South Glasgow nor a relocated **Royal Hospital for Sick Children** if that were transferred.

        iii) advice from town planners confirms that the acquisition of Queens Park Recreation site would require

a change of use of land currently designated as Open Space. We are advised that areas designated as Open Space are "key elements in the green-space network of the city and .... there will be a strong presumption against loss of designated open space, whether in public or private ownership" and that the Open Space Land Use Policy requires that such areas "should remain primarily as open space and that development will only be permitted which relates to open space\recreation purposes" (letter from City Council Development Control dated 22nd August, 2000). It would require specific public consultation, the formal overturning of its own Land Use Policy by the City Council as town planning authority, and the agreement of Sport Scotland.

It is likely that a formal public enquiry would be held. The complex town planning process would take between one to two years. It would also be necessary for the Trust to meet the cost of providing replacement playing fields in the vicinity. Given the size of site involved it is far from clear whether such alternative space is available (it would already have been identified by Scottish Enterprise – Glasgow if it were since they are very anxious to find large sites for industrial development in South Glasgow and are finding it difficult to identify any).

The existing Queens Park Recreation site is used as overflow car parking for matches at Hampden Park – its loss for that purpose would also pose problems in finding acceptable alternatives.

This option would almost certainly add two years to the process of securing a new hospital for the Southside, thus prolonging the present problem of improvement blight experienced by the Southside's hospital service.

Acquisition and re-provision would clearly add to the cost and delay of any hospital development. It is more likely however, that the option would fail to overcome the planning barriers.

d. The Victoria is located in a "highly developed area where there is little spare capacity on the existing road network and little opportunity to substantially improve it". (Source : Travel Time Study commissioned by the Glasgow Health Forum (South-East)). It hardly seems likely that the **traffic impact** of bringing the Southern General's in-patient work into the area would be viewed favourably, nor would they be physically easy to resolve. This issue

adds to the town planning complexity already described earlier.

e. A new Southside Hospital at the Victoria Infirmary campus would have to be phased since a quarter of the total 34.2 acres (if Queens Park Recreation were available) is already occupied by the existing hospital which would have to remain in use while new facilities were built on the adjacent site. A two phase development would therefore be unavoidable. Added to the town planning delays, this means that the Victoria Infirmary option would be much slower to deliver than the Southern General option.

7. These reasons continue to be compelling.

8. In leaflet 16 we set out the **differences between the other two alternatives** (Cowglen and the Southern General). We said that the differences centred on:

a. accessibility.
b. speed of completion.
c. risks.
d. cost.

During the consultation period three other factors have been raised:

a. wider implications for other areas of public policy.
b. traffic impact.
c. the environmental impact of the Shieldhall Sewage works.

9. It is important to revisit each of these in turn in the light of consultation. However, before doing so it is necessary to **revisit the position on Ambulatory Care**.

10. An **Ambulatory Care Centre** at the Victoria Infirmary campus would provide local access for at least 85% to 90% of all patient contacts that currently use the Victoria Infirmary. (Details given in leaflet 16). Many of the letters of concern we have received have been from people who currently go to ambulatory care services at the Victoria and who have gained the impression that in future they would have to go to the Southern General. There is no basis for such anxiety.

Such patients would continue to go to the Victoria Infirmary as they do now:

- around 275,000 out-patients No change [1]

- around 5,000 day patients No change

- around 9,000 day surgery cases No change [2]

(1 - "out-patients" also includes visits to x-rays, physio, speech therapy, hearing aids etc.)

(2 - assumes the issues around complication rates are satisfactorily resolved)

Of around 75,000 A & E attendances, between a minimum of around 14,900 would go to the Minor Injuries Unit at the Victoria, more likely a figure of 27,000 would go there. (Annex 6 explains this range) Around 14,000 children attend the Victoria A & E Department each year; an expert Paediatric A & E Review Group has recommended that all such children should go to the Yorkhill A & E or else attend local primary care services.

In addition the proposal to provide 120 rehabilitation beds in a new building next to the Ambulatory Care Centre would help local people needing to visit a patient who needs more extensive time in hospital to recover.

Thus for over 310,000 patients concerns about access to a new Southside Hospital at Cowglen or to the Southern General do not arise.

As Section 4 of this paper sets out GGNHSB sees no reason to depart from its original view that stand-alone Ambulatory Care Centres have a major part to play in the future pattern of service.

11. Section 6 of this paper explores the issues of **accessibility** which attracted a large amount of comment in the consultation.

    We suspect that much of the concern was from people who did not appreciate the significance of providing an Ambulatory Care Centre and 120 rehabilitation beds at the Victoria Infirmary (see above). Certainly many of the letters specifically referred to difficulties in attending out-patient clinics – which we are not proposing to move from the Victoria Infirmary campus. Others quoted the concerns of elderly people visiting their partners or friends during lengthy spells in hospital – the 120 rehabilitation beds are aimed to meet precisely the needs of such people.

    For **in-patients** we suggest, in section 6, that the number relying on public transport to get from the present Victoria Infirmary catchment area to either Cowglen or Southern General (i.e. those not taken to hospital by ambulance, by taxi or by car driven by family, friends or neighbours) is unlikely to exceed 20 to 25 people a day. This would involve a public transport journey averaging 57.1 minutes (if Cowglen) or 62.4 minutes (if Southern General) if off-peak or 60.3 minutes and 64.7 minutes respectively if at peak hour – an average difference of between 4 and 6 minutes.

In the case of **patients' visitors** we have drawn on a useful analysis commissioned by the Health Forum (South-East) – see Annex 7. We analyse the position in some detail in section 6. We concluded that:

a. at an individual public transport user level, **public transport** is **not a differentiator** between the Southern General and Cowglen because:

    - for 19 of the 34 places examined in Annex 7, the difference is 10 minutes per journey or less.
    - in both cases public transport would need to be improved.
    - in both cases most of the more onerous differences can be resolved by the development of express shuttle buses.

b. for **car users** the difference is contained within a **10 minute margin either way** and on a personal level the significance of this will be subjective.

c. the **economic advantage** of Cowglen over the Southern General option in terms of travel times and costs was more than outweighed by the economic advantage to the NHS and taxpayers of the Southern General option over Cowglen.

d. the significance of the 120 rehabilitation beds at the Victoria Infirmary site had been overlooked by many respondents but would significantly remove differences in public transport access for many patients' visitors, especially the elderly.

A further issue that was raised during the consultation concerned the **speed** with which a new hospital for the Southside could be achieved. Many of those who commented on this issue preferred the **Cowglen** option because it assumed a **single phase construction** completed in approximately 7 years time (i.e. 2007). By contrast the Southern General option would involve a first phase of new building (not upgrading) complete by the same time scale and with a second phase of new building following demolition of old buildings elsewhere on the site freed up by the availability of the new hospital blocks.

The two phase approach was principally determined by the need to create potential site space for the relocation of the Royal Hospital for Sick Children (if that was decided). The Trust has reviewed the way in which site space could be released for new building and there **might be scope for a single phase provision of a Southside hospital at the Southern General**

site. This needs further consideration both in terms of practicality and the profile of revenue funding requirements which the Trust would be able to examine reliably at Outline Business Case stage.

12. A major differentiator in the choice between the two principle options has been **cost**. In our original consultation material we highlighted that the **Cowglen option** would cost an extra **£18.4 million per year** more than the present cost of hospital services in South Glasgow compared with an extra **£11.1 million per year for the Southern General option**. We felt that the difference of £7.3 million was too high both in terms of absolute affordability and as an opportunity cost (i.e. taking into account that the £7.3 million could otherwise be spent on doctors, nurses and other healthcare staff providing extra healthcare for patients).

The responses to consultation were not impressed by this argument. However, the significance of this issue is now greater because the revision of bed numbers (see Section 8) means that the running costs of a new Southside Hospital (whether at Southern General or Cowglen) will be higher than we estimated in our original consultation period.

In Section 8 of this paper we revisit the issues of financial affordability in the light of the consultation responses the revision in bed numbers and new developments in NHS funding. Section 8 includes a new financial model for the period up to 2004\5 but also looks at the prospects for 2005\6 and beyond.

Its conclusion is that there is a very real risk that in 2006\7 the Cowglen option revenue requirement would be unaffordable within the GGNHSB formula allocation from the Scottish Executive. Indeed even the Southern General option with its higher number of beds will require careful financial stewardship over the next few years if its additional revenue costs are to be met.

13. **Cowglen - site issues.**

At the start of the consultation we said two potential sites had been identified in the Cowglen area.

a. a 44.7 acre site incorporating the present Cowglen Hospital and the National Savings Bank. Adjacent land owned by Retail Property Holdings Ltd would have created just enough additional space to build a hospital.
b. a 73.6 acre site incorporating the Pollok Playing Fields and owned by the Pollok Estate.

Early in the consultation period the South Glasgow NHS Trust met representatives of the National Savings Bank (NSB) and, at the latter's request, recognised that the NSB site was not for sale. Siemens, who run the operation on behalf of NSB, have recently won another contract which will further increase employment on this site. Building a hospital

on the site would not create new jobs in South Glasgow (since NHS jobs would simply be transferring from the Southern General and Victoria to Cowglen) but would involve displacement of the NSB and all the hundreds of jobs it provides.

This leaves the Pollok Playing Fields site as the only potential location large enough in the Cowglen area.

14. **Cowglen : New Hospital on the Green Belt for Pollok?**

The Greater Pollok Social Inclusion Partnership has written to point out that this site has been identified as an alternative site for the reprovision of playing fields at South Pollok which were lost when the M77 was built. The Greater Pollok Partnership wrote that they "would not support construction of a new hospital which encroached onto Broompark Farm without the full support of the local community. The provision of these playing fields is a requirement under the National Planning Guidance following the loss of the former facilities at South Pollok".

It is also the case that this site, which is designated as Green Belt Open Ground and as a Conservation Area is subject to a Conservation Agreement between Nether Pollok Ltd (now Pollok and Corrour Ltd) and the National Trust for Scotland. Use of the site would therefore require the agreement of the National Trust, the Trustees of Pollok Park and the City Council as local planning authority. The City Council's Pollok Park Local Plan aims to "promote and maintain it as a high quality countryside area within which leisure and cultural pursuits can be undertaken without detriment to the countryside environment. In these circumstances ..... serious doubts as to the viability of any proposal to develop a new hospital on this site" (City Council Development Control letter dated 22nd August, 2000).

Any planning application to build on designated Green Belt needs to demonstrate very special circumstances which include demonstrating that:

- there is nowhere else that the proposed development could go.
- the development could not be reasonably undertaken on another site.
- the development would not materially diminish the openness of the Green Belt.
- there are substantial benefits for the community.

Even if, contrary to its own Local Plan and policies, the City Council approved a planning submission that approval would still need to be referred to the Scottish Executive who might decide to 'call it in' and then to hold a public enquiry. It seems inconceivable that there would be no "green\conservation" interest groups that would not be opposing loss of Green Belt in the sensitive Pollok Estate. The odds on a public enquiry must be very high and the certainty of a successful outcome

very low. The process would take a minimum of one to two years. It would also be unfortunate, to say the least, for a Health Board committed to promoting physical exercise as a major contributor to good health maintenance to be dismissive of recreational space close to an area of significant health and social deprivation. Likewise for a Health Board to seek to convert a Green Belt Conservation Area into a high density concentration of buildings, car parking and yet more traffic is also out of tune with what is expected in responsible corporate decision-making.

15. Are there any **other sites in a central location** in the Southside? In their response the Local Health Council urge GGNHSB "to pursue a longer term strategy which is more radical and will lead to the development of a much needed new hospital on a more centrally located site in South Glasgow". We understand this ambition, and who could not be tempted by its challenge? However, in starting its work on the proposals last year the South Glasgow Trust and its property advisers were unable to locate any such sites of adequate size other than those at Cowglen, Darnley and the Southern General.

At a meeting of the Glasgow Alliance Management Board on 25th August Scottish Enterprise – Glasgow gave a presentation on its programme to secure an adequate supply of good quality, well located, serviced sites in order to attract employment opportunities into Glasgow.

Among their criteria for success are:

- approximately 50 acres or more.
- high quality environment.
- motorway connections.
- access to facilities.
- scope to achieve unified public ownership.

They reported that the city is running out of the first class sites now needed to attract major inward location of new industrial\business opportunities. Such sites usually take two or three years to assemble and make ready for business occupation. They were aware of our initial interest in the Cowglen NSB site and were intending to work in partnership with the owners to help bring the Savings Bank building into full business use thereby increasing employment opportunity in the area. The only other site identifiable in the city south of the river was Darnley Mains. Scottish Enterprise – Glasgow were concerned that use of prime vacant sites for a new Southside Hospital would possibly deny the city a major new net extra employment opportunity in one of the very parts of the city where such opportunities are both needed (adjacent to Pollok) and most difficult to create. It was also pointed out that although an NHS development in such a site large enough for a new hospital would in due course release the Southern General site for industrial development that opportunity would not be ready for use until

the end of the decade whereas the need to attract net additional employment existed here and now.

The sense of the Glasgow Alliance Management Board meeting was that the creation of net extra employment opportunity for the Southside should not be overlooked when decisions are to be made about Southside Hospital configuration (which offers no net increase in employment). Three issues therefore arise in addressing the Health Council's challenge:

a. what alternative sites are there?
b. if there were alternative sites how should we weigh employment opportunity against those considerations of public feeling about the Southern General site explored elsewhere in this paper?
c. how long are we prepared to wait in order to identify a site and resolve tortuous planning issues (or find that we cannot resolve them) when we already own a site (Southern General) which is certainly large enough and has fewer town planning problems associated with it?

16. Some responses to consultation rightly draw attention to the **traffic impact** of options for the Southside. In section 6 we analyse this issue in overall terms. There will certainly need to be a traffic impact analysis as part of the next stages of planning, involving liaison with the City Council in its planning, roads and traffic management roles. The salient points emerging from our considerations of comments made so far are as follows:

a. **<u>any</u> reconfiguration** of hospital services in Glasgow **will change traffic patterns** one way or another.
b. our creation of a stand-alone **Ambulatory Care Centre** at the **Victoria Infirmary keeps overall traffic change to a minimum**. It will however reduce traffic around the congested area of Battlefield Road\Langside Avenue\Prospecthill.
c. conversely our judgement not to locate a single hospital for the whole of the Southside at the Victoria Infirmary site avoids what would almost certainly be a quite unacceptable increase in local traffic and reduction in local environmental amenity.
d. the **Cowglen** option would clearly be better than the Southern General in involving a more manageable **traffic impact** but, as we identified in 11.13 and 11.14 above there are serious other problems involved with the acquisition and use of sites at Cowglen.
e. the whole issue of **traffic impact at the Southern General** would need to be examined alongside issues of existing road capacity, scope for improved public transport to reduce extra traffic, neighbouring

developments at Braehead, Pacific Quay, Meadowside Granary and Yorkhill and any road or bridge developments associated with them.

17. A large number of consultation responses cited the smell from **Shieldhall Sewage Works**, adjacent to the Southern General as a significant reason why a single-site Southside hospital should not be located there. GGNHSB has raised the issue with West of Scotland Water who replied that they were very conscious of the potential impact that the Shieldhall facility can have on neighbouring properties. They went on:

"Consequently, three years ago this Authority developed an outline plan to reduce odours from this site. This plan is based on reliable measurement of odour nuisance to locate the principal sources of complaint and , therefore, to find innovative and cost effective solutions.

Measurement of odour levels has been undertaken at Shieldhall continuously since 1997. The information collected is utilised by site personnel on a daily basis to monitor and improve operational performance. A site specific odour dispersion model has been developed by a specialist consultant and is used to help identify the problem locations and determine priority investment.

The Authority has invested in excess of £1 million at Shieldhall during the past 18 months addressing odour issues.

In addition, the underlisted investment is planned:

Financial year 2000\1

- Physical covering of high risk channels and pump wells.
- Consultant investigation to optimise the operation of the site to mitigate odour generation.
- Review of odour model to incorporate new measurement techniques identified in the latest European CEN Standard.

Financial year 2001\2

- Discontinue the use of the Interim Sludge Treatment Centre.
- Reduce the quantities of sludge delivered to Shieldhall for processing.
- Improve\upgrade odour abatement plant on site.

When this programme of work is completed, all of the presently identified significant sources of odour will be largely abated. Thereafter, there will be a further programme of measurement to ensure that there will be no outstanding odour generators.

The operation of this site does generate odours. However, West of Scotland Water is endeavouring to ensure that at the boundary with our neighbours, there is no cause for complaint as a result of site operations. In this regard, we have established day-to-day liaison with representatives of the local community, Barr and Stroud and your hospital to assist in identifying sources of complaint and speedy advice of difficulties."

Clearly it is not possible for us to predict the precise success of these measures but we are confident that West of Scotland Water recognise the importance of the issue and are demonstrating a significant commitment to tackling it. Because they are monitoring complaints and linking them to specific site operations and weather conditions it will be possible to assess with some precision the effect of their current investment when it is completed by Spring, 2002.

Some consultation responses raised concern about the risk of airborne infection from the Sewage Works. Public health monitoring shows no pattern of disease in the area which could be attributed to the Sewage Works nor is there any experience elsewhere of disease being transmitted from a sewage works to neighbouring communities by an airborne route.

The issue of the Shieldhall Sewage Works is not, in our view, a factor that should influence the decision about future strategic configuration of hospitals, particularly since by the time change occurs West of Scotland Water's investment programme will have been undertaken and its effectiveness monitored. If an odour nuisance remains it will be necessary to press for further measures by West of Scotland Water.

18. In leaflet 16 we identified a number of **risks** associated with the two main options on the Southside. They concerned:

    a. site availability.
    b. site acquisition cost.
    c. degree of flexibility in relating ultimate bed numbers to clinical experience and need over time.
    d. relationship of building contract size to degree of risk of cost-overruns.
    e. traffic impact issues.
    f. the risk, with two or three phase developments, of hiatus between phases.
    g. on-site disruption during building works.

19. In terms of differentiating between the Southside option, the risk profile is as follows:

Southern General	Cowglen	Victoria (incl. Queen's ParkRecreation)

a) Site availability	Nil risk. Already fully owned by Trust	High risk. Competing public policy considerations and long town planning process delays. Successful outcome cannot be guaranteed.	High risk. Competing public policy considerations. Long town planning process delays. Successful outcome cannot be guaranteed.
b) Site acquisition cost	Nil risk. Already fully owned by Trust.	Medium risk. Costs of reprovision\relocation of playing field space (but where?) likely to arise.	Medium to high risk. Cost of providing alternative playing field space arises, so amount of land to be paid for is almost twice the area needed for the hospital itself.
c) Flexibility on future bed numbers	Good flexibility unless we seek to achieve a single phase exercise.	Low flexibility because single phase project.	Good flexibility because it would have to be a two phase project.
d) Risk of cost overrun magnified by sheer scale of building contract	High, especially if a single phase approach is sought and if PPP not used.	Medium if PPP used.	High because of site complications and phasing.
e) Traffic impact	Medium, depending on other nearby retail and leisure developments.	Low, although any expansion of other retail\ commercial activity around junction 2 of the M77 may raise this risk.	High, due to existing lack of local road capacity.
f) Phasing hiatus	High, unless single phase approach is feasible.	Nil risk.	High.
g) Building work disruption on site	Medium. Site layout makes demolition and new building on a zoned basis possible without excessive disruption of other zones.	Nil risk.	Low risk. Disruption would be to the local neighbourhood rather than to the Victoria Infirmary itself.

Of these (a) is critical – no site, no hospital. Risk (b) is also a first order risk, since it will magnify cost differences between options to a significant degree. Risk (c) is not a significant differentiator. In our view the risks at (a) and (b) outweigh the risks at (e), (f), and (g). If risk (d) becomes high for the Southern General option because a single phase approach is adopted, then risk (f) becomes a nil risk for the Southern General.

20. **Taking Stock**

Taking into account all the perspectives raised and explored during the consultation process how does GGNHSB view the position now?

a. Firstly we wish to re-affirm our ambition that the Southside should have a pattern of hospital services that stand comparison with those available north of the river. This means:

- a coherent range of general acute services offering state-of-the-art ambulatory and in-patient care, with specialties and sub-specialties viably staffed and assuring the local population reliable access to specialist teams at all times.
- the presence of regional services which add richness to the clinical life of a hospital.
- co-location of acute mental illness services with general acute services so as to reduce the stigma of mental illness and to provide clinical links where they are needed (e.g. in relation to overdose patients and emergency patients with physical and mental illness).
- thoroughly modern facilities helping to make the patient experience as good as it can be.

b. Secondly, we do believe a stand-alone Ambulatory Care Centre, including a Minor Injuries Service and 120 rehabilitation beds, located at the Victoria Infirmary will provide the best possible local access to as many services for as many people as possible.

c. Thirdly, we continue to subscribe to a pattern of two Accident and Emergency Services for Greater Glasgow (supported by a network of more local Minor Injuries Units) which is best positioned on a north\east and south\west axis.

d. Fourthly, we are anxious that the strategic planning blight which has afflicted South Glasgow for at least two decades should be brought to an end. We wish to see an early start to replacing the Southside's obsolete hospital buildings.

Ending the blight requires a decision on siting to be made within the next few months. If decisions become dependent on the most lengthy town planning processes, including public enquiry and the decision-making timescales that flow from a public enquiry, then the planning blight afflicting the Southside hospital service will remain rigidly unresolved for up to three years or more.

During that period of blight no resources could be committed to planning the new Southside Hospital in any meaningful detail,

which in turn means that building would be unlikely to start until 2005 or 2006. The Southern General option is the only one which avoids this prospect of blight.

21. The Board has reviewed its decision matrix for the Southside which is as follows:

	Victoria + Queens Park Recreation	**SGH (+ACAD at Victoria**	**Cowglen (+ACAD at Victoria)**
Site Issues			
1. Site size	34.2 acres.	67 acres (SGH) + 5.5 acres (Victoria).	73.6 acres (Cowglen) + 5.5 acres (Victoria).
2. Site availability	Highly uncertain.	Already owned.	Highly uncertain.
3. Site acquisition problems and cost	Highly uncertain. Need to include cost of reproviding playing fields and re-routing main sewer on Grange Road. Would enable sale of SGH site (?£7.5 million).	Nil (apart from 4 acres next to Annan Street). Would enable sale of part of Victoria site (? £6m) + Mansionhouse (? £2 million).	Highly uncertain. Would enable sale of SGH, part of Victoria site and Mansionhouse (? £15.5 m in total).
4. Building work disruption	Low risk to hospital. Significant impact on local neighbourhood.	Medium risk but minimised by zoned nature of site and order of demolitions. Less intrusive impact on local neighbourhood.	Nil risk.
5. Environmental impact\issues	High. Removes local playing fields and open space. Heavier traffic in residential\ recreational\shopping area with congested roads already.	Minimal. No loss of public amenity space. No change in use of site. Modern buildings replace muddle of older buildings on site. Options available for resolving traffic impact. Sewage works nuisance being addressed by West of Scotland Water.	High. Loss of open space. Traffic impact unlikely to be a major problem.
Accessibility			
6. Number of patients affected by change of location.	All SGH patients = 450,000	VI in-patients + A & E less MIU = 75,000	VI in-patients + A & E less MIU + All SGH = 525,000
7. Number of patient unaffected by change in accessibility	All VI patients = 375,000	VI ACAD\MIU = 300,000 SGH = 450,000 750,000	VI ACAD\MIU = 300,000
8. Public transport	Best. Current off-peak average journey of 34 minutes (based on Mr. Drewette's	53 minutes average journey.	48 minutes average journey time.

	work).		
9. Car\taxi access	Best. Average off-peak journey of 11 minutes.	Average of 17 minutes.	Average of 12 minutes.
Town Planning Risk			
10. Ease\difficulty of of town planning (also see factor 5)	Very difficult. Likely to take several years. Prospect of successful outcome is highly uncertain.	Easiest of the three options. Unlikely to take years. Prospect of successful outcome is very good.	Very difficult. Likely to take several years. Prospect of successful outcome is highly uncertain.
Conflict with Policy Considerations (see also factor 5)			
• Impact on employment opportunities in South Glasgow	Exports jobs from Govan to Langside\Queens Park area.	Exports jobs from Langside\ Queens Park to Govan.	Exports jobs from Govan, Langside\Queens Park to Pollok.
• A & E Services for Glasgow	Will require 3 major A & E Departments in Glasgow.	Consistent with 2 A & E Department configuration.	Will require 3 A & E Department configuration.
• Possible relocation of Children's Hospital	Not possible. Site too small.	Achievable.	Achievable.
• Co-location with Mental illness services	Not possible. Site too small.	Achievable.	Achievable.
Cost			
• Capital cost (leaflet 16). Excl. Yorkhill relocation and site acquisition\disposal	Not costed but would be no less than Cowglen option, certainly much more than SGH option.	£190 million.	£295 million
• Annual running costs (leaflet 16)	Not costed but would be similar to Cowglen option.	£11.1 million.	£18.4 million.
• Risk of capital cost	High.	High.	Medium (if PPP)

overrun			
• Is there a big 'sunk cost' penalty of walking away from recent significant capital investment?	Yes. £41 million spent on new build at SGH in last 10 years (excluding refurbishment of old buildings).	No. Capital spending at Victoria has been refurbishment only.	Yes. £33 million at SGH.
Other risks			
• Flexibility in provision of most appropriate bed numbers	Good flexibility.	Good unless done in single phase.	Low flexibility.
• Risk of delayed start and planning blight.	Very high.	Low.	Very high.
• Risk of phasing hiatus (e.g. non-completion of a second phase)	High. Two phases unavoidable.	High unless single phase approach is feasible.	Nil risk.

22. This analysis indicates that the **Southern General option** is significantly the **best in terms of**:

Factor

2 Site availability.

3 Site acquisition.

5 Environmental impact.

6\7 Access disruption to the smallest number of people.

10 Lowest town planning risk.

12 Fit with GGNHSB policies on A & E.

15 Value for money in capital investment terms.

16 Affordability **and** least adverse opportunity cost for other health care services.

18 Least ‘sunk cost’ penalty.

20 Minimum risk of further delay and planning blight.

On some **other factors** there is **little difference** between it and the Cowglen option.

1 Site size (both are large enough).

11 Employment.

13 Scope to re-locate Children’s Hospital services (no difference).

14 Fit with GGNHSB policy on mental health services (no difference).

19 Flexibility on bed numbers (possibly some advantage to SGH).

For factor 17 (risk of capital cost overrun) is difficult to judge since it depends on whether the SGH scheme is phased or not (higher risk), or subject to Public Private Partnership (lower risk) or not.

In four factors Cowglen has an advantage:

4 Site disruption during building work.

21 Lower risk of phasing hiatus (although this would not be the case if the feasibility of a single phase approach at SGH proves to be possible.)

8 Public transport (but both involve the need to improve it. Current time differences between them are within a narrow band. We do not see this as a significant differentiator).

9 Car\taxi access (depending on how differences of 10 minutes or less are viewed).

But factors 8 and 9 need to be seen in the context of the Cowglen option causing access disruption to the largest number of patients (factors 6\7).

23. The **Victoria Infirmary\Queens Park Recreation Site option** falls, in our view, due to the significance of its position in relation to:

- too small a site (factor 1) to address factors 14 and 13 (mental health and children.
- its inevitable delay (factor 20).
- its adverse environmental impact (factor 5).
- its adverse impact on job opportunity in Govan (factor 11).

- its cost disadvantages shared with the Cowglen option (factors 15 and 16).
- its exposure to phasing hiatus (factor 21).
- its much higher access disruption score (factors 6\7).
- its lack of fit with GGNHSB policy on A & E provision (factor 12).

We do not see these as being outweighed by its advantages in relation to factors 4 (building work disruption), 8 and 9 (public transport and road access – many residents in the present Southern General catchment area would feel as much dismayed by their perception of increased travel difficulty to the Victoria as do many of those from the Victoria Infirmary catchment area who complained about this issue during the consultation period), 19 (flexibility on bed numbers).

24. **Our conclusion therefore is to re-state our preference for the option of locating the Southside in-patient hospital at the Southern General, with an Ambulatory Care Centre (including Minor Injuries Unit) and 120 rehabilitation beds at the Victoria Infirmary campus.**

25. Is this unambitious? We think not.

    a. it meets a vision of clinical services significantly stronger than the present pattern and on a footing that will no longer compare adversely with other parts of the city.
    b. it retains as much local access as possible.
    c. it provides the Southside totally with all-modern buildings within which a high quality patient experience can be provided by well organised and supported teams of staff.
    d. it is the solution capable of the fastest delivery.

26. Does this mean we have not taken notice of what has emerged from the consultation process? No, it does not. We have:

    - reviewed the arguments about Ambulatory Care and minor injuries in more depth and identified how to examine some detailed issues more fully in the next stages of planning.
    - revised the estimates of future bed numbers.
    - examined the public transport analyses carefully and now have a much clearer understanding of what we need to do to improve public transport (which applies as much to the Cowglen option as it does to the Southern General option).
    - recognised the need to explore more fully the scope for extended primary care services in Castlemilk, Rutherglen\Cambuslang, Pollok and Gorbals.
    - re-opened the issue of a possible single phase approach at the Southern General site.

- understood more fully the town planning and alternative land use issues associated with Cowglen.
- checked West of Scotland Water's plan for Shieldhall Sewage Works.

27. We have also thought hard about how to deal with a number of pressing clinical service issues that need to be addressed in the period between now and the completion of the major capital investment later in the decade:

    a. an urgent need to ensure that the Victoria Infirmary has stronger capacity to deal with the rising tide of medical emergency admissions during the next few years.
    b. concentrating haemato-oncology (cancer of the blood and lymphatic systems) services.
    c. concentrating gynaecology in-patient services.
    d. concentrating breast cancer surgery.
    e. concentrating in-patient vascular surgery services.

28. The biggest single clinical pressure at the Victoria Infirmary for years has been its lack of capacity to deal satisfactorily with **medical emergency admissions**. In part that was due to inadequate staffing (mainly medical and nursing) and a need for improved organisation. The Trust has been addressing these issues in the last 12 months, with significant additional financial support from GGNHSB. However, the problem will remain intractable for as long as there are too few medical beds. At present medical patients continue to "board out" in the wards of other specialties, principally general surgery. This makes it more difficult to manage the patients efficiently and it also causes significant disruption to general surgery, making it more difficult to improve waiting list performance.

    Unfortunately the Victoria Infirmary does not have any vacant wards which can simply be staffed and re-opened.

    In order to tackle the problem, and put the hospital onto a sound footing for the remaining years of its acute in-patient role, we suggest the following sequence of changes should take place:

    a. It is already the case that when in-patient ENT moves to newly created accommodation at the Southern General in 2001 (a move already agreed following earlier consultation), an adult ENT ward of 24 beds will become vacant at the Victoria Infirmary.
    b. It is proposed also that in-patient gynaecology should be concentrated at the Southern General Hospital by the autumn of 2001. The benefits and implications of this are explained more fully below. This transfer from the Victoria Infirmary will free up ward 12A (25 beds).

c. It is already the case that within the Victoria Infirmary general medicine bed complement 12 beds are allocated (in a 12 bed ward) for haemato- oncology. However, it is often the case that 3 or 4 haemato-oncology patients are also placed in another 11 bed general medical ward across the corridor.

Our proposal aims to produce a significant improvement in the Victoria general medicine capacity, simultaneously provide some small easement for general medicine capacity at the Southern General and improve quality of service for Southside haemato-oncology patients.

The current haemato-oncology ward at the Victoria Infirmary has single rooms with positive and negative ventilation systems to reduce risks of infection in patients whose treatment may make them vulnerable to infection. The ward across the corridor does not have this and haemato-oncology patients are placed alongside other patients with a range of general medical conditions. Haemato-oncology in-patients at the Southern General Hospital currently use 5 beds within a general medical ward. The proposal is to convert the ward adjacent to the existing haemato-oncology ward at the Victoria Infirmary so that an integrated unit for the whole of the Southside with suitable facilities and environment can be dedicated to this patient group. The cost of conversion would be around £200,000. This would affect 124 in-patient haemato-oncology admissions per year that currently go to the Southern General who would in future go to the Victoria for in-patient and day case care (375 attendances per year). Their routine out-patient consultation would continue at the Southern General.

This conversion would allow the concentration of haemato-oncology staff expertise in the Southside and would allow better cover for staff absences.

This manoeuvre would free up 5 extra beds for general medicine at the Southern General but would reduce the Victoria's designated general medical bed complement by 11 beds (slightly less in terms of current availability for general medicine), but

d) ..... general medicine's bed complement would be increased by allocating to it the wards vacated by gynaecology (25 beds) and adult ENT (24 beds). There would thus be an extra 38 beds for the designated general medicine bed complement. GGNHSB would provide the revenue necessary for this expansion. This

should provide significant easement of the Victoria Infirmary's difficulties in absorbing general medical workload and should significantly reduce the level of patients boarding out in general surgical wards. Waiting list performance will also benefit therefore.

We believe these changes would provide enormous benefit to the Victoria Infirmary and its busiest acute services.

29. As already indicated, this manoeuvre depends on a ward being vacated by **gynaecology**. What is the rationale for this and what are its implications?

Firstly **the clinical logic** flows from the advice of the Area Sub-Committee in Obstetrics and Gynaecology which favours co-location of gynaecology with obstetrics (maternity services) and urology. As is the case with other surgical specialties there are also trends towards the development of sub-specialisation within gynaecology which are particularly difficult to accommodate at a time when legal and regulatory constraints on doctors' working hours (senior and junior doctors) are tightening. As specialisation continues so does the importance of ensuring as much continuity and strength in depth among the dedicated nursing team (and other staff) for gynaecology, many of whom also develop specialist knowledge and skills.

The Glasgow-wide proposal for gynaecology envisages in-patient gynaecologybeing located at the Glasgow Royal Infirmary and the single in-patient hospital for the Southside. Ambulatory Care would continue to be provided at the Victoria Infirmary, Stobhill and Gartnavel (as well as at GRI and the Southside hospital), although the Gynaecologists share the caution of some other surgeons about day-surgery in stand-alone centres (an issue discussed earlier in this paper).

There are strong reasons for proceeding with the concentration of in-patient gynaecology on the Southside at the earliest opportunity:

a. It allows the benefits of a larger clinical team (specialisation and better staffing cover) to be secured without waiting several years.
b. It allows use to be made of currently idle ward space at the Southern General.
c. It creates sorely needed space to expand general medicine at the Victoria Infirmary.
d. It allows in-patient gynaecology services to be relocated from West Glasgow at an early opportunity, thereby freeing up room for manoeuvre to facilitate the highly desirable service changes that would release West Glasgow acute services from their present wholly

unsatisfactory pattern of split-site services for in-patients during their episode of care.

e. It will save about £300,000 a year, mostly as a result of a reduction in junior doctors' rota commitments and from more efficient use of beds. GGNHSB is currently underwriting that excess cost and no longer having to do so will allow that £300,000 to be spend on expanding general medicine capacity at the Victoria Infirmary.

30. The impact of these changes for patients would be as follows:

	Out-patient Attendances	Day Cases	In-patient episodes	TOTAL
Southern General	9,361	985	1,909	
Victoria Infirmary	9,746	1,296	2,390	
Western\Gartnavel	10,587	1,367	1,668	
No change	29,694	3,648	1,909	**35,251**
Change	Nil	Nil	4,058	**4,058**

The total bed days in hospital for the 4,058 patients affected by change (based on data in the 1998\99 Blue Book) is 9,450, an average of 2.3 days per patient.

These figures assume that the patient population currently attending the West Glasgow hospitals would in future have their in-patient stays at the Southern General. GPs would be able to refer their patients to the GRI\Stobhill service if they wished for clinical or other reasons.

31. **How** could the concentration of gynaecology in-patient services be achieved?

There is currently one 25 bed gynaecology ward at the Victoria Infirmary and one 25 bed gynaecology ward at the Southern General (located in the Maternity Block). There is also a vacant 25 bed ward in the Southern General Maternity Block.

The Trust would propose to upgrade the existing and vacant wards (Wards 40 and 49) in the Maternity Block at a cost of £1.2 million (£600,000 per ward). The service would also need to be supported by a triple theatre suite by the time gynaecology from West Glasgow joined the concentrated service. A site exists adjacent to the gynaecology wards in which to locate this.

If capital funding is available, this work could be started in the Spring of 2001, allowing gynaecology to vacate its ward at the Victoria Infirmary by the Autumn of 2001, it time for general medicine to occupy it before the winter of 2001\2.

The detail of the scheme to create a triple theatre capacity to accommodate the current West Glasgow in-patient workload would depend on whether the Southern General or Yorkhill was the location of the second of only two maternity delivery services in Glasgow (an issue subject to separate consultation – see Section 15).

Whatever the outcome of that, there is site space in which the necessary theatre capacity could be created.

If the need to expedite changes to split-site working for medicine and surgery between the Western and Gartnavel pointed to the desirability of transferring in-patient gynaecology from there to the Southern General in late 2001\2, theatre time would need to be accommodated. According to the 1998\99 Blue Book the number of operating theatre hours is as follows:

	Day cases (Hours per year)	In-patient cases (Hours per year)	Total needed at SGH (Hours per year)
Victoria	Stays at Victoria	1,912	1,912
SGH	394	1,336	1,730
West Glasgow	Stays in West Glasgow	1,334	1,334
			4,976

4,976 hours equate to 103 theatre hours per week over a 48 week work year, which for 3 theatres equates to 34 hours per week each (7 hours per day).

The two upgraded wards would provide space for 50 beds. The transfer of in-patient Gynaecology from the Victoria Infirmary would see one of the two wards working on a day a week basis and one on a 5 day a week basis. When the West Glasgow service moved both wards would work on a 7 day a week basis.

