

A HOSPITALS' STRATEGY FOR GLASGOW SOUTH

**“KEEPING THE SCOTTISH NHS
LOCAL”**

HEALTH SERVICE FORUM SOUTH EAST

JANUARY 2005

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1 INTRODUCTION

The Health Service Forum South East was constituted in 1992. It exists to promote the understanding and discussion of all aspects of the NHS in Glasgow, and to encourage high standards and quality of provision of healthcare. Its purpose is to inform the residents of south Glasgow of the changes in the NHS which relate specifically to their area, covering the hospitals, GPs, community care and the NHS overall, to the best of its ability. All of its members are users of the NHS in Glasgow. They bring a wide range of expertise from backgrounds in healthcare professions, civic representatives, skilled trades, architecture, university teaching and research, but most importantly, personal experience of the service. The membership operates through subcommittees each with professional expertise. The Forum has also commissioned reports by independent authorities and organisations. These can be found on our web site: **www.healthforumglasgow.org**

Electoral and political pressures have culminated in a new political determination throughout the country to reverse the historical decline in the NHS. This is reinforced by government determination to back this with a budget for healthcare provision which will increase in real terms and which will close the gap in provision between the UK and its European neighbours. It is of major importance to the healthcare of Glasgow and Scotland as a whole that this opportunity is acted upon and not squandered by blindly pursuing out-dated directions of provision.

After over five years of NHS Greater Glasgow (NHSGG) planning and consultation processes, no quantitative parameters for a new system, such as the number of beds, estimates of environmental impact or costings have yet emerged. As at December 2004 the actual number of A&E departments is awaited.

Evidence of the deterioration of the current system accumulates almost daily. Serious damage to Glasgow's healthcare infrastructure will result unless this planning stasis can be broken.

In bringing forward a Strategic Plan once again, we do so with a determination to demonstrate that a high standard of health provision for Greater Glasgow can be achieved in a cost-effective and evolutionary manner.

2 EXECUTIVE SUMMARY

This document sets out a plan for healthcare in the 21st century that takes account of existing best practice, state-of-the-art technology, and the clearly expressed views of the people of Glasgow.

Since the modification to the Acute Services Review was announced in December 2003, it has become clear that severe capacity shortages within the city's hospitals have rendered it unworkable. The present ASR cannot provide the quality of acute hospital care, which the city expects and requires, for its own population and for a significant proportion of the population of the West of Scotland.

Principal Components of the Plan

The goal is state-of-the-art acute hospital services for South Glasgow.

The key elements are:

- There will be two acute hospitals in South Glasgow. Each hospital will provide for the majority of the medical and surgical patients in its catchment area, with properly planned staffed bed capacity.
- The case against the construction of a mega hospital in south Glasgow is that large hospitals reduce patient accessibility and make communications between hospital, primary care and community services more difficult. There is no evidence that such large hospitals would either improve clinical outcomes or provide economies of scale. Alternative designs are being actively considered in England for smaller, modern hospitals that provide consultant-led acute, medical and surgical care across a range of specialties, including accident and emergency.
- Any new hospital should be sited and phased so that its construction can be rapid and unencumbered by the requirements of maintaining services.
- Small specialties will be concentrated on one site or the other and patients will attend the appropriate site. This arrangement, applying to only a minority of patients, will overcome the difficulties of achieving sufficient specialty patients and post-operative 'cover'.
- Clinical networks will provide the basis for care of individual patients, integrating primary care and acute hospital facilities.
- Information technology systems will improve cost-effectiveness of NHS resources and will enable services to be delivered across a decentralised environment.