VI	SGH	Western\ Gartnavel

a) In-patient episodes	2,390	1,909	1,668
b) Average length of stay (days)	2.0	2.8	2.8
c) Beds days per year (a x b)	4,780	5,345	4,670
d) Victoria and Southern General combined	10,125		
(bed days)			
e) All combined (bed days)	14,795		

First phase (Victoria and Southern General combined)

25 beds @ 7 days per week x 85% occupancy = 7,756 bed days

25 beds @ 5 days per week x 85% occupancy = 5,525 bed days

13,281

Second phase (West Glasgow service included

50 beds @ 7 days per week x 85% occupancy = 15,512 bed days

This analysis demonstrates that the configuration provides sufficient capacity.

32. As far as **staffing implications** are concerned there would be a reduction in the number of Senior House Officer posts in gynaecology, but with the reduced number working in a pattern consistent with the new national agreement on working hours and pay.

The interim arrangement of one ward working 7 days a week and the other 5 days would require fewer nurses than at present but this will be more than compensated by the increase in general medical beds at the Victoria Infirmary. In overall terms the net change in capacity is created by re-opening the closed Ward 49 and increasing theatre capacity at the Southern General. There will be no fewer overall jobs in nursing, professions allied to medicine, ancillary or administrative\clerical at the Victoria and slightly more overall at the Southern General.

33. The impending transfer of ENT in-patient services to the Southern General creates an opportunity to achieve a significant **early improvement in the breast surgery service** by **concentrating its in-patient element at the Victoria Infirmary**.

Currently there is a breast unit staffed by two consultant surgeons and their teams with high quality accommodation at the Victoria Infirmary – single rooms in a dedicated ward with its own team focused on a specific group of patients needing

great sensitivity at a difficult and worrying time. At the Southern General one consultant surgeon specialises in breast surgery and the in-patients are managed within the general surgical bed complement.

The existing children's ENT ward at the Victoria is located next to the Breast Unit. It is proposed that in the summer of 2001 it be converted (approximate cost £200,000) to the standard of the Breast Unit. Together the two wards would form an integrated Breast Unit to provide the in-patient care for the Southside breast service.

It would:

a. create a 3 consultant team, giving better absence cover.
b. strengthen the multi-disciplinary specialist breast care team.
c. create a ward environment purpose-designed for all Southside breast surgery patients needing in-patient treatment.
d. create a bed complement protected from emergency admission pressures, thereby reducing the risk of late cancellation of booked admissions.
e. use a dedicated elective theatre, also protected from emergency admission pressures.
f. create the capacity at the Southern General to allow a similar strengthening of the in-patient vascular surgery service (see below).

Out-patient clinics and day case surgery would continue to be undertaken a both the Victoria Infirmary and the Southern General.

The number of patients affected would be around 100 per year which in future would go to the specialist unit at the Victoria Infirmary rather than to the Southern General.

There would be no net change in staffing, although some change in the base hospital of a small number of staff would occur.

34. The creation of a single in-patient Breast Unit at the Victoria Infirmary would create the capacity at the Southern General simultaneously (i.e. in the second half of 2001) to form **a single integrated vascular surgery service** whose in-patient work would be **based at the Southern General** (out-patients and day cases still provided at the Victoria Infirmary).

The key features of this service would be:

a. the creation of a 3 consultant team (compared with the current pattern of 2 at the Southern General and 1 at the Victoria Infirmary).

b. a dedicated in-patient area for vascular surgery created at the Southern General, with a trained dedicated nursing team.
c. more in-patients would be in closer proximity to the specialist Vascular Laboratory (mainly using ultrasound imaging) located at the Southern General (there is currently no dedicated equivalent at the Victoria).
d. the Southside vascular service would be better placed to play a leading role in the South Clyde Vascular Network currently being developed with vascular service clinicians in hospitals in Argyll and Clyde.

Emergency vascular surgery could still be undertaken when necessary at the Victoria Infirmary by the surgeons going to the patient rather than vice versa. This is already the arrangement in Glasgow, where vascular surgeons work as a specialist network to cover out-of-hours emergencies.

The number of in-patients affected would be around 240 per year who would be treated at the Southern General rather than at the Victoria Infirmary.

There would be no significant impact on staff other than possibly a change of hospital base for a small number.

PRESS BRIEFING

September 2000

1 Introduction

On 8 September 2000, Greater Glasgow NHS Board completed the largest ever public consultation process undertaken by the NHS in Scotland. Our overarching aim is to improve the patient's experience of using acute hospital services, by redesigning the way those services are provided. We want to keep local access for as many patients as possible as well as strengthening the medical and surgical teams to ensure a better quality of service.

Simple as it may sound, the reality is very complex. Most proposals for minor service changes has a potential knock on effect for many other areas. We have been explaining, listening to views and reading the comments (over 3,000) that have been made on our proposals. The next stage is to refine them into a more coherent strategy and seek further debate before deciding the best way forward. This however will not be the end of the process. Some of the proposals will need further discussion, debate and consultation before the Board can finally support them.

It is recognised that there might not be agreement on everything, but to make progress there has to be a developing consensus and choices made to move forward. A common theme for having the status quo is no longer sustainable. Change must happen.

The public and the medical professionals alike have their own interests and perspectives. Therefore GGNHSB tried to take a genuinely strategic view about the future health care needs of its population. That vision includes a far superior patient centred hospital service to complement the advances taking place in primary care. It is not about sustaining old unfit for purpose buildings because they happen to be close at hand.

2 Consultation

To involve as many people as possible in the debate we produced 22 plain-English leaflets detailing the proposals. The summary leaflet entitled 'Let's Plan Together' was sent to every household in the health board area. We also made copies available in hospitals, GP surgeries, libraries and other public places. In total almost 470,000 leaflets were issued over the five month period.

A series of public meetings was put in place across Greater Glasgow to encourage debate and feedback on the proposals. Advertisements were placed in all local papers to publicise the dates of the meetings, supported by posters locally. In total there were 45 public meetings held throughout Greater Glasgow between April and September. Greater Glasgow Health Council also played a key role in the debate and held two public meetings in June. The Health Board also undertook a series of meetings with key organisations and partners across the West of Scotland.

The Health Board received over 3400 written responses to the consultation proposals.

3 FEEDBACK ON THE Key Questions Posed in the Consultation

Q1 Should we strengthen A & E services by creating two trauma units – one in the South and the other at the GRI? While maintaining local access for minor injuries at Stobhill, the Victoria Infirmary and a new service at Gartnavel?

A1 The proposal is to invest in two 'gold standard' A & E Departments developed at the South and at the GRI. By concentrating A & E we can strengthen the clinicians' rotas ensuring that full support is on hand in the event of a serious injury or accident.

These centres would be supported by Minor Injury Units (MIU) across the city at the Victoria Infirmary, Stobhill and at Gartnavel General Hospitals. We recognise there are concerns that the GRI A & E may become to large to manage, but with the expected change in patterns (people using the MIU services more appropriately), we believe that the benefits to patient care can be realised. A detailed analysis of comments relating to the capacity of, and access to, the new GRI unit will be considered fully before any final conclusion is reached.

We would also begin work to plan development of more accessible local healthcare provision, including for minor conditions, for the East End, Rutherglen, Cambuslang, Castlemilk, Drumchapel and Clydebank and Kirkintilloch.

Q2 Does our aim to maintain local access to out-patient clinics, x-ray, day case surgery and out-patient rehabilitation services at the Victoria Infirmary, Southern General (or new hospital), GRI, Stobhill and Gartnavel have widespread support?

There has been wide support to provide services locally and on accessible sites. However there has been concern about the suitability of some procedures being carried out without on-site back up facilities.

The vast majority of procedures which would be carried out in an Ambulatory Care and Diagnostic Unit (ACAD) are the services which the public want locally. Having visited the Bexhill model in Sussex, they have an extremely low rate of transfer of patients to hospital in Hastings seven miles away. Most of Stobhill's experience with day surgery shows that slow recovery from anaesthesia rather than surgical complications is the most common reason for keeping a patient in.

An ACAD would provide walk-in, walk-out, same day services for 85% - 90% of patients using our hospitals. Services would include out-patient clinics, diagnostic tests such as x-ray or ECG, endoscopy, out-patient physiotherapy, speech therapy, day surgery and minor injuries (sprains, pulled muscles, surface cuts and bruises etc)

Q3 Do the public agree that the Victoria Infirmary and Stobhill are the top priorities for the creation of the new Ambulatory Care Centres?

A3 There has been little response by way of alternative suggestions. The discussions have centred around the perceived safety issues of stand-alone units. They have also touched on what it means for other services currently provided at these sites i.e. in-patient beds moving off the sites.

Q4 In seeking to modernise the outdated hospital facilities and deal with issues of specialisation and doctors' hours in South Glasgow it is our conclusion that a new Ambulatory Care Centre with rehabilitation beds at the Victoria Infirmary and a two phase redevelopment to concentrate Southside acute inpatients at the Southern General the most practicable option.

A4 The benefits of specialisation by creating one inpatient site in the Southside have been widely supported. Larger clinical teams will help to address some of the issues related to meeting the European Directive on Doctors' Hours.

Much of the debate centred on where the best place would be for the single inpatient site. If we chose build on a new site, it will cost the taxpayer an extra £7 million each year more than redeveloping the Southern General. a site owned by the Health Service and one which is large enough to accommodate the rebuild programme as it stands. More importantly we don't believe that a large enough alternative site can be found. The Cowglen site that people favour is actually Green Belt – imagine the years of planning appeals and the limited prospects for success.

The proposal for the Southern General is to carry out a rebuild of the site and phased demolition. That means that by 2010 there will be a totally new hospital in the South of Glasgow – not a refurbished one.

Q5 Should we take the opportunity of creating a new Child and Maternal Health service based the Southern General as an integral part of the first construction contract for the redevelopment of the Southern General campus?

A5 Responses were mixed and no clear conclusions have emerged. Further work needs to be developed on the choices and benefits of the proposal. Consideration will also need to be given once the Maternity Services Liaison Committee have come to a conclusion on factors that need to be taken into account when reducing the city's maternity capacity from 3 sites to two. Their recommendations, which will be subject to further consultation, are expected in the next month or so.

Most medical advisory committees commenting on this issue reinforced the Area Medical Committee's view supporting the principle that there are advantages of being co-located with an adult general hospital. All parties are agreed that we must not lose sight of the particular needs of children within the wider health service, nor the unique identity of the Royal Hospital for Sick Children regardless of where it is sited.

Yorkhill Trust commissioned W S Atkins to provide an estate development plan for the Yorkhill site. This was not received in time for a full analysis to be taken of the report, therefore further work needs to be carried out in this area.

Q6 In seeking to tackle the specialisation and issue of doctors' hours in the North Glasgow Trust we are making firm proposals to concentrate inpatient gynaecology and orthopaedics at GRI in association respectively with the new facilities for maternity services and Accident and Emergency/Trauma. In each case there is strong medical advice in support of change. Ambulatory care for these two services would also be provided at Stobhill and Gartnavel. Are there any persuasive and practicable alternatives to this solution?

A6 Clinical opinion on the proposal to create a single in-patient unit for orthopaedics in North Glasgow is divided. Centralising it at the GRI will enhance expertise, integrate more fully with rheumatology and plastic surgery services and it will provide the best training opportunities for staff. This move could take place in 2001.

There is also general agreement that gynaecology and obstetrics should be on the same site. The North Trust has identified an area in the Queen Elizabeth building for the gynaecology services, close to the new obstetrics department which is scheduled to open in 2001.

There will be further discussions over the next two months about where best to place the inpatient gynaecological oncology service currently based at Stobhill.

Q7 In tackling the same issues of specialisation and doctors' hours in the North Glasgow Trust there is a need to decide what the inpatient base for several specialties should be (with ambulatory care provided at the GRI, Stobhill and Gartnavel). The specialties are urology, ophthalmology (eyes), ENT (Ear, nose and throat), nephrology (kidneys) and vascular surgery (veins and arteries).

A7 There is strong support across Glasgow for two in-patient centres in the North, one at GRI and the other at Gartnavel. This will allow the Western Infirmary to close as approved back in 1996. The transfer of smaller specialties from Stobhill has also been widely accepted by clinical opinion.

Specialty review teams have been involved in formulating the way forward in all specialities. The outcome of these reviews have supported:-

- Ophthalmology from Stobhill (2 beds) to Gartnavel
- Urology from Stobhill (20 beds) to the GRI and Gartnavel. Further work needs to be carried out to identify the best site at a later stage for one in- patient urology service for the North of the city.
- ENT from Stobhill (6 beds) to Gartnavel

The centralisation of in-patient services will help to strengthen the capacity to manage out of hours rotas more effectively and strengthen the training and development opportunities which arise from larger clinical teams.

Q8 Similarly the North Glasgow Trust will lead a debate about how medicine and surgery can work in partnership between GRI and Stobhill so that medium to long term clarity can be achieved.

A8 The transfer of smaller specialties from Stobhill and the eventual transfer of general surgery and general medicine to the GRI has been accepted by the clinicians across the city. This acceptance is dependant on the modernisation of the facilities and the timescales involved in transferring the services.

The key requirements of a satisfactory standard of accommodation and access to diagnostic, theatre and other supports would mostly need to be provided at the GRI. The North Trust estimates that this will be on offer within seven years. If the principle is agreed after phase two of our consultation, local consultation will take place later regarding the implementation plans.

Q9 The achievement of single site working for medicine and surgery for West Glasgow was previously agreed in the 1996 consultation. This updated plan includes a proposal to create a single cardiothoracic unit in Glasgow, concentrated initially at the Western Infirmary in modern accommodation. This has benefits for the specialty but helps to create space at GRI for other use of modern accommodation there as part of the wider picture of modernisation. Are there any good grounds for <u>not</u> making this change?

A9 The North Trust initially proposed centralisation of cardiothoracic services at the Western. This has now been overtaken by the debate to accelerate the closure of the Western and the transfer of services to Gartnavel.

This would be undertaken in 2 stages (centralise within the Western and then to Gartnavel) and the Trust will be working through the implications of this with clinicians and others during the second phase of this consultation.

4 Accelerated Programme to move the Beatson Oncology Centre

Most responses have urged us to accelerate the move to provide cancer services on one site. Three new linear accelerators will come into operation at Gartnavel by the end of 2001. The Trust is developing an outline business case to move the services from the Western Infirmary to Gartnavel General. It is anticipated that this can be achieved within five years. The Beatson Oncology Centre will also be relocated to Gartnavel.

5 Transport Issues

This consultation process has generated a much fuller understanding of the current problems with public transport access, road congestion and car parking at most hospitals in Glasgow. Even if we were not proposing changes in hospital configuration, the transportation issues would need to be addressed.

As part of the discussions around the proposals in Phase 1, the Health Board met with the Strathclyde Passenger Transport Executive to look at future service patterns and ways of improving the services. Further talks need to take place with bus companies servicing the area.

The 'Southside Hospital Travel Time Study', commissioned by the South East Health Forum, is a useful insight into some of the issues facing the transfer to and from and between hospitals on the Southside. It does not however include analysis of the people who travel to the Southside from the North of the river, or from Renfrew and therefore has limited use in assessing the wider transport issues.

Detailed proposals of actions to alleviate the traffic problems at each hospital have been identified and tabled in the Board paper. Work will now get underway to improve the transport issues.

6 Financial Affordability

These proposals will result in a significant investment in the health services in Greater Glasgow. Difficult choices will have to be made for example the proposal for a new Southside hospital would cost £11 million per year extra whereas a new Southside hospital built at say Cowglen would cost an additional £18 million per year. That is £7 million per year in the South that would not be available for use on front line patient care. The Board do not wish to see valuable resources being tied up in bricks and mortar when adequate services could be developed on the most cost effective site. The end result is still a brand new shining hospital geared up for the needs of patients..

We recently received the findings of the Arbuthnott Committee Report but we can't be certain of what our allocations will be until Ministers make decisions on allocations later this month.

The top line figure of £400 million of capital expenditure will begin to get further clarified as the Trusts' work through their proposals, as the detail becomes clearer.

7 The Dental Hospital and School

Separate consideration will be given on the future of Glasgow's Dental Hospital and school following a structural survey of the existing building. Options to be explored.

8 What are the Key Issues?

Southside

- a new single in-patient hospital for the Southside – but where?
- transferring in-patient services from the Victoria to the new South hospital
- transfer of in-patient gynaecology from Victoria and Gartnavel to new South hospital
- transfer of A & E services from the Western to GRI and the new South hospital
- ambulatory care services and Minor Injuries Unit at the new South hospital
- centralise Southside in-patient vascular surgery at the new South hospital
- continue planning for an Ambulatory Care Hospital at the Victoria
- minor Injuries Unit at the Victoria
- centralise Southside in-patient haemato-oncology at the Victoria
- centralise Southside in-patient breast surgery at the Victoria

North and East

- continuing planning for an Ambulatory Care Hospital at Stobhill
- Minor Injuries Unit at Stobhill
- continuation of in-patient beds at Stobhill unlikely to be sustainable
- create a single North Glasgow in-patient orthopaedics service at GRI from Stobhill and later from Western/Gartnavel
- transfer in-patient gynaecology to GRI from Stobhill
- ambulatory care services and Minor Injuries Unit at the GRI
- transfer of A & E services from the Western to GRI and the new South Hospital

- A& E at the GRI– what's involved in detail to make it big enough?
- begin work to plan the development of more accessible local healthcare provision including for minor conditions, for the East End, Rutherglen, Cambuslang, Castlemilk, Drumchapel and Clydebank and Kirkintilloch.

West Glasgow

- medical and surgical receiving at Gartnavel
- single North Glasgow in-patient centre for ophthalmology and ENT Gartnavel
- cancer and cardiothoracic services transferring from the Western to Gartnavel
- transfer of orthopaedics in-patient beds from Gartnavel to GRI
- transfer of in-patient gynaecology from Victoria and Gartnavel to new South hospital
- ambulatory care services and a Minor Injuries Unit at Gartnavel
- closure of the Western as approved in 1996
- A & E at the Western transferring to the GRI and the new South hospital

Yorkhill

- continue to explore the original proposal to transfer the Royal Hospital for Sick Children to a site at the Southern General

9 What Happens Now?

A summary document will be produced based on the Board paper to distil the areas for consideration before coming to a conclusion on the best way forward for Glasgow's hospital services. A further period of consultation will run until December 8th. The full Board will consider the final package to go forward to the Minister for Health at its meeting on December 19th,2000.

EMBARGOED UNTIL MEETING
BOARD: 19 SEPTEMBER 2000

3

GGHB(M) 00/9
Minutes: 145 - 162

GREATER GLASGOW HEALTH BOARD

Minutes of a Meeting of the Greater Glasgow Health Board held in Conference Room 6, Ground Floor, Nye Bevan House, 20 India Street, Glasgow on Tuesday, 19 September 2000 at 10.00 a.m.

PRESENT

Professor D L Hamblen (in the Chair)

Professor G C A Dickson	Miss A C Samuel
Dr F Marshall	Councillor J Gray (to Minute 148)

Professor B Whiting (to Minute 148)

Mr R Cleland	..	Chairman, North Glasgow University Hospitals NHS Trust
Professor F Cockburn	..	Chairman, Yorkhill NHS Trust
Mrs E Smith	..	Chairman, South Glasgow University NHS Hospitals NHS Trust
Mr C J Spry	..	Chief Executive
Dr H Burns	..	Director of Public Health
Mr S T Haldane	..	Director of Finance

IN ATTENDANCE

Mr J C Hamilton	..	Head of Board Administration
Mr J Whyteside	..	Public Affairs Manager
Mrs E McKean	..	Public Relations Manager
Mrs H McKee	..	Assistant Director, Commissioning Directorate (to Minute 149)
Mr T Jackson	..	Community Planning Co-ordinator, West Dunbartonshire (for Minute 149)
Mr L Jacobs	..	Finance Analyst (to Minute 149)

BY INVITATION

Dr Y Taylor	..	Chairman, Area Medical Committee
Dr D Attwood	..	Chairman, Area Dental Committee
Mrs C Ritchie	..	Vice Chairman, Area Paramedical Committee
Mr P Hamilton	..	Convener, Greater Glasgow Health Council
Mr W Murray	..	Vice Chairman, Hospital Sub-Committee
Miss F McCulloch	..	Chairman, Area Nursing and Midwifery Committee

ACTION BY

145. APOLOGIES

Apologies for absence were intimated on behalf of Miss C Renfrew, Director for Commissioning; Mr A O Robertson, Chairman, Primary Care NHS Trust; Dr Carol E Tannahill; Mrs Carol Anderson, Chairman Area Pharmaceutical Committee; Mr E P McVey, Chairman, Area Optometric Committee.

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ACTION BY

146. CHAIRMAN'S REPORT

The Chairman made reference to events in which he had been involved since the last meeting of the Board:

(a) Attendance at a meeting with Glasgow University on "The Vision for Glasgow Medicine" held at the Western Infirmary Lecture Theatre on 22 August, accompanied by Mr Chris Spry.

(b) Attendance at the Launch of the West Dunbartonshire Community Plan by Wendy Alexander MSP, Minister for Communities, and Jackie Baillie MSP on 23 August at Faifley Regeneration Centre.

(c) Attendance at the Opening of the Salvation Army – Eva Burrows Centre for the Elderly in Cambuslang on 24 August.

(d) Attendance at a Conference on Winter Planning at Peebles Hydro Hotel on 4 September which was attended by Ms Susan Deacon, Minister for Health and Community Care.

(e) Informal visit on 7 September with Professor Dickson, Vice Chairman, to the Interim Forensic Psychiatry Unit at Leverndale Hospital.

(f) Attendance at the official opening of the Sandyford Initiative by the Minister for Health and Community Care on 11 September. Miss Agnes Samuel was also present.

(g) Attendance at the Open Space Event on Men's Health on 15 September.

With Miss Agnes Samuel's period of appointment ending on 30th September 2000, the Chairman took the opportunity to thank her for her work and contribution to the Board over the last four years. He commented that Miss Samuel's contribution to Women's Health and Human Resources issues had been greatly appreciated as had her attendance and contribution to the many Board Committees of which she was a member. The Chairman, on behalf of the Board, wished her well in her future activities.

147. MINUTES

On the motion of Miss A Samuel, seconded by Dr F Marshall, the Minutes of the meeting of the Board held on 15 August 2000 [GGHB (M) 00/8] were approved as an accurate record and signed by the Chairman.

148. CONSULTATION ON FUTURE CONFIGURATION OF ACUTE SERVICES IN GLASGOW

A report of the Chief Executive [Board Paper No. 00/109] was submitted detailing the outcome of the consultation of the Board's plans to Modernise Glasgow's Acute Hospital Services, together with a framework for the further work to be undertaken in the second phase of consultation up to 8th December 2000.

The Chairman opened the discussion by commenting that 3,466 responses had been received, the vast majority of which had been received in the last week of the consultation period. He thanked all those involved in the team effort of recording, analysing and presenting the views received for Board Members' consideration. Annexes 2 and 3 of the submitted paper showed the consultation processes followed and the summary of the responses received.

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ACTION BY

The Board paper had been set out in a systematic way covering all the main issues raised by consultees and the Chairman invited the Chief Executive to present the paper to the Board.

The Chief Executive presented the main chapters of the Report on the First Phase of Consultation:

1. The Nature of the Debate

It had been difficult to achieve the right balance between the weight of medical opinion which wished to see 3 acute hospitals with specialist teams concentrated on these sites against the weight of public opinion which wished to retain local access to hospital services.

The debate had been vigorous, including sectional campaigning, but others had recognised the complexity of the issues and the knock-on effect one decision could have on the remainder of the strategy.

It was important for the Board to determine the strategic direction and shape of the Acute Services Strategy for Glasgow and thereafter the development of Outline Business Cases would be the means by which the detailed operational issues underpinning the proposals would be shared and discussed.

Annex 3 described the range and weight of responses received – common themes emerged across Glasgow on public transport, traffic impact, stand-alone Ambulatory Care Centres, bed numbers etc. The southside proposals attracted by far the most comment. There had been little response from the recognised areas of deprivation and those who most used the hospital services. In the 2nd phase of consultation the Board was making concerted efforts to engage more with the Social Inclusion Partnership Boards (SIPs).

The Vice Chairman emphasised the Non-Executive Director's role in the Board as probing and challenging the Executive to ensure the proposals submitted were rigorous and sustainable. He appreciated the consultation process had been rigorous and no effort had been spared by the Chief Executive and his team in trying to explain the Board's proposals to a wider audience, but one could never be completely satisfied that the consultation process had reached all those who could have contributed to the debate. Equally there was no single "right answer" and not everybody would be satisfied with any conclusions reached. For these reasons he felt it was right for the Board to consult for a further period to December 2000 on its reflections on the outcome of the 1st phase of consultation.

A Non-Executive Member reiterated these comments and encouraged Board officials to make greater efforts in the 2nd phase of consultation to hear from the areas which had clearly not responded, felt disenfranchised, or knew nothing about the Board's plans.

Greater effort would be made in the areas identified and work with the SIPs would be underway almost immediately after the Board meeting.

Mr Hamilton, Convener, Local Health Council, expressed surprise at the lack of response from the catchment area around Stobhill Hospital: this may have been influenced by the fact that the documentation for the 1st phase of consultation by posing questions, was consequently not explicit that in-patient acute beds at Stobhill Hospital would close.

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2. The Theme of Consolidating In-Patient Services

The proposal that creating larger specialist teams would increase the ability to ensure patients most needing treatment and care by specialist teams received it was recognised and reinforced during the consultation. This would make it easier to fulfil the new limitations on senior and junior doctors' hours commitments: the present pattern of rotas in Glasgow was unsustainable and unaffordable.

The response regarding single in-patient acute sites was as follows:

a) West – new Western Infirmary at Gartnavel – a decision formally approved by the Secretary of State in 1996 had not been challenged.

b) South – the creation of a single in-patient centre was overwhelmingly supported (the difficult choice was where should it be located).

c) North-East – the long-term continuation of in-patient beds at Stobhill was unlikely to be sustainable, but there was little public feedback on this issue. Medical opinion supported a single in-patient centre for the North and East Glasgow at Glasgow Royal Infirmary (although the facilities needed to be genuinely "fit for purpose").

3. Ambulatory Care

Dr H Burns, Director of Public Health, presented the Board's proposals on Ambulatory Care and emphasised that 85% to 90% of patients' encounters with acute hospitals was on a "walk-in, walk-out, same day basis". These included out-patient physiotherapy, speech therapy etc., out-patient consultant clinics, day surgery and minor injuries.

Ambulatory Care Services would complement in-patient services at the Royal Infirmary, Gartnavel General and the Southern General. This had been welcomed.

To preserve as much local access to hospital services as possible, the Board proposed 2 new-build, purpose-designed Ambulatory Care Centres at Stobhill and the Victoria Infirmary. The concerns expressed during consultation centred upon them being "untried", having no in-patient back-up should complications arise from day surgery and, lastly, creating "split-site working".

Dr Burns explained that ambulatory care was what the NHS did already and the plans were to see a purpose-designed environment organised around the patient's needs rather than the present haphazard development of patient-related services.

On the issue of patient safety, he explained that Day Surgery in an Ambulatory Care Centre amounted to around 5% of the expected workload. The experience of the Ambulatory Care Day Surgery Service at Bexhill, Sussex – which had operational links to Conquest Hospital, Hastings (around 7 miles away) had suggested that only 0.5% of 14,000 day surgery cases had required transfer to Hastings. The admissions were usually for the side effects of anaesthesia or pain medication and were usually confined to nausea or vomiting. At the Day Surgery Unit at Stobhill, in 1998/99 – out of 12,045 cases, 105 (0.87%) were subsequently admitted to an in-patient bed. 20 were for social reasons, 24 for post-operative nausea or vomiting, and 32 for similar symptoms of slow recovery. (A full breakdown was given in the agenda paper.)

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In the USA there were around 1,300 free-standing Ambulatory Care Centres undertaking endoscopies, and day surgery in ENT, gastroenterology, ophthalmology, urology, orthopaedics and general surgery.

There was no evidence to suggest that a properly run protocol-driven ambulatory care centre would be anything but safe for patients. The service would be designed around their needs and there would be rapid access to diagnostic services and minor surgery.

The issue of "split-site working" was often seen in the context of the unsatisfactory patterns of care and working arrangements experienced between the Western Infirmary and Gartnavel General where, in mid-episode of care, patients were transferred between the two hospitals (and staff found themselves shuttling between the two sites).

In ambulatory care centres only a very small proportion of patients might find themselves transferred to the southside in-patient centre or the Royal Infirmary (currently 3,500 patients were transferred annually by the Ambulance Service between the Western and Gartnavel).

It would be hoped that by the time ambulatory care centres are commissioned and in use, electronic records would be available. The logistics of moving paper-based records ought to be amenable to good organisation.

Creation of the larger clinical teams should ensure that, for most staff, that work can be planned on a weekly or monthly basis and the designation of team members to concentrate on emergency cover, on a programmed basis, would free up other team members from clashes between emergency and elective work. It would not be expected that a consultant programmed to work all day at an ambulatory care centre would be expected to be called back to the in-patient centre to deal with an emergency.

Mr Murray emphasised that ambulatory care centres had become a concern because their role had not been explicit or fully understood. Medical opinion supported ambulatory care centres, in principle, but it could not be said that there was no risk to patients from stand-alone ambulatory care centres. He had been reassured that the ambulatory care centre at Stobhill Hospital would have the advantage of acute in-patient beds being on site for a period of time and the Area Medical Committee would support an evaluation of the role of the ambulatory care centre based on the experience at Stobhill.

The Chairman of the North Glasgow University Hospitals NHS Trust emphasised that this was a new hospital, specifically designed around ambulatory care. Mr Hamilton supported the idea of Stobhill as a pilot with the chance to measure its success and acceptability. The concern lay at the Victoria where there would be no access to in-patient beds on the site of the ambulatory care centre. The Chief Executive stated that the overnight bed facility at the Victoria would be available for those cases that needed overnight accommodation. The Director of Public Health went on to say that protocols for accepting day surgery patients at the ambulatory care centre would assist in reducing the likelihood of patients requiring in-patient facilities.

Members expressed the belief that the ambulatory care element of the Board's plans was one of the most exciting parts of the proposals which would lead to a real improvement in patient care. Safety was of prime importance to all involved in developing the concept and would be underpinned during the process of planning and commissioning the new facilities.

ACTION BY

Mr Murray stated that, if it was fully explained to people what ambulatory care centres would do and how they would benefit the patients' experience of hospitals, the support for them would be forthcoming.

4. Accident and Emergency and Related Services

Dr Burns explained that the Board's proposals were for two Accident and Emergency (A&E) Centres (or Trauma Centres) – one at the Royal Infirmary and one at the Southern General or Cowglen, supported by locally accessible Minor Injuries Units at the Victoria, Stobhill and Gartnavel. Medical and surgical emergency referrals by GPs would be received at the Royal Infirmary, southside in-patient site and Gartnavel General.

The creation of two Major A&E Centres would lead to increased chances of survival for multiply injured patients.

The A&E Sub-Committee supported a maximum of three adult A&E Departments in Glasgow – two being in the north, but in about 10 years time moving to one in the north and one in the south.

Mr Murray emphasised that the different terminology used in describing these services made it difficult for patients to fully understand what was being proposed. The development of a nurse-led protocol service, without medical staff, could cause concern.

He also emphasised that Cardiothoracic Services should be co-located with an A&E Unit.

The Chief Executive acknowledged the issue of terminology and described what the Board's plans set out:

- GP referrals – medical and surgical receiving units at GRI, Gartnavel and the southside hospital.
- Blue light 999 ambulance – would go to nearest A&E Unit.
- Children – receive a children's focused A&E service from Yorkhill and the development of more locally based services for primary care for minor injuries.
- Sprains, cuts, etc. – Minor Injuries Units.
- Self-referrals – skilful diagnosis would be needed at the presenting hospital, supported by clinical protocols, tele-medicine links and, where necessary, rapid transfer by ambulance to another hospital.

Extra investment in the ambulance services was recognised – more money is already being spent on recruiting another 20 staff for emergency ambulance services and every emergency vehicle was to have a trained paramedic on its crew by 2004. It was acknowledged that further investment beyond this would be needed.

Ambulance journey times would be increased, wherever a new southside in-patient hospital was located, and the North Glasgow Trust was looking at how to increase the capacity of the new A&E centre at the Royal Infirmary to cope with the extra workload.

Mr Hamilton advised that the Local Health Council supported the A&E Sub-Committee's view for a single A&E Centre on the southside but in a new centrally located southside hospital. It was explained that the effect of having a central location would have a knock-on effect on the east-west axis for A&E services and might therefore affect the location of A&E services in the north of the city.

ACTION BY

Board officials would discuss with SIPs improved access to services for people (including children) with minor conditions in areas such as the East End, Drumchapel, Clydebank, Castlemilk, Rutherglen/Cambuslang and Kirkintilloch.

5. Access, Public Transport and Traffic Impact

The Board's plans for Ambulatory Care Centres and Minor Injuries Units at the Victoria and Stobhill were intended precisely to address the issue of local accessibility, resulting in the minimum adverse change for the maximum possible number of people.

The consultation process had made it clear that public transport access, road congestion and car parking at hospitals were significant problems now with the current pattern of services. Transport had been the second most commented-on issue from consultees.

The Chairman of the South Glasgow University Hospitals NHS Trust advised that it had been raised continually at public meetings, and meetings with other groups, and much of the concern focused on the transport arrangements to the existing hospitals. It was important that people realised that changing patterns of service would lead to changing patterns of transport. The Board would continue to consider subsidising or stimulating hospital shuttle buses from key points; exploring community transport schemes and strengthening local health services.

A Member raised the benefits of talking to the Roads Department of the City Council now, in order to plan to shape the services and transport issues.

In reply to a Member's question, it was confirmed that the patients in the Mansionhouse Unit would remain at the Victoria Infirmary site in the 120 rehabilitation beds at the Ambulatory Care Centre.

6. Population Change, Cross Boundary Flows and Wider Planning Choices

Some responses highlighted that future population changes had not been adequately covered in the consultation documentation.

The Board's population was expected to continue to decline although that might be counter-balanced by the creation of new neighbourhoods, better housing and the arrival of asylum seekers.

The impact of the changes in population might have an impact on the number of beds provided but would not affect the number of hospitals there should be, how many A&E Centres nor the concept of Ambulatory Care Centres.

The issue of neighbouring Health Boards' plans for their services and the possible impact on reduced cross-boundary flows, and greater collaboration between clinical teams, could have an impact on the services to be delivered and would be fed into the more detailed planning processes that lie ahead.

7. Bed Numbers

Two different projections had been used for bed requirements – 5% continued growth by 2005 in general medicine demand and an assumed 2% growth in all specialties. The calculations in the Leaflet were queried by clinicians in relation to average length of stay calculations and some assumptions on occupancy. To correct the error, further discussions were to take place with clinicians in order to finalise a meaningful agreed bed model.

ACTION BY

Mr Murray was pleased that the Board had responded to the error and wished an assurance that there would be no repetition in such an important part of the Board's plans.

The information would be shared with other Health Boards although it was recognised that the error related solely to a piece of work commissioned specifically for the Board's Acute Services Strategy and would have no effect on other bed number calculations for other Health Boards.

8. The Financial Position and Affordability

The Chief Executive explained that the Board's plans saw the investment of more revenue into acute services in order to pay the higher capital charges by moving to modern buildings which would replace heavily depreciated old buildings. This would equate to an investment of an extra £11 million per year for new buildings on the southside and some increased revenue costs in north Glasgow. It had been disappointing that the responses to consultation had ignored the fundamental issue of choice between spending an extra £11 million per year for new buildings at the Southern General Hospital, as opposed to an extra £18.4 million in revenue for a new southside hospital at Cowglen. This equated to an opportunity cost of £7.3 million per annum which could pay for better primary care, shorter waiting times, better services for children, more frontline staff, purely on the basis of having the hospital building in one place rather than another.

Since the Board launched its consultation documentation the UK Chancellor's March Budget announced significant additional funds for the NHS. This extra funding must secure a transformation in the NHS' responsiveness and quality, including drastically shorter waiting times. The allocation of resources to Health Boards was based on a formula and the paper gave an illustrative projection of what the Board's allocation might be, as a result of the Arbuthnott Report, although it was important to await Ministerial announcement before the framework could be confirmed. In the model money was shown as being available for service development and this would need to meet a range of competing service priorities, already identified in previous Health Improvement Programmes, and meet the response in Scotland to the National Plan for the NHS.

The real term growth in NHS spending for the period 2000-2004 was at an all-time historic high, surpassing anything the health service had seen since its inception in 1948. There could be no guarantee that this unusually high level would be continued in 2004/2005 and beyond, and therefore planning of services should take account of this.

It was explained that Trusts would need to follow the capital investment procedures, in relation to new building projects, and that involved a comparison between the cost of the public sector comparator compared to the Public/Private Partnership costs.

The Chairman of the Area Medical Committee intimated that they had written to the First Minister, Minister for Finance, and Minister for Health and Community Care, advising that Greater Glasgow Health Board had been under-resourced for 20 years or so and no account had been taken of the effects on health by those living in deprived areas or inequalities in health. She advised that the Area Medical Committee supported the Board and its plans but wished to apply pressure on Ministers, to bring about change quickly and ensure the correct levels of investment within the health service in Glasgow.

EMBARGOED UNTIL MEETING
BOARD: 19 SEPTEMBER 2000

ACTION BY

9. South Glasgow Services

The Chief Executive advised that this issue had attracted by far the most comment from consultees and that there was overwhelming support for the concept of a single in-patient hospital on the southside – the issue of debate was where it should be located. Initially the majority of responses supported it being built at Cowglen. However, in the last few days of the consultation period the volume of responses shifted to a preference for it to be located at the Victoria or Queen's Park Recreational site. The lack of response, however, from the people of the south-west of Glasgow did not mean that the option of the Southern General did not have support.