The key challenges and opportunities facing healthcare in the UK and in Glasgow in particular in the 21st Century are:

- Healthcare must make provision for a major increase in the elderly population (the number of people aged 75 or over in the UK is expected to increase from 4.3m to 7m by 2036).
- Advances in medicine including improved diagnostics.
- Availability of new drugs and vaccines derived from the BioInformatics revolution.
- Increased specialisation in surgery, leading to new treatments.
- Improvements in Information Technology, which will revolutionise the management, form and delivery of healthcare.
- Increasing costs in transport (transport costs are likely to escalate over the lifetime of the plan, from 2 times the year 2000 costs in 2010 to 8 times the year 2000 costs in 2030).
- Clinical networks are seen as key tools for improving quality of services (in many countries clinical networking not hospital centralisation is the cost-effective way towards better healthcare).
- Day surgery is increasing but is not replacing the need for in-patient services.
- Concentration of surgical specialties WITHOUT disproportionate centralisation.

3 KEEPING THE SCOTTISH NHS LOCAL: A NEW DIRECTION OF TRAVEL

Following the election of Dr Richard Taylor to the Wyre Forest Constituency in the 2001 General Election, with the largest majority of any English constituency, the Health Secretary, Alan Milburn, initiated a detailed review of the policy of closing and removing services from smaller hospitals. The prospective closure of Kidderminster Hospital and the transfer of all services to a new PFI-funded hospital in Worcester had prompted Dr Taylor's election.

This resulted in demands from many Labour MPs in marginal constituencies that there "should be no more Kidderminsters" at the next general election. In February 2003, a consultation paper was produced entitled "Keeping the NHS Local – a New Direction of Travel" which suggested a number of options for delivering acute inpatient and day case services from smaller hospitals without resort to closure. This was followed by a series of definitive papers in July 2004, setting out these options in more detail, with examples of their implementation in smaller hospitals. In two documents (The Configuring Hospitals Evidence File: Parts One and Two), the Department of Health sets out detailed peer-reviewed evidence, which confirms that there is no relationship between case-volume and clinical outcomes for the majority of common medical and surgical conditions managed in NHS, European and North American hospitals. This evidence validates the case that bigger is not necessarily better. The Evidence File commends the use of Managed Clinical Networks with telemedicine and video links to ensure close communication between smaller and larger hospitals, with flexible rotation between hospitals and modified multidisciplinary on-call rotas to facilitate compliance with the European Working Time Directive (EWTD). This evidence underpins the Department of Health's policy that has, for the most part, stopped hospital closures and withdrawal of services from smaller English NHS hospitals since the last general election.

The current centralisation agenda being pursued by Scottish health boards, with the support of the Scottish Executive Health Department, runs contrary to the policy of the Department of Health, which rests on a well-researched evidence base. The contrast with the Scottish Executive's uncoordinated centralisation agenda, which has resulted in the present political crisis for the devolved Parliament, could hardly be greater.

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Sources: - Web site: www.doh.gov.uk; search "Keeping the NHS local"

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4 GLASGOW'S SOUTH-SIDE NEEDS TWO ACUTE HOSPITALS

4.1 Introduction

NHS Greater Glasgow (NHSGG's) Acute Services Strategy remains mired in confusion. The infrastructure of Glasgow's hospitals continues to deteriorate, morale among staff is low and resources are insufficient to meet demand. While these problems are common to the NHS as a whole, there is increasing evidence of dysfunctional management in Glasgow's hospitals while the planning process lacks numeracy, clarity and direction.

The number of adult staffed acute beds in Glasgow's hospitals fell by 33% from 4264 beds in 1990-91 to 3026 beds in 2001 [1]. Despite growing evidence of bed shortages, salami slicing of acute bed numbers has continued. Since 1994-95, length of stay has ceased falling in surgical specialties in Scottish hospitals and slowed markedly in acute medical specialties because of the exhaustion of efficiency improvements [2]. With an ageing population, Glasgow needs more, not fewer, acute and post-acute beds. Despite this evidence, NHSGG currently projects fewer acute surgical beds in its new hospitals than at present [3]. NHSGG intends to concentrate its acute services in three large hospitals, which will replace the city's present five acute hospitals [4]. This involves the construction of a large south-side hospital to serve the 350,000 catchment population of the area together with substantial cross-boundary flows of patients from Lanarkshire, Renfrewshire and the west of Scotland to the secondary and tertiary specialties currently provided in the Victoria Infirmary and the Southern General Hospital.