In relation to the Cowglen site it became clear in the early part of the consultation period that the National Savings Bank site would not be for sale and planned expansion with further employment on this site was to take place in the near future.

A new hospital on the adjacent greenbelt at Cowglen was contrary to the City Council's local plan and the Council's Development Control Department had expressed the view that there would be serious doubts as to the viability of any proposal to develop a new hospital on this site. It would also require the agreement of the National Trust, the Trustees of Pollok Park, the local planning authority, and the appropriate Scottish Executive Minister responsible for major town planning issues. As well as being a time consuming process, a favourable outcome would appear unlikely.

The utilisation of the whole of Queen's Park Recreation site did not seem viable. Its available 34.2 acres compared unfavourably with the 67 acres at the Southern General and 73.6 acres at Cowglen and would not be large enough to accommodate the acute mental illness beds for South Glasgow, nor a re-located Royal Hospital for Sick Children if that were transferred. It would also be a requirement to change the use of the land, as it is currently designated open space and would require specific public consultation for the formal overturning by the Council of its own Land Use Policy and agreement of Sport Scotland. Again this would be a lengthy process which would clearly add to the cost and delay of any hospital development, again with the possibility that the option would fail to overcome the planning barriers.

The Chief Executive referred to the decision-making matrix for the southside on pages 62 and 63 of the submitted report on the first phase of consultation and pointed out that the Southern General scored better on the matrix than the other two sites.

The Local Health Council urged the Board to pursue a long term strategy to lead to the development of a much needed new hospital on a more centrally located site in south Glasgow. However, thus far the South Glasgow Trust and its property advisers had been unable to locate any such sites of adequate size other than those at Cowglen, Darnley and the Southern General. Quite separately, Scottish Enterprise, Glasgow reported that that the city was running out of first class sites now needed to attract major inward location of new industrial/business opportunities and in a survey of their own, they had not identified any site of the required size in a central location on the southside.

A Member raised the issue of liaising with the City Council to discuss possible site options and it would be important to get a definitive response from the Council as to what might be available.

ACTION BY

The Chief Executive advised that the Outline Business Case would, as an integral part of it, include an option appraisal exercise which was required to look at all other site options and it would be important to confirm with the City Council the availability of any sites which could be added to the option appraisal exercise. It was clear that planning procedures required to be adhered to and the sites at Cowglen and Queen's Park Recreation Park were beset with time constraints and procedural issues which could not be resolved prior to the Board discussing again the acute services review at its December meeting.

The Chairman of the South Glasgow Trust emphasised that the Southern General site was owned by the Board, therefore had no acquisition costs and that there might be scope for a single phase provision of a southside hospital which could be examined as part of the Outline Business Case. It had been made clear to the Trust that people were looking for local services with local access to in-patient and ambulatory care services and that there should be an end to the debate and uncertainty and progression should now be made with the planning and thereafter implementation of the strategy.

The Chairman advised that, just prior to the start of the Board meeting, a petition had been handed to the Head of Board Administration from Oatlands Community Council and signed by 183 people stating "we need a new hospital in the southside". The Board noted the petition and included it in the responses to the Consultation.

Any option appraisal undertaken within the Outline Business Case would be made public and no element would be concealed from anyone who wished to see the outcome and detail of the process.

The Chief Executive referred to proposals for changes in the location of in-patient Gynaecology, Breast Surgery, Vascular Surgery, Haemato-Oncology and an increased number of medical beds at the Victoria Infirmary which it was considered should take place during the transitional years before transferring to a new South Glasgow University Hospital.

10. GRI/Stobhill Partnership

The consultation documentation had identified that the future of in-patient services at Stobhill, especially in the smaller specialties of Orthopaedics, Gynaecology, Ophthalmology, ENT and Urology were unlikely to be sustainable in the light of increasing specialisation, restriction on doctors' working hours and continued reductions in already small bed numbers as lengths of stay reduced and day surgery increased. It was likely that general surgery would face similar pressures, ultimately pointing to it being integrated onto one site at the Royal Infirmary. Consultees were asked whether general medicine would be sustainable, in the absence of general surgery, and medical opinion was emphatic that general medicine and general surgery were seen as complementary and general medicine could not be sustained in the absence of general surgery. This pointed, therefore, to a proposal to transfer general medicine and general surgery from Stobhill to the Royal Infirmary but there should be further consultation nearer the time to confirm that the implementation arrangements met the tests of adequacy.

The North Glasgow Trust had been explicit in its discussions and public meetings etc. that they envisaged the transfer of all in-patient services from Stobhill principally to the Royal Infirmary (but with some referrals going to Gartnavel) and the Trust Board had endorsed its support for this move. This would provide clarity about the future of Stobhill but did so in a way which meant that the future could be pioneering and innovative in terms of provision of ambulatory care services for its catchment population.

ACTION BY

The previously mentioned point about the need to improve access to a wide range of extended primary care services in the East End was again re-emphasised and this would be pursued by the Board working with Local Healthcare Co-operatives and the Social Inclusion Partnerships.

11. Services in West Glasgow

The Chief Executive advised that the transfer of services from the Western Infirmary to Gartnavel General (as approved by the then Secretary of State for Scotland in 1996) was again supported with medical and surgical receiving and a Minor Injuries Unit being located at Gartnavel.

One of the main issues of debate during consultation had been whether there should be a separate orthopaedic service at Gartnavel or whether there should be a single orthopaedic service for the whole of the North Glasgow Trust with its in-patient facilities located at the Royal Infirmary. The Area Medical Committee stated that it was "unable to support the withdrawal of in-patient Orthopaedic services from the Gartnavel site" but did so because it was "unconvinced that the change from 5 A&E sites to 2 could be safely managed in the current climate" and the presence of on-site Orthopaedics was essential to the viability of an A&E service. The Orthopaedic Surgeons at the Royal Infirmary, Stobhill and southside favoured a 2-orthopaedic unit configuration for Glasgow although those in West Glasgow advocated a 3-unit configuration. The paper's conclusion was that there should be a single orthopaedic team for North Glasgow with its in-patient service located at the Royal Infirmary, undertaking out-patient and day case work at all 3 hospitals, Royal Infirmary, Gartnavel and Stobhill.

There was general support for accelerating the planning and development of an Outline Business Case for the transfer of the Beatson Oncology Centre from the Western Infirmary to Gartnavel General within the next 5 years.

The plan to centralise Cardiothoracic Surgery at the Western Infirmary, notwithstanding the time of the move to Gartnavel, should remain a two-stage process with an initial consolidation to the Western Infirmary Phase I building and subsequent re-location to Gartnavel on a timescale that would be addressed in Phase 2 of the consultation.

In creating an ambulatory care service provision at Gartnavel this would allow a purpose-design facility to be developed for such patients from the west of the city.

12. Maternal and Child Health

The Chief Executive advised that the responses to consultation on this element of the strategy had emerged in the last few days of consultation and therefore they had not yet been evaluated or further discussed with consultees.

Yorkhill NHS Trust conducted extensive consultation themselves with a wide range of staff, family/parent support groups and others. The Board received very few letters from the general public on this issue. The Trust had developed ten key principles which they felt should guide the continued development of child and maternal services and had also commissioned an estate development plan for the Yorkhill site.

It was clear that more information about choices and benefits required to be developed before any decision was reached on the possibility of re-locating Yorkhill Trust Hospital services into new facilities. The issue also needed to be seen alongside the future disposition of maternity services and the need to consult on which delivery units would provide maternity services in the future.

ACTION BY

The Chief Executive advised that if any plans were agreed to re-locate Yorkhill Trust Hospital services to brand new facilities there would be proper and specific consultation at the appropriate time.

The Chairman of Yorkhill NHS Trust welcomed the opportunity for children's services to be included within the Acute Services Review and welcomed the opportunity to be involved in the further work which would take place in the next phase of consultation before a clear way forward could be identified.

13. Future of Glasgow Dental Hospital and School

The Chief Executive advised that separate consideration would be given in the second phase of consultation to the future of the Glasgow Dental Hospital and School following a structural survey of the existing buildings. A number of options would be considered and more work would be carried out on this issue over the coming weeks.

14. Summary of Proposed Decisions and Further Work After December 2000

The Chief Executive set out the summary of proposed decisions required at the end of the consultation process as well as those issues which would be addressed during the subsequent detailed planning and development of Outline Business Cases. He reminded Members that the Board would shortly see a consultation document on the future of maternity services and also that the Acute Services Strategy once agreed by the Board in December, would be submitted to the Scottish Executive for consideration, including endorsement of the Health Board's decisions as appropriate.

He returned to the issue of the decision matrix for the southside on pages 62 and 63 of the submitted report and asked if the right questions or factors had been identified: had each site been assessed correctly against each factor and did the decision matrix leave open to question any other issue. The factors had not been weighted and he felt it was doubtful whether weighting them would cause a big enough swing which would alter the best fit offered by building the new southside Glasgow University Hospital at the Southern General.

The Chairman thanked the Chief Executive for his comprehensive and systematic review of all the issues raised during the 5-month consultation period and acknowledged that much work was still required to be done up to December to keep the public informed and engaged with the second phase of consultation.

DECIDED:

1. That the outcome of the consultation on Modernising Glasgow's Acute Hospital Services be noted.

2. That the Summary of Proposed Decisions and Further Work After December 2000, as detailed in paragraph 17 of the submitted report, be approved.

3. That the principle of a single in-patient for Dermatology for Greater Glasgow and the commissioning of further work to identify the preferred location be endorsed. **Chief Executive**

4. That seeking definitive advice on the pattern of provision for Nephrology Services based on the disposition of other specialties, be approved. **Chief Executive**

5. That a further period of consultation to 8 December 2000 on the Board's reflections of the outcome of the first phase of consultation be approved. **Chief Executive**

EMBARGOED UNTIL MEETING
BOARD: 19 SEPTEMBER 2000

ACTION BY

149. COMMUNITY PLANNING IN WEST DUNBARTONSHIRE

A report of the Director for Commissioning [Board Paper No 00/110] was submitted setting out the progress made with the development of Community Planning in West Dunbartonshire. Mrs Helen McKee, Assistant Director of Commissioning, and Mr Tom Jackson, Community Planning Co-ordinator, West Dunbartonshire Council, attended the meeting to present the progress to date and next steps of the Community Planning concept in West Dunbartonshire.

Community Planning aims to deliver:-

- a strategic vision for the area
- community consultation and involvement
- partnership
- community leadership

Consultation took place on preparing an action plan and it was published in the summer, with a summary leaflet sent to all households in West Dunbartonshire.

A pivotal part of the Community Plan was the 17 key actions for implementation with the Health Board being the lead agency in taking forward improvements in the discharge of older people from hospital and delivering integrated information facilities.

Implementation, closer working ties and improved communication lines, cohesion of planning structures and consistency of approach and more engagement with local aspirations were now required and were the priorities for the success of Community Planning.

The Chief Executive thanked Mrs McKee and Mr Jackson for their presentation and emphasised the importance of this area of work and the continued commitment required to this type of partnership. The Director of Public Health and Mr Jackson would consider the possible input Public Health could have to Community Planning in the future. **Director of Public Health**

NOTED

150. DEFERRED ITEMS

The Chairman sought approval, due to time constraints, to the deferment to the next meeting of the Board of the following items:

i) **Scottish Ambulance Service: Review of Developments**

ii) **Current Health Issues – Chlamydia Trachomatis Infection**

iii) **Managing Waiting Lists and Reducing Waiting Times**

DECIDED:

That the above agenda items be deferred to the October 2000 Board meeting for consideration. **Head of Board Administration**

EMBARGOED UNTIL MEETING
BOARD: 19 SEPTEMBER 2000

ACTION BY

151. NHS PROPERTY TRANSACTIONS MONITORING HANDBOOK: POST TRANSACTION MONITORING 1999/2000

A report of the Internal Auditors [Board Paper No. 00/114] was submitted in accordance with the requirements of the NHS Property Transactions Handbook on the monitoring of property transactions which have been concluded during the last financial year by the Board.

The Internal Auditors' report had been considered and agreed by the Audit Committee on 5 September 2000 and submitted to the Board, with agreed amendments, for approval and onward transmission to the Scottish Executive.

Three property transactions had been completed to the year ended 31 March 2000, namely, Ruchill Hospital, the Eastern College of Nursing and 100 Waverley Street, Glasgow.

The Internal Auditors' comments on the Ruchill Hospital transaction were noted.

DECIDED:

That the Post Property Transaction Monitoring Report – 1999/2000 be approved for submission to the NHS Scottish Executive. — **Director for Commissioning**

152. BOARD AND COMMITTEE MEETINGS FOR 2001 AND SCHEME OF DELEGATION

A report of the Head of Board Administration [Board Paper No 00/1115] was submitted setting out the proposed dates for the scheduled meetings of the Board, the Finance and General Purposes Committee and Board Seminars for 2001 and seeking authority to amendments to the Scheme of Delegation – Schedule of Authorised Signatories.

DECIDED:

1. That the dates for meetings of the Board and its main Committees for 2001 be approved. — **Head of Board Administrati**

2. That the amendments to the Scheme of Delegation – Schedule of Authorised Signatories be approved.

153. CHILD CARE ARRANGEMENTS

A report of the Head of Board Administration [Board Paper No 00/116] was submitted seeking approval to extend the Child Care Voucher Scheme for employees of the Board based on revised eligibility criteria.

In July 1999 the Board had approved the issuing of Child Care Vouchers as the most appropriate way to provide assistance with child care costs to parents employed by the Board. This was in line with the Human Resource Strategy for the NHS in Scotland.

ACTION BY

The scheme was set up for a year as a pilot and was evaluated by means of a users' survey which was conducted with the involvement of the Local Partnership Forum. As a result of the evaluation the Local Partnership Forum recommended continuation of the scheme with amendments to the eligibility criteria to keep the costs of the scheme within the figure contained within the Board's Revenue Plan.

DECIDED:

That the Child Care Voucher Scheme and revised eligibility criteria be approved. — **Head of Board Administration**

154. ECONOMIC AND MONETARY UNION (EMU)

A report of the Director of Finance [Board Paper No 00/117] was submitted setting out the steps Health Boards were to take to plan for the possible adoption of the Euro in the UK.

The Scottish Executive had issued two Circulars – FIN(T)(1994)4 – "The Euro" and FIN(T)(2000)2 which covered the requirements of bodies to undertake some preparation work ahead of any referendum on the issue.

A Euro Project Team was to be established which had four deliverables:

- a Project Initiation Document was to be submitted to the Scottish Executive after adoption by the Board;
- a Project Plan which must be submitted to the Scottish Executive by 31 October 2000, again after adoption by the Board;
- Draft Project Plans for the NHS in Scotland presented to the Scottish Executive by 1 December 2000;

Final Project Plan submitted by the Scottish Executive to the Treasury by 11 December 2000.

DECIDED:

1. That the requirement to commence planning for the possible adoption of the Euro in the UK be noted.
2. That the framework (contained within the Project Initiation Document) of how the process would be managed and monitored be noted.
3. That the submission of the Project Initiation Document to the Scottish Executive be approved. — **Director of Finance**

155. NURSING HOMES: APPLICATION TO GRANT A LICENCE: SCOTNURSING LTD.

A report of the Head of Nursing Home Registration and Inspection [Board Paper No. 00/118] was submitted seeking approval to grant a licence to operate a nursing agency until the next renewal date.

DECIDED:

That a licence be granted to Scotnursing Ltd., Napier House, Erskine Ferry Road, Old Kilpatrick, Glasgow, to operate a nursing agency which should be valid under the terms of Section 3 of the Nurses (Scotland) Act 1951 until the next renewal date. — **Head of Nursing Home Registration and Inspection**

EMBARGOED UNTIL MEETING
BOARD: 19 SEPTEMBER 2000

ACTION BY

156. NURSING HOMES : APPLICATION FOR A VARIATION – HILLVIEW NURSING HOME

A report of the Head of Nursing Home Registration and Inspection [Board Paper No 00/119] was submitted seeking the Board's approval for a variation to the conditions of registration of Hillview Nursing Home, 36 Singer Road, Clydebank, Glasgow, under the terms of Section 1(3F) of the 1938 Act to amend the registration category to include one place in the category of Terminal Care within the existing bed complement of 150.

DECIDED:

1. That the application for a variation to the registration category to include one place in the category of Terminal Care within the existing bed complement of 150 under the terms of Section 1(3F) of the 1938 Act be approved. — **Head of Nursing Home Registration and Inspection**

2. That this variation be granted for a defined period of time under the terms of Section 1(3G) of the 1938 Act to cover the period of residency of the specific patient.

3. That upon the departure from the home of the specific patient the variation be nullified and the number of places allocated to the category of Terminal Care would revert to nil.

157. NURSING HOMES : APPLICATION FOR A VARIATION – OPTIMAX LASER EYE CLINIC

A report of the Head of Nursing Home Registration and Inspection [Board Paper No. 00/120] was submitted seeking the Board's approval for a variation to the conditions of registration of Optimax Laser Eye Clinic, 18 Charing Cross Mansions, Glasgow, under the terms of Section 1(3F) of the 1938 Act to amend the registration to include the category of carrying out the Lasik surgical procedure at the Glasgow Clinic.

DECIDED:

That the application for a variation to the registration category to carry out the Lasik surgical procedure at the Glasgow Clinic under the terms of Section 1(3F) of the 1938 Act be approved. — **Head of Nursing Home Registration and Inspection**

158. NURSING HOMES: APPLICATION FOR A VARIATION – KNIGHTSWOOD NURSING HOME

A report of the Head of Nursing Home Registration and Inspection [Board Paper No. 00/121] was submitted seeking the Board's approval for a variation to the conditions of registration of Knightswood Nursing Home, 2032 Great Western Road, Knightswood, Glasgow, under the terms of Section 1(3F) of the 1938 Act to amend the registration category to include one further place in the category of Young Physically Disabled within the existing bed complement of 85.

DECIDED:

1. That the application for a variation to the registration category to include one further place in the category of Young Physically Disabled within the existing bed complement of 85. — **Head of Nursing Home Registration and Inspection**

ACTION BY

2. That this variation be granted for a defined period of time under the terms of Section 1(3G) of the 1938 Act to cover the period of residency of the specific patient.

3. That upon the departure from the home of the specific patient the variation be nullified and the number of places allocated to the category of Young Physically Disabled would revert to one.

159. NURSING HOMES: APPLICATION FOR REGISTRATION: HAZELWOOD HOUSE

A report of the Head of Nursing Home Registration and Inspection [Board Paper No. 00/122] was submitted recommending that concurrent with a change of ownership, approval be given for an application made on behalf of Thortoun Estates (the new owners) in respect of Hazelwood House Nursing Home, 52 First Gardesn, Glasgow, to reduce the maximum bed complement from 48 to 30 in the categories of Frail Elderly, Dementia, Young Chronic Sick and Day Care Services.

DECIDED:

That the application for registration to the Hazelwood House Nursing Home in accordance with the Nursing Homes Registration (Scotland) Act 1938 (as amended) to reduce the maximum bed complement from 48 to 30 in the categories of Frail Elderly, Dementia, Young Chronic Sick and Day Care Services be approved. **Head of Nursing Home Registration and Inspection**

162. MINUTES – GLASGOW ALLIANCE BOARD

The Minutes of the meeting of the Glasgow Alliance Board held on 30 June 2000 [Board Paper No. 00/123] were submitted and noted.

163. MINUTES – GREATER GLASGOW HEALTH COUNCIL/GGHB

The Joint Minutes of the meeting of the Greater Glasgow Health Council/GGHB held on 21 June 2000 [Board Paper No. 00/124] were submitted and noted.

164. MINUTES – AUDIT COMMITTEE

The Minutes of the meeting of the Audit Committee held on 5 September 2000 (A(M)004) were submitted and noted.

The meeting ended at 1.25 p.m.

Modernising Glasgow's Acute Hospital Services

Return to Acute Services Main Index

OUTCOME OF SECOND PHASE OF CONSULTATION

1. INTRODUCTION – A VIGOROUS PATTERN OF DEBATE

1.1 In September 2000 Greater Glasgow NHS Board (GGNHSB) reflected on the outcome of 5 months consultation on how best to reshape Glasgow's hospital services. The proposals had five aims:

a. Modern facilities for a better patient experience.
b. Creating larger specialist teams of doctors in order to assure more continuous availability of specialists and to tackle new requirements governing the working hours of senior and junior (trainee) doctors.
c. Maintaining local access for as much as possible.
d. Creating a pattern of hospital services that made sense across Glasgow as a whole.
e. Levering in major capital investment in a way that was affordable.

1.2 The existing pattern of Glasgow's hospital services is complex. Six major adult acute hospital sites. Some specialties currently present on all sites, some on five sites, some on four, others on three, a small number on two and a couple on one. Institutional loyalties are strong. Staff are intensely committed to their own hospital (but many also equally mindful of the wider needs of their own specialty or service across Greater Glasgow as a whole). Local communities fiercely value their access to their local hospital (but are also aware of how much needs to be done to overcome decades of under-investment in new hospital facilities for Glasgow).

1.3 The significance of increasing specialisation in surgery and medicine and the implications of working hours legislation on senior and junior doctors alike are widely understood. Changes in clinical practice have swung the balance of clinical work in some specialties – especially the surgical services – more towards ambulatory care ("walk-in, walk-out, same day" services). These challenges make the status quo untenable.

1.4 Although GGNHSB's proposals for change were emphatically not finance-driven, they have to be financially realistic. The NHS financial regime is essentially formula- based, so Greater Glasgow has to plan intelligently within a circumscribed financial framework. Certainly its plan should be ambitious but it should recognise its many other obligations in fields such as primary care, mental health, child and maternal health, care of the elderly, services for disabled people, addiction services and so on.

1.5 Against this background it is hardly surprising that there are numerous permutations of what different sectional groups or different parts of the population of the conurbation would like to see. The general public would almost certainly prefer to see all or most of the existing hospitals re-built on their existing sites, offering the same (or a wider) range of services as they currently do. Some sections of opinion within the general public recognise that the present number of hospitals offering the same service as they do now is untenable and see the solution as shutting one or more hospitals – albeit that the hospital(s) to shut should not be their own particular local hospital.

1.6 Other interested parties have different perspectives again. For example Strathclyde Passenger Transport point out that concentration of in-patient sites will inevitably worsen access for some people. They also point out that retaining workload on existing hospital sites does nothing to improve public transport access. It says "few hospitals in the Greater Glasgow area are best located to maximise public transport access". However, Strathclyde Passenger Transport has not said what locations in Glasgow would maximise public transport access.

1.7 The majority opinion among hospital doctors is that there should ideally be only three hospitals – two north of the river and one south. And they would prefer to do all of their own work on one individual site, without having to travel to other sites to do part of their work.

1.8 Greater Glasgow's neighbours face similar instabilities of their own due to changes in clinical practice, specialisation and pressures on working hours. They are mindful of the fact that what GGNHSB does or does not do could have knock-on implications for their own hospitals' capacity to re-shape for the future.

1.9 Since September the debate has continued. There has been further discussion and correspondence with a number of MSPs (and MPs), meetings with the Local Health Council, debate within the professional advisory machinery, a number of additional public meetings and meetings with Community Councils. Many letters have been received. Further work has been done on some of the issues identified in September.

1.10 Against the background of conflicting opinion it was inevitable that debate would continue to be vigorous. There is no "ideal solution" lying out there which, if only it could be discovered, would both attract universal acclaim and be practically feasible. There are those who would argue that the hunt for a hidden "ideal solution" should continue. However, clinical opinion – and some public opinion – is so frustrated by the two decades already spent on this quest that it now wishes to see implementation of the important areas of agreement that have in fact been confirmed during the consultation.

1.11 Dr. Dunnigan, writing in support of the views expressed by the Health Service Forum (South-east), makes the point that "Vision-based planning is not enough". He is right but GGNHSB is firmly of the view that the starting point for planning should be vision-based. In other words, what is the best pattern for achieving as much as possible of what the clinician consensus for the future says while at the same time recognising what the public want? The two strands cannot be made identical. Firstly although strong clinical consensus has emerged it is not unanimous and it is fragile because of doctors' concerns about the compromises the Health Board feels it needs to make to accommodate as much of public opinion as it reasonably can. The resulting dissonances emerging from the world of clinical opinion makes it more difficult for public opinion to gauge what clinical opinion actually is. And the more anxious public opinion is about future proposals, the more difficult it is for the Health Board to find a tenable point of compromise. A vicious circle ensues.

1.12 The Greater Glasgow Local Health Council, in its response said:

"While the media and others tend to highlight those areas of controversy which the Acute Strategy has thrown up, it is the Health Council's view that the consultation Process has been worthwhile. It has identified a number of areas of common agreement as well as a number of issues where there are important qualifications highlighted as a result of the consultation exercise. The fact that the consultation process has resulted in some measure of agreement on important issues and at the same time highlighted areas of concern should not be seen as negative but rather the healthy and appropriate consequence of a proper consultation exercise."

1.13 Although the search for a vision of what the service should be is difficult in the extreme, that does not make it the wrong foundation for planning. The quest for the vision has involved thousands of hours of dialogue, analysis and reflection, comparing the strengths and weaknesses of different patterns. It has been supported by quantitative analysis, albeit not in the detail one would only find in an Outline Business Case or Full Business Case. However, that illustrates the "chicken and egg" nature of the planning dilemma. You cannot proceed to those stages in the absence of a broad service strategy – or vision of what you are trying to achieve. With the exception of the Health Services Forum (South-east), most of the responses to consultation have usually ignored the quantitative analyses put into the public domain – except on the two issues of bed numbers (where initial errors were highlighted quickly and where much work is being done to get the analysis right – see Annex 7) and estimated capital costs (which are based on Design Guide norms and which cannot be more reliably refined without being authorised to proceed to Business Planning stages).

1.14 During the debate some people have criticised the documents produced by GGNHSB because they do not incorporate analysis of issues such as the continuum of care for elderly people, the inter-relationship between primary and acute care or the importance of community development in tackling problems caused by socio-economic deprivation.

The reason for this is that such areas of service policy and development are complex in their own right and if incorporated into this consultation exercise would have overwhelmed it with yet more detail and caused confusion about what the focus for consultation actually is. The place to see where all these crucial interactions work is the Board's Health Improvement Programme (HIP), published each year. Over the past 3 years the HIP has gone into considerable detail on these issues and sought to demonstrate how they relate to each other. More recently GGNHSB has been working with the Greater Glasgow Primary Care Trust to develop a strategy for Primary Care. This is now in its final stages of drafting and is already on the threshold of implementation through both a series of projects developed by each Local Health Care Co-operative and a programme to improve the infrastructure of primary care.

1.15 This paper provides further reflection following this second period of consultation. It considers what GGNHSB should do next in pursuing a process of significant improvement in the pattern of Glasgow's hospital services.

1.16 An analysis of some of the detailed arguments raised in response to the second phase of consultation is included at Annex 3. The responses themselves are at Annex 2.

2. BRINGING SHAPE OUT OF THE DEBATE

2.1 It is important to reflect that three apparently contradictory strands in the consultation point not to an irreconcilably confrontational outcome to the process but to the fact that everyone is in fact listening to, and learning from, each other. The fact that the debate is noisy and sometimes quite wounding should not undermine that insight.

2.2 Firstly, GGNHSB has had to maintain the basic clarity of what the fundamental choices are. Without that clarity of reference point, searching debate becomes either muted or confused. (That is evidenced by the fact that in the first phase of consultation GGNHSB was posing questions about north-east Glasgow rather than making proposals. Debate was sparse. Only when proposals were developed in time for the second phase of consultation did debate become focused).

2.3 Secondly, as some of the issues have become better understood, the weight of professional opinion has begun to shift in favour of some of the key elements in the GGNHSB proposals. This can be seen in the responses of the Area Medical Committee and the Area Nursing and Midwifery Committee. The Local Health Council too has confirmed areas of agreement in the GGNHSB proposals. But at the same time these commentators have pointed to aspects of anxiety over important issues of detailed planning which usually involve a complex mixture of principle and operational capacity. Examples include the question of whether there should be two Accident and Emergency Departments or three. The issue of anaesthetic and surgical risk management in day surgery in a free-standing Ambulatory Care Hospital is another. Coming through loud and clear is the importance of people having confidence in the integrity, competence and affordability of the next stages of planning.

2.4 The third strand is that of public opinion. On the face of it the picture is one of implacable public hostility to "the plan". But it would be wrong to generalise. The reality is very complex. The vast majority of people have been silent in the debate. Some of the most vocal describe themselves as a 'campaign' and a danger in campaign postures is that they become locked in one position. It is evident that some people do not understand what the proposals actually mean (many, for example, still believe that the Victoria Infirmary will close – lock, stock and barrel – which is not what GGNHSB have proposed). Yet it is apparent too that many people do understand some of the underlying forces which are driving change (specialisation, doctors' hours etc). Some of the points people are making (about the care with which any centralisation of medicine and surgery from Stobhill to the GRI should be planned, for example) are ones that GGNHSB recognised in September but the significance of what GGNHSB said in September may not yet have been recognised.

2.5 So why do these three strands not point to an irreconcilable confrontation at this stage?

The reason is that areas of disagreement or lack of confidence tend to overshadow areas where there is consensus.

a) The areas of agreement are as follows: GGNHSB's original five aims (see paragraph 1.1) are generally supported.

b) There should be a single in-patient hospital for the Southside (the argument is about where it should be).

c) There should be a concentration of adult Accident and Emergency Departments from the present four to either two or three.

d) Creating a single-site New Western Infirmary on the Gartnavel site is a matter of some urgency.

e) The concept of purpose-designed Ambulatory Care Centres, focused on the needs of patients, is eagerly embraced in Glasgow and there is an emerging consensus that if provided on a stand-alone basis they can be valuable in maintaining valued local access for a wide range of services and are safe in terms of the anaesthetic and surgical practice required for their agreed range of day surgery procedures (See Annex 4).

f) The need to reduce the number of maternity delivery units from three to two is accepted but the decision on how to do it needs to be seen in the context of assuring strong local community-based ante-natal and post-natal services.

g) We have reached a fork in the road requiring us to reflect on how best to plan for future child and maternal health services. We can either sustain the Royal Hospital for Sick Children on its present site (with or without maternity services on site) or re-locate the Yorkhill services in their entirety on the same site as an adult hospital during a period when the opportunity will arise.

h) There is a recognition that many of the smaller specialties urgently need to concentrate their in-patient services onto fewer sites.

i) The Dental Hospital and School building cannot be sustained for much longer. A new location needs to be decided.

j) In implementing change in the acute services they should attract additional revenue investment but not at the expense of what the 'fair share' of service improvement in primary and community care, mental health, children's health, learning disabilities, addictions, services for people with disability and public health improvement measures would add up to financially.

k) The need to invest in fundamental change in Glasgow is urgent. Glasgow has suffered too long from repeated failures to reach agreement about change.

2.7 This is a formidable area of common agreement

2.8 What are the areas of disagreement or lack of confidence?

a) The location for the Southside in-patient hospital (and its implications for the need for a stand-alone Ambulatory Care Hospital at the Victoria Infirmary site).

b) Whether there should be an Accident and Emergency Department at Gartnavel or not. The balance of clinical (medical and nursing advisory) opinion supports two and has set out the conditions which need to be met to ensure satisfactory operation of such a pattern.

c) The issue of bed numbers remains unresolved. Work by the North Glasgow Trust to revise the methodology to respond to concerns raised in the first phase of consultation has only recently been completed and people have not been able to review it. Bed numbers remain an issue of great

sensitivity in the NHS generally. There is a consensus in Glasgow that we need to get this right but further time is needed to secure consensus about the numbers themselves.

d) The issue of affordability has not yet been demonstrated sufficiently widely to build a strong platform of confidence. Some commentators argue that the original capital estimates were too low. The capital cost profiles have been revised by the Trusts but not yet more widely scrutinised. The re-phasing of capital investment in West Glasgow could cause a bunching of revenue consequences that needs to be tested in further stages of Business Case planning.

e) The answers to the questions about the location of hospital services for child and maternal health and the Dental Hospital have not been systematically explored. A process is needed to examine these questions in a way that secures as much collective confidence as possible.

f) The question of the future role of Stobhill remains unresolved. The majority of clinical advice is that there should be three in-patient hospitals in Glasgow – the GRI, Gartnavel and one on the Southside. Local opinion in and around Stobhill maintains either disagreement with that advice (i.e. they argue that there should be four in-patient hospitals in Glasgow) or that GGNHSB should be planning to discontinue any further development of the GRI, build a large new hospital at Stobhill and then abandon the GRI, concentrating all the services for the north and east Glasgow at Stobhill. There are others who accept the logic of the Area Medical Committee's advice but argue that any move of in-patient general medicine and surgery from Stobhill should only take place if and when everyone can be confident that the workload could be satisfactorily managed at the GRI. (This was the position GGNHSB took in September, 2000).

g) There is clearly a lack of confidence in the capacity of managers to plan and to manage the processes of change. This is most clearly described in the comments of the Area Medical Committee but it is a theme which has been raised in many forums.

2.9 What does this analysis mean for GGNHSB's decision-making processes and timetable?

The way forward is to build on the areas of agreement and to work to resolve the areas of disagreement and lack of confidence. The only alternative is to abandon any proposals for fundamental change – which would be disastrous for Glasgow.

To understand what this means in practice we need to think what the sequence of events might be. We also need to recognise that although different strands need to be addressed in a variety of different ways, in the end the total strategy needs to hang together as a coherent whole. That is because the scale of capital investment is so large that detailed governmental scrutiny of the major Outline Business Cases cannot be undertaken in isolation one from the other.

3. THOUGHTS ON MAKING TANGIBLE PROGRESS REFLECTING AREAS OF AGREEMENT

3.1 There are three strategically significant capital investments on which there is already widespread consensus:

a) the creation of a new Western Infirmary at Gartnavel enabling the closure of the existing Western Infirmary site.

b) the building of an Ambulatory Care Centre at Stobhill.

c) the principle of a single Southside in-patient hospital.

3.2 What needs to be done to move these forward?

Gartnavel

3.3 In broad terms the majority of the additional functional content at Gartnavel is clear and agreed:

a) provision of additional beds on site to allow transfer of medical and surgical in-patient services from the Western Infirmary.

b) Intensive Care, Coronary Care and High Dependency Nursing facilities.

c) provision of sufficient Ambulatory Care capacity to allow transfer of out-patient clinics, diagnostic and rehabilitation services from the Western Infirmary.

d) creation of an Emergency Receiving Centre with a capacity and facilities to manage at least 12,000 GP referrals, and 20,000 Minor Injuries cases per year (consistent with Scenarios 3 and 5 of Annex 6 of GGNHSB's September, 2000 paper).

e) linear accelerator, treatment planning, in-patient beds and associated facilities to complete the transfer of the Beatson Oncology Centre.

f) facilities for the creation of a single West of Scotland Cardiothoracic Centre, allowing transfer of services from the Western Infirmary and GRI.

g) expansion of laboratory facilities consistent with North Glasgow Trust's laboratory services strategy.

h) additional car parking.

3.4 The planning challenge for the site is to absorb these additional services in a design solution which is functionally effective and efficient and which satisfies whatever town planning and traffic requirements are determined by the City Council. The next step is for the Scottish Executive to authorise the North Glasgow Trust to proceed to the next step of capital planning – namely the production of an Outline Business Case.

3.5 If approval to proceed to Outline Business Case were given in February, 2001, it would be possible to have it ready for submission to GGNHSB by September, 2001, with subsequent submission to the Scottish Executive for the necessary governmental scrutiny, alongside parallel work undertaken for the South Glasgow Outline Business Case. In Annex 8 on Affordability we identify how the affordability of the Southside and Gartnavel Outline Business Cases are interdependent with savings that are achievable through reconfiguration elsewhere, including North Glasgow as a whole.

3.6 The need for the Trust to maintain a fast-track approach to completing the Outline Business Case lies in the widespread agreement on the importance of:

a) Completing the second phase of linear accelerator capacity and associated in-patient and out-patient accommodation at Gartnavel.

b) Integrating acute medical and surgical in-patient services wholly at Gartnavel, to end the bane of split-site working between the Western Infirmary and Gartnavel.

<u>Stobhill Ambulatory Care Centre (ACAD)</u>

3.7 This has already received Outline Business Case approval. Capital investment procurement is underway and subject to approval of a Full Business Case should be completed and in use by 2003. GGNHSB has already committed itself to meet recurring revenue costs of up to £1.1 million per year.

3.8 This timetable means that the Ambulatory Care Centre will be in operation alongside acute medical and surgical in-patient services at Stobhill. The ACAD includes a casualty facility and its model of service is sustainable without change for as long as its current medical staffing remains in post and acute medicine, surgery and anaesthetic services continue at Stobhill.

3.9 Is there any long term risk in investing in the ACAD prior to achieving definitive certainty about Stobhill's long term future for in-patient services? We do not think so. If medical and surgical in-patient services did transfer away from Stobhill in due course the Ambulatory Care Centre would be both viable and clinically safe as a stand-alone facility in offering continuing local access to a wide range of services for its surrounding population.

Southside in-patient hospital

3.10 The proposition that there should be a single Southside in-patient hospital has almost universal support. Southside MSPs have expressed support, the Area Medical Committee reminds us that it has supported the concept since 1996, and the Local Health Council has urged the Board to pursue a much needed new hospital for the Southside.

3.11 In the debate on location the majority of opinion urges the Health Board to find a "central location" – the MSPs, Health Council and Area Medical Committee have all promoted this view.

3.12 In its September, 2000 paper GGNHSB reviewed the choices against 21 relevant factors. It concluded that the Victoria Infirmary\Queens Park Recreation site option falls due to its weaknesses on 12 of the factors. It recognised the weight of public opinion favouring the Cowglen option and so focused its choice between Cowglen and a combined Southern General Hospital\ACAD at Victoria Infirmary option. It concluded, by reference to the 21 factors, that the latter option had the greatest balance of advantage. On only 4 factors did Cowglen have an advantage.

3.13 In the second phase of the debate the Area Medical Committee, having considered the Health Board's analysis, has expressed support for a new build hospital at the Southern General Hospital site. The Area Nursing and Midwifery Committee has also supported this conclusion. The Local Health Council continue to aspire to a more central location than the Southern General and say that the opportunity (should) then be taken to provide ambulatory care on that site rather than at the Victoria Infirmary. They also say, however, that "should the Health Board decide to develop acute in-patient services at the Southern General, then it will be essential to have ambulatory care episodes provided at a stand-alone Ambulatory Care site at the Victoria Infirmary".

3.14 These comments help to confirm the amount of underlying agreement there is as to the goal for the Southside and what the nature of the choice is – i.e. a central location or the Southern General plus Victoria Infirmary ACAD.

3.15 Glasgow Trust with Mr. Rodger McConnell, Director of Development and Regeneration Services at Glasgow City Council held on 7th November, 2000. Mr. McConnell confirmed that the original GGNHSB\Trust assessment of potentially available sites described in consultation leaflet 16 (published in the Spring of 2000) was sound (namely the Southern General; Victoria Infirmary\Queens Park Recreation; Cowglen and Darnley). The only other site of anything like the necessary size was the former Freightliner Terminal between Govanhill and Hutchesontown. However, the site is bisected by Aitkenhead Road and certainly not the "centrally located site" most favoured by those who disagree with the Board's judgement on the Southern General.

Mr. McConnell agreed that the town planning processes associated with the Green Belt involved in the Cowglen option were those set out in the September, 2000 Board paper. It will be recalled that City Council Development Control said, in a letter dated 22nd August, that the City Council's Pollock Park Local Plan aims to "promote and maintain it as a high quality countryside area within which leisure and cultural pursuits can be undertaken without detriment to the countryside environment. In these circumstances .... serious doubts as to the viability of any proposal to develop a new hospital on this site".

3.16 The need now is to move forward in a way that harnesses the agreement that exists while at the same time addressing the area of disagreement that remains between the Cowglen and Southern General\Victoria Infirmary ACAD option.

3.17 It is important to do so on a timescale that keeps pace with that necessary to expedite the creation of new facilities at Gartnavel so that the need for the Scottish Executive to receive a coherent and mutually consistent set of Outline Business Cases in the autumn is fulfilled.

3.18 This requires eight steps:

a) Firstly we need to be able to demonstrate at this stage broad affordability within the wider strategic framework for Glasgow. This requires some initial assumptions about functional content, including bed numbers. These issues are dealt with later in this paper.

b) Secondly endorsement of the concept by the Scottish Executive, since it will entail hospital closure and\or change of use. One option would entail closure of both Southern General and the Victoria Infirmary, the other would involve change of use of the Victoria Infirmary (with the closure of its existing buildings and building of a new ACAD\rehabilitation beds) and closure of the Mansionhouse Unit.

c) Thirdly the conduct of an option appraisal between the "do nothing", Cowglen and Southern General\\Victoria Infirmary ACAD options as an early part of the Outline Business Case process. This needs to be done in an objective, systematic and transparent way. We would expect planning consultants selected by competitive tender to report to a reference group comprising representatives from the Trust management, Medical Staff Association, GGNHSB, the Primary Care Trust, the Trust Partnership Forum, Local Health Council and three MSPs (two chosen by all the MSPs representing South Glasgow constituencies and one chosen by Glasgow List MSPs).

d) Fourthly the completion by the Trust of the Outline Business Case (OBC) which confirms the proposed functional content, including bed numbers, and estimated capital and revenue costs. We propose a single contract for construction. These conclusions will reflect the Option Appraisal element undertaken in developing the Outline Business Case. If the Southern General were confirmed as the preferred site, the scheme would include an Ambulatory Care Centre at the Victoria Infirmary in order to maintain local access for as many services as possible. Assuming that GGNHSB approves the Outline Business Case it would be submitted to the Scottish Executive for approval. The target date for consideration by GGNHSB, in order to maintain parallel momentum with Gartnavel is September, 2001.

e) In parallel with this, the Trust would start the process of identifying the procurement partners for the scheme.

f) After OBC approval by the Scottish Executive, a further 15 months would be necessary to produce the Full Business Case (FBC).

g) Subject to rapid approval of the FBC, financial closure with the PPP partners would take up to 12 weeks and construction would normally start within a few weeks. If steps (a) to (f) all proceed without difficulty, a start on site would be possible in around July or August, 2003.

h) As new facilities come on stream and are commissioned, services would move from their present location(s). On completion, all acute in-patient facilities in the Southside would be located on the single site.

3.19 <u>Other issues needing early practical action</u>

The other areas of agreement that require early practical action are:

a) concentration of the smaller in-patient specialties.

b) turning agreement in principle that examination of choices in hospital provision in child and maternal health needs urgent resolution into a process that generates a specific proposal.

c) completing a similar piece of work in relation to the Dental Hospital and School.

3.20 Concentration of smaller in-patient specialties

The proposals in the September, 2000 GGNHSB paper fell into four categories:

a) a group of changes needing urgent implementation in South Glasgow. These affect strengthening the medical emergency admissions capacity, especially at the Victoria Infirmary, to allow it to cope better while building of the brand new hospital facilities for the Southside proceeds. The September, 2000 document set out a series of interlocking moves between the Victoria Infirmary and the Southern General involving gynaecology, haemato-oncology, breast surgery and vascular surgery. The detail of these proposals is reproduced in Annex 5. The proposals also included transfer of in-patient gynaecology from West Glasgow to the Southern General.

Surprisingly, despite that detail, the Local Health Council in its latest response neither gave a definitive response to the proposals (claiming they give insufficient information on the service level which will be available following rationalisation), nor even offered any comment on them. Disappointingly, they did not seek additional information during the consultation period.

Since the manoeuvres require capital investment if they are to be in place before the winter of 2001\2 their implementation is now a matter of pressing urgency. The Health Board requests the Health Council to review its position as a matter of great urgency, since every month of unjustified delay will directly cause real harm to the NHS ability to cope with emergency workload in South Glasgow. The number of emergency admissions is so high that delay perpetuating the present bottlenecks of capacity will affect hundreds of patients. Whatever happens about the timetable and location for the new South Glasgow in-patients, these changes and the small amount of capital expenditure they entail are crucial to ensuring that the two South Glasgow Hospitals can best mange clinical pressures in the intervening period.

b) a second group of changes related to some changes in North Glasgow. In particular these were:

i) in-patient orthopaedics from Stobhill to the GRI (17 beds).

ii) in-patient ophthalmology from Stobhill to Gartnavel (2 beds).

iii) in-patient ENT from Stobhill to Gartnavel (6 beds).

iv) In-patient gynaecology from Stobhill to GRI (2 wards – although further discussion was needed regarding gynaecological oncology which offers a regional service).

v) in-patient urology to GRI and Gartnavel.

The Local Health Council has declined to comment on these also, for the same reason referred to earlier. We accept that precise detail is lacking in relation to urology and gynaecological oncology. However, the September, 2000 paper did include information about orthopaedic, ophthalmology and ENT service levels and how they would be provided. The Health Council need to clearly specify precisely what information they think is lacking in relation to all of the specialties concerned.

c) the third category concerned a number of specialties where the September GGNHSB paper signalled that work to produce proposals was still in progress. These were: i) dermatology.

i. gynaecological oncology.
ii. nephrology.
iii. the final North Glasgow configuration for urology.

Work on these has made further progress but is not yet complete. There will be consultation as soon as the proposals can be specified with sufficient clarity.

d) the fourth category concerned the transfer of in-patient orthopaedics from West Glasgow, allowing the creation of a single orthopaedic unit in North Glasgow.

This issue is inseparable from the Board's judgement on Accident and Emergency Services (see section 5 of this paper). The earliest it could be Implemented is August, 2002, when new capacity comes on stream at the GRI.

In the meantime GGNHSB have provided a significant amount of detail Underpinning the proposal. If the Local Health Council consider that information Lacking in any of the detail that might be reasonably required they should specify It now so that no avoidable delays arise later.

Child and maternal health

3.21 There is widespread recognition of the need to explore choices. Annex 6 reviews some of the principles that need to be considered. What is needed is a process to explore the choices dispassionately in order to identify what in principle is in the best interests of child and maternal health, what conflicts there might be in balancing different areas of clinical benefit and risk, what the practical possibilities are and what the best balanced choice might be.

3.22 The topic is inevitably a sensitive one and is best examined in a way that combines:

a) access to expertise.

b) representation of children's, mothers' and families' interests.

c) staff Partnership Forum involvement.

d) input by NHS management, on whom local responsibility for decision-making will fall when the process of examination is complete.

e) observation and interrogation of the process by representatives of the wider public interest (such as the Local Health Council, MSPs and local authorities).

f) impartial facilitation of the process.

3.23 GGNHSB would propose to establish a process that meets these characteristics. There is a degree of urgency since some of the alternatives remain open only until such time as Outline Business Cases are completed in the summer. So we need to understand whether a child and maternal health element is to be included in it or not. This means reaching some initial conclusion by March, 2001, allowing a period of consultation between April and August, 2001. In total the issue would have been explored transparently in the public domain for nearly 8 months.

3.24 Dental Hospital

The urgency on this issue relates more to the physical state of the building than to any service or educational imperatives. There are no fundamental service interconnections which would require reprovision to be an integral part of new hospital provision in South Glasgow or at Gartnavel. However, we should aim to tease out the options as soon as possible and to do so in a way that is properly inclusive and transparent. GGNHSB has therefore asked the North Glasgow Trust to suggest an appropriate planning mechanism with an aim to reaching initial conclusions by March, 2001 so that a consultation process can then ensue.

3.25 Summary

These various actions will all help to move the Glasgow NHS forward on those aspects of the future structure of acute hospital services where there is now a good platform of basic consensus. Where there are areas of current lack of agreement within these main elements, the processes suggested in each instance should allow agreement to be reached in an inclusive and transparent way. If, in the end, agreement is not forthcoming and decisions have to be made amidst continuing disagreement, at least (we hope) people will recognise that the process has been open and systematic.

4. RESOLVING AREAS OF UNCERTAINTY, CURRENT DISAGREEMENT OR LACK OF CONFIDENCE

4.1 Earlier we identified eight areas of uncertainty, current disagreement or lack of confidence:

a) The location for the Southside hospital.
b) Whether there should be an Accident and Emergency Department at Gartnavel.
c) Lack of resolution on the issue of bed numbers.
d) The need to demonstrate affordability.
e) The future of hospital provision for child and maternal health.
f) A future location for the Dental Hospital.
g) The future role of Stobhill. h) Concern about management capacity.

4.2 For the **Southside Hospital, child and maternal health and the Dental Hospital** we have suggested earlier in the paper processes for resolving these areas of uncertainty or lack of agreement, using the platform of underlying consensus that does exist on each issue. The following sections consider the others.

5. ACCIDENT AND EMERGENCY SERVICES (A & E SERVICES)

5.1 This is an issue where there may almost be agreement but not quite. The Area Medical Committee says it "considers that Consultant-led Accident and Emergency Services should be developed on two sites, these being the Southern General and GRI, with acute medial and surgical receiving continuing at Gartnavel". It goes on to say that "in making this recommendation, the AMC is seeking assurance from the North Glasgow Trust that previously stated concerns regarding additional workload at GRI are being satisfactorily addressed". It makes it clear that its support is conditional on this commitment by the Trust.

5.2 The Local Health Council, while accepting the logic of one A & E Department in South Glasgow expresses reservations about there being just one in North Glasgow. It goes on to say "the size of the population in West Glasgow justifies an A & E Department situated at Gartnavel". In commenting on the Board's preference for a two A & E model it says that it has not had enough information about the planning assumptions made in respect of the capacity of the A & E Departments (although it does not refer to the detailed scenarios contained in Annex 6 of the September, 2000 paper nor asked any questions about the numbers set out there). It also makes a similar point to the AMC regarding capacity at the GRI.

5.3 The Accident and Emergency Sub-Committee say "it would be inappropriate to have two fully appointed A & E Departments in close proximity. There should not therefore be main A & E Departments at both Gartnavel and the Southern General site". Earlier it makes it plain that its earlier advice favouring two A & E Departments in North Glasgow could not be amended in the absence of acceptable solutions to the issue of capacity at GRI. The Health Board Chief Executive met the Sub-Committee on 13th December to hear from them their views on the current state of planning on the capacity issue. It is clear that the Trust has done extensive work but not to the point of full agreement and conclusion.

5.4 The Area Nursing and Midwifery Advisory Committee support a two A & E model – one North, one South.

5.5 The need for confidence that a busier A & E Department at the GRI could be provided with sufficient capacity, including the medical and surgical beds needed to support it, is clearly the issue

most prominent in the minds of those uneasy about the Board's two A & E model. Postcode analysis of A & E attendances in the 1998 one week survey suggests that the majority of the additional workload would come firstly from south-east Glasgow (when, in due course, the A & E Department at the Victoria Infirmary moves westward to the new in-patient hospital and is replaced at the Victoria site by a Minor Injuries Unit) and secondly from Stobhill (in the event of there no longer be sustainable medical staffing in its Casualty Department and there no longer being medical and surgical receiving services there). The workload expected to flow from the eastern side of West Glasgow when the Western Infirmary A & E Department closes is less significant. Annex 6 of the GGNHSB September, 2000 paper set out the relevant assumptions and incorporated them into the calculation of various scenarios.

5.6 This confidence issue needs to be explored through the establishment of a Glasgow A & E Services Planning Steering Group comprising Health Board and Trust senior managers, representatives of the Accident and Emergency Consultants, GPs and others with expertise to contribute to the work. Initially three areas of work will be pursued:

a) the North Glasgow Trust will bring everyone up to date with their work on GRI capacity.

b) work with Trusts and A & E Consultants to decide what data set is needed to inform the next phase of deciding what clinical policies, staffing and other resources need to be developed to support the future pattern of A & E Departments with supporting Minor Injuries Units at other sites. This will need to take into account relationships with Primary Care and Medical and Surgical Receiving.

c) analysis of the expected timescales for change (mostly dependent on other aspects of change in Glasgow, such as the new in-patient facilities for the Southside, the movement of acute services from the Western Infirmary to Gartnavel, the opening and enlargement of new facilities at GRI etc).

5.7 The completion of the Option Appraisal for the Southside in the summer of 2001 will overcome people's present uncertainty about the location of the Southside A & E and hence its proximity to Gartnavel.

6. BED NUMBERS

6.1 In September we reported that the North Glasgow Trust had initiated further work in conjunction with ISD and Clinical Directors to take a fresh look at how future bed requirements could be more sensitively modelled.

6.2 We have always said that the key objective is to get bed numbers right rather than to pursue some mechanistic target. However, it is also the case that the number of beds in a hospital or provided in a new building has a strong impact on the direct running costs. Just as it is important not to under-provide beds, so it is self-defeating to over-provide. Having too many makes the challenge of affordability of many expensive new buildings to replace depreciated old buildings all the more difficult to accommodate.

6.3 The challenge is made more complex because we need to consider future changes in population, burdens of illness, cross-boundary flow, clinical technologies and practice, and systems efficiency.

6.4 Annex 7 describes the useful progress that has been made in these matters and what more needs to be done to refine the results.

6.5 What is now necessary is to encourage debate about these most recent analyses and their implications. There will need to be a Steering Group overseeing this process with representation from the two acute Trusts, the medical advisory machinery, GGNHSB, the Local Health Council and ISD.

6.6 Consideration of the issue needs to be reviewed within a timescale that does not delay preparation of the Outline Business Cases. We should aim for a final report to be made to the Health Board on 17th April, 2001, although both Trusts will be able to reflect the implications of "work in progress" as they develop their Outline Business Cases.

7. AFFORDABILITY

7.1 Annex 8 sets out the issues of affordability based on the most up-to-date assessment of recent experience elsewhere with PFI\PPP and equipment costs and incorporating work on capital planning feasibilities at Gartnavel and GRI undertaken by W.S. Atkins on behalf of the Trust.

7.2 Affordability is sustainable but will require careful management throughout the decade. It also means that the opportunity costs will need to be clearly understood throughout the period. The price of physical renewal of Glasgow's hospitals is that the mission of improving service performance will rely on high quality clinical service management and flexibility in promoting change.

7.3 Once approval can be given to Outline Business Case planning the capital and consequential revenue costs will be further refined. The Option Appraisal process within the Outline Business Case stage will include a detailed equivalent comparison of the Southern General\\Victoria ACAD with the (inevitably more expensive) Cowglen option and a comparison of GRI in-patients\Stobhill ACAD with GRI in-patients\Stobhill ACAD and in-patients (see section 8 below).

8. THE FUTURE ROLE OF STOBHILL

8.1 This is the issue which appears to display the greatest gulf of disagreement.

8.2 The Area Medical Committee advice is pretty unequivocal. "The Area Medical Committee confirms its support, first given in 1996, to a reduction in adult acute in-patient sites from five to three sites. These sites are Glasgow Royal Infirmary, Gartnavel General Hospital and one site south of the River Clyde".

8.3 The Stobhill Medical Staff Association subscribe to the concept of 2 acute hospitals north of the river but that support is conditional on it being demonstrable that the two hospitals have adequate capacity (emergency receiving and elective beds, theatres, diagnostic and rehabilitation support) in genuinely fit for purpose facilities.

8.4 Local public opinion is adamant in its support of Stobhill. Some wish to see Stobhill continuing its present role, being modernised in due course. Others recognise the logic of a reduction in in-patient hospitals in Glasgow but argue that the GRI should be abandoned, with a brand new hospital built at Stobhill to combine the roles of both hospitals.

8.5 GGNHSB has supported the specific transfer of the in-patient services of the smaller surgical specialties from Stobhill (to the GRI and Gartnavel). This involves Ophthalmology (2 designated beds), ENT (6 beds), Orthopaedics (17 beds), Urology (20 beds), and Gynaecology (2 wards) and it is difficult to see how these services can be sustained in the face of the severe pressures now applying to doctors' hours. On the other hand GGNHSB's support for the building of an ACAD at Stobhill is a mark of long term commitment to the maintenance of general hospital services on the site (of 325,000 total patient encounters\episodes per year currently at Stobhill, the ACAD and associated out-patient capacity elsewhere on the site would maintain around 288,000 – nearly 90%).

8.6 GGNHSB shares the Stobhill Medical Staff Association's caution about the circumstances in which people could feel confident about a transfer of in-patient medical and surgical services to GRI (and some to Gartnavel). That is why, in September 2000, GGNHSB, while expressing support for the concept of two in-patient hospitals north of the river, stipulated that such a move could not happen without further formal consultation at a time when there were tangible practical plans to allow it to happen satisfactorily.

8.7 Although there will be differences in emphasis between the perspectives of GGNHSB, the Stobhill Medical Staff Association and the Glasgow Medical Advisory Committee the underlying reality is that their positions are not divergent.

8.8 What decision-making choices does GGNHSB have at this stage?

a) **It could confirm Stobhill's long term future as a hospital with general medicine and general surgery in-patient services together with a full range of ACAD services**. It would lack on-site in-patient services in other specialties but since several specialties can in future only be sustained on one or two sites in Glasgow, it is inevitable that in a three – or four – hospital Glasgow no site will have all specialties. That said the presence of an ACAD means that clinicians in most specialties would be present at Stobhill regularly during the week, available to give advice where necessary.

This would be a popular decision for the Board to make but it would be ethically dishonest if the Board genuinely felt that the trends in specialisation, bed numbers, staffing pressures etc, were inexorable. It would not be a guarantee that the issue would never arise again.

It would also be a decision that put at risk the successful submission of Outline Business Cases for the Southside and Gartnavel in September, 2001. Why? Because the scale of investment proposed will cause the Scottish Executive to review the affordability of both Cases alongside each other and within the total financial capacity of the Glasgow NHS. Work on the affordability issue so far suggests that the savings that would accrue from rationalising acute hospital infrastructure in north-east Glasgow is a key part of the total equation of affordability.

b) **It could subscribe to the popular public view that a new hospital should be built at Stobhill to concentrate general acute facilities there, enabling either the abandonment of the GRI or its conversion into a specialist hospital** (providing, say, plastic surgery, a single cardiothoracic surgery unit for Glasgow, women's services and perhaps Dental Hospital facilities).

Abandonment of the GRI, with all its recent capital investment arising out of the 1996 strategy, is difficult to contemplate. Taxpayers and the Scottish Parliament would likely be most vexed at such a waste of money. The variation on this choice, using GRI as a specialist hospital, might be a reasonably popular decision with the public. It is unlikely to be seen by clinicians as having any advantages over the GRI\Gartnavel\Southside configuration since it results in more diffuse clinical relationships. The opportunity cost consequences would likely be high because we would be maintaining four rather than three large in-patient facilities in Glasgow, with all the expensive infrastructure needed to sustain each of them.

c) **It could pursue its present position** – a decision in principle to create two in-patient hospitals in North Glasgow (Gartnavel and GRI) but one that can be enacted without a firm and fully worked out plan of how medical and surgical in- patient services could be satisfactorily transferred from Stobhill. There would need to be consultation on such a plan.

This timing in turn means that, in effect, there has to be an Outline Business Case for change in north-east Glasgow ready to be considered alongside the South Glasgow and Gartnavel Outline Business Cases in September, 2001.

We would need to design a process whereby this work could be done in that time.

The revenue affordability and service interdependence of making progress on the Southside and at Gartnavel mean that we need to be clear about the future pattern in north-east Glasgow and to enact any necessary capital investment in time to ensure that whole-system affordability remains viable.

8.9 Of these choices (a) is untenable, might hold the Southside and Gartnavel to ransom and would be intellectually dishonest. The reason why the perceived threat to Stobhill keeps reappearing under very different local Administrations throughout the last couple of decades is because with a population served of just over 1 million, a pattern of more than four in-patient hospitals is inevitably going to become increasingly fragile and open to question. This current Health Board administration could not guarantee that its successors would not find themselves exploring the same issue. But more immediately pressing is the threat posed to the affordability of change elsewhere in Glasgow.

8.10 Choice (b), if it involved abandonment of the GRI, would be seen by the rest of Scotland as a reckless waste of public money. It would hardly create the right conditions in which Glasgow's claims to receive accelerated benefit from the Arbuthnott funding formula (or any other discretionary financial benefit from the Scottish Executive) would be sympathetically received. Its alternative, (using GRI solely as a specialist hospital) would not, we think, be seen by the clinical world as a genuinely advantageous clinical arrangement. It would make integrated approaches to patient care for in-patients with different combinations of illness more difficult to achieve. This is not easy to achieve even in a three in-patient pattern – it is even more difficult in a four centre pattern. Choice (b) is, however, an option that could be explored within the context of the Option Appraisal component of the Outline Business Case that would need to be developed under choice (c).

8.11 Choice (c), the position GGNHSB adopted in September, is the most consistent with clinical advice. We recognise that public support is lacking. The work needed to pursue it cannot be deferred because of the issue's impact on the affordability of the Gartnavel Outline Business Case – which coincides with the need to find the resources to implement the South Glasgow strategy.

8.12 We therefore need to set up a Planning Group with extensive clinical and staff partnership involvement. In view of the importance of local community opinion there should also be a wider reference group drawn from community representatives served by the GRI and Stobhill which can interrogate and influence the option appraisal and the clinical and other issues associated with it.

9. MANAGEMENT CAPACITY

9.1 The consultation process has highlighted a tension. Highly detailed work on planning; designing systems; calculating staffing levels, costs and savings; and working out complex sequences of synchronised manoeuvres can only be sustained when broad strategic direction is known. If it is not, then the amount of detailed work that would be done on the full range of strategic choices multiplies geometrically and is unsustainable. Yet it is clear that the parties to consultation – staff, public, Health Council, other agencies etc – find it difficult to gain confidence in supporting particular strategic direction if they cannot see the full detail of how it will work in practice. A chicken and egg problem.

9.2 It is therefore quite a significant achievement that we have reached as much Agreement as we have. However, we must now increase our capacity to tackle the Degree of detail people want in the next stages of work.

9.3 This is a matter of:

a) strengthening project management capacity for the Southside, Gartnavel and north-east Glasgow components.

b) putting in place a pan-Glasgow financial modelling capacity for this whole programme of acute services development.

c) appointing a pan-Glasgow Project Controller who oversees the whole range of interlocking projects and advises Trusts and GGNHSB accordingly.

d) putting in place an overall Steering mechanism that keeps all the necessary elements of work under review and ensures good communications with the NHS stakeholders, MSPs and the public.

e) securing Scottish Executive approval to move into Outline Business Case stage for South Glasgow, Gartnavel and north-east Glasgow so that the necessary consultancy expertise can be brought to bear in developing the complex Option Appraisals that are needed and the design and financial analyses to underpin them and convert them into robust Outline Business Cases.

9.4 It is particularly important that these new arrangements connect adequately to clinicians, staff partnership mechanisms and local communities. The frustrations articulated by the Area Medical Committee and others must now be resolved.

10. SUMMARY OF DECISIONS

[Still to be drafted in the light of the Board's reflection on these issues]

ANNEXES

1. Contents page of the GGNHSB September, 2000 document.

2. Responses received in the second phase of consultation.

3. Analysis of some of the detailed arguments raised in responses to the second phase of consultation. [Still being drafted. Principal themes picked up in main paper + Annexes 4, 7 and 8]

4. Stand-alone Ambulatory Care Centres.

5. Urgent Specialty Manoeuvres in South Glasgow

6. Principles for Child and Maternal Health

7. Modelling of Bed Numbers

8. Affordability

Return to Acute Services Main Index

CONCLUSIONS AT THE OUTCOME OF SECOND PHASE OF CONSULTATION

1. After seven months of extensive consultation GGNHSB is confident that its **five key aims** have widespread recognition and support. The five aims are:

    a. **Modern facilities** for a **better patient experience**.
    b. Creating **larger specialist teams** of doctors in order to assure more continuous availability of specialties and to tackle new requirements governing the working hours of senior and junior doctors.
    c. Maintaining **local access** for as much as possible.
    d. Creating a pattern of hospital services that **makes sense across Glasgow as a whole**.
    e. Levering in **major capital investment** in a way that is affordable.

2. Equally GGNHSB recognises that it is the **interaction of these aims** that makes a single universal consensus about the precise future pattern of services so difficult to achieve.
3. GGNHSB's decisions at this stage in a continuing process of capital – and service – planning seek to **build on those areas where there is widespread agreement** while at the same time putting in processes for the next stage of planning which provide **transparency and further interrogation** for those aspects where agreement is not widespread.
4. The component service\specialty structure around which the proposed pattern of acute hospital reconstruction should be built is as follows:

    a. **Local access** to a wide range of consultant out-patient clinics, diagnostic services, out-patient rehabilitation services, day surgery and minor injuries services (**Ambulatory Care**). This local access to be provided at the GRI, Stobhill, Gartnavel, Victoria Infirmary and Southern General (unless a new greenfield site hospital were built on the Southside, in which case these services would not be provided at the Victoria Infirmary or Southern General).
    b. **In-patient general medicine (including respiratory medicine and cardiology), general surgery and acute geriatric assessment services** should be located alongside each other on the same hospital campus. GGNHSB accepts the advice of the Area Medical Committee that there should be **three in-patient sites** for these services in Glasgow – one in South Glasgow, one in West Glasgow and one serving north and east Glasgow.
    c. **Regional services** should be organised so as to give them the best possible in-patient platform on which to build their future service development. In some instances this means retaining their present base, in others amalgamation or transfer is in hand or proposed:

- neurosciences: retain in their present modern facilities at Southern General (unless a new greenfield site hospital were built on the Southside).
- plastic surgery\burns: to be concentrated at GRI when new facilities currently under construction are complete.
- Beatson Oncology Centre: to be concentrated in new facilities at Gartnavel.
- Cardiothoracic surgery: to be concentrated in new facilities at Gartnavel.
- Spinal injuries: retain in their present modern facilities at Southern General (unless a new greenfield site hospital where built on the Southside).
- Westmarc: retain in their present modern facilities at Southern General.
- Infectious diseases: retain in their present modern facilities at Gartnavel.
- Homoeopathy: retain in their present modern facilities at Gartnavel.

d. The term **"Accident and Emergency"** covers a wide **range of different needs**:

i. a receiving point for medical and surgical emergency referrals from GPs.
ii. resuscitation and emergency stabilisation of patients who arrive with cardiovascular or other acute systems failure.
iii. patients with multiple injuries requiring a prompt trauma response.
iv. a minor injuries service which can be provided by nurse practitioners working to clinical protocols determined by A & E Consultants.
v. patients with initially indeterminant symptoms (breathlessness, abdominal pain etc) who need assessment, treatment and\or onward referral where appropriate. (Such patients also present to GPs in primary care and similar diagnostic skills are required).

Each acute receiving hospital should have policies and capacity for managing (i) and (ii). For the number of patients in category (iii) Glasgow needs no more than two units with this clinical capability, as long as their strategic accessibility on the main road networks are complementary (as would be the case with one unit at GRI and the second at the Southern General). Services for category (iv) should be provided as part of locally accessible Ambulatory Care services. Each acute receiving hospital and each minor injuries unit should have clinical protocols, staff training and onward referral arrangements that allow category (v) ("primary care at hospital") to be managed in a way that is clinically competent and helps to reinforce the necessary links with primary care.

e. **Orthopaedic in-patient services** should be co-located alongside category (iii) trauma services. If there were two such services (at the GRI and Southern General) this would indicate two orthopaedic in-patient units (which has benefits for orthopaedics as a specialty in terms of capacity to sustain sub-specialisation, optimum working hours cover arrangements and research

interests). If there were three category (iii) services (e.g. in the event of there being a greenfield site Southside Hospital at Cowglen), then there would need to be three orthopaedic in-patient units.

f. There are several **specialties where their future bed numbers will be such as to make their presence on three (or even two) sites in Glasgow non-viable**. The future pattern for these in-patient services is proposed to be as follows:

Specialty	South Glasgow	North Glasgow	
ENT	✔	Gartnavel	LHC seek further consultation
Ophthalmology	✔	Gartnavel	on North
Urology	✔	1 or 2	Further consultation needed in North
Gynaecology	✔	GRI	LHC seek further consultation.
Dermatology	✔ (?)	-	Further consultation needed on proposed single unit for Glasgow, probably in South Glasgow.
Nephrology	?	?	Policy still to be finalised. Will require consultation.
Rheumatology	✔	?	Policy in North still to be finalised. Will require consultation.
Maternity	?	GRI	Consultation on location of Glasgow's second maternity unit still subject to consultation.
Maxillo-facial surgery	✔	-	Already being implemented following 1996 strategy.
Haemato-oncology	✔	Gartnavel	

5. In **integrating this shape of clinical services into a pattern of capital investment**, GGNHSB proposes that:

South Glasgow

a. there should be a **single in-patient hospital** on the Southside of Glasgow (a South Glasgow University Hospital).
b. this will entail **transferring in-patient services from the Victoria Infirmary** to the new South Glasgow University Hospital.

c. its **preferred site** for the South Glasgow University Hospital is the **Southern General** Hospital. The new hospital will be completely new construction, with the exception of:

   - the Institute of Neurosciences (including the new Maxillo-facial and ENT units).
   - the Spinal Injuries Unit.
   - Westmarc.
   - Podiatry Department.
   - the new PFI wards for the elderly.
   - the maternity unit (subject to consultation).

d. **in recognition of widespread public preference for a greenfield site option** (Cowglen is the only available suitable site), the **option appraisal element of the Outline Business Case** should compare the Southern General, Cowglen and do nothing options – with the option appraisal process being overseen by a reference group composed of representatives from the Trust management, Medical Staff Association, GGNHSB, Primary Care Trust, the South Glasgow Trust Partnership Forum, Local Health Council and three MSPs (one from a South-east Glasgow constituency, one from a South-west Glasgow constituency and one chosen by Glasgow List MSPs).
e. in the event that the Southern General is confirmed as the preferred site at Outline Business Case stage, an **Ambulatory Care Centre should be provided at the Victoria Infirmary site, together with approximately 120 rehabilitation beds**, replacing the **Mansionhouse Unit**, which would close.
f. **in the event that the Southern General was not confirmed as the preferred site** at Outline Business Case stage, then **in due course it would close** when replaced by the new build hospital. In this event the **Victoria Infirmary would also close**, with no facilities remaining on site.

West Glasgow

g. an **Outline Business Case** be developed for capital investment at **Gartnavel** to include:

(i) the concentration of **medical and surgical receiving** services for West Glasgow.

(ii) creation of **Ambulatory Care** facilities.

(iii) creation of **Emergency Receiving Unit** facilities enabling Gartnavel to deal with medical and surgical emergency referrals from GPs, minor injuries services and patients with initially indeterminant symptoms. Further detailed planning will examine what arrangements should be made to deal with the resuscitation and emergency stabilisation of patients who arrive with cardiovascular or other acute system failure. Provision for patients with multiple injuries requiring a prompt trauma response is not proposed unless the South Glasgow option appraisal produces a conclusion which does not support the Southern General as the preferred option.

(iv) creation of **ITU and High Dependency Nursing Unit**.

(v) the single North Glasgow in-patient centre for **ophthalmology and ENT**.

(vi) the **Beatson Oncology Centre** (including haemato-oncology).

(vii) the single Regional **Cardiothoracic Centre**.

(viii) **laboratory** facilities.

(ix) **car parking** provision.

h. On completion of the necessary alternative facilities, the **Western Infirmary should close** (in accordance with the 1996 approval by the then Secretary of State). GGNHSB wishes the Trust to give early priority to any interim steps that can be taken to secure the early integration of acute medical and surgical receiving at Gartnavel prior to completion of the full capital investment programme at Gartnavel.

North and East Glasgow

i. the work to complete a Full Business Case for an **Ambulatory Care Centre at Stobhill** should continue.
j. a **Planning Group be established** to develop an **Outline Business Case** for further capital investment to provide a sustainable in-patient service configuration for north and east Glasgow. This Planning Group will undertake an **option appraisal** around the respective **roles of GRI and Stobhill** within the context of service policy decisions made for other parts of Glasgow (e.g. the role and service complement of Gartnavel, the closure of the Western Infirmary, the probability of some A & E flows from parts of South-East Glasgow). There will be a wider reference group drawn from community representatives served by the GRI and Stobhill which can interrogate and influence the option appraisal and the clinical and other issues associated with it.
k. GGNHSB's commitment to there being **formal public consultation** on how medical and surgical receiving services in north and east Glasgow can be satisfactorily and viably provided will be met by using the product of the Option Appraisal element of the Outline Business Case as the vehicle for formal consultation.

6. In the case of **child and maternal health** GGNHSB proposes to establish an inclusive and transparent process to examine options, reaching some initial conclusions by March, 2001. This will allow a period of consultation between April and August, 2001. In total the issue would have been explored transparently in the public domain for nearly 8 months.
7. The development of Outline Business Cases for South Glasgow, Gartnavel and north and east Glasgow will be informed by **parallel work in some areas of detailed planning**:

    a. **bed numbers**: a Steering Group comprising representatives from the two acute Trusts, the medical advisory machinery, GGNHSB, the Local

Health Council and ISD will aim to produce a report to GGNHSB for 17th April, 2001.

b. **A & E Services**: the physical capacity, support services, in-patient service back-up, clinical policies and public information details for the five different service elements need to be reflected in the Outline Business Cases. This work will be overseen by a Glasgow A & E Services Planning Steering Group comprising Health Board and Trust senior managers, representatives of the A & E Consultants, GPs and other clinical groups affected by the services.

8. The three major Outline Business Cases will provide the springboard for significant capital investment which will come on stream from the middle of the decade onwards. In the **interim period** there are **several specific transfers of in-patient services** which GGNHSB would wish to see take place. Details were given in the September, 2000 paper:

    a. **Southside** – a number of changes aimed to improve patient care in specific services and to improve the capacity of both the Victoria Infirmary and Southern General to manage the pressures of medical and surgical receiving in the years prior to the building of the new Southside Hospital:

        - centralise in-patient **gynaecology** from Victoria and Gartnavel to Southern General in 2001.
        - centralise Southside **haemato-oncology** at the Victoria Infirmary in 2001.
        - centralise Southside in-patient **breast surgery** at the Victoria Infirmary in 2001.
        - centralise Southside in-patient **vascular surgery** at Southern General in 2001.

GGNHSB now regards these changes as urgent in order to relieve pressures without unnecessary delay. It is however awaiting a Local Health Council response on these specific proposals – which were set out in detail in the September, 2000 Board paper.

    b. In **North Glasgow** there are a number of intermediate changes which were specified in the September, 2000 paper and on which the Local Health Council is requesting further information:

        - transfer in-patient **orthopaedics from Stobhill to GRI** in 2001.
        - transfer in-patient **gynaecology from Stobhill to GRI** by or in 2002.
        - transfer in-patient **ENT and ophthalmology from Stobhill to Gartnavel** in 2001\2.
        - transfer in-patient **urology from Stobhill to GRI and Gartnavel** by or in 2003.

GGNHSB will ask the North Glasgow Trust to ascertain precisely what information is deemed sufficient by the Local Health Council and to produce consultation proposals accordingly.

c. There may be **other interim changes** that become either feasible or necessary as part of the process of preparing for the proposed major investment. These will be more clearly understood when the three major Outline Business Cases have been prepared. Examples include:

    - whether there should or should not be an **interim amalgamation of cardiothoracic services at the Western Infirmary** as a prelude to the new facilities at Gartnavel.
    - transfer of in-patient **orthopaedics from Western\Gartnavel to GRI**.