4.2 How large will a new south-side hospital be?

NHSGG's intention is to construct one large new hospital on the present site of the Southern General Hospital. An Ambulatory Care and Diagnostic Centre (ACAD) will replace inpatient services at the Victoria Infirmary for outpatients and day surgery.

At 2000-2001 staffed bed and inpatient admission levels [5], the first phase of the new south-side hospital for adult specialties would contain 1434 staffed beds and admit about 66,000 inpatients annually. A hospital of this size would be the biggest in Britain. The largest hospital in Scotland, Aberdeen Royal Infirmary, has just over 1000 beds. Only five English hospitals have more than 1000 acute beds. The largest, St. James Hospital in Leeds, had 1157 beds in 2000 [6].

Glasgow's other two acute hospitals will also have over 1000 beds. The enlarged Gartnavel site will have 1020 beds at 2000-2001 staffed bed levels [5]. The enlarged Royal Infirmary site will have 1354 beds if Stobhill's acute and geriatric assessment beds transfer following the projected closure of inpatient services [5]. Glasgow will then have the largest and second largest acute hospitals in Britain.

4.3 From mega hospital to mammoth hospital.

There are currently proposals to triple locate maternity, paediatric and adult acute services on one site which will see the closure of the Queen Mother's and Yorkhill Hospitals. Although this programme may be undertaken as a National project, it is highly probable that the site selected for this new development will be at the Southern General. At 2000-2001 staffed bed levels, the new south-side hospital will then have approximately 1800 staffed beds and can expect 81,700 admissions yearly [5]. The enlarged hospital will be 55% larger than Britain's current largest hospital [6 see above]. At current ratios of inpatient admissions to day cases, outpatients and accident and emergency attendances in Scottish acute specialties, the hospital

can expect about 46,000 day cases, 100,000 attendances at A&E, and 450,000 outpatients annually

4.4 Large hospitals reduce patient accessibility

The removal of inpatient facilities from the Victoria Infirmary and their relocation to the Southern General site will reduce the accessibility of acute hospital facilities for the population of south-east Glasgow. This comprises the greater part of the south-side catchment population. Public transport across the south-side is poor since most bus and rail links run to the city centre. The south-side, like the city generally, has many areas of high deprivation, and levels of car ownership are low, particularly among older people who will comprise the majority of the hospital's patients. The prospect of losing an accessible acute hospital is opposed by the overwhelming majority of the population of south-east Glasgow.

4.5 Large hospitals make communication between the hospitals and the primary and community care sectors more difficult

Ease of communication between hospital and community staff is much easier in a hospital of moderate size. These communications deteriorate as the size of the hospital increases, to the detriment of patients' overall management in the primary, community, and hospital care sectors.

4.6 There is no relationship between hospital size and clinical outcomes in NHS hospitals in Britain

The evidence relating hospital size to clinical outcomes has been reviewed previously [8]. The Centre for Health Economics in the University of York carried out the most comprehensive study of the relationship of hospital size to clinical outcomes [9]. The initial paragraph of the Conclusion to this study states: -

"The result of this work suggests that there is no compelling reason to believe that further concentration of hospital services will result in improved efficiency through exploiting economies of scale, or to automatic improvements in the quality of clinical outcomes. In assessing the potential negative effects of increased concentration on access and utilisation, the implications for disadvantaged groups in particular should not be overlooked. Even where specific effects on cost, outcome or utilisation can be demonstrated in the literature, the process by which such effects are generated is poorly understood." The report concludes: -

"The burden of proof must be with those who propose change to quantify the expected costs and benefits, to demonstrate the process by which benefits will be realised in practice, and to explain the way in which efficiency gains will be assured and monitored."

The clinical outcome indicators published by the Scottish NHS Executive's Clinical Resource and Audit Group found no relationship between hospital size and outcomes for a range of common conditions managed in Scottish hospitals [10]. Professor Sir Brian Jarman and his colleagues found no relationship between hospital size and mortality rates in all English acute hospitals [11]. Clinical outcomes have much more to do with the skills and organisational capacities of individual groups of clinicians within an efficiently run hospital than with the size of the hospital. There is no evidence that large NHS hospitals are automatically safer than small NHS hospitals. Harefield NHS hospital, a world-class centre for heart transplantation, had 113 staffed beds in 1998!