    There will be detailed consultation on these if and when they are substantively identified.

d. A consultation proposal for centralisation of **dermatology** in-patient services will be published shortly.
e. Work on future policy for **nephrology and gynaecological oncology** is still underway and there will be consultation on proposals in due course.

9. In the case of the need to replace the **Dental Hospital and School**, GGNHSB has asked the North Glasgow Trust to suggest an appropriate planning mechanism with an aim to reaching initial conclusions by March, 2001 so that a consultation process can then ensue.
10. GGNHSB confirms that **other strands of work** signalled in the September, 2000 Board paper are in hand and will continue to complement the capital planning processes. These include:

    a. continuing a dialogue with Strathclyde Passenger Transport Executive, bus companies and other interests to secure **improvements in public transport**.
    b. discussion with SIPs, LHCCs and others about strengthening **extended primary care** services in those parts of the Greater Glasgow area most distant from hospital facilities (Clydebank, East End\Easterhouse, Ruthergle, Cambuslang, Castlemilk, Drumchapel and Kirkintilloch).

1. Finally GGNHSB and the Trusts agree that there is a need to strengthen overall **project management capacity** and will be taking steps to:

a. strengthen project management capacity for the Southside, Gartnavel and north-east Glasgow components.
b. put in place a pan-Glasgow financial modelling capacity for this whole programme of acute services development.

c. appoint a pan-Glasgow Project Controller to oversee the whole range of interlocking projects and advise Trusts and GGNHSB accordingly.
d. put in place an overall Steering mechanism that keeps all necessary elements of work under review and ensures good communications with NHS stakeholders, MSPs and the public.
e. secure Scottish Executive approval to move into Outline Business Case stage for South Glasgow, Gartnavel and north-east Glasgow so that the necessary consultancy expertise can be brought to bear in developing the complex Option Appraisals that are needed and the design and financial analyses to underpin them and convert them into robust Outline Business Cases.

18.12.00

ACUTE SERVICES RECONFIGURATION
UPDATE ON IMPLEMENTATION OF NEXT STEPS

Board Meeting Board **Paper No.**
Tuesday, 16th January, 2001
CHIEF EXECUTIVE

RECOMMENDATION: The Board is asked to note progress on implementation of the conclusions reached at the Board meeting on 19th December.

1. A letter setting out the outcome so far of the statutory consultation exercise has been sent to the **Scottish Executive**. It includes a **request for authorisation to proceed to Outline Business Case stage** for three major investment projects on the basis set out in the December Board paper (with the exception of the proposal for an ACAD at the Victoria Infirmary (see paragraph 5 below).

   a) South Glasgow.

   b) West Glasgow.

   c) North and East Glasgow.

2. Discussions have been held with Trust Chief Executives, the Chairman of the Area Medical Committee and other interested parties as a prelude to establishing:

a) the **A & E Services Planning Steering Group**.

b) the Steering Group to address the issue of **bed numbers**.

c) a process for examining options for **child and maternal health** (more detail on this will be reported to the next meeting of the Board).

3. The Local Health Council have produced a matrix of where they perceive information shortfalls in the **interim specialty manoeuvres** proposed in both acute Trusts (copy at Annex A).

In the case of **South Glasgow**, the additional information required is relatively minor and the Trust has been asked to provide it as soon as possible. **It is suggested that a consultation paper be issued as soon as the information is to hand** since there is now considerable urgency if the extra general medicine capacity at the Victoria Infirmary which the manoeuvres will yield is to be available without further delay.

In the case of **North Glasgow**, similar urgency applies in the case of the transfer of **in-patient orthopaedics from Stobhill to GRI** (issues of junior medical staff and deficit recovery) and hence **ophthalmology** (since its 2 beds are located in the same ward used by orthopaedics). Again the Trust has been asked to provide the necessary information and **it is suggested that a consultation paper be issued as soon as possible**. Papers relating to the proposals to transfer in-patient **ENT, urology and gynaecology** from Stobhill will be brought forward for the Board's consideration in due course.

4. Further work has been done on the setting up of the **Reference Group** for the option appraisal element of the Outline Business Case for **South Glasgow**. This is described in Annex B. Further work needs to be done to confirm the precise composition of the public interest element and the Reference Group itself will need to consider how the wider range of interest groups can best be kept in touch with the option appraisal process while it is being undertaken.

5. Attention is also drawn to the final section of Annex B which clarifies the Board's continuing view of the role of a **stand-alone ACAD at the Victoria Infirmary** (see paragraphs 15 to 23 of Annex B).

6. As far as the **option appraisal element of the North and East Glasgow** Outline Business Case is concerned a more complex process needs to be established. There has been some discussion with the North Glasgow Trust Chief Executive about the mechanics of internal service planning in the Trust for this next stage of work. During the next fortnight there will be further thinking about how the Reference Group element of the work might be established.

7. Finally, regarding the **Dental Hospital and School**, the next step is for the Trust to confirm Dental School space requirements with Glasgow University. The Trust Chief Executive is pursuing this issue.

9\1\01

ANNEX B

RECONFIGURATION OF ACUTE HOSPITAL SERVICES

IN SOUTH GLASGOW

REFERENCE GROUP TO OVERSEE OPTION APPRAISAL

INTRODUCTION

1. At the December, 2000 Board meeting it was agreed to endorse the proposition that there should be a single in-patient hospital for South Glasgow, that approval should be sought to proceed to Outline Business Case stage and that a Reference Group should be established to oversee the option appraisal element of the Outline Business Case.

2. This paper suggests broad terms of reference for the Group.

BACKGROUND

3. At its September, 2000 meeting the Board identified 21 factors against which the choice of site for a single in-patient hospital for the Southside should be considered. On the basis of that analysis the Board concluded that the order of preference for site was:

    1. Southern General Hospital site.
    2. Cowglen green-belt site.
    3. Victoria\Queens Park Recreation Ground site.

    The advantage of 1 over 2 was considered to be significant. By contrast option 3 scored extremely poorly against the 21 factors. The Board therefore stated that it regarded the Southern General as the preferred site but it would ensure that the option appraisal element of the Outline Business Case would re-visit the comparison between Southern General and Cowglen in a systematic way so that the soundness of the Board's judgement could be evaluated in a rigorous way. Since September none of the responses to the second phase of consultation has included any considered critique of the Board's dismissal of option 3.

4. At its December, 2000 meeting the Board decided to make the option appraisal element even more transparent, and hence rigorous, by exposing it to the scrutiny of a Reference Group.

MODUS OPERANDI

5. The role of the Reference Group will be to:

- oversee (i.e. observe with unimpeded vision).
- interrogate (i.e. to ask questions).
- report (i.e. to describe for the public the option appraisal element of the Outline Business Case, not simply at the end of the process but during it).

6. This will include overseeing, interrogating and reporting on:

- the selection of the necessary professional advisers\consultants.
- definition of terms of reference for the option appraisal work.
- the criteria used in the option appraisal.
- the programme of investigation and analysis needed to inform the option appraisal.
- evaluation of work in progress during the option appraisal.
- the scoring of options.

7. The intention is that the Reference Group should be able to observe, interrogate and report in a completely open fashion.

8. The Reference Group cannot supplant the responsibility of the South Glasgow Trust in drawing up the Outline Business Case nor of GGNHSB in considering whether to support it. These responsibilities cannot be abdicated, since to do so would undermine the chain of accountability that must run all the way through to completion of the capital project later in the decade.

9. The Reference Group will timetable its work to both anticipate and track the elements. Its meetings will be comprehensively minuted. The Group will be asked to agree how it will communicate with wider interest groups during the process of the option appraisal. It will be encouraged to find some acceptable consensus on how areas of agreement and areas where there may not be a single view on an issue or element are faithfully and accessibly reported into the public domain.

DIFFERENCE FROM NORTH AND EAST GLASGOW REFERENCE GROUP

10. Perhaps unhelpfully the December, 2000 Board paper referred to two quite different mechanisms as 'Reference Groups'. In South Glasgow the in-patient service model is fundamentally agreed – the controversy relates to the question of location, which is amenable to a technical but systematic process of option appraisal. By contrast the task in north and east Glasgow is more discursive. Although GGNHSB and the North Glasgow Trust have expressed their proposed service model with some clarity, there remains fundamental controversy about the necessity, viability and intrinsic balance of the proposed service model. Quite different service model alternatives need to be explored between GGNHSB, the Trust and a whole range of interested parties.This difference in focus determines the difference in proposed mechanisms:

a) in South Glasgow the mechanism aims to achieve a rigorous scrutiny and interrogation of a site option appraisal. A relatively small group is necessary to enable the necessary rigour to be systematically applied (while at the same time its openness and modus operandi will ensure transparency).

b) in North and East Glasgow the iteration between a Project Group and a much wider Reference Group will encourage the widest possible participation in a considered exploration of clinical service models.

MEMBERSHIP

11. Accordingly the membership proposed for the Reference Group was as follows:

Representing the public interest - 4 people

Representing staff interests

South Glasgow Hospitals Medical Staff Association - 2 representatives

South Glasgow Trust Partnership Forum
- 2 representatives

Providing perspectives from the 3 NHS management bodies involved

Trust Chief Executive - 1 person

GGNHSB Chief Executive - 1 person

Primary Care Trust Chief Executive

(or senior colleague) - 1 person

13. The composition combines an even balance of key stakeholder interests while ensuring that the group's size does not detract from its exercise of systematic rigour.

14. The Reference Group would be supported by minute taking and secretariat functions and would be able to access Trust Finance and Estates expertise as required. It is suggested that the Group be convened by a South Glasgow Trust non-executive member (Trustee) who will not only act as its Chair but will provide a communication link to the South Glasgow Trust Board.

AMBULATORY CARE

15. Attention has been drawn to the importance of clarity about the provision – or not – of an Ambulatory Care Centre (ACAD) at the Victoria Infirmary campus.

16. The original proposal of Spring, 2000 envisaged an ACAD (and 120 rehabilitation beds) being provided at the Victoria Infirmary campus regardless of whether Cowglen or the Southern General was the preferred location for the in-patient site.

17. The Health Service Forum – South-East has throughout the consultation period opposed the stand-alone ACAD concept.

18. Throughout the consultation process GGNHSB has consistently maintained the view that an ACAD should be provided at the Victoria Infirmary campus so as to assure local access for as many services as possible.

19. In its final response to consultation the Local Health Council said it "would hope that the Board and the Health Minister would agree to the development of an acute hospital in South Glasgow which is more centrally located than the Southern General and the opportunity would then be taken to provide ambulatory care on that site rather than at the Victoria Infirmary".

20. In the December Board agenda paper the need for the Board to explicitly debate the LHC's important proposition regarding ACAD location was overlooked. Moreover the paper rather too readily took as its presumption that an option that included an Ambulatory Care Centre at Cowglen would entail there being no such facility at the Victoria. Although this is a possible implication of the LHC's suggestion, a re-reading of the LHC paper does not make it clear whether this would be their view if Cowglen were the more centrally located site.

21. For the purposes of clarity we should therefore specify that the option appraisal should look at both of the competing variations within the Cowglen option:

a) All Southside in-patient, A & E and Ambulatory Care services at Cowglen with no services at all at either the Victoria or Southern General sites (other than continued use of the PFI scheme for the elderly currently under construction at the Southern General).

b) All Southside in-patient and A & E services at Cowglen with limited Ambulatory Care services at Cowglen for South-west Glasgow residents, plus a comprehensive ACAD (out-patient clinics, out-patient rehabilitation services, diagnostics, day surgery and minor injuries service) at the Victoria Infirmary campus (the original GGNHSB variant).

22. These two Cowglen variant options would be compared with the Southern General option (all in-patient and A & E services plus local South-west ambulatory care services at SGH, plus a comprehensive ACAD at the Victoria as in (b) above).

23. As required by NHS capital planning procedures all these options would be compared with the benchmark "do nothing" option.

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Issue 3

March/April 2001

GREATER GLASGOW HEALTH BOARD

GREATER GLASGOW HEALTH BOARD IN PARTNERSHIP WITH THE NHS TRUSTS IN GLASGOW

Modernising Glasgow's Acute Hospital Services

Progress so far.....

In March 2001, Greater Glasgow Health Board received confirmation that the Scottish Executive endorsed the first stage of the proposals to modernise Glasgow's Hospital services. Following extensive consultation last year, we reached agreement on some issues which, subject to Scottish Executive approval, could be taken forward to the next stages in the process.

Much has happened since we first consulted on the proposals and this newsletter updates the overall position of the modernisation programme. It also outlines the work in progress to bring about the much > needed improvements to Glasgow's hospitals.

Throughout the process the Health Board has encouraged informed discussion and debate and we aim to continue that dialogue, as the details of the proposals are worked through. To secure Executive support for the funding of the overall project, we need to take forward each component in tandem.

There are to be groups looking at services in the North, the South and Child and Maternal Health as well as specialist groups focussing on bed numbers and Accident and Emergency services.

In the South of the City.....

The debate on improving services has been taking place for some time and the consensus of opinion supports one in-patient hospital in South Glasgow. The issue is around where that hospital should be placed. In December we agreed to look in detail at the site options and carry out a thorough investigation, in public, of the merits of each site. The Scottish Executive has approved the development of an Outline Business Case for a single site South of the river. Now the detailed work can commence to evaluate the sites being considered. The sites are – an acute hospital at Cowglen; a new hospital at Cowglen with an ambulatory care hospital (ACAD) at the Victoria; a new hospital on the Southern General site with an ACAD at the Victoria; and the option of "do minimum" (which is the comparison that all NHS > capital investment proposals have to make in order to get approval).

A group including the public interest will watch over this work and their job will be to oversee, question and inform (the wider community) of the process as it goes through the different stages in considering the best site for the new Southside hospital. The MSPs Janis Hughes, Bill Aitken, Robert Brown and Kenny Gibson have agreed to serve on the group as has the Local Health Council's Brian Beacom.

It is hoped that this work will be completed by Autumn 2001 which will allow the Board to put forward (to the Scottish Executive for approval) an Outline Business Case which is the first step in seeking funding through the Treasury or via the Public Private Partnership.

Background information on the proposals is available by visiting our website at www.show.scot.nhs.uk/gghb

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In the North of the City.....

Firm proposals in the North on what services should be developed where are not as advanced as they are in the South and much work still needs to be done. At the moment there are four options people have suggested should be explored further. They include:- all in-patients at the Royal with an ambulatory care hospital at Stobhill; close the Royal and redevelop Stobhill as a district general hospital; provide specialist services at the Royal with a district general hospital Stobhill; and the "do minimum" comparison.

Similarly a group with representation of the public interest will need to be formed to oversee the option appraisal process and ensure that the wider community are informed and involved in the issues. This group will also include MSPs and community representatives, Peter Hamilton of the Local Health Council has agreed to serve on the group.

Regardless of what option becomes the preferred option, there will need to be significant redesigning of services in the North and East to meet the future demand. The future site for the Dental Hospital will also require further discussion and consultation. It is hoped that conclusions can be reached by Autumn 2001.

Child and Maternal Health.....

The number of births is continuing to drop in Glasgow. We cannot sustain the three maternity units we have, we only need two. The issue is around which sites. The new maternity unit at the Royal to replace Rottenrow is due to open later this year. The others currently are Yorkhill and a unit at the Southern.

At the same time Yorkhill Trust have come up with proposals to invest £60 million in new facilities on their site. For a proposal of that size we need to undertake an option appraisal to see whether it is best to redevelop the present site or to locate children's services in a new Children's Hospital on the same site as an adult hospital. This would need to take into account what is in the best interests of mothers and children.

We expect to make an announcement soon on how this option appraisal can be done in an open and participative way.

Accident & Emergency.....

The A&E group has been set up to consider the physical capacity, support services, in-patient service back-up, clinical priorities and public information which will feed into the planning process for the Outline Business Cases in the North and South.

The group includes representatives from the Health Board, Trusts, A&E Consultants, and GPs and other clinical services. Its first task is to agree the collection of data needed to inform the next detailed stages of planning. Arrangements to design the necessary survey work is in hand.

The Beds issue.....

Assessing the bed numbers needed in five or more years time to deliver an improved service is very difficult. Both clinical practice and patients' needs change in that timescale. We need to take account of a range of anticipated factors as we try to calculate future demand.

A group has been set up to examine the bed occupancy rates, health and treatment trends and developments and implications of service re-design. Similarly, this work will feed into the overall plans as we move towards Outline Business Cases for the North and South Trusts in Glasgow.

What happens now?.....

We will continue to update the progress at our monthly public meetings. The Health Board meets in public at 10.00am on the third Tuesday of each month. (except July – fourth Tuesday)

The timescale we have to work towards is Autumn 2001. All the pieces of the planning jigsaw need to be completed to feed into the Outline Business Case proposals. This will ensure that the Scottish Executive are in the position to consider the package as a whole.

This is a very challenging timescale but we aim to carry out the preparation work open to public gaze, with an informed debate of all the issues. These improvements have been long awaited and we want to involve the public fully in considering the issues affecting the NHS in Glasgow.

modernising Glasgow's Acute Hospital Services

Return to Acute Services Main Index

South Side Reference Group
Minutes of the Inaugural meeting

held at 2.30 p.m. on Monday 23 April 2001
in Board rooms A & B Greater Glasgow NHS Board.

Present:

Mr G Craig	Trustee, South Glasgow Trust (Chair)
Mr B Aitken	MSP, Scottish Parliament
Mr J Anderson	Medical Staff Association South Glasgow Trust (SGH site)
Ms M Barrie	Staff Partnership Forum Rep South Glasgow Trust(SGH site)
Mr R Brown	MSP, Scottish Parliament
Mr R Calderwood	Chief Executive, South Glasgow Trust
Mr T Findlay	Divisional General Manager, Glasgow Primary care Trust
Mr K Gibson	MSP, Scottish Parliament
Ms J Hughes	MSP, Scottish Parliament
Ms P McNally	Staff Partnership Forum Rep South Glasgow Trust (VI site)
Mr D Ritchie	Medical Staff Association South Glasgow Trust (VI site)
Mr C Spry	Chief Executive, Greater Glasgow NHS Board
Ms M Macleod	Corporate Affairs Manager, South Glasgow Trust (secretariat)

Apologies:

Mr B Beacom MBE	Glasgow Local Health Council

1 WELCOME & INTRODUCTIONS

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Mr Craig welcomed Members to the first meeting of the South Side Reference Group. Introductions were made. He then invited Mr Spry to speak to Members about the context in which the group had been set up.

Mr Spry reported that discussions about the Review of Glasgow's Acute Services had commenced about 1½ years previously, there had followed in-depth discussions within the service and two phases of public consultation, out of which it was now agreed that there was a need for a single inpatient hospital on the south side of Glasgow. He reminded Members that the Health Board at its meeting on 19 September 2000 had concluded that there was a strong consensus of support that there should be a single inpatient hospital on the south side of Glasgow . Site options at the Victoria Infirmary (current site and adjoining recreation ground), Cowglen (two potential sites which might be available), and the redevelopment of the Southern General Hospital site, had been systematically reviewed.

The preferred option of the Health Board had been the Southern General site with the location of an Ambulatory Care Centre, and rehabilitation beds for the elderly, at the Victoria Infirmary.

Mr Spry reminded Members of the three strategic aims endorsed at the September 2000 Health Board meeting:

A. more equality of services across north and south Glasgow
B. the co-location of acute mental illness services on the same site as general acute services
C. the possible re-location of children's hospital services, and the associated issue of moving from three maternity delivery units to two

Following the outcome of the second phase of public consultation, the Health Board at its meeting on 19 December 2000, agreed that although new analysis of the options had been proffered, it had to be recognised that the public was of the opinion that the possibility of another more centrally site in the south of Glasgow should be explored. Faced with this opinion the Health Board undertook to ensure that the option appraisal element of the Outline Business Case (OBC), that now needed to be prepared, should be vigorous and transparent, compare the Southern General option with the Cowglen option and, as a comparator, the status quo

2 TERMS OF REFERENCE

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Mr Craig invited Mr Spry to indicate the Terms of Reference for the South Side Reference Group. Mr Spry suggested that the Terms of Reference for the Group should be:

1. To oversee the preparation of the Outline Business Case for submission to the Health Board by October 2001
2. In particular to oversee the Option Appraisal process based on the three options: the status quo; the redevelopment of the Southern General Hospital; a new hospital at Cowglen.

In essence, the crucial role of the Reference group was to monitor the bona fides of the next stages of the planning/option appraisal process, so that the interested public could be assured that it was truly vigorous, unbiased and transparent.

The Group agreed with the Terms of Reference.

With regard to the process for the Option Appraisal exercise, Mr Spry reported that this would culminate in an open and inclusive workshop with public involvement. He suggested that the Local Health Council might be contacted to nominate members of the public who could usefully participate in this process. The Group agreed that this way forward would help to demonstrate the qualities of openness and lack of bias the process demanded.

Mr Craig advised that there were four elements within the Option Appraisal for the OBC:

A) The Benefits Appraisal

The identification of the non-financial benefits, an indication of when they were expected to occur, and quantification. These should, in an option appraisal, be compared with a set of desired service benefits which had previously weighted in terms of their degree of desirability compared with another. On a subsequent occasion each option would then be scored against these weighted benefits to see which option scored the best.

B) The Financial Appraisal

Identification and assessment of capital and revenue costs associated with shortlisted options over the life span of the scheme. This would include how much the Health Board was prepared to spend on the services in the proposed scheme and the financial impact on the Trust's balance sheet.

C) Economic Appraisal

The presentation of capital and revenue costs, excluding VAT and capital charges. This would include the identification and high level assessment of risks and uncertainties associated with the shortlisted options. It would result in the options being weighed in terms of their Net Present Values relative to the lifetime of the scheme.

D) Risks and Uncertainty Appraisal

A full description of the risks associated with the leading options and how those risks could (or could not) be managed.

3 CURRENT POSITION

. Mr Craig invited Mr Spry to give an update on any recent developments on the Strategy. Mr Spry reported that the Scottish Executive approval to proceed to Outline Business Case had not been received until March. In the meantime, work was underway on the whole-Glasgow issues concerning:

§ Bed numbers
§ Clinical service models for the range of services provided under the umbrella heading of "A&E"

It was also anticipated that the work to explore Child Health and Maternity issues (very relevant to the Southside) was due to get underway with a "Reference Group-type" workshop on 31 May 2001.

In addition to the development of definitions and weightings for non-financial benefits, there were two other requirements on a pan-Glasgow Basis

§ The appointment of independent Financial Advisers
§ The appointment of transport and traffic advisers

Mr Calderwood reported that the South Glasgow Trust had commissioned James Barr & Son, Chartered Surveyors, to do some work on issues relating to land, and in particular:

§ To conclude matters with Glasgow City Council on the purchase of the land adjacent to Grange Road (to develop the ACAD at the VI)
§ To approach the owners of the land surrounding Cowglen Hospital including the savings bank and the Retail Property Holdings regarding disposal/purchase/timescale/costs

He also advised that the Trust had requested its lawyers to look into the legalities of developing the greenbelt site at Cowglen.

Mr Calderwood informed Members that the Trust had instructed Boswell Mitchell & Johnston, Architects to obtain definitive responses to planning permission in respect of :

a. the development of an ACAD at the Victoria Infirmary
b. the redevelopment of the Southern General site
c. the redevelopment of Cowglen

Mr Aitken asked if the Council had been approached. Mr Calderwood responded that the Trust had written on 15 December 2000 to the planning department but there had been no formal response.

Mr Brown sought clarification on the likely restrictions on developing a site at Cowglen. Mr Calderwood advised that it was understood that there were four owners of land surrounding Cowglen: the Savings bank; Greater Pollock Trust; Retail Property Holdings; and a farmer. Clearly the willingness of any, or all, of the parties to sell would be a factor to consider. He reported that verbal advice from the Glasgow City Council planners indicated that a greenbelt site (which applied to one of the two sites at Cowglen)could be used to build a hospital if there were no other site options within the area. He pointed out that it would be difficult for the NHS to assert that that was the case.

Mr Aitken asked about the appeals procedure if the Council refused an application to develop a greenbelt site or to redevelop an existing site. Mr Calderwood reported that the right of appeal used to be the Secretary of State and he presumed this power had now transferred to the First Minister of the Scottish Parliament. Mr Brown asked if a Compulsory Purchase Order was a possibility. Mr Calderwood indicated that he would need to obtain legal advice on that issue.

4 PARTNERSHIP UK

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Mr Craig invited Mr Spry to advise on the role that Partnership UK might play. Mr Spry advised that Partnership UK was the successor to the HM Treasury PFI Task Force, and had been set up by the government to assist public sector bodies in the best possible procurement practice in using PFI/PPP. He reported that Partnership UK concentrated on large, complex and risky projects, and aimed to ease the regulatory processes by maintaining close relationships with government departments, the Scottish Executive Finance Department, HM Treasury and Ministers.

Mr Spry reported that Partnership UK would be a partner on the Project Committee and would have the right of veto. This right was intended to ensure adherence to sound procurement strategy. They would receive a percentage payment if the PFI was successfully procured.

Mr Calderwood indicated that the role of Partnership UK, at this stage, was to advise on the level of risk with the proposed scheme. He reported in addition to the role Partnership UK would play, there was still a need for a financial adviser to advise on the pan-Glasgow proposals.

Mr Calderwood further indicated that there was a requirement for a level of design to be available for each of the three options in order that a full option appraisal was possible. He also indicated that ground conditions would need to be assessed for the proposed sites. Mr Calderwood reported that the Trust would be approaching the Health Board and the Scottish Executive on funding for this work.

Mr Brown asked whether it was likely to be one PFI for the whole of Glasgow, or three individual PFIs. Mr Calderwood responded that it was likely that there would be three or more PFIs, although no formal decision had been made.

Mr Brown sought further clarification on how Partnership UK would be paid. Mr Spry reported that they would receive an agreed percentage on delivery of a successful PFI. He advised that he was unsure of the exact details but agreed to obtain this information for the next meeting. (*Post - meeting note*: the percentage is agreed by negotiation prior to finalising Partnership UK involvement. Those negotiations have not yet taken place).

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Mr Calderwood reported that a transport consultant would also need to appointed on a pan-Glasgow basis to measure transport and traffic implications for all the proposed sites.

Mr Calderwood reiterated the professional input required to move forward:

Pan-Glasgow
- *Financial Advisers*
- *Transport Consultants*

South Side
- *Technical advice* – including engineering
- *Architectural advice* – to provide provisional designs for each of the options (ie SGH redevelopment, Cowglen, status quo)
- *Construction accountants*

Mr Calderwood stated that the architects would be excluded from involvement at a later stage.

Mr Craig asked how long it would take to appoint the necessary professionals. Mr Calderwood indicated that representatives from the two acute Trusts and the Health Board had been meeting regularly to look at funding in order that the appointments could be made as quickly as possible following agreement. Mr Calderwood advised that the tenders for the two pan-Glasgow appointments were being prepared and he did not envisage unnecessary delays in any of the appointments. He commented however, that sourcing funding for this advice had still to be agreed.

Mr Craig commented that any delay might impact on the proposed October 2001 date for submission of the OBC to the Health Board. Mr Spry advised that the aim was still to complete the process for autumn 2001 but this could be reviewed at a later stage.

5. THE ORGANISATION OF A SINGLE PROCESS TO DEFINE CRITERIA AND WEIGHTINGS FOR GLASGOW AS A WHOLE

Mr Craig advised that the definition of criteria and process to determine weightings was concerned with the non-financial benefits. Mr Calderwood reported that the Scottish Executive defined non-financial benefits as:

Benefit criterion	Benefit definition
Promote modern clinical practice	§ Enables benefits from changes in practice & technology § Improves quality of care & services § Positively promotes health § Facilitates seamless working between services § Facilitates innovation

Acceptability	§ Good strategic fit § Acceptable to users & improves patients' experience § Facilitates patient choice § Facilitates smooth "patient journey" § Promotes positive image of healthcare
Flexibility	§ Capable of further development § Offers opportunities to respond to changes in service levels § Facilitates changes in clinical practice
Accessibility	§ Addresses inequalities and delivers improved access to services
Practicality	§ Practical and deliverable to required timetable § Improves management of risk § Ease implementation
Attracts, retains and mobilises staff	§ Provides opportunities for improved recruitment, retention and job satisfaction
Sustainability	
Promotes good communications and inter-agency working	
Meets current and projected forecasts of demands	
Improves performance of Trust property	
Positive environmental impact	
Facilitates efficient use of resources	

Mr Craig asked if the weightings exercise would be carried out for the whole of Glasgow. Mr Spry responded that it had been suggested non-financial benefits and their weightings should be standardised for all three sections of the Glasgow Review. This would ensure that all the option appraisals for the OBCs were conducted on the same basis, and therefore less prone to the subjectivity associated with specific localities.

Mr Calderwood agreed to provide a paper for the next meeting of the group on the process for weighting non-financial benefits.

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Mr Craig asked who would conduct process of defining the criteria and weightings. Mr Spry advised that this might include:

§ Public perspective – it had been suggested that the local health council would be approached for appropriate citizens
§ Staff Partnership forum representation
§ Clinicians
§ Local Health Council

Mr Spry advised that the group formed in this way would define their own criteria for weighting through a process of mutual interrogation. He suggested that an external company should be used to facilitate the event and advised that this would require a tendering exercise. Ms Hughes asked if this would delay the process. Mr Calderwood indicated that this should only take 2/3 weeks and suggested a June 2001 date for the workshop. He commented however, that some of the work being done by the A&E Group might assist in the weightings exercise. Ms Hughes asked when this work would be completed. Mr Spry reported that it was anticipated the bulk of the work would be completed by mid-summer 2001. He reported that the work involved:

§ A prospective study of A&E presentations. This would include what elements of A&E services were most in demand in which areas of the city.
§ Sizing of facilities at Glasgow Royal infirmary e.g. which hospital do areas like Rutherglen access: Hairmyres? GRI? Cowglen? SGH?
§ A&E modelling project being conducted at GRI. How are people accessing A&E – self? GPs? Out of Hours services? NHS24?

Mr Spry indicated that whilst a June 2001 workshop would be preferred as neither the West nor the North/East Reference Groups had been convened this might be an ambitious timescale.

Mr Craig posed the following questions and the group responded:

1. Should there be a Pan-Glasgow workshop to define criteria and weight the non-financial benefits?
   THE GROUP
   Agreed this should be done on a pan-Glasgow basis

2. Should there be wider public involvement in that workshop?
   THE GROUP
   Agreed there should be wider public involvement and the Local Health Council should be approached to assist with
   nominations

3. Should the Reference Group be directly involved in the workshop?
   THE GROUP
   Agreed that the Reference Group Members should not be directly involved in the weightings workshop

4. Should Members of the Reference Group be able to oversee the workshop?
   THE GROUP
   Agreed Members could attend to observe if they so wished

6 DATE OF NEXT MEETING

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10.30 a.m. MONDAY 11 JUNE 2001 at Dalian House

Return to Acute Services Main Index

Issue 4
April/May 2001

GREATER GLASGOW HEALTH BOARD

GREATER GLASGOW HEALTH BOARD IN PARTNERSHIP WITH THE NHS TRUSTS IN GLASGOW

Modernising Glasgow's Acute Hospital Services

South Starts Off.....

The Reference Group for South Glasgow hospital services met for the first time on Tuesday 24th April. Group members, including the MSPs Janis Hughes, Bill Aitken, Robert Brown and Kenny Gibson, had a productive meeting. Terms of Reference for the group were agreed and there was also agreement on arrangements for appointing technical consultants, such as architects and transport analysts, to help provide information on which to assess the different site options.

There was discussion (see below) on how to develop benefits criteria for subsequent use in option appraisal workshops. There was support for doing this on a pan-Glasgow basis. This will now be discussed with the North East Glasgow Reference Group. The South Reference Group meets again on Monday 11th June, by which time fresh reports are expected from the A & E and Bed Numbers working groups.

The Options for South Glasgow: A Reminder

- *Cowglen as the site for a new in-patient hospital for the Southside. The Victoria Infirmary has a new Ambulatory Care Hospital (ACAD) but no acute in-patient beds. The Southern General closes*
- *Both the Southern General and the Victoria close and a new general hospital is built at Cowglen*
- *The Southern General as the site for a new build in-patient hospital for the Southside. The Victoria Infirmary has a new Ambulatory Care Hospital (ACAD) but no acute in-patient beds*
- *The 'do minimum' option for comparison (hospitals stay as they are with investment only to keep them open and running)*

Clyde-Wide

Consideration is being given to ways of a setting up a Glasgow-wide event, or series of events, that will allow members of the public to participate in establishing the way in which the benefits of different options for hospital services are later to be compared. The goal is to gain agreement on which sorts of factors should be considered against all options, and how much importance (or 'weighting') should be attached to each different factor. This will allow the various planning and reference groups around the city to sponsor "option appraisal" on a common basis. The South and North East Reference Groups and the Greater Glasgow Health Council will all have an input to the way in which the public involvement arrangements are set up.

Busting the Jargon

"Option Appraisal" - is the process by which possible different locations and combinations of hospital services are compared to each other. This might include a look at land and planning restrictions, operational arrangements, how the use of facilities meets patient care needs, traffic flow and access, cost profiles and risk assessment. The option that provides the best overall advantages against these sorts of factors would achieve the highest 'score'.

"Outline Business Case" - the option which comes out of the appraisal process is worked up into detailed financial and service plans. These go to the Scottish Executive for approval before money is secured and detailed building specifications issued in what is called a 'Final Business Case'.

Yorkhill's Launch Day Revealed

Yorkhill NHS Trust, which manages child and maternal services based at the Royal Hospital for Sick Children and the Queen Mother's Maternity Hospital, has confirmed that the start date for public and patient involvement in the review process will be the Thursday, 31st May. The programme of survey and seminar work will contribute directly to shaping the option appraisal process for the services, which in turn will help to resolve the issues of city-wide over-capacity for maternity services, and the possibility of a new location for the "Sick Kids" hospital contrasted with the alternative of investing more in new buildings at the existing Yorkhill site.

Background information on the proposals is available by visiting our website at www.show.scot.nhs.uk/gghb

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All Points North

Real progress has been made in pulling together a Reference Group to oversee and test the process that will compare the possible future options for Stobhill Hospital and Glasgow Royal Infirmary. The MSPs Paul Martin, Frank McAveety, Pauline McNeill, Patricia Ferguson and Sandra White have agreed to join the group along with Peter Hamilton, who is the Convenor of Greater Glasgow Health Council.
Robert Brown MSP, due to his existing commitments to the South Glasgow Reference Group, will maintain a 'watching brief' and a similar courtesy has been offered to Tommy Sheridan MSP. The involvement of a Scottish Conservative MSP is also likely to be confirmed shortly. It is hoped that the group will be in a position to meet in a matter of weeks.

A petition was recently submitted to the Scottish Parliament's Public Petitions Committee concerning the future of Stobhill Hospital. The Committee has asked the Health Board to respond by outlining the process that will lead through option appraisal to development of an outline business case.
The Board's position has shifted considerably since the original set of proposals for Stobhill and the Glasgow Royal Infirmary of March 2001. Although at no time has closure of Stobhill ever been proposed, the suggestion that its future role be bound up with an new Ambulatory Care Hospital to provide day-care, out-patient and day-surgery services for about 90% of existing patients, with in-patient services for the remainder being provided at the Glasgow Royal Infirmary, has been set along with a number of other options (see panel). The difficulty for the Board and the North Glasgow University Hospitals NHS Trust has been that no overall consensus emerged from the 2000 public consultation, and therefore this why such a wide field of options will have to be explored.
Whatever option emerges from the appraisal process, an Ambulatory Care Hospital will be part of the Stobhill 'package', whether or not as part of a larger hospital complex on the site or working in tandem with services delivered via the Glasgow Royal Infirmary. Permission to develop an outline business case for the Stobhill Ambulatory Care Centre had been granted by the Scottish Executive in 2000, and the latest step in the process was a public meeting to discuss the 'patients journey' through the proposed facility hosted by Maggie Boyle, Chief Executive of the North Glasgow University Hospitals NHS Trust at Stobhill on 2nd May 2001.
GGHB was aiming to submit its formal response to the Public Petitions Committee in time for discussion at its session on 8th May.

The Options for North East Glasgow Hospitals: A Reminder

- *Glasgow Royal Infirmary as the site for all in-patient services for the north and east. Stobhill has an new Ambulatory Care Hospital (ACAD) but no acute in-patient beds*
- *Glasgow Royal Infirmary closes. Stobhill is re-built as the sole hospital for the north and east*
- *Glasgow Royal Infirmary retains a specialist services role. Stobhill is redeveloped as a district general hospital*
- *The 'do minimum' option for comparison*

Chris Spry

GGHB's Chief Executive recently announced that he would be stepping down at the end of September. Despite concerns from some quarters that this would affect the ongoing review of hospital services, Mr Spry provided reassurances, *"The Acute Services Review is a matter of policy for the Health Board and the NHS Trusts as a whole and is not dependent on just one person. The decisions taken in the next few months will shape hospital services for the next decade and I am confident that the reference group, public involvement and management arrangements now coming into place will deliver the best possible decisions. I will still be on the scene for another six months and fully intend to make a full contribution to the most intensive and important stages of option appraisal and the development of outline business cases."*

Upcoming Board Meetings

There are frequent updates on the progress being made on hospital services at GGHB Board meetings. These take place every month in the HQ building, Dalian House, at 350 St Vincent Street, Glasgow and are open to the public. The meetings commence at 10.00 am and are scheduled for 15th May, 19th June, 24th July, 21st August and 18th September.

For further information call Jim Whyteside, Communications Manager on 0141 201 4445 or write care of: GGHB, PO Box 15329, 350 St Vincent Street, Glasgow G3 8YZ

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EMBARGOED UNTIL MEETING

GREATER GLASGOW HEALTH BOARD

Board Meeting
Tuesday, 19th June, 2001

Board
Paper No. 01/69a

CHIEF EXECUTIVE

ACUTE SERVICES

PROGRESS REPORT ON DEVELOPMENT OF OUTLINE BUSINESS CASES

RECOMMENDATION: The Board is asked to note this Progress Report.

BRIEF OVERVIEW

Progress continues to be made on a wide range of work needed to delivery Outline Business Cases by the autumn. This can be summarised as follows:

- The Child and Maternal Health Group met on 31st May, 2001 and will meet again in early August. The first meeting basically set the scene for the later stages of work.

- The Steering Group for Bed Numbers has met and surgeons and physicians are working with the North Glasgow University Hospitals NHS Trust on this issue. A further meeting of the Steering Group will consider the conclusions reached in that work in a few weeks time.

- The Director of Public Health is working on the design of a comprehensive survey of all Accident and Emergency Department workloads in Greater Glasgow, including Stobhill General Hospital and the Royal Hospital for Sick Children. It is envisaged that this survey would be over a two week period and would provide data to assist the detail of service design.

- The South Glasgow Reference Group met on 23rd April, 2001 and again on 11th June. It has agreed its terms of reference, and has had discussions about arrangements for Option Appraisal Workshops, the appointment of technical advisers, and examined a number of planning issues. It will meet again on 2nd July.

- The North-East Reference Group will hold its first meeting on 29th June, 2001.

- A consultation paper on Orthopaedic Services in North-East Glasgow was published on 8th June.

- The Chief Executives of the North and South Glasgow Trusts have mapped the data needed to draw up Outline Business Cases and agreed on arrangements to gather it. Proposals for project management are expected soon.

- A tendering process has commenced to appoint consultants to produce information needed for the transport and accessibility aspects of Outline Business Cases. The appointment of a facilitator for the Option Appraisal Workshops is also about to go out to tender.

- Discussions are continuing with the Board's external auditors, PriceWaterhouseCoopers (PWC), on the level of their involvement in overseeing the development of Outline Business Cases in the various Trusts. Advice has been taken from the Accounts Commission regarding this issue. Mr. Spry will send a copy of the PWC proposal to Professor Dickson in his capacity as Chairman of the Audit Committee.

- A detailed proposal from Partnership UK has been received and discussions are ongoing.

THOUGHTS ON THE CONDUCT OF OPTION APPRAISALS

After the total 9 months of consultation last year, the Scottish Executive has authorised NHS Greater Glasgow to draw up Outline Business Cases as the next step in securing major capital investment to renew Glasgow's old hospital stock.

The process in West Glasgow is relatively straightforward. In South Glasgow there is widespread agreement about the service configuration; there remains controversy about the location of a single in-patient hospital for the Southside. In North East Glasgow there is no agreement yet about the service model.

Here we describe the arrangements for conducting the option appraisal element of the Outline Business Cases for the Southside and North East.

The Conduct of Option Appraisal

The process of formal option appraisal can be summarised as follows:

Initial Briefing Workshop — A

- What option appraisal involves - methodologies and disciplines.
- Understanding the typical balance in UK NHS option appraisals of weightings between
  - service benefits
  - economic factors
  - financial factors
  - risk profile

  and agreement the weightings balance to apply in Glasgow.
- Likely to take half a day.
- Will involve participants of Workshop B and of Workshops C and E.

Service Benefits Weighting Workshop — B

- Define the service benefits criteria.
- Agree a weighting between them.
- Likely to take one whole day.

Workshop to Compare Options Against Service Benefits Criteria — C

- Each option is considered and is scored according to the extent to which it delivers the service benefits previously defined in Workshop B.
- The scores are then adjusted by the weightings agreed in Workshop B.
- Likely to take one whole day.

Technical Desk-Top Assessments of Economic Factors, Financial Factors and Risk Profile — D

- Undertaken by Trust Finance Departments\Advisers.
- Independently validated by Price Waterhouse (GGHB's external auditors). and by Partnerships UK (organisation part-owned by HM Treasury).

Workshop to bring all the elements of Option Appraisal Together — E

- Brings together all the elements developed in C and D.
- Allows results of D to be interrogated and explained.
- Seals the overall scoring in accordance with the agreement reached in Workshop A.
- Likely to take half a day.

Arrangements for Workshop B

It has been suggested that Workshop B should define service benefits criteria and agree the relative weightings between them on a pan-Glasgow basis. There are several reasons why this is sensible:

a) the definitions of access to hospitals (for example difference in travel times) should be the same for all Glaswegians. If, say, public transport travel in 15 minutes or less were "very acceptable", 16 to 25 minutes "fully acceptable", 25 to 45 minutes "acceptable" and so on, that standard should be applied for assessing all hospital choices. It should not be different between Glaswegians living in different parts of Greater Glasgow.

b) the definitions for clinical quality or safety should be standard. Arrangements regarded as "poor" in one part of the city should not be "acceptable" in another.

c) the weightings (relative importance) of different service benefits (such as access, clinical quality etc) should likewise be standardised. It would be odd if clinical quality were regarded as more (or less) important than, say, access in one part of the city and vice versa in another. This is not merely a matter of tidiness - it is conceivable that choices might have to be made, in terms of affordability, timing or phasing between different projects and it is important that any such choice should be capable of being made on a like for like comparison.

To allow this to be done it has been suggested that a single pan-Glasgow Workshop B be organised. Its participants would therefore need to take a bird's eye view of service benefits, liberated from the more localised pressures associated with site preferences (Southside) or service models\site preferences (North East). Those issues will be addressed in two separate versions of Workshop C.

Local Authorities would be involved in Workshop B, together with some representatives of the public identified from Community Councils by the Local Health Council. Members of the North- East and Southside Reference Groups would be welcome to observe Workshop B.

Issue 5

August 2001

GREATER GLASGOW HEALTH BOARD

GREATER GLASGOW HEALTH BOARD IN PARTNERSHIP WITH THE NHS TRUSTS IN GLASGOW

Modernising Glasgow's Acute Hospital Services

First steps north east

The first meeting of the **Reference Group** to oversee the option appraisal process for the **future of hospital services in north east Glasgow** took place on Friday 29th June.

The group, consisting of MSPs, medical, health service managers and local health council representatives (see panel), spent three hours clarifying its remit and discussing the technical processes of option appraisal.

By the end of the meeting, the group, chaired by Peter Hamilton, Convenor of Greater Glasgow Health Council, reached some important conclusions:

- It was felt that one of the service configuration options on the table - namely **the closure of the Glasgow Royal Infirmary**, with concentration of all services at a new hospital built at Stobhill - would not score well in economic terms, nor would it find much support in communities or from clinicians. **It was therefore felt to be wrong to spend time and money pursuing it**
- Since (unlike the Southside) the service model was still unresolved, it was agreed that an option involving new in-patient facilities at Stobhill should be compared with the other options.

Designing **a large workshop to compare the different options** was seen as urgent – it was agreed that **representatives of the public would be invited to join the Reference Group in doing this** and also to advise on the best way of communicating with the general public.

As a result **representatives attended the group's second meeting on 27th July** including Eddie Cuisack of North Glasgow Community Forum, Richard Hunter of Townhead Community Council, Margaret McNaughton, Bishopbriggs Community Council, Helen Scammell of the East End Social Inclusion Partnership and GPs Dr I. Brown of Fernbank Medical Centre and Dr P. Ryan of Glenmill Medical Centre.

At the second meeting **the option appraisal workshop arrangements were discussed** and **it was made clear that all of the options proposed for the north east would lead to a new Ambulatory Care and Diagnostic Centre (ACAD) being built at Stobhill**. The group next meets on 31st August.

Updated Options for NE Glasgow Hospitals

1. Glasgow Royal Infirmary as the in-patient site for the North and East. Stobhill as a walk-in, walk-out same day diagnostic and treatment centre (ACAD) with minor injuries service.
2. Glasgow Royal Infirmary as a specialist hospital and new build at Stobhill as a "district general hospital" for north and east Glasgow with integrated ambulatory services
3. Stobhill as a local hospital providing general medicine and general surgery services with an ACAD, including a 'casualty' service
4. The "do minimum" option (The status quo but with money spent only on remedying essential backlog maintenance problems)

Those invited to the inaugural meeting of the North East Reference Group included:

Peter Hamilton, Convenor of Greater Glasgow Health Council (who chaired the meeting)
Bill May, Greater Glasgow Health Council
Paul Martin MSP
Pauline McNeill MSP
Sandra White MSP
Frank McAveety MSP
Patricia Ferguson MSP
Brian Fitzpatrick MSP
(the MSPs Bill Aitken and Robert Brown also maintain a 'watching brief')
Dr Brendan Devine, Glasgow Royal Infirmary Medical Staff Association
Dr Frank Dunn, Stobhill Hospital Medical Staff Association
Bill Gouldie, Partnership Forum, North Glasgow University Hospitals NHS Trust
Chris Spry, Chief Executive, Greater Glasgow Health Board
Maggie Boyle, Chief Executive, North Glasgow University Hospitals NHS Trust

Sleeves rolled up on the Southside

The **Southside Reference Group** (see panels overleaf for membership) met for the third time on 2nd July. Like the North East Reference Group, they discussed the appointment of external advisors, such as traffic consultants, and **public representation on the option appraisal workshops** (see 'As Easy as A B C' on page 3).

Also discussed were **land issues**, such as planning regulations as they apply to the two main sites in question. As **a new Ambulatory Care and Diagnostic Centre** *(continued on page 2)*

Background information on the proposals and the minutes of the Reference Groups are available by visiting our website at www.show.scot.nhs.uk/gghb

(continued from front page)

or **ACAD will be built at the Victoria Infirmary irrespective of the new in-patient hospital going to either Cowglen or the site of the Southern General,** some time was also devoted to Glasgow City Council's title to the former school at Grange Road and a portion of the Queens Park Recreation Grounds adjacent to it.

The Group meets again on Monday 27th August.

Members of the Southside Reference Group:

Gordon Craig, Trustee, South Glasgow University Hospitals NHS Trust (Chair)
Bill Aitken MSP
Mr J Anderson, Medical Staff Association, Southern General
M Barrie, Staff Partnership Forum Representative (Southern General)
Brian Beacom MBE, Greater Glasgow Health Council
Robert Brown MSP
Robert Calderwood, Chief Executive, South Glasgow Trust
Terry Findlay, Greater Glasgow Primary Care Trust
Kenny Gibson MSP
Janis Hughes MSP
P McNally, Staff Partnership Forum Representative, Victoria Infirmary
Dr R Sharp, Medical Staff Association, Victoria Infirmary
Chris Spry, Chief Executive, Greater Glasgow Health Board

The Options for South Glasgow Hospitals

1. Cowglen as the site for a new in-patient hospital – the Victoria Infirmary has a new Ambulatory Care and Diagnostic Centre (ACAD) but no in-patient beds. The Southern General closes
2. The Southern General becomes the site for a new-build in-patient hospital and the Victoria Infirmary becomes the site for a new ACAD
3. The "do minimum" option (The status quo but with money spent only on remedying essential backlog maintenance problems)

Yorkhill off and running

Background

Although the majority of proposals outlined in the Acute Hospital Services Review related to adult hospital services, the Review also included an idea about relocating Yorkhill to an adult hospital site on the South-side of Glasgow. In February 2001, after considering the findings of a three month period of public consultation, an independent site evaluation of redevelopment opportunities on the existing Yorkhill site and an evaluation of the South-side option - GGHB decided that wider analysis, which took into account all the options for the future of Yorkhill, was required.

It was therefore agreed that an **Option Appraisal** for Yorkhill should be carried out which would look at the future location of **both child and maternal services** within the city. Maternity services were previously the subject of a separate review that recommended that the number of units should be reduced from three to two to reflect the falling birth rate. One of the two units will be the new Princess Royal Maternity Hospital and the other will be either The Queen Mother's Hospital at Yorkhill or the maternity unit at the Southern General.

An Overview of the Option Appraisal Process

The appraisal process, which started in June 2001, is co-ordinated by a Steering Group which has membership from a wide range of interested parties and is directed by Pat Kilpatrick, an independent facilitator who is employed by a NHS Trust outwith Greater Glasgow. Members include public representatives from the Yorkhill Patient/Public Forum, staff representatives from the Yorkhill and Glasgow-wide Partnership Forums, Greater Glasgow Health Council, Glasgow University, the local MSP and clinical and managerial representatives from Greater Glasgow Health Board and the Yorkhill, South and North Glasgow NHS Trusts. A **Yorkhill Futures Group**, comprising of volunteer representatives from the Public/Patient Forum, has been created to increase public/patient representation during the Option Appraisal process.

Stakeholder Involvement

During the Option Appraisal Yorkhill NHS Trust will actively seek the views of staff, parents, patient support groups, NHS colleagues and other organisations who have an interest in the future of Yorkhill. All comments will then be fed back to the Option Appraisal Steering Group who will take them into account during the option appraisal process.

Timetable

The Steering Group will hold 4 meetings up to October 2001 to identify all possible options, agree the criteria against which they will be judged and recommend the preferred option for the future. This will be followed by a 3 month period of public consultation to consider the recommendation before a final decision on the future location of Yorkhill will be made by the Scottish Health Minister.

Anyone wanting to find out more about the Yorkhill Option Appraisal Process can contact **Linda Fleming, Head of Corporate Planning, Yorkhill NHS Trust, Royal Hospital for Sick Children, Dalnair Street, Glasgow G3 8SJ. Tel 0141 201 0034.**

Way out west

Back in 1996, the then Secretary of State for Scotland **sanctioned the closure of the Western Infirmary**. What prompted this decision was the fact that services for west Glasgow were split inefficiently between Gartnavel General and the Western, with clinical staff wasting time that could otherwise be spent on patients travelling between the sites several times in the course of one day, as well as patients having to shuffle between the two sites.

Gartnavel is therefore to be the site for a new west Glasgow hospital, fully integrated and with modern equipment. Consultation with the public, patients groups and clinical staff suggested that this was an acceptable solution to providing local services, which cover west Glasgow and Clydebank for general hospital services. Therefore a project team is the process of coming together in order to draw up an 'Outline Business Case' to set out the changes and investment needed. *(continued on page 3)*

(continued from page 2)
medical and surgical representatives are already on board the project group and other staff and patient representatives will be recruited shortly. Early work will focus on a new multi-storey car park at Gartnavel and laboratory services.

As easy as A B C

Whatever else it is, option appraisal is not easy, although everyone concerned is trying to put together the most logical and straightforward process possible. **Basically, what must happen is that the different options for Yorkhill, NE Glasgow and the Southside must in each case be compared to one another to confirm which offers the best overall 'package' of patient and clinical benefit with long-term sustainability and meeting financial and economic tests which the public sector must observe.** Yorkhill is working hard with various stakeholders to find a way forward (see 'Yorkhill Off and Running' on page 2) regarding child and maternal services, and **in the case of the adult acute hospitals, the Greater Glasgow Health Council and the Southside Reference Group have been helping GGHB map out a practical, clearly staged way of making the process work.**

This is how the process sketched out so far would run:

The **Reference Groups** (NE Glasgow and Southside) **don't actually make the decisions** on the most appropriate options – what they do is oversee the option appraisal process and make sure that it is valid, fair and consistent. The Groups also help to engage public representatives in decision-making.

- **Stage A**

The first workshop will be held with the purpose of **marking out exactly the benefits and standards that each option must be measured against.** For example: when clinicians talk about 'improved patient experience', what exactly does that mean and how is it measured? Another example: what is 'acceptable' travel distance by public transport to any particular hospital site? – 10, 20 or 30 minutes – or more?

Once key definitions have been provided, **the next task is to then decide how important each type of benefit is relative to the others** – for example: again, 'improved patient experience' as defined by clinical staff – is that more or less important than transport time, and if so by what level?

At the end of what is going to be a very systematic and thorough discussion, the workshop should have arrived at a series of **'weightings'**, which are later applied to the 'score' generated for each benefit criterion in later workshops. The weightings reflect the relative priority or importance attached to the benefits.

Both the definitions of **benefits and the weightings attached to them have to be the same across Greater Glasgow** (A benefit relating to clinical quality, for example, cannot be less important in south Glasgow than it is in north east Glasgow).

This rather technical workshop will take at least a full day and local authorities and members of the Local Health Council are likely to represent the public interest.

- **Stage B**

This is a **briefing session for all the people who will be involved in scoring the different options** for the future of hospital services in different parts of the City, **including the public and community representatives involved in Stages C and E.** They will have the chance to see how the process of option appraisal fits together, to understand how similar processes in other parts of the UK have worked and to run through the results of the workshop at Stage A. This will take at least one day.

- **Stage C**

At this stage new workshops are run to **concentrate on the specific options in south Glasgow and north east Glasgow.** The Reference Groups are involved in designing these events and ensuring that **people and groups representing patients, the public and communities will have a chance to take part** (see 'First Steps North East' and 'Sleeves Rolled Up on Southside' on the cover).

The pan-Glasgow benefits and weightings defined at Workshop B are now applied to the local options and 'scores' allocated by people at the workshop. Each workshop will take at least one day.

- **Stage D**

This doesn't stream from a single workshop or meeting as such, but **represents the work of acute hospital trust finance departments and other advisers, such as transport analysts, in pulling together 'desk top assessments'** of the economic and financial factors required to make each option possible. To make sure that the information provided is fair and accurate, GGHB's external auditors, Price Waterhouse Coopers, will examine it. A similar role will be taken by Partnerships UK, the former HM Treasury PFI panel, which has amassed considerable experience in assembling successful Public Finance Initiative (PFI) and Public-Private Public Partnership (PPP) packages, such as that for Glasgow City's new secondary schools.

- **Stage E**

The **final workshop brings the whole process, and all the people involved, together one last time.** All the different elements, decisions and findings at each stage of the process are assembled to provide final scores against each of the options being considered, based on the conventions and arrangements signed up to back at Workshop A.

From this, there should be one option each in south Glasgow and north east Glasgow which provides the best range of 'scores' across all the different factors assessed.

From **start to finish, from A to E, the option appraisal process will probably take about three months to complete.** If Workshop A took place in early September, for example, the results would be clear by December. The final options become 'outline business cases' sent to the Scottish Executive. If approved, then tendering of contracts can begin and the way is open to the serious building work taking place between 2005 and 2010 with new services starting up throughout that period.

Jargon-busting

In the course regenerating Glasgow's hospitals more than a few technical terms and names will crop up frequently. Here's an explanation of some of them:

ACAD – Ambulatory Care and Diagnostic Centre or Ambulatory Care Hospital

No matter the outcome of the acute hospitals review regarding in-patient services, an ACAD is to be built at the site of the Victoria Infirmary and one is in the advanced stages of planning for construction at Stobhill Hospital.
An ACAD provides hospital treatment for those patients capable of walking in or walking out on the same day. The reality in 2001 is that this is already true of 85 – 90% of NHS patients at Greater Glasgow's existing hospitals – only a minority of patients in the NHS actually need an in-patient bed.
New technology and treatment methods mean that more and more people can be seen as an out-patient, or as a day case or be given day surgery without the need for a protracted stay in hospital. For example, it is not that long ago that removal of a cataract might have meant a couple of nights in a hospital bed – now it is routine enough a procedure to be taken care of in a couple of hours.
ACADs are common in the US, and similar facilities have begun to appear in other parts of the UK .
The kind of model being looked at in Glasgow could provide a Minor Injuries Service (lumps, bumps and sprains) plus out-patient and day case consultations, as well as a wide range of minor surgical procedures.
Recovery beds would be provided so that patients could recuperate from the effects of anaesthetics and receive proper pain control, but as with current day surgery services, well-organised patient selection procedures should mean very few people ever have to be admitted for longer than 23 hours.
Therefore, whatever the outcome of the wider option appraisal, **85 – 90% of patients at the Victoria and Stobhill can be guaranteed to be treated at these sites indefinitely, in brand new purpose-built buildings.**

Option Appraisal

The process by which different possible locations and combinations of hospital services are compared to each other. This might include a look at land and planning restrictions, operational arrangements, how the new facilities would meet patient care needs and predicted trends in patients types and numbers, as well as traffic flow and access, cost and risk assessment. The option that is judged to have the best levels of advantage across a range of factors (or criteria) like these picks up the highest 'scores' through the process of option appraisal.

Outline Business Case

The option which comes out of the option appraisal—for example, to build hospital X at site Y—still has to be worked up as a proposal on paper which sets out financial and service plans. This goes to the Scottish Executive for approval before money can then be secured to start building. There needs to be one more stage—a 'Final Business Case'—which allows fully detailed specifications to be put together.

Partnerships UK or 'PUK'

Partnerships UK used to be the Government's PFI (Public Finance Initiative) Panel but was later privatised, with 49% of ownership remaining with the UK Government and the Scottish Executive. The company is expert in the field of pulling together financial packages, with the bulk of the money coming from the private sector, to pay for large scale public projects. An example of this is the redevelopment of schools in Glasgow City.
PUK will help the NHS source the over £500 million needed to transform Glasgow's hospitals. Their role is mainly linked to the procurement of finance to build the new facilities.

NHS Greater Glasgow

At the end of September, Greater Glasgow Health Board ceases to exist when a new 'unified' Board responsible for the functions of GGHB and overseeing the NHS Trusts is launched. NHS Greater Glasgow will have Board members drawn from local authorities as well as clinical professional bodies and trade unions. The Trusts will no longer have separate Boards of Trustees. The Chief Executive of NHS Greater Glasgow will be Tom Divers (currently Chief Executive of Lanarkshire Health Board) and the Chair, until July 2002, will be Professor David Hamblen, GGHB's current Chair. The process established for the review of acute hospital services will carry on as planned.

Upcoming Board meetings

There are frequent updates on the progress being made on hospital services at GGHB (and later NHS Greater Glasgow) Board meetings. These normally take place once a month in the GGHB headquarters building, Dalian House, 350 St Vincent Street, Glasgow and are open to members of the public to attend. The meetings commence at 10.00 am and the next ones are scheduled for 21st August (to be held in the Mitchell Library) and 18th September 2001. The NHS Greater Glasgow dates will be announced soon.

For further information call Jim Whyteside, Communications Manager on 0141 201 4445, e-mail via [redacted] or write care of Greater Glasgow Health Board, PO Box 15329, 350 St Vincent Street, Glasgow, G3 8YZ.

RECONFIGURATION OF ACUTE HOSPITAL SERVICES

As of 14th March 2001 Greater Glasgow NHS Board was granted approval by the Scottish Executive to take the acute hospital services review to the next level; the development of 'Outline Business Cases'.

The Scottish Executive now anticipates that GGNHSB will implement the measures outlined in the Board papers of December 2000 and January and February 2001 (which see) and proceed to Outline Business Cases for South, West and North East Glasgow by the autumn of 2001. In respect of South and NE Glasgow this will include an 'Option Appraisal Process' that will test the merits and demerits of different sites and service combinations against the others. This process is to be overseen and interrogated by Reference Groups which will include local health council, MSP and community representation.

In his letter, Trevor Jones of the Scottish Executive states that, "I would stress the importance of continuing with the option appraisal work already underway on service configuration in the North and South of the City. The Executive regards it as particularly important that the Health Board continues to take an inclusive approach to decision-making in consultation with the major stakeholders, including the public."

Progress is now being made in assembling Reference Groups and further details will be announced shortly.

March 2001

MODERNISING GLASGOW'S ACUTE HOSPITALS

SOUTH SIDE REFERENCE GROUP

Minute of the second meeting of

the South Side Reference Group

held at 10.30 a.m. on Monday 11 June 2001

in Board rooms A & B Greater Glasgow NHS Board.

Present:

Mr G Craig	**Trustee, South Glasgow Trust (Chair)**
Ms M Barrie	**Staff Partnership Forum Rep South Glasgow Trust(SGH site)**
Mr B Beacom MBE	**Greater Glasgow Health Council**
Mr R Calderwood	**Chief Executive, South Glasgow Trust**
Mr T Findlay	**Divisional General Manager, Glasgow Primary care Trust**
Mr K Gibson	**MSP, Scottish Parliament**
Ms J Hughes	**MSP, Scottish Parliament**
Ms P McNally	**Staff Partnership Forum Rep South Glasgow Trust (VI site)**
Dr R Sharp	**Medical Staff Association South Glasgow Trust (VI site)**
Mr C Spry	**Chief Executive, Greater Glasgow NHS Board**
Ms M Macleod	**Corporate Affairs Manager, South Glasgow Trust (secretariat)**

Apologies:

Mr B Aitken - MSP, Scottish Parliament

Mr J Anderson - Medical Staff Association South Glasgow Trust (SGH site)

Mr R Brown - MSP, Scottish Parliament

1. MINUTES OF PREVIOUS MEETING HELD ON 23 APRIL 2001

The Minutes of the meeting held on 23 April 2001 were approved as an accurate record.

2. APPOINTMENT OF EXTERNAL ADVISERS

Mr Calderwood reported that PriceWaterhouse Coopers had been appointed as the independent external financial advisers for the Pan-Glasgow strategy. He reported that progress was being made in respect of the appointment of professional advisers for the south side strategy, and tabled a paper on the South Glasgow Design Team Services Prospectus. He highlighted that architects were being asked to design the following for the option appraisal exercise:

- A hospital at a Greenfield site in Cowglen/Pollock
- An ACAD
- The phased re-development of the Southern General campus

Mr Gibson sought clarification on the brief for the schedule of accommodation, particularly in respect of the numbers of beds. Mr Calderwood reported that the current assumptions for Glasgow in terms of need was 1000 for both the Southern site and the Cowglen option based on 85% occupancy. He advised that the breakdown by specialty was:

- Surgery 399 beds to 319 beds
- Medicine 643 beds to 706 beds

- Institute of Neurosciences 146 beds
- Obstetrics 52 beds
- Gynaecology 52 beds
- Spinal Injuries Unit 48 beds
- Physically Disabled Rehabilitation Unit 30 beds

Mr Calderwood agreed to circulate a paper with the Minutes highlighting the proposed bed complement.

RC

Mr Spry commented that there were proposals to move two further specialties to the new south side hospital: Yorkhill Hospital which, if it did transfer, would add a further 300 paediatric beds (approximately); and in-patient beds for those with acute mental illness. Mr Findlay advised that the current bed complement for the Southern General and Leverndale for this category of patient was 182 beds.

Mr Gibson asked about the expected difficulties in building such a large hospital. Mr Calderwood commented that if all the specialties were to be provided on the one site it would be one of the largest hospital sites in the UK, but there were others of similar size in Nottingham & Leeds, for example.

Ms Hughes stated that the campaign by supporters of the Victoria Infirmary continued to promote the argument for two DGHs and suggested that more information should be issued which explained why the Victoria Infirmary site had not been included as an option. Mr Calderwood advised that this information had been included in the papers considered by the Health Board in December 2000. He reiterated the reasons that the Victoria Infirmary and adjacent land was ruled not suitable:

1. There were none of the benefits associated with a greenbelt site
2. The site including the adjacent land was too small
3. The hospital did not meet the strategy requirements in terms of a critical population mass (the critical mass of the population needs to be wide enough to allow consultants to get practice at treating particular conditions)

He pointed out however, that the status quo of two hospitals had to be compared for the Option Appraisal exercise.

Dr Sharp commented that the size of the hospital would make the acute medical receiving function particularly challenging.

Mr Beacom sought clarification on the proposed ACAD. Mr Calderwood advised that an ACAD would be built in the south east no matter which site was chosen. He advised if there if the Victoria Infirmary inpatient services were to be closed there would need to be locally accessible medical facilities in this area. He reported that the elective nature of the procedures to be undertaken at the ACAD would drastically reduce the number of operations cancelled, as emergency cases would not be referred to this facility. Dr Sharp stressed that the back-up facilities in the ACAD would require careful consideration.

3. PLANNING PERMISSION

Mr Calderwood referred to the request by Mr Brown at the previous meeting on information about Compulsory Purchase Orders (CPO). He then tabled a paper entitled "Acquisition of Land Issues". He advised that the paper detailed the processes for a Compulsory Purchase Order which was in effect an application to the Minister for consideration. He commented that the Trust's legal advisers had been unable (so far) to identify a recent application for a CPO by a public sector body.

Mr Craig asked about progress with the Council to purchase the land on the recreation ground adjacent to Queen's Park House. Mr Calderwood responded that to date there had been no formal response from the City Council to the Trust's approaches to buy this land. He advised however, that a letter from the Council in May 2001 had indicated that "…it might not be possible for the Council to act as agents for this land…." . He informed members that a further letter had been sent to the Council on 7 June 2001 seeking clarification on the vendors for the land but a response had not been received.

With regard to planning permission to build an ACAD on the recreation ground, Mr Calderwood highlighted the planning criteria for building on the site and the consultees. He summarised that whilst these problems could be overcome they would add some difficulties and possible delays. Ms Hughes commented that this could delay progress of the Acute Services Strategy for the whole of Glasgow. Mr Calderwood stated that if the Trust had not received permission to purchase this land by October 2001 it would have a bearing on the whole strategy. He commented that it had been planned that the ACAD would be opened one year before the Victoria Infirmary closed but this now looked unlikely.

Mr Gibson requested copies of the correspondence received from the City Council. Mr Calderwood agreed to provide this.

RC

Mr Gibson asked about other potential sites in the south east for the ACAD. Mr Calderwood advised that the Gorbals freightliner terminal had been suggested, but there could be other possibilities.

Dr Sharp asked about costings for the project. Mr Calderwood responded that the purchase of private land might be more expensive but the strict planning criteria for the recreation ground at Queens park would also add to the costs.

Mr Calderwood then tabled a paper from James Barr Co on the Planning Appraisal (dated 7 June 2001). He reported that the firm had been instructed to undertake a planning appraisal of two sites for the possible new acute hospital, he cautioned that the report did not take account of land ownership, contamination or the extent of the services infrastructure. He advised that **site 1** was the current Cowglen Hospital site with some surrounding land and **site 2** was Broompark Farm, Pollock Park.

Mr Calderwood highlighted that the current design would "fit" into the two sites being considered and drew members' attention to the report's conclusion that site 1 was the preferred option. He then referred to the three recommendations contained in the report:

7.1 Review and reject the Glasgow City Council Plan

7.2 Review and reject the application by Retail Property Holdings

7.3 In planning terms, consider site 1 as the preferred site for development for a new acute hospital

Mr Calderwood advised that the Trust had acted on recommendations 7.1 & 7.2 and would pursue recommendation 7.3 once details regarding purchase of the land and the suitability of the site for building were established. He indicated that it was expected that this information would be available for the next meeting.

4. THE ORGANISATION OF A SINGLE PROCESS TO DEFINE CRITERIA AND WEIGHTINGS FOR GLASGOW AS A WHOLE

Mr Calderwood tabled a paper on the invitation to tender for the facilitation support of the Option Appraisal Process for the Reconfiguration of Acute Services. Mr Craig asked why the document was being issued by North Glasgow University Hospitals NHS Trust and not the Health Board. Mr Spry advised that North Glasgow had a project team in place to deal with the tender process. Ms Hughes suggested that the

tender should be changed to: North Glasgow Trust on behalf of Greater Glasgow NHS Board and the South Glasgow Trust.

Mr Craig asked which companies were on the tender list, and Ms Hughes asked how the list had been compiled. Mr Calderwood agreed to provide a paper on detailing the tender process.

RC

Mr Spry tabled a paper on the Council involvement in the Development of Business Cases. He then detailed the workshop arrangements for conducting the Option Appraisal element of the Outline Business Case:

Workshop A *Initial Briefing Workshop*

- Explanation about the Option Appraisal process
- Understanding and agreement of the Option Appraisal weightings for Glasgow
- Participants will be members of Workshops ***B, C & E***

Workshop B *Service Benefits Weighting Workshop*

- To define the service benefits criteria
- To agree a weighting between them

Workshop C *To Compare Options against Service Benefits Criteria*

- Each option will be considered and scored dependent on the extent to which it delivers the service benefits defined in *Workshop B*
- The scores will then be adjusted by the weightings agreed in *Workshop B*

Workshop D *Technical Desk-top Assessment of Economic Factors, Financial Factors and Risk Profile*

- To be undertaken by the Trust Finance departments/advisers
- To be independently validated by PriceWaterhouse Coopers and by Partnership UK

Workshop E *Finalisation of Option Appraisal Exercise*

- To bring together the work done in *Workshops C & D*
- To give an opportunity for the results of *Workshop D* to be explained and interrogated
- To seal the overall scoring in accordance with the agreement reached in *Workshop A*

Ms Hughes asked if there would be the opportunity for wider public participation in Workshop C, and not just members of the Local Health Council and the Local Community Councils. Mr Spry advised that further discussion was required on Workshop C participation.

Mr Craig asked when it was expected that Workshop B would be held. Mr Spry responded that this was likely to be in August 2001.

Dr Sharp asked for details on the Option Appraisal process. Mr Calderwood responded that there were 4 element within the Option Appraisal exercise:

a) The Benefits Appraisal

b) The Financial Appraisal

c) The Economic Appraisal

d) Risks and Uncertainty Appraisal

He advised that there were about 10 measures under each Benefits Appraisal heading and the agreed weights would be applied to these measures. Mr Spry commented that the tenor of previous Reference Group consideration of this issue was that the same weightings would apply pan-Glasgow.

Mr Craig asked about the public participants to be recruited via the Local Health Council. Mr Beacom reported that there was a meeting of the Health Council scheduled for 12 June 2001 when the subject would be discussed.

5. THE NEXT STEPS

Mr Calderwood advised that the next step for the Trust was to progress the work on the design team. He reported that non-recurrent funding was being allocated from Capital Funding to pay for this work.

Mr Calderwood reported that the next stage for the pan-Glasgow work was to progress the Workshops. He reported that the tender for a Traffic Consultant had now been issued to 4 companies. He agreed to obtain a copy of the tender for circulation.

RC

6. ANY OTHER COMPETENT BUSINESS

a) Membership of Workshop C

Mr Craig suggest that there should be a detailed discussion on the composition of Workshop C at the next meeting. Members agreed with this suggestion.

b) Papers

Mr Craig suggested that due to the number of papers tabled at the meeting (5), members would be invited to raise any questions concerning them at the next meeting.

7. DATE OF NEXT MEETING

10.30 a.m. Monday 2 July 2001 at Dalian House

Return to Acute Services Main Index

NHS GREATER GLASGOW

ORGANISING OPTION APPRAISAL WORKSHOPS

1. WHAT ARE OPTIONS?

1.1 "Options" is another word for "choices". In Glasgow's hospital service we have choices about what services are provided where. Earlier consultation has narrowed the choices still needing exploration in Glasgow.

1.2 For the **Southside** the choices are:

a) the status quo - in other words only the minimum of investment to bring existing buildings up to minimum safety\maintenance standards.
b) the redevelopment of the Southern General Hospital.
c) a new hospital at Cowglen.

In options (b) and (c) there would also be a walk-in walk-out same day Diagnostic and Treatment Centre next to the present Victoria Infirmary.

All option appraisals submitted to the Scottish Executive need to include a "status quo" - not because anyone thinks the status quo is a good idea but it is used as a yardstick against which the relative benefits and costs of other options can be compared.

1.3 In the case of **North-East Glasgow** the choices to be considered in the option appraisal are:

a) Glasgow Royal Infirmary as the in-patient site for the North and East. Stobhill Hospital as walk-in, walk-out same day Diagnostic and Treatment Centre (ACAD) with minor injuries service. GRI would need new ward block and support service facilities to accommodate the extra workload.

b) Glasgow Royal Infirmary as a specialist hospital. New build at Stobhill as the District General Hospital for North and East with integrated ambulatory care services.

c) There is a third service model which sees:

Stobhill as a local hospital providing general medicine and general surgery services with a walk-in walk-out same day Diagnostic and Treatment Centre (ACAD), including a "casualty" service.

GRI also retaining its present role.

There are some choices about how much new capital investment is committed in this service model and these choices will need to be covered in the option appraisal:

i) Totally new buildings at Stobhill for in-patient general medicine and surgery and for the hospital's Diagnostic and Treatment services and 'casualty'.

ii) Additional new buildings at the GRI to allow those services still using old buildings at the Cathedral end of the site to move into new buildings.

iii) Retain medicine and surgery in existing accommodation at Stobhill but build a new ACAD (to include a 'casualty' service). No more new buildings at GRI. Where existing old buildings remain in use at Stobhill and the GRI money would be spent to bring them up to an acceptable safety and maintenance standard.

2 WHAT DOES AN OPTION APPRAISAL CONSIDER?

2.1 An option appraisal to meet Scottish Executive requirements must look at four elements:

a) What non-financial benefits will the investment deliver, together with an indication of when they are expected to occur. They should be weighted and scored.

b) Financial appraisal - the capital and revenue costs over the life span of the scheme. There is a standard Scottish Executive format for showing this. It also needs to cover:

- whether the costs can be afforded.
- impact on the Trust's balance sheet and income and expenditure.
- sensitivity analysis.
- the cost of risk (all major investments have risk, which can be reduced, but usually there is a cost involved in reducing risk).

c) Economic appraisal - which puts the financial costs in the context of risks and uncertainties, value for money and Net Present Value and Equivalent Annual Cost calculations.

d) Risk and uncertainty appraisal - a systematic assessment to identify, quantify and value risks, their probability of arising and how they can be managed.

2.2 Non-financial benefits typically include improvement in the quality of clinical services; enhancement of the patient's experience; accessibility; improvement in recruitment, retention and experience of staff; flexibility for future change; environmental impact. In an option appraisal these need to be defined (what do they mean? how can they be measured?) and then weighted in terms of their relative importance (e.g. is access more important than clinical quality or vice versa?).

2.3 In undertaking option appraisal in Glasgow we will start by looking at typical definitions and weightings used in other option appraisals elsewhere in the UK.

2.4 Financial appraisal and economic appraisal are different. The former compares the cost of options in terms of whether the Health Board can afford them. The latter is about whether the capital investment constitutes a good investment of capital, bearing in mind value for money and the economic impact of risk. An option might be affordable but be a poor investment. Conversely an option could be a good investment but be unaffordable.

3. HOW MIGHT THE OPTION APPRAISAL BE CONDUCTED?

3.1 This has been considered by both the Southside and North-East Reference Groups and the process can be summarised as follows:

Service Benefits Weighting Workshop — A

- Define the service benefits criteria.
- Agree a weighting between them.
- Likely to take one whole day.

Initial Briefing Workshop for those who will be scoring the options — B

- What option appraisal involves - methodologies and disciplines.
- Understanding the typical balance in UK NHS option appraisals of weightings between
  - service benefits
  - economic factors
  - financial factors
  - risk profile

  and agreeing the weightings balance to apply in Glasgow.
- Understanding and interrogating the output of Workshop A.
- Likely to take a day.
- Will involve participants of Workshops C and E.

Workshop to Compare Options Against Service Benefits Criteria — C

- Each option is considered and is scored according to the extent to which it delivers the service benefits previously defined in Workshop A.
- The scores are then adjusted by the weightings agreed in Workshop A.
- Likely to take one whole day.

One Workshop for Southside

C

Similar, separate Workshop for North-East

Technical Desk-Top Assessments of Economic Factors, Financial Factors and Risk Profile — D

- Undertaken by Trust Finance Departments\Advisers.
- Independently validated by Price Waterhouse (GGHB's external auditors). and by Partnerships UK (organisation part-owned by HM Treasury).

Workshop to bring all the elements of Option Appraisal Together	E
• All participants of Workshops C North-East and Southside in a single event.	
• Brings together all the elements developed in C and D.	
• Allows results of D to be interrogated and explained.	
• Seals the overall scorings in accordance with the agreement reached in Workshop B.	
• Covers North and East and Southside so that everyone can see overall consistency of approaches and consider next steps.	
• Likely to take a day.	

3.2 It has been agreed by both Reference Groups that Workshop A should define the service benefits criteria and agree the relative weightings between them on a pan-Glasgow basis. There are several reasons why this is sensible:

a) the definitions of access to hospitals (for example difference in travel times) should be the same for all Glaswegians. If, say, public transport travel in 15 minutes or less were "very acceptable", 16 to 25 minutes "fully acceptable", 25 to 45 minutes "acceptable" and so on, that standard should be applied for assessing all hospital choices. It should not be different between Glaswegians living in different parts of Greater Glasgow.

b) the definitions for clinical quality or safety should be standard. Arrangements regarded as "poor" in one part of the city should not be "acceptable" in another.

c) the weightings (relative importance) of different service benefits (such as access, clinical quality etc) should likewise be standardised. It would be odd if clinical quality were regarded as more (or less) important than, say, access in one part of the city and vice versa in another. This is not merely a matter of tidiness - it is conceivable that choices might have to be made, in terms of affordability, timing or phasing between different projects and it is important that any such choice should be capable of being made on a like for like comparison.

To allow this to be done it has been agreed that a single pan-Glasgow Workshop A be organised. Its participants would therefore need to take a bird's eye view of service benefits, liberated from the more localised pressures associated with site preferences (Southside) or service models\site preferences (North East). Those issues will be addressed in two separate versions of Workshop C (one for the North-East, the other for the Southside).

The public interest in Workshop A will be achieved by the participation of elected representatives from the Local Authorities plus five representatives of the Local Health Council.

4. OPTIONS FOR THE ORGANISATION OF WORKSHOP C

4.1 We have identified four different models for running Workshop C. The Reference Groups are currently at different stages in deciding on which model they prefer in order to achieve:

a) reasonable participation of stakeholders;

b) a process which satisfies the expected disciplines of genuine option appraisal.

Model 1 Multiple separate stakeholder groups

The separate stakeholder groups might be as follows:

Southside	North-East
1. SGH doctors	1. GRI doctors
2. Victoria doctors	2. Stobhill doctors
3. Southside GPs	3. North and East GPs
4. Advisory Committee doctors	4. North and East LHCC
5. SGH staff	5. Advisory Committee doctors
6. Victoria staff	6. GRI staff
7. Nursing and PAMs Advisory Committees	7. Stobhill staff
8. Community Councils & SIPs	8. Nursing and PAMs Advisory Committees
9. Health Forum South East and Friends of the Victoria	9. East End Community Councils & SIPs
10. Local Health Council	10. North Glasgow Community Councils & SIPs
11. Glasgow City Council	11. Strathkelvin Community Councils (+ relevant N. Lanarkshire Community Councils)
12. East Renfrewshire Council	12. North Glasgow Action Group
13. South Lanarkshire Council	13. Local Health Council
14. Managers	14. Glasgow City Council
15. Glasgow University	15. East Dunbartonshire Council
16. MSPs	16. South Lanarkshire Council
17. Primary Care Trust (reflecting Mental Health Service provision)	17. North Lanarkshire Council
	18. Managers
	19. Glasgow University
	20. MSPs

[Note: At a meeting of the North-East Reference Group on 27th July it was suggested and agreed that in addition to GPs, the relevant Local Health Care Co-operatives be invited to participate since LHCCs included other staff in addition to GPs. If applied on the Southside, this would mean 18 stakeholder groups].

Each group would debate and score in breakout rooms. Each room would have a "process adviser/runner" able to access expert advice to the group where necessary.

Each group would report back its single agreed scores for each option against each of the criteria - (i.e. one set of scores per group).

The size of each group needs to strike a balance between enough people to allow a dialogue in comparing options with criteria but not so large as to be unmanageable in generating a considered score. [Note: At the North-East Reference Group it was felt that groups of 10 people was the optimum size to create a workable balance between good participative dialogue and an ability for a group to 'self-manage' its approach to scoring the options against the criteria in a disciplined way].

The option appraisal facilitator would conduct a real time calculation of the scores in order to produce an overall average score of each option against each of the criteria. This would be made known to everyone at the end of the day.

Model 2 Clustered separate stakeholder groups

Similar to Model 1 but clustering some of the groups in order to encourage a more balanced debate within related stakeholder constituencies. An example of this approach would be:

1. Doctors
2. Staff
3. Community Councils, SIPs, local pressure groups who have been active in the debate so far.
4. Local authorities
5. Managers
6. Local Health Council
7. Glasgow University
8. MSPs
9. Mental Health Service stakeholders

Each group would need a facilitator - as well as access to expert advice when wanted.

Model 3 Multiple constituencies in mixed groups

This would mix doctors, staff, community councils, local authorities etc. randomly in groups with a range of, say, 10 to 15 members per group. Under this model it would be feasible to have an event of, say, 200 people in 13 to 20 mixed groups, with each group self-managing its debate and scoring of the options.

As with the other models each group would debate and score in breakout rooms and then report back its scoring of each option against each of the criteria.

Model 4 The classical 30-40 person Workshop

A single Workshop Group of 30 to 40 people would be drawn from the 20 or so Stakeholder constituencies identified in Model 1 and would score each option against each criterion in a single Workshop process - i.e. all together, in one room.

4.2 **How to compare the Models**

In making a choice between Models, the two Reference Groups have considered a number of issues:

a) To what extent does each model allow reasonable direct participation of relevant stakeholders?

b) Does the model encourage active debate between different stakeholder groups?

c) Would the model allow participants to feel comfortable in making their contribution?

d) Is the model susceptible to distortion if some stakeholders score according to prejudice?

e) Would agreement on scoring be more or less difficult to achieve?

f) How important is transparency in the scoring - i.e. being able to see at and after the event how different stakeholders approached the scoring?

4.3 The North-East Reference Group at its meeting on 27th July decided to adopt Model 3 and to invite the participation of some 200 people from the 20 Stakeholder Groups. Each mixed group would have 10 members - so there would be 20 groups.

4.4 The Southside Reference Group at its last meeting felt that Model 4 allowed too little participation, bearing in mind the number of people and stakeholder groups with an interest. Model 1, although providing the maximum of transparency, did not facilitate debate between different stakeholder perspectives. The Reference Group concluded that Model 2 provided a good balance between debate and transparency whereas Model 3 increased the scope for debate between stakeholders (albeit at the expense of losing transparency).

The Reference Group decided to review the choice between Models 2 and 3 at its next meeting (27th August). In the meantime it would seek some wider community opinion on the models.

General Issues about the Workshops C

4.5 In each case the event would have been preceded by the briefing event (Workshop B) and would be working with the criteria developed at Workshop A. The output of Workshop A would be interrogated by the participants of Workshop C at the Workshop B event so that there is a good understanding of how they have been derived and weighted.

4.6 Workshop C generates a score on service benefits. The **other** elements of Option Appraisal **(finance, economic and risk profiles)** calculated by finance and economic specialists in Process D, would be reported to a Workshop E, attended by all the participants of the two Workshops C, around one week after Workshops C, so that the overall picture can be seen in the round.

4.7 It is critical for everyone to bear in mind that the product of the Option Appraisal process is a key part in securing approval for major capital investment from the Scottish Executive. The Scottish Executive will want to be satisfied that the scoring of each option against each criterion is explained rationally in the text of the Outline Business Case of which the option appraisal forms part. The Scottish Executive, in judging the Outline Business Case, will check whether the scoring of each option against the criteria is rational both in terms of absolute logic and mutual consistency in the application of judgement one option to another.

The broadly based participative process we are pursuing in Glasgow will only succeed if:

a) all participants genuinely subscribe to the rigour of the process, rationally weighing each option against criteria without having decided beforehand which preferred option they wish to see as "the winner". If people approach option appraisal with that prejudice the scoring process is intellectually flawed and will be seen to be so by the Scottish Executive.

b) debate around how each option performs against each criterion is genuinely constructive and encourages different points of view to be aired, respected and explored without anyone feeling put down.

5. TIMING

Accommodation has been booked on the following dates:

Workshop A	Friday, 7th September	9.00 a.m. to 4.30 p.m.
Workshop B	Monday, 17th September	9.00 a.m. to 4.30 p.m.
Workshop C North-East	Friday, 28th September	9.00 a.m. to 5.00 p.m.
Workshop C South	Monday, 1st October	9.00 a.m. to 5.00 p.m.
Workshop E	Friday, 12th October	9.00 a.m. to 5.00 p.m.

Our Ref: CJS\FEB
Contact: Mr. C.J. Spry
Direct Line: [redacted]
Fax No:

13th August, 2001.

Mr. Peter Daniels,
Chief Executive,
East Renfrewshire Council,
Eastwood Park,
Rouken Glen Road,
Giffnock, G46 6UG.

Dear Peter,

INVESTMENT IN GLASGOW'S ACUTE HOSPITAL SERVICES
ARRANGEMENTS FOR OPTION APPRAISAL

The NHS in Greater Glasgow has been pursuing a consultative process over the last 15 months to build a consensus about how best to attract significant capital investment into Glasgow to replace its many clapped out hospital facilities.

By December of last year we had reached a point where there was good agreement about a number of things but continuing disagreement about others. We decided to do further work to advance the position in both these areas.

In order to get capital investment we have to submit an "Outline Business Case" to the Scottish Executive. We now aim to do that for all parts of Glasgow by the end of this year. An Outline Business Case is a document which explains the aims of the proposal, its costs, risks, staffing issues, timetable etc.

In West Glasgow there is widespread agreement that the Western Infirmary should close and that the majority of its services should be located in brand new facilities at Gartnavel. The detailed work to turn this into an Outline Business Case is underway.

For the Southside there is widespread agreement that there should be a single in-patient hospital, supplemented by a walk-in walk-out same day Diagnostic and Treatment Centre next to the Victoria Infirmary site. The disagreement concerns whether the in-patient hospital should be on the Southern General campus or on a new site assembled by purchasing land at Cowglen. This choice will be resolved by a process called "option appraisal", which will become part of the Outline Business Case submitted to the Scottish Executive.

In North-East Glasgow there is little agreement about what pattern of hospitals there should be. Everyone agrees the Royal Infirmary is there to stay, just as everyone agrees that whatever happens there should be a modern walk-in, walk-out same day Diagnostic and Treatment Centre at Stobhill. The debate is around whether there should also be in-patient beds at Stobhill and what the outcome of that debate means for the role and size of the Royal Infirmary. Our aim is that an option appraisal process should explore these questions, that the outcome would be the subject of further public consultation and that the conclusion should then be reflected in an Outline Business Case to attract capital investment.

The issues involved in thinking these questions through carefully, logically and systematically are complicated. Nevertheless we aim to explore them in ways which give large scale opportunity for public involvement in the process.

In designing the process we have been working with two Reference Groups, one for the Southside and one for the North-East Glasgow. Their membership includes MSPs, Local Health Council representatives, and staff representatives. The role of the Reference Groups is not to make the choices but to ensure that the processes we design combine the technical competence demanded by the Scottish Executive with the genuine scope for public involvement that everyone wants to see.

My purpose in writing to you now is to alert you to the dates on which the various option appraisal events are being held. Bearing in mind the large numbers of people involved we have had to reserve space large enough to accommodate us and so to fix dates too.

To help people get some clarity about the process itself I enclose a paper which describes option appraisal and how the sequence of events connects together. It shows dates for all the relevant events.

As far as East Renfrewshire Council is concerned the relevant dates are:

Event	Date	Time	Venue
Workshop A	Friday, 7th September	9.00 a.m. to 4.30 p.m.	Celtic Park
Workshop B	Monday, 17th September	9.00 a.m. to 4.30 p.m.	Hampden Park
Workshop C - South	Monday, 1st October	9.00 a.m. to 5.00 p.m.	Hampden Park
Workshop E	Friday, 12th October	9.00 a.m. to 5.00 p.m.	Celtic Park

You had already indicated that Councillor Danny Collins would represent the Council at the pan-Glasgow Workshop A (defining and weighting the service benefits criteria) and it would be helpful if you could confirm that he is able to attend.

As far as number of people attending the other Workshops are concerned we have still to agree precise numbers with the Reference Group within the next few weeks. We anticipate that each Council might have at least two representatives at these meetings (possibly more - the arithmetic of balancing attendance of 200 people at each Workshop C among 20 Stakeholder Groups is quite complex). I will write to you again before 5th September to confirm the number and at that time I will ask you to let me know the names of who will represent the Council.

I am sorry this is so long and detailed but I hope it is all reasonably clear. This will be the largest process of direct public involvement in a decision of this type in the NHS in Scotland and we hope all those we invite will want to play a part in it.

Yours sincerely,

C.J. Spry
Chief Executive

South Glasgow
University Hospitals
NHS Trust

Trust Headquarters
Southern General Hospital
1345 Govan Road, Glasgow G51 4TF
Telephone: [redacted]
Fax: [redacted]

cc JW
Elaine Mckean
Ken return

Our Ref: GC/AM

24th August, 2001

Mrs. Enid Penny
19 Graffham Avenue
Giffnock
GLASGOW
G46 6EL

Dear Mrs Penny,

South Glasgow Reference Group

Many thanks for your letter of 17th August. As I intimated to you during our telephone conversation, the Friends of the Victoria will be invited to participate in two workshops. The first is to be held on Monday 17th September in Hampden Park between 9.00 a.m. and 4.30 p.m. and the second in the same venue on Monday 1st October between 9.00 a.m. and 5.00 p.m.

The purpose of the workshop on the 17th is to brief participants in both the North and the South of the optional appraisal exercises that are presently taking place on the Acute Services Review. Representatives from both the North and South will be present at this workshop.

On Monday 1st October, the workshop will be confined to representatives from the South and this workshop will be charged with scoring the criteria that will be explained on 17th September for the options for a new hospital in the South.

You will receive from the Health Board an invitation to both workshops following the South Side Reference Group meeting which is to be held on Monday 27th August. 2001.

Yours sincerely,

[redacted]

Gordon Craig
Chairperson
South Glasgow Reference Group.

c.c. Chris Spry, Chief Executive, Greater Glasgow Health Board
R. Calderwood, Chief Executive, South Glasgow University Hospitals NHS Trust.

Friends of
THE VICTORIA INFIRMARY

19 Graffham Avenue,
Giffnock,
GLASGOW,
G46 6EL

Tel: [redacted]

17th August, 2001

Mr Gordon Craig,
Trustee,
South Glasgow University Hospitals NHS Trust

Dear Mr Craig,

Working Party - Acute Hospital Service Provision South Glasgow.

At our recent Committee meeting it was reported that a Working Party is being set up following the Reference Group meetings on the provsion of Acute Hospital Services in South Glasgow. We understand that representatives from the South East Health Forum have been invited to participate.

May I, on behalf of our Committee request that the Friends be also represented on the Working Party.

The Friends Committee comprise community councillors, councillors, clergy and other community representatives whose aim is to link the hospital and community in supporting and campaigning for acute hospital services. Over the past eight years we have faithfully attended Trust Board meetings, AGMs, conferences, seminars, social functions and lobbied MPs and MSPs in pursuit of our aim. We have also contributed thousands of pounds to both the Victoria and the Mansionhouse Unit. In view of this long and arduous commitment to the cause, we feel that the Friends should not be excluded at this critical stage in developments.

I trust that you will give this matter your urgent attention,

I am,
Yours sincerely,

[redacted]

ENID PENNY
Secretary.

Our Ref: CJS\FEB
Contact: Mr. C.J. Spry
Direct Line: [redacted]
Fax No:

15th August, 2001.

Ms. Janis Hughes, MSP
Mr. Kenneth Gibson, MSP
Mr. Robert Brown, MSP
Mr. Bill Aitken, MSP

Dear Colleague,

SOUTH GLASGOW REFERENCE GROUP

You will recall we discussed at a previous Reference Group's inaugural meeting the involvement of MSPs in what was then described as Workshop B. This was the Workshop intended to work on a pan-Glasgow basis to define and weight the service benefits criteria to be used in the scoring of options in the later Option Appraisal Workshops. The question was whether MSPs would wish to take part in the Workshop or attend as an observer only.

As you will be aware the Reference Group is scheduled to meet again on 27th August, 2001 and it would be helpful if we could reach a firm conclusion on the issue at that time.

In the meantime on the basis of the progress made in how to organise the Option Appraisal Workshop we have now booked the accommodation needed for the various Workshops in the sequence. I enclose a copy of a typical letter sent to the likely participants in the Workshops together with a paper which should help them understand the process.

We have booked accommodation on dates which we hope will be convenient for MSPs. We also suggest a couple of dates for Reference Group meetings to take place at key points in the sequence. The complete set of dates is as follows:

Southside Reference Group	To decide on organisation of, and invitations to, Workshops B, C and E	Monday, 27th August	10.30 a.m.	Dalian House
Workshop A	Define the benefits criteria	Friday, 7th September	9.00 a.m. to 5.00 p.m.	Celtic Park
Joint Meeting of North-East and Southside Reference Groups	To review outcome of Workshop A	Friday, 14th September	10.30 a.m. to 2.00 p.m.	Committee Room, South Glasgow Trust HQ, SGH
Workshop B	Briefing for all participants	Monday, 17th September	9.00 a.m. to 4.30 p.m.	Hampden Park
Workshop C - South	To score options	Monday, 1st October	9.00 a.m. to 5.00 p.m.	Hampden Park
Southside Reference Group	To review outcome of Workshop C and prepare for Workshop E	Monday, 8th October	2.00 p.m.	Committee Room, South Glasgow Trust HQ, SGH
Workshop E	Joint North-East and South Review of Outcomes of Stage D and Workshops C	Friday, 12th October	9.00 a.m. to 5.00 p.m.	Celtic Park

Kindest regards,

C.J. Spry
Chief Executive

c.c. Mr. G. Craig, Chairman, Southside Reference Group
Mr. R. Calderwood, Chief Executive, South Glasgow University Hospitals NHS Trust

Enc.

- Get it right for a new building – appreciate financial constraints but confidence of the general public and medical nursing staff are also necessary.

616. [redacted] G76

- The Southern General is sited in an inconvenient area for the majority of Southsiders.
- The Southern General is an old Victorian building which has had many adaptations and does not meet modern standards.
- Travel by car from Clarkston takes 40 minutes. Public transport is very complicated taking 3 times longer.
- Sludge holding tanks for Shieldhall Sewage Works always create an unhealthy obnoxious and sickening smell.

617. [redacted] G41

- Support for building of a new hospital on a site suitable for easy access to service the whole of the Southside of Glasgow.

EMBARGOED UNTIL MEETING

610. [redacted] G44

- Southern General is inaccessible for all the reasons previously expressed.

611. [redacted] G42

- Emergency patients will die trying to reach the Southern.
- The Southern is very difficult to get to by public transport and will cut down the number of visitors for patients; maybe GGHB should provide the transport system and also pay for travelling expenses for patients and visitors.
- The Geriatric Unit seems to be closing – what is going to happen to the elderly patients?
- Have contingencies been made up for worst case scenarios happening at Hampden and Ibrox.

612. [redacted] G46

- Finance should not be a problem now so priority must now be given to patient care.
- The Southern General is poorly located for the majority of potential patients form the Southside.
- The Southern is right next to a very foul smelling sewage disposal plant – it should not be extended.
- Depending on bus routes patients would have to walk past a filthy, smelly and vandalised underpass – and it's unsafe.
- Public transport to Southern General is poor and travel time is considerable.
- Parking at the Southern General is a nightmare, finding a space is a major achievement.

613. [redacted] G44

- Agree the Victoria is in need of repair and upgrading but moving services to the Southern is not right
- Hopes that common sense will prevail and a new hospital will emerge for the Southside.

614. [redacted] G52

- It takes 2 buses to get to the Southern and then you have to go through a tunnel.

615. [redacted] G44

- GGHB should listen to the doctors and nurses and go forward with plans which look years ahead.
- It is necessary to have an excellent casualty, diagnostic unit, day surgery unit and medical and surgical units.

EMBARGOED UNTIL MEETING

597. [redacted] G77

- The Southern General is too far away, too old, too crowded and impossible to modernise.
- It's got smells from the nearby sewage works and severe car parking problems which won't be helped by extra vehicles coming from the South-East of Glasgow.

598. [redacted] G 43

- Travel by public transport to the Southern General can take 2 hours – 4 hours for a return journey.

599. [redacted] G44

- It will take an hour and a half to reach the Southern General to attend diabetic, eye clinic and chiropody.

600. [redacted] G46

- Difficult to reach the Southern General by public transport.
- Victoria is also in a terrible state
- A new hospital is needed not the outdated Southern General

601. [redacted] G46

- Southern General is too far away for some of the desperately ill patients of the Southside – they would also face long and harrowing journeys to reach the hospital.

602. [redacted] G41

- The Southern General is much too far away and inconvenient for the residents living in the South-East of Glasgow.
- Nevertheless the hospital services will be centralised at the Southern General whether we wish it or not.
- No matter how overwhelming the publics' objection is the decision was reached at the very beginning will materialise.
- Sought information on how consultation exercise was undertaken and whether in the light of overwhelming objections to the Board's proposals will they abandon proposals to centralise services at the Southern.
- Enquired about the form of analysis being used for responses received to consultation and the criteria for the basis of the Board's decisions.

603. [redacted] G 41

- Travel to the Southern by public transport is a nightmare.
- Fad for centralising hospitals will only last long enough to prove itself wrong.

EMBARGOED UNTIL MEETING

591. [redacted] G41

- Southern General is not a suitable alternative for the Victoria – build a new hospital for the 21st Century.

592. [redacted] (emailed response)

- Being forced to go to a hospital on the other side of the City – the Southern General – bearing in mind the time spent in traffic and hold ups would cause great suffering and more health problems particularly for those with emergencies.
- The sheer expense and time involved in travelling to the Southern would add a great deal of stress emotionally and financially.

593. [redacted] G76

- Southern General totally unacceptable to the residents of South-East due to additional distance involved in getting there – this would be worse in an emergency and could be the difference between life and death.
- People using their own transport would find it extremely inconvenient and expensive to get to the Southern – the roads are always busy and traffic hold ups are inevitable. Victoria and Southern are old hospitals and both were stretched to the limit during the flu epidemic.
- Health service should be treated as a top priority and a new Southside Hospital built.

594. [redacted] G76

- Cost of building at the Southern General is expensive due to the type of land and it is situated beside a sewage works giving off an offensive odour.
- Travelling to and from the Southern General is difficult and time consuming.
- ACAD at the Vicky with no medical backup is not ideal.

595. [redacted] G77

- We want a new hospital and not a makeshift extension in an out of the way Victorian Institution – the Southern.

596. [redacted] G76

- It will be difficult for visitors to get to the Southern – even travelling by car will take 40 minutes from Clarkston.
- People travelling by public transport will have to take 2 busses to get there and 2 buses back.
- They then need to walk through the underpass and then through the sprawling grounds of the hospital – how would an elderly disabled person manage?
- I understand the Southern is only within easy reach of 30% of the population of the South of Glasgow.

EMBARGOED UNTIL MEETING

579. [redacted] G44

- Southern General has a smell from the sewage work across the road and your Health Board planners should visit this area and think again.

580. [redacted] G43

- General public feelings do not seem to bear any relevance to the Board – this is worrying. Southside requires 2 hospitals and the Board should know and understand this.
- Can waiting lists really be reduced under one hospital regime – we think not.
- Southern General has been horrific by the virtue of the stench from the nearby sewage works.

581. [redacted] G43

- Too late with summary leaflet. Health services were being run down in Glasgow some 10 – 15 years ago.
- Southside of Glasgow has lost Mearnskirk, Philipshill, Samaritan and Rutherglen Maternity – and now the Victoria and Victoria Geriatric are under threat.
- Southside is a very high elderly population and getting transport to the Southern General together with the dangers of the underpass are very difficult. GGHB case for centralising services at the Southern because of shortage of consultants and nursing staff – some years ago the Board decided there were too many nurses and retired them.
- Southern General is going to be a building site for 10 years or more – the dust and pollution will not be good for patients.
- Not a lot of thought has gone into these plans and the consequences of the decisions being made.

582. [redacted] G13

- Neither the Southern General nor the Royal Infirmary is suitable for the majority of children from Glasgow or the West of Scotland.
- Southern General is difficult to get to with public transport – particularly from the West End of Glasgow.
- Car parking at the Southern is difficult.
- Children should not be treated next to adults in an A&E department.
- Royal Infirmary more central but nowhere to park.
- Yorkhill has had no problems being on its own and the Western Infirmary is only a couple of minutes away with Gartnavel only a further few minutes away. GGHB were planning to move Yorkhill why did they build a new theatre block and what would happen to the Ronald MacDonald House?

EMBARGOED UNTIL MEETING

- A&E at the Vicky is one of the busiest and yet has to be transferred to the Southern.
- Have any of the people at GGHB tried to get from Castlemilk or Rutherglen to the Southern by public transport?

545. [redacted] G76

- Both Southside Hospitals are outdated. Health professionals who work in them work under extremely difficult circumstances.
- Neither location of the 2 hospitals is suitable for the entire population.
- Moving services to the Southern General is completely outrageous.

546. [redacted] G43

- Victoria and Southern are well past their sell by date.
- To move services to the Southern General is out of the question.

547. [redacted] G77

- Appreciate facilities must be constantly upgraded but wrong to continue to close units in the South-East and then centralise services adjacent to a sewage treatment plant.
- GGHB are here to serve the public not satisfy their own dogma and gratification.

548. [redacted] G76

- Southern General is most unsuitable - ancient buildings and difficult to reach by public transport.

549. [redacted] G76

- Southern General is completely inappropriate given its location – difficult for patients and visitors.

550. [redacted] G44

- South Glasgow is too vast to have only one hospital and the Board must listen to the views of people and medical staff.

551. [redacted] G44

- Don't want Southern to be the local hospital delay for serious ill patient to get from South-East to Southern.
- Money shouldn't be wasted on unimportant things – the health of the people should receive utmost importance.

552. [redacted] G76

- Unthinkable that the local population in South-East should travel across the City to the Southern for hospital services.

EMBARGOED UNTIL MEETING

522. [redacted] G46

- Southside served by 2 antiquated hospitals more suited to the 19th Century.
- Moving services from the Victoria to the Southern is incomprehensible and completely unacceptable.

523. [redacted] G44

- A&E at the Southern or the Royal which is on the opposite side of the river seems absurd. Rush-hour traffic in Glasgow is congested and emergency journeys will be delayed, possibly fatally.
- Public transport to the Southern is extremely difficult from all districts in the southside of the city.
- Car parking at the Southern is a real problem.
- Mansionhouse Unit to close although no plans made for the elderly long term patients.
- I fail to understand the blind insistence of the Health Board on developing the Southern.

524. [redacted] (emailed response)

- Numbers of acute medical beds at Stobhill is wrong in leaflet number 19.
- No mention is made of the rehabilitation beds at Stobhill.
- Integration of general medicine and medicines for the elderly depends on having rehabilitation beds which can treat patients early on admission – they can not be left isolated at Stobhill.

525. [redacted] G44

- Southern General is directly in line with the stench from a major sewage works and only convenient to those who live in the immediate vicinity.
- Difficulty to travel to the Southern from the South-East.
- Think beyond your middle-class mindset and consider the average working class citizen – using public transport to get to a mismatch of buildings at the Southern is not good.

526. [redacted] G76

- Have attended a number of public meetings and studied the 21 booklets published by the Board.
- Hope consultation is not a sham.
- Gather much money has already been committed to the renovation and extension of Southern thereby possibly making it difficult for the Board to accept the need for a new southside hospital.

- The Victoria Infirmary is well served by existing bus and train services the Southern isn't.
- GGHB should follow the principle of putting the patient first.

492. [redacted]

- Cowglen and the Southern General are hopelessly distant from the centre of the relevant area.
- The Southern General is older than the Victoria and has been badly built and is a disjointed complex.
- Consultants concerned at ACADs being isolated – this is not acceptable.

493. [redacted] G44

- Southern General as the main hospital for the Southside is completely unacceptable to the people of South-East.
- It is expensive and timely to get to the Southern General.

494. [redacted] G41

- Support for building of a new hospital on a site suitable for easy access to service the whole of the Southside of Glasgow.

495. [redacted] G73

- I've read the leaflet and discussed plans with friends.
- The Southern General is not suitable location to be the main central hospital for the Southside. An ambulatory care centre is a second rate service.
- It is easier to go from Rutherglen to the Royal Infirmary than it is to the Southern.
- The Southern General is sited beside a busy football ground and visiting on a Saturday afternoon is appalling – especially if you are elderly.
- Should an ACAD not be alongside a main hospital? – is this not the reason the Rutherglen Maternity was closed down because it was not attached to a district general hospital?
- Who will staff the ACAD? Is it the same doctors who will have to staff the Southern General.
- Appreciate what GGHB is trying to do but the Southern General will never be acceptable.

496. [redacted] G73

- Realises the monetary pressures which local services are put under to give value for money under scrutiny for performance – but can't see a justification for the closure of the Victoria Infirmary. Northside has 4 commendable hospitals, the southside is to have one.

- There is sewage works across the road from the Southern .

481. [redacted] G46

- Very clear over many years the Southern General is in the extreme North-West corner of the Southside with difficult access by public and private transport.
- Ridiculous to run down the Victoria Infirmary, the sale of Philipshill, the Samaritan, Rutherglen Maternity and most of the Mearnskirk estate when money has been poured into the Southern General site.
- Implies that the consultation exercise that proposals were promoted by clinicians only to discover a large majority of clinicians were not in favour of GGHB's proposals.
- ACAD opposed by clinicians on the grounds of viability and safety; South Trust attempted to justify ACAD by comparing it to the Day Surgery Unit at Bexhill whose geography and demography is quite incompatible.
- Victoria is too small and the Southern General is hopelessly misplaced
- The City Council states there are sites available.

482. [redacted] G44

- Realises the monetary pressures which local services are put under to give value for money under scrutiny for performance – but can't see a justification for the closure of the Victoria Infirmary. Northside has 4 commendable hospitals, the southside is to have one.
- There has already been enough hospital closures on the southside already.
- It boils down to dreadful lack of care for people living in the south of the city. We are paying for these hospitals and we deserve better. The Board should look to their political decision and resurrect their humanity by building on the Queen's Park Recreation Ground – giving a solution for those souls it greatly affects and may one day save.

483. [redacted] G73

- Never felt the need to write to any MP, newspaper etc until hearing of the change of status to the Victoria Infirmary.
- Can not but wonder what the outcome of the illnesses affecting himself and family would be if they had been compelled to make a journey to the Southern General involving some 40 minutes (and not just 10 minutes to the Victoria Infirmary).
- Shudder to think what will become of all potential patients from the South-East of Glasgow should the Victoria Infirmary close.

484. [redacted]

- Appear that to extend the facilities at the Southern would be the preferable option giving much easier access from Isle of Arran.

EMBARGOED UNTIL MEETING

- Southern General unsuitable location for the largest percentage of the population on the South of the river – unbelievable stupidity of having sewage works producing noxious smells which permeate the whole site.

- If we're saddled, unimaginative expense arguments about the difference in cost in leaflet 16 is offensive in the extreme.

476. [redacted] G76

- Travelling to the Southern General from Eaglesham would take an hour and probably longer to return.

477 [redacted] G44

- Why GGHB closed Samaritan, Mearnskirk, Rutherglen Maternity and now propose to close the Victoria Infirmary – leaving just one hospital to serve South–East and South-West of the City.

- Has GGHB given any thought to the travel visitors will have to make to get to the Southern General especially if they have to go by public transport and in inclement weather?

- Why was the option of the City Council to sell at a nominal sum a section of the playing fields together with Grange Road School building not pursued? That would have provided enough space and the sale of the site the present hospital is on would have helped offset the cost of the new hospital.

478. [redacted] G41

- Support for the building of a new hospital on a site suitable for easy access to service when whole of the Southside of Glasgow.

479. [redacted] G43

- Attended the public meeting at Coupar Institute – the only medical people in favour of the GGHB proposals were those on the platform, all other medical staff are totally against them.

- ACAD argument may be an adequate sop for the Health Board but everyone else views it with considerable mistrust.

- Considerable amount of the investment has been spent on the Southern General before consultation took place – the consultation is, therefore, irrelevant unless a new build hospital in the centre of the Southside is built there will be an appalling dis-service to the vast majority of the population of the Southside.

- The difference in cost seems a small amount in the overall scheme of things.

480. [redacted] G77

- Southern General does not meet the requirement for many residents in the Southside.

- Ridiculous to put money and very expensive medical equipment into buildings that date back to the Victorian times.

- Without a car travelling to the Southern General would be timely and costly.

469. Occupier, G43

- Southern General in the wrong area and very difficult for people to get to by public transport.
- Publish the number of letters you receive so we know the feelings of the Southside before decisions are taken.

470. Occupier, G44

- Southern General is not centrally placed to serve the Southside population.
- Extra buildings will have to be added to existing hospital.
- Hospital services are run for the benefit of the people and GGHB duty to respond to the real concerns of the Southside folk.

471. Occupier, G43

- Southern General being next to the sewage works has a terrible smell.
- Moving to the Southern General for in-patient services and A&E will cause extra pain and deaths.

472. [redacted] G42

- As there seems no doubt the Victoria Infirmary will close – we would prefer the redevelopment of the Southern General.

473. [redacted] G77

- Southern General is difficult to travel to from South-East both for patients and their visitors.

474. [redacted] G76

- Demand bold and radical approaches to be adopted by GGHB to put patients' needs first.
- Stakes are too high to get this wrong – millions spent on the Dome, surely an investment of £340 million required for a new southside hospital represents a worthwhile outlay.

475. [redacted] G44

- Read summary leaflet produced by GGHB and obvious that the preference is to expand Southern General.
- GGHB emphasise the cost of building a new hospital on the Southside but omit the real sum involved in their preference to redevelop the Southern General

351. [redacted] G44

- Concerned that over recent years and with no reference to anyone a number of specialties have been removed and transferred from the Victoria to the Southern General linked with the closure of the Samaritan and Rutherglen Maternity.
- Number of concerns around the Southern General site distance, although stated as being small for many patients the distance can be double.
- Convenience – convenience is more important than distance. Travel by public transport and by private means to the Southern General is poor compared to public transport services around the Victoria. Cowglen is in many ways even more difficult to reach than the Southern General.
- Land – There appears to be extra land available adjacent to the Victoria on the Queen's Park Recreation Ground.
- Finance – We should challenge the labour government to keep its election promises on Finance for the Health Service. Mentions that he is aware that the Health Budget was underspend last year.
- Consultation – He believes that the meeting held at the Couper Institute showed clearly with no ambiguity the wish of the local people for the retention and indeed the expansion of the Victoria.
- The express the wish of the public, rather than some of the clinical staff, is paramount.

352. [redacted] G44

- Writes to express great concern over the proposal to move Acute Services from the Victoria to the Southern General. Based on experience of both sites is aware of the difficulty of access to the Southern General by public transport. Feels local people deserve a centrally located modern hospital not cheese paring to move to an ancient converted poorhouse adjacent to a major sewage works.

353. [redacted] G46

- Expresses concerns about the proposal to transfer medical services from the Victoria hospital in Langside to the Southern General in Govan. The Victoria serves a wide area of the South side and the transfer would have a devastating effect on all the residents.
- Quotes a local newspaper article on the time taken to get to the Southern General by bus from Newton Mearns, namely 3 hours and 10 minutes, which he would regard as unacceptable.
- Strongly advises that we consider the need for the Victoria to be brought up to date, and that relocation to a more suitable site probably Cowglen which has a large area of development land available, and with public transport operates effectively.

354. [redacted] G76

- Writes to express concern about the proposed transfer of hospital services from the Victoria to the Southern General.

EMBARGOED UNTIL MEETING

- Fancy new build is no use without the staff to fill it.

305. [redacted] G43

- Plan to move services to the Southern General is unacceptable.
- Distance to travel is considerably greater with poorer public transport provision and road congestions already and can only be exacerbated by the transfer of services.
- Southern General is sprawling and antiquated – not an efficient medical care centre for the 21st Century.
- The proximity of the Sewage Works is hardly ideal.

306. [redacted] G77

- Southsiders having to travel to the other side of the city in cases of accident and emergency is sheer lunacy.

307. [redacted] G46

- The Victoria and the Southern are absolutely obsolete.
- New hospitals have been built almost everywhere in Scotland, the southside should now receive one.

308. [redacted] G77

- Requesting additional information about longer term patient usage, staffing and treatment patterns relevant to the year 2010-2015.

309. [redacted] G42

- Public transport to the Southern General is time consuming and costly and therefore unacceptable.

310. [redacted] G77

- Southern General not an option – very old, parking impossible, is built on a geological fault and too far away from the areas currently served by the Victoria.
- The distance to get to the Southern General could cost lives.
- Travelling could be a problem for mothers with young families and people who have to attend clinics regularly.

311. [redacted] G41

- Turning the Victoria into an ACAD defies creditability, concern over transfer of patients due to emergency to Southern, particularly in heavy traffic, also doctors travelling between two sites.
- Southern General is older than the Victoria and depressing, poorer parking, and above all odious smell.

EMBARGOED UNTIL MEETING

271. [redacted] G44

- Accessibility to the Southern General is a major concern.

272. [redacted]

- A&E at the Victoria Infirmary is one of the busiest in the country. To move it more than 7 miles away makes no sense.
- The ACAD at the Victoria will be too far away from the skilled help, diagnostic aids and necessary amounts of blood for transfusion should emergency arise.
- Travel to and from the Southern General will be extremely difficult for many parts of the south-east by private or public transport.
- The Southern General is in close proximity to the Shieldhall Sewage Disposal Works and that is unacceptable. I don't know why the Environmental Health Department have not done something about the complaints about the stench.
- If the Mansionhouse Unit closes where will the long term beds for the elderly be sited.

273. [redacted] G76

- An extension of modernisation of the Southern would not be a reasonable or acceptable alternative to the residents of the south-east on grounds of distance alone.

274. [redacted] G44

- Please consider someplace nearer for the people on the southside to travel to the Southern General is not much help for the elderly and those in poor health.

275. [redacted] G41

- Dismay at the proposed fragmentation of hospital services in the south of Glasgow.
- Appalled at the proposed closure of the Mansionhouse Road Unit with no mention of replacement provision.
- Proposals can only lead to confusion, traffic chaos and time delays for ambulances getting patients to the Southern or Royal Infirmary.
- Some services already transferred – what happened to public consultation.

276. [redacted] G43

- Proposal to site all in-patient activity at the Southern would be a retrograde step and would perpetuate the old way of thinking – modify old buildings to suit modern requirements. Same argument that using an old building like the Victoria as an ACAD.
- GGHB should be starting from the beginning and designing a new building to house both in-patient and ACAD patients – PFI would be an acceptable way to the southside of doing this.

244. [redacted] G41

- Public consultation has been a sham as Chief Executive did not listen to the voices of the public meetings he has attended.
- Southern General has a smell from the Sewage Works which intolerable.
- Access to Southern during a Rangers home game would be impossible.
- The Victoria Infirmary already has adequate transport to it.

245. [redacted] G73

- Leaflet 11 – Number of Beds we Propose to Provide: even allowing for keyhole surgery and day surgery a growth of 2% in orthopaedics does not seem correct.
- Leaflet 15 – How the Finance Works: £2.5 million for more efficient laboratory services will not be enough and will not cover large facilities at an ACAD.
- Leaflet 16 – Detailed Analysis of the Options for the Southside: crux of the matter is the £7.3 million per annum difference in running costs between a new build and the development at the Southern. Incumbent upon the Health Board to make representations to the Scottish Executive to make this significant difference up to provide a better acute service on a more suitable site than the Southern.

246. [redacted] G73

- How can the Southern General possibly deal with the work of 2 hospitals.

247. [redacted] G43

- With ancient buildings why can't we have a state-of-the-art hospital – listen to the voice of the people.

248. [redacted] G44

- The Mansionhouse Unit may close with no mention of alternatives. This is worrying to many elderly residents.

249. [redacted] G44

- Has heard no understandable reasons for closing the Victoria Infirmary and proposing the closure of the Mansionhouse Unit – this is concerning for elderly and those who have no access to private transport.

250. [redacted] G76

- The state of the NHS is a disaster. GGHB must support a new hospital for the southside.

251. [redacted] G41

- The Victoria Infirmary to have full casualty facilities – my views are second to none.

EMBARGOED UNTIL MEETING

167. [redacted] G44

- Concern at the apparent transfer of dermatology, urology, orthopaedic and haematology from Victoria Infirmary to Southern General. The proposal to close the Victoria will see a health desert compared to the north of the river.
- Distance is not small but convenience is probably more important than distance.
- Public transport to the Southern General is poor with little likelihood of increased future demand for a better public transport service to the Southern.
- There seems to be enough finance available for expansion elsewhere, now it's our turn.
- Challenge the Government to keep its election promises.
- Was the health budget not underspent for last year.

168. [redacted] G41

- Support for building of a new hospital on a site suitable for easy access to service the whole of the southside of Glasgow.

169. [redacted] G46

- Alternative sites to the Victoria Infirmary would incur at least half-an-hour extra travel for hundreds of people plus extra expense – not everyone has private transport and the public service is badly lacking.

170. [redacted] G44

- Real and genuine difficulties getting to the Southern General by public transport – don't know if you've managed to get there when taxis are not affordable for the elderly.
- The southside must have access for medical care nearer their home.

171. [redacted] G76

- Southern General is very inaccessible, in other words, a nightmare to travel to.
- Shudder to think of the consequences if emergency cases have to travel to the Southern.

172. [redacted] G44

- Too long to get to Southern and public transport takes ages.
- Finance should be available to do new build.

173. [redacted] G44

- Southern General has a foul smell permeating the air from the Sewage Works. This can't be healthy for any patient or hospital staff. I cannot believe that any right thinking person would consider this a proper place for the health care of so many people.

EMBARGOED UNTIL MEETING

- Concern has been expressed about day surgery being carried out at the Victoria – some distance from the main surgical hospital. If things go it means transporting a patient across the city in circumstances that are far from ideal.

161. [redacted] G43

- Southern General is an awkward place to get to both by car and public transport and poses severe difficulties for patients and visitors.

162. [redacted] G44

- Expresses disgust and dismay at closure of the Victoria which is apparently a fait accompli despite the obvious wishes of the southside population.
- How could one hospital possibly serve the whole of the southside of the city – coupled with miserable public transport to the Cowglen area – it will never be understood.

163. [redacted] G44

- No way of getting to the Southern General from Croftfoot and Castlemilk – if they can use Grange Road School area, why not use that as an annex to the Victoria.
- Southern General is more noted for the dreadful smell from the Sewage Works.

164. [redacted] G78

- GGHB should re-consider the decision to move the A&E services from the Victoria Infirmary.
- Lives must be more important than budgets. Lengthy journeys would be involved with changes of buses to reach the Royal Infirmary and the Southern.
- Parking facilities at the Royal Infirmary almost non-existent for those who have a car.

165. [redacted] G43

- Be extremely inconvenient and very expensive to be treated at the Southern General.
- Demands that GGHB build a new hospital in the southside to serve the citizens living there.
- City seems to be very well off since it can spend millions on the refurbishment of Argyle Street, Sauchiehall Street and St Enoch Square – money which would have been more wisely spent on a new hospital.
- Hope that, for a change, GGHB listens to the people.

166. [redacted] G44

- Ground available adjacent to the Victoria Infirmary – use it for the new hospital.
- Public transport to the Southern General very difficult.

EMBARGOED UNTIL MEETING

150. [redacted] G73

- Travel to the Southern from Rutherglen would take 2-3 buses and the taxi cost be prohibitive.
- How could the Southern General cope with double the amount of patients.
- Thought voting for a Scottish Parliament would help OAPs but their record has been poor so far.

151. [redacted] G46

- Travelling to and from the Southern General is a major factor and could be a matter of life and death – it will also be difficult visiting especially for relatives.
- Hopes the views of the ordinary folk will be taken into account in this important decision.

152. [redacted] G44

- Proposed action to transfer services to the Southern General is obviously absurd. Its remoteness in public accessibility, its structural limitations and its stinking presence all act against it.
- Would hold the Scottish Parliament and its appointees directly responsible for the loss of the Victoria Infirmary.

153. [redacted] G44

- Closing the Victoria Infirmary is dangerous and wrong – 2 examples given of benefits of accessibility to Victoria Infirmary being lifesaving.
- Negligent in the extreme to close a well needed and well used hospital.
- How many lives will be lost due to its closure.

154. [redacted] G44

- The Victoria Infirmary should be kept – be restored and cleaned up in the way hospitals used to be.
- Patients should be properly cared for with trained staff. Where are the standards gone.

155. [redacted] G77

- Plan to move services to the Southern General is unacceptable.
- Distance to travel is considerably greater with poorer public transport provision and road congestions already and can only be exacerbated by the transfer of services.
- Southern General is sprawling and antiquated – not an efficient medical care centre for the 21st Century.
- The proximity of the Sewage Works is hardly ideal.

EMBARGOED UNTIL MEETING

156. [redacted] G77

- Southside deserves a completely new hospital for the 21st Century which is convenient for all people who live in the south of Glasgow.
- Southern General is not easily accessible by bus – 2-3 buses to get there.
- Car park at the Southern General is completely inadequate.
- Can't understand why the Mansionhouse Unit has been threatened with closure – what happens to the elderly then.

157. [redacted] G43

- The proposed ACAD located at the Victoria Infirmary site causes it to be a stand-alone facility – where is the evidence of a similar arrangement working safely elsewhere.
- Leaflet 16 – Detailed Analysis of the Options for South Glasgow pointed to the fact that the bottom line difference is cost, i.e. £7.3 million per annum for 30 years and this is described as massively significant. It was admitted, however, that the revenue from the sale of the redundant site estimated at £22 million had not been taken into account.
- It emerges in the press that the bulk of this cost is made up of site cost charging introduced by the previous Government and presumably reversible given a change of political will. Southside of Glasgow has been the poor relation of Glasgow medicine for too long.
- GGHB – think big. This is something for the next Century, not the next 5-10 years.

158. [redacted] G73

- Taxi cost to the Victoria £3.50 but to the Southern at least £8 – rather daunting price increase.
- What happens if someone requires urgent hospital treatment – only half of the ambulances in Glasgow are staffed by fully trained paramedics.

159. [redacted] G46

- If the in-patient services are transferred to the Southern General it will leave us with severe travel problems.
- It is extremely difficult to find a car parking space at the Southern.

160. [redacted] G76

- Southern General lies on the boundary between GGHB and Argyll and Clyde – patients and visitors living in the southside of the city without their own transport could be faced with a 2-hour journey to and from the Southern and involving 2 buses. This is unacceptable.

EMBARGOED UNTIL MEETING

- The Southern is in close proximity to the Shieldhall Sewage Works and if the wind is in the wrong direction the smell can be quite overpowering.

135. [redacted] G76

- Strongly support campaign for building a new hospital in the southside of Glasgow to replace the ageing Victoria Infirmary.

136. [redacted] G73

- The authorities do not appreciate the difficulties of travelling on public transport if you are elderly or unwell.
- The facilities being offered at the Southern are entirely overestimating the abilities of senior citizens etc. to find their way there when they are not in the best of health.
- Plans are totally inadequate and useless for the citizens of Glasgow who are not situated in the west of the city.

137. [redacted] G44

- I would like to see a new hospital built on the southside of Glasgow rather than having the Southern General to cover the whole southside population.

138. [redacted] G42

- Attended various meetings held locally and cannot understand why there can't be a simple solution for this ongoing problem. The majority of people agree a new hospital is badly needed.
- Can someone explain why it can't be built next to the Victoria Infirmary as the City Council has offered the land.

139. [redacted] G44

- We could be dead on arrival by the time we got to the Southern General if we are unlucky enough to take a heart attack etc.

140. [redacted] G44

- Anyone currently using the Victoria Infirmary will find it exceedingly difficult and expensive to use public transport to get to Cowglen or the Southern. The extra distance needed to reach such sites could have a severe disadvantage in an emergency.

141. [redacted] G41

- Build a new hospital for the 21st Century convenient to the population of the south of Glasgow.
- Southern and Cowglen are a nightmare to get to particularly if you don't have your own transport.

EMBARGOED UNTIL MEETING

- Public transport not good to Southern General and there is an awful smell from the sewage plant.
- I Understand that the City Council have offered Queen's Park Recreation Ground which would be ideal for the new hospital.
- My opinion is that people have already made up their minds to do away with the Victoria.

130. [redacted] G46

- The thought of having to travel either as a patient or a visitor to the Southern is really worrying.
- In emergency there is absolutely no way someone could travel from here to the Southern quickly enough.
- Even for a non-emergency it would take around 40 minutes by car and I do not know of a direct bus route.

131. [redacted] G46

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- In emergency there is absolutely no way someone could travel from here to the Southern quickly enough.
- Even for a non-emergency it would take around 40 minutes by car and I do not know of a direct bus route.

132. [redacted] G44

- Southern General, with no disrespect, is difficult to reach for patients and visitors alike.

133. [redacted] G42

- To get to the Southern General, particularly for the elderly, it would be a real difficulty as you are required to get two buses (the taxi cost would be too expensive).
- We must do our best for the elderly and those who find it difficult to travel due to age or are on disability allowances.

134. [redacted] G44

- Don't agree with the rather hotchpotch affair proposed with the ACAD at the Victoria and main hospital at the Southern.
- We have a history of producing the best nursing and medical people in this country – surely they deserve the finest facilities to work in.
- All the alterations in the world will not make the Southern General a state-of-the-art hospital.

EMBARGOED UNTIL MEETING

123. [redacted] G44

- Access to the Southern General for the elderly and the ill and visitors would be a nightmare.
- We cannot speak highly enough of the first class treatment received at the in-patient and out-patient departments of the Victoria Infirmary.

124. [redacted] G73

- Concerned at the time it takes to get to the Southern General by public transport.
- Transferring heart patients to the Royal – what a farce. The hospital is already working to capacity and has no transplant surgeon.

125. [redacted] G46

- Don't waste money patching up – build new in the southside.

126. [redacted] G43

- Need a brand new 21st Century hospital – and then perhaps the top doctors who are leaving Glasgow in their droves will be persuaded to stay.
- We are so generous with spending money on ridiculous and unnecessary projects. Let's do something for the benefit of our citizens. It is not a luxury, it is an absolute necessity.
- The Southern General is in the wrong location, it is across the road from Sewage Works which smell to high heaven, it is an old building and no amount of patching up will turn it into a new building.
- The entrance for pedestrians on this side of the city is by an underpass which must surely qualify as the most disgusting entry for any hospital on record. We may not be that well off but we are a comparatively prosperous country and surely our city's health care should be of paramount importance.

127. [redacted] G46

- Agree the southside is in need of a review of medical services as the Victoria Infirmary is now outdated.
- Only satisfactory solution is a new modern hospital. Walk-in/walk-out unit have been attached to main acute hospitals in other parts of the country.

128. [redacted] G44

- Travelling to the Southern General is totally unacceptable.

129. [redacted] G43

- It is a disgrace that a city the size of Glasgow does not have a brand new hospital built on the southside.

EMBARGOED UNTIL MEETING

107. [redacted] G46

- The whole family hopes the Victoria Infirmary never closes – what's wrong with it anyway.

108. [redacted] G76

- How would Southern General cope with roughly 700 patients from the closed Victoria – especially during a 'flu epidemic.
- Don't fancy any patient's chances in getting to the Southern General by ambulance in time.
- No doubt this letter will do no good as it has already been settled that the Victoria Infirmary will close against the wishes of thousands of people from the southside.

109. [redacted] G76

- Seems a complicated set of arrangements for different departments – apart from not knowing which hospital to go for when looking for accident and emergency treatment.
- With Mansionhouse Unit possibly to close there appear to be no plans for the long term needs of the elderly.

110. [redacted] G76

- Not convinced of the merits of the proposal to revamp the Southern General and establish an ACAD for the Victoria.
- The Southern General will be patched up facilities and is also close to the stench emanating from the nearby Sewage Works.
- Patient care must always be the overriding consideration.
- Perhaps being unfair, and although the present consultation process is much publicised, can't help feeling that GGHB has already decided in the favour of the split-site option to save or possibly re-locate money.
- Advocates the building of a new, modern hospital on a suitable site in the southside of Glasgow.

111. [redacted] G46

- Has a strong belief that the citizens of the southside need a hospital which is easily accessible to them.
- GGHB should do what it can to ensure that the services provided by the Victoria Infirmary will continue to be available for all southside residents.

112. [redacted] G44

- Need a new hospital for the southside – why not use the land opposite the present Victoria Infirmary – you own the land.
- Why are you moving all services from the Victoria without consulting everyone.

- It boils down to dreadful lack of care for people living in the south of the city. We are paying for these hospitals and we deserve better. The Board should look to their political decision and resurrect their humanity by building on the Queen's Park Recreation Ground – giving a solution for those souls it greatly affects and may one day save.

87. [redacted] G43

- The Southern General is not at all convenient to get to, it's badly laid out, has terrible car parking problems and not to mention the disgusting smell from the nearby Sewage Works.

88. [redacted] G76

- Delayed writing until she had heard a cross-section of the views and the changes to Glasgow's acute services south of the river.
- Public transport can take up to 1½ hours involving 2 buses and a walk of 10-15 minutes accumulating by having to use a dirty, lonely underpass as the only way to cross the dual carriageway: apprehensive when using the subway and does not use it at quiet times of the day or night. Must be even more daunting and traumatic for the elderly, sick and mentally ill and pregnant women with toddlers to make this journey.
- Hospitals should be located centrally to maximise access for the majority of the southside population.
- Southern General is nearer to the population of Argyll and Clyde and North Glasgow citizens than the population it is meant to serve.
- Gridlock of traffic at rush hours, accidents on roads and frequent repairs to the tunnel and bridge.
- Southern General is generally in a poor state of repair with disjointed buildings.
- Problems associated with close proximity to Ibrox Stadium.
- Close proximity to large Sewage Plant creating unpleasant smell.
- The Southside has seen the closure of many hospitals already and many other areas of Scotland have had new purpose-built hospitals. Why should the southside population deserve anything less.
- Concern about stand-alone ACAD service – that was the argument to close Rutherglen Maternity.
- Journey time alone could result in loss of lives from heart attack, asthma, stroke, convulsions or serious injury when time is crucial.
- The main argument in favour of Southern General seems to be cost and the £7 million it would have to use on other services – better to use some of the £34 million the Health Board handed back as surplus to the Government.
- If the Victoria Infirmary had had the investment over the last 2-3 decades that the Southern General has had, then this difficult decision would not have arisen.

EMBARGOED UNTIL MEETING

59. [redacted] G44

- The Southern General is not easily accessible for most of the southside population and its buildings are old.

60. [redacted] G42

- A new up-to-date hospital for the southside is required – in a site close to the proximity of the Victoria Infirmary which would give it good bus and train services. The Southern General would entail an unreasonable amount of travelling time for patients and relatives.

- An ACAD on the Victoria Infirmary site is an extremely bad idea as a lack of resuscitation and other facilities provided by an acute hospital, worry to patients, relatives and hospital staff if unforeseen circumstances arise which necessitate a patient's stay in hospital.

- Transfer of medical records, specimens, laboratory tests, x-rays etc. would cause duplication of cost. Blood for transfusion would be a particular worry.

- Urges retention of Mansionhouse Unit for long term elderly.

61. [redacted] G76

- Obvious necessity for southside to have a new hospital built as so many of them closed.

- Travelling and costs to go to the Southern General would cause great distress.

62. [redacted] G73

- Travelling to and from the Southern General is too far away.

63. [redacted] G43

- Common sense says the location of a new southside hospital is crucial to benefit the majority of the people living in the southside – use the former football park.

- Southern General is basically a collection of sheds wedged between motorway sliproads and the empty borders of Glasgow City and Renfrewshire.

- Land at Cowglen is liable to flooding at certain times of the year.

- New roads would need to be built to access the hospital, never mind the dearth of frequent and suitable public transportation for visitors.

- Southern General has Sewage Works adjacent to it from which a horrible smell permeates.

- A friend has said that major building works have already started on the site of the Southern General – does this mean decisions have already been taken. It will be the case that it will be no surprise to the voting population that so little respect has been given to our political representatives and the credibility of public consultation. Can MSPs, MPs, Councillors and hospital boards not be aware of what the people want and then endeavour to comply with these.

EMBARGOED UNTIL MEETING

36. [redacted] G44

- Smell outside Southern General Hospital was terrible.

37. [redacted] G46

- Too many people have been content to retain the old hospitals at the level which was the custom many years ago – but that is not good for health care nowadays.

- Scotland has advanced in education for our children, the amenities they expect, personal hygiene and general cleanliness – it is only right we should have a newly built hospital fit for people of the 21st Century. Not a makeshift attempt to patch up old hospitals from a different era.

38. [redacted] G46

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39. [redacted] G46

- The proposed closure of the Victoria Infirmary in favour a redeveloped Southern is a bridge too far – after all the previous closures within the southside. The removal of services from the Victoria Infirmary by piecemeal has caused great anger and anxiety in the population.

- The cavalier and arrogant approach by the Health Board, its Executives and a few opportunists at recent consultative meetings has done nothing to reassure the public that the proposals are anything other than a bad deal for people in the south-east of Glasgow.

- The ACAD sweetener – only one of which exists in the UK – is inappropriate, flawed and a derisory gesture. The map of acute hospitals shows the Southern to be too close to Gartnavel but it may as well be north of the river. In 1992 GGHB catchment areas for south of the River Clyde showed the Victoria Infirmary as the virtual population epicentre.

- Southern General would result in lengthy and expensive journeys by public transport from Castlemilk and Newton Mearns, the journey time being 3 hours 10 minutes round trip.

- Traffic congestion along the routes and the hospital too close to Ibrox Stadium where some 50,000 supporters converge up to twice a week adding to traffic congestion.

- The Clyde Tunnel also has its share of problems and delays due to accident and tunnel maintenance procedures.

- This all adds up to unease for patients who have to travel by ambulance for treatment.

- This is the worst possible solution to the problem.
- Public transport so poor couldn't visit her husband at the afternoon and evening visiting, she just had to stay at the Southern most of the day.
- The smell of sewage works forced her indoors.
- The southside needs a proper hospital on a site which can be easily reached by all and not adjacent to a sewage works.

25. [redacted] G76

- Do not spend more money on an old hospital which is next to a sewage plant – this would be the height of folly.
- Hope your leaflet 'Plan it Together' and recent Board Chairman letter in the Herald do not mean we will consult but will have already decided that a new hospital is not an option – hope this is not the case.

26. [redacted] G44

- GGHB should build a new hospital on a greenfield site or even a brownfield site – a great city such as Glasgow is worthy of a new hospital.

27. [redacted] G42

- Realises the monetary pressures which local services are put under to give value for money under scrutiny for performance – but can't see a justification for the closure of the Victoria Infirmary. Northside has 4 commendable hospitals, the southside is to have one.
- There has already been enough hospital closures on the southside already.
- It boils down to dreadful lack of care for people living in the south of the city. We are paying for these hospitals and we deserve better. The Board should look to their political decision and resurrect their humanity by building on the Queen's Park Recreation Ground – giving a solution for those souls it greatly affects and may one day save.

28. [redacted] G77

- Travelling to the Southern General is an impossible journey from Newton Mearns unless one has a car.

29. [redacted] G46

- The arrival of the new millennium would demand a bold and radical approach to be adopted by GGHB and one that puts the patient before the accountant's profit and loss column. What more valuable commodity has any society than a healthy, active population.
- The stakes are too high. Penny pinch now and future generations will pay the price.

EMBARGOED UNTIL MEETING

9. [redacted] G41

- Having worked in a day surgery ward she knows from experience that emergencies do occasionally happen with minor operations – if this happened in an ACAD the main hospital would be 6 miles away.
- GGHB should listen to the opinion of the consultants and also the general public.

10. [redacted] G41

- Fewer visitors if in-patient services transferred to the Southern. 3 times as long to get to the Southern as it is to the Victoria.
- GGHB should listen to the opinions of Consultants, doctors and nurses and the general public – the vast majority of whom would be against the closure of the Victoria. Funds could and should be found for a new hospital.

11. [redacted] G44

- We object strongly to having to travel on public transport to the Southern General.
- Southern General nowhere near the southside of the city.

12. [redacted] G66

- The availability of the 21 booklets to the public is a major step forward in communication of information and advice to the public and community groups in the GGHB area. The series of public meetings organised by the Health Board and Trusts has also been a useful exercise although the response by organisations and the public for some meetings was poor.
- Would have preferred to see an additional booklet on the subject of long term care of the elderly both in hospital and in the care of community projects.
- Stobhill is a major and necessary part of the health requirement for the community.
- Would wish to see a clear and concise document being issued with positive and achievable proposals on the strategy for hospitals/clinical services, community based projects for the care of the elderly, at home or in nursing homes.

13. [redacted] G77

- Dismayed at the prospect of only one A&E hospital in the southside of Glasgow – at the Southern. The closure of the Victoria Infirmary could cause serious problems and the extra time to travel to the Southern General could make all the difference between life and death on some occasions.
- Not practical to expect people to make long journeys to the Southern General by public transport.
- Shieldhall Sewage Treatment Plant is adjacent to the Southern General and therefore it does not seem the best place to have a hospital.

HEALTH COUNCILS	
Greater Glasgow Health Council	NEUTRAL Insufficient information in the public domain to allow a decision to be taken to create new maternity hospital at SGH or new Southside Hospital There may be advantages to maternity being next to adult acute services but other options - such as redevelopment of Yorkhill - also should be explored It would be wrong for GGHB to move services away from Yorkhill at this stage
Ms R Hill, Acting Chief Officer Argyll and Clyde Local Health Council The Gatehouse Hawkhead Hospital Paisley	Relocation of paediatric and maternity services to SGH could have impact on both the Vale of Leven and RAH leading to restricted choice for patients from Argyll and Dumbarton.
LOCAL AUTHORITIES	
Alex Mosson The Rt. Hon. Lord Provost of Glasgow Glasgow City Council	DISAGREE Relaying and concurring with view of Garnethill Community Council that 'Yorkhill Children's Hospital' should be retained at the current site To move the facility to the SGH would disadvantage citizens North of the Clyde
MSPs and MPs	
Dorothy Grace-Elder MSP (List MSP for Glasgow - SNP) Member of the Health and Community Care Committee	Both hospitals should remain at Yorkhill site.
Ms Sandra White MSP Constituency Office 74 Miller Street Glasgow G1 1DT	Urge the Health Board to retain the Yorkhill Hospitals on their current site.
SERVICE USER GROUPS	
David McVicar (Chairman) Yorkhill Family House Limited (Ronald McDonald House)	DISAGREE Point of charity is to provide accommodation for parents whose children are attending Yorkhill Concerned over any threat to maintain accommodation adjacent to children's hospital Doubly concerned over financial consequences of fund-raising for a new building if Yorkhill Trust moves and meeting loan charges on old site which is only 5 years old Had read GGHB comments that suggested that Ronald McDonald House would move wherever the new hospital went but have never been consulted
Elsie Watson, Support Worker Cystic Fibrosis Support Group Royal Hospital for Sick Children Cystic Fibrosis Trust	DISAGREE Current RHSC location at Yorkhill ideal for transport around and from outside Glasgow Parents of children with CF concerned at consequences of disruption/extra travel Sewage works at SGH also caused concern for them Facilities for adolescents with CF are currently inadequate and there is concern as to what will happen in the future Would like a dedicated CF Unit to be established

MATERNAL AND CHILD

Mrs E Penny, Health Representative Giffnock Community Council 19 Graffham Avenue Giffnock Glasgow G46 6EL	Travel to SGH either by public or private transport is extremely difficult and in accessible. Demand a new build hospital on south side.
Mr W Milner, Secretary Newlands and Auldhouse Community Council 53 Glasserton Road Glasgow G43 2LN	Impact of public transport on the plan to have two sites shown to have defects - east/west services compared with north/south services are abysmal. Present public service to SGH disgraceful. Ambulance services seems to be unresourced.
Mrs D Green, Honorary Secretary Milngavie Community Council 5 Birrell Road Milngavie Glasgow G62 7JX	Existing hospitals and those proposed are too inaccessible and too overcrowded to allow any significant development - feasibility study should be carried out. Suggest a duplex hospital complex.
Mr J F Sutherland, Secretary Mansewood and Hillpark Community Council 94 Hillside Road Mansewood Glasgow G43 1BY	Horrific smell from sewage works at SGH. Lack of transport to SGH.
Ms A Wild, Secretary Eaglesham Community Council 89 Montgomery Street Eaglesham Glasgow G76 OAU	Proposal are flawed and inadequate.
TRADE UNIONS AND PROFESSIONAL ORGANISATIONS	
Unison, Glasgow Area (large number of pre-printed leaflets signed by individuals and forwarded to GGHB) John Gallacher, Regional Officer Robert Rae, Secretary to the Area Steward's Committee	DISAGREE Object to 3 month consultation period - want it extended
Margaret Walsh, Secretary Joint Staff Organisation North Glasgow Trust	AGREE/DISAGREE Welcome modernisation of acute hospitals as status quo cannot continue Reservations over consultation period - want it extended to December 2000 100% opposed to any use of private finance in the reconfiguration of services Need to address transport infrastructure - lack of parking and public transport features at the Sandyford Initiative site: do we really want this for all our patients Will respond again once GGHB provides more detail
Dr Gladys H Smith, Programme Action Convener Soroptmist International of Glasgow South 325A Albert Drive Glasgow G41 5EA	Proposed changes given at cautious welcome with two provisos in the areas of accessibility and transport and the need for information made available in easily understood language.
Mr C Rodden, Chairman Staff Side Joint Consultative Committee Pharmacy Department Gartnavel General Hospital	A major overhaul of transport links from all over Glasgow to the various sites is required.
Mr D W Sime, MSF Branch Chairperson MSF Glasgow Health Service Branch Clinical Microbiology Western Infirmary	Ensure equity of access to services.

NHS TRUSTS	
North Glasgow University Hospitals NHS Trust	AGREE NGT strongly supports locally dispersed, accessible outpatient, day case and diagnostic services at 5 sites Wish to include Dental Hospital in strategy - e.g. in autumn review period as the exercise has now advanced to the stage where public consultation can take place - it would be preferable to ensure that GDH's future is linked to other acute services The Trust embarked upon and extensive consultation process which included 27 public meetings, 100 internal meetings and other meetings with patients' advocacy groups etc. before producing its response The fundamentals of the strategy proposals were not challenged in this process The Trust would like to reinforce a point made in public meetings that there might not be total agreement but choices have to be made in order to move forward
Duncan Porter, Consultant Rheumatologist (via E-Mail from North Glasgow University Hospitals NHS Trust)	Consultation process poorly managed. Genuine concerns of large sections of the clinical community have been ignored.
Elinor Smith, Chairman South Glasgow University Hospitals NHS Trust	Maintaining status quo is not an option - change is essential. Concern over existing public transport infrastructure.
Mr T P Davison, Chief Executive Greater Glasgow Primary Care NHS Trust	Effective interface between acute service providers and Primary Care providers is essential and we are committed to work with acute service providers and GGHB in achieving the best service possible within available resources. A topic which does not receive attention is ensuring appropriate psychiatry services are provided to medical patients within acute hospital settings.
HEALTH BOARDS AND NON-GLASGOW TRUSTS	
Ms R Bryson Argyll and Clyde Health Board	Assessment of need relates only to Glasgow population - no account has been taken of the wider population base. Transport difficulties for Argyll and Clyde residents need to be taken into account.
HEALTH COUNCILS	
Greater Glasgow Health Council	AGREE Acute review is much needed - injection of capital proposed in 1991/92 never took place and infrastucture is "clapped out" Status quo is not an option: services must be improved and not just maintained There is an urgent need to improve public transport links to all acute facilities, no matter their location Similarly the case for parking provision, especially at the GRI
Ms R Hill, Acting Chief Officer Argyll and Clyde Local Health Council The Gatehouse Hawkhead Hospital Paisley	Express concern about the proximity of SGH to sewage works.

GENERAL ISSUES

EMBARGOED UNTIL MEETING

- GGHB will not listen to the medical people who can be trusted.
- GRI or any other location is not an option.

132. [redacted] G46

- Had to write regarding GGHB's PR exercises at moving care to other hospitals in Glasgow.
- The Victoria is old but so are the other buildings you are proposing to use. If you do not live in the southside and access their services how can you make the decision for thousands of people who do. The southside of Glasgow needs a new build. Nothing learned from the last century – false economy to patch up here and there; bring back in-service cleaning facilities, matrons or a more senior nurse.
- Public transport possible for visitors and relatives (especially the elderly). Taxis are expensive.
- Just pay all your taxes and other people will decide your well being for you.
- Too many quangos and departments doing the same thing, getting high salaries for pushing paper.

133. [redacted] G76

- Protests at proposed closure or conversion of the Victoria Infirmary to an ACAD (which will not be open 24 hours a day).
- Journey time to the Southern General by public transport is time consuming and inconvenient.
- Car parking at both the Southern and the Victoria is virtually non-existent – also difficult to deliver a disabled person to casualty and then trying to park the car.
- The close proximity of Shieldhall Sewage Works is not conducive to quick and comfortable recovery and treatment for patients. Last year there appeared to be leaking drains with a strong smell on one of the main ward blocks.
- The Board should seek funds to build a new hospital on the southside of the city which has easy access by public transport and adequate parking for visitors.

134. [redacted] G66

- Concerned that GGHB are set on reducing the necessary facilities available at Stobhill with the intention of closing this quality hospital – no justification for this.
- Compacting 5 Glasgow hospitals and their current patient numbers into 3 with an overall capacity below the present 5 in a city with acknowledged poor health records requires convincing explanation.
- GRI located within heavily congested part of Glasgow – difficult to access for patients, visitors and staff.

- Nothing is said about car-parking at the SGH, as the site is already at saturation point and public transport is pitifully inadequate.
- Board has not confirmed consequences of this site being the lone in-patient hospital if there is a major incident.
- Strongly object to Board's claims to be impartial in its consultation and implying that the only choice is between the Board's proposals or keeping the old buildings because they happen to be close at hand.

145. [redacted] G64

- Strongly objects to further closures of wards and units at Stobhill and transfers to GRI and Gartnavel – the opposite is required.

146. [redacted] G77

- Appears GGHB unwilling to accept public concerns about the closure of the Victoria Infirmary and transfer to the Southern.
- Enormous difficulties in finding the way to the Southern by public transport.
- Southern General is at the extreme north-west corner of the area and located beside the local sewage works.
- Facilities at the Victoria have been allowed to deteriorate over a number of years and those responsible require to be held accountable for their negligence.

147. [redacted] G77

- The public of the southside of Glasgow should have a full service for health and a modern fully operational hospital built in an area that covers the southside of this great city.
- Fail to understand why they are having this debate – is it purely for financial reasons.
- GGHB putting certain proposals to the Scottish Executive at the beginning of 2001 so why can't the Health Minister make a comment at this time – it would not compromise an urgent situation.
- I am assured that the medical consultants are all in favour of a new site for the hospital covering the southside.

148. [redacted] G42

- Concerned that the Health Board is planning to move all hospital services from the Victoria to the Southern and leaving an ACAD at the Victoria.
- Southern General not centrally placed to serve the population of over 300,000 who live in the southside.
- The extra new build at the Southern will not be as effective as a new building designed for maximum efficiency.
- Best hospital care must be a priority – not short term saving of money.

- It is regrettable to have seen the Victoria Infirmary fall into disrepair over 40 years.

164. [redacted] G21

- One of the many people concerned by proposals for Stobhill.
- Suggestion that services being moved to GRI and Gartnavel.
- GGHB should listen to the people who matter and leave Stobhill and its staff with security.

165. [redacted] G42

- In the Southside 'decision-matrix' it is claimed that building a new in-patient hospital at Queens Park would lead to the removal of recreation land, yet the 'old' Victoria would under the Board's preferred option be sold off – so therefore the proposed ACAD would have to be built on part of the very same land – why is this acceptable for the ACAD and not for the in-patient hospital?
- Concerned that Board seems to regard a 53 minute off-peak journey by public transport to the SGH site as acceptable – some clinics commence at 9.00am, which entails a journey in rush hour which will increase the time taken by at least 30 minutes – it is not acceptable for an elderly person to get up at 6.30am to undertake the journey.
- No mention is made of accessibility to the SGH A & E unit in the event of a disaster at Hampden Park – a 53 minute journey with badly injured patients would reduce survival rates.

166. [redacted] G66

- Objects to transfer of services from Stobhill to GRI – this will lead to the eventual closure of Stobhill as a general hospital.
- Catchment area for Stobhill does not at Kirkintilloch – it extends to many villages beyond.
- Stobhill is necessary to cope with this catchment area, GGHB should re-consider its proposals.

167. [redacted] G66

- Most residents spoken to agree that GGHB won't listen or ignore them.
- We want the continuation of a general hospital for Stobhill – it will be used to more than full capacity and has a good car park for both patients and visitors.

168. [redacted] G44

- Amazed that GGHB is determined to go against the people of Glasgow with their acute plans.
- Southern General is on the periphery of the south and south-east of the city and situated next to a sewage works.

...ildren and family members in emergencies

SCOTTISH HOSPITALS INQUIRY

Bundle of documents for Oral hearings commencing from 13 May 2025 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow

Bundle 30 – Acute Services Review Papers