4.7 Large hospitals do not provide economies of scale

While there is a close relationship between the size of acute Scottish hospitals and revenue expenditure, larger hospitals are not cheaper to run per patient treated. International comparisons show reasonable evidence of a U-shaped curve between hospital size and unit costs per 1000 episodes of care. Very large hospitals are usually less efficient because they impose severe organisational challenges on their managements. As a result, there is an almost total absence of efficient large hospitals [12]. Optimum efficiency appears to be achieved at between 20,000 and 50,000 episodes of care per annum.

4.8 Closing acute hospitals to meet short-term staffing problems is unreasonable

A primary reason given by NHSGG for closing Stobhill Hospital and the Victoria Infirmary is that changes in doctors' hours dictated by the European Working Time Directive make it difficult to staff surgical and anaesthetic teams to cover five hospitals [13]. Staffing issues may lead to the closure of two viable hospitals. In the case of the Victoria Infirmary, removal of orthopaedic and surgical services on staffing grounds may lead to the transfer of a much larger number of medical and geriatric assessment admissions which accounted for 63% (17,479) of all admissions to the hospital in 2000-2001 [5]. The physicians and geriatricians dealing with the majority of admissions to the Victoria infirmary do not wish to move to a large south-side hospital in which total medical admissions of about 27,000 annually will impose a huge organisational burden on the Medical Division. These will deal with an average of 74 admissions daily, rising in winter to about 100 admissions daily. It is irrational that short-term surgical and anaesthetic staffing issues should close a hospital. Given the present Government's commitment to injecting more money into the NHS, the solution to the staffing problem is to provide more consultant surgeons, anaesthetists and junior staff to bring staffing levels closer to average European levels.

4.9 A rational alternative to very large hospitals: managed clinical networks

Despite NHSGG's intention to create the largest hospitals in Britain, the enthusiasm of NHS managers and the medical profession for building very large NHS hospitals serving catchment populations of 300,000 to 500,000 is waning. The realisation that organisational networks, which integrate clinical services across a range of hospitals, can combine a wide range of specialist expertise with local accessibility is driving this reappraisal. The Scottish Hospitals Acute Services Review, chaired by the former Chief Medical Officer, Sir David Carter, introduced the concept of managed clinical networks as a way of coordinating a wide range of expertise in clinical specialties from small district general hospitals to highly specialised care in teaching hospitals [14]. The conclusion to chapter 6 of the review states: -

"The Acute Services Review has not approached its remit from the premise that concentration of services in large centres and the closure of smaller hospitals are necessary or indeed appropriate ways forward for acute services in Scotland."

The review concludes that: -

"(1) The critical mass needed to achieve the benefits which might flow from increased volume of activity can come through managed clinical networks rather than the centralisation or concentration of services. Concentration of some services may still be necessary but this must take place within an integrated regional service, the exact nature of which will vary from specialty to specialty.

(2) Managed clinical networks are based on appropriately trained and skilled individuals working in partnership in a hierarchy of appropriately established and managed facilities. Thus the benefits of any economy of scale can be achieved without having to incur the penalties of diseconomy of scale."

The Acute Hospitals Review Group for Northern Ireland concurs with the view expressed in the Scottish document [15]. The review embraces the concept of managed clinical networks for nine acute hospitals in the province. No hospital will have more than 800 beds and the smallest hospital will have just over 200 beds. There are no plans for large mega hospitals on the Glasgow model.

The Royal College of Physicians and the NHS Confederation are rethinking delivery of acute emergency services in NHS hospitals [7]. This envisages linking small local hospitals to larger hospitals with more integrated services and staff, combining the advantages of a larger specialist skill base within a managed care network without the disadvantages of inaccessibility and the poor communications, which inevitably accompany concentration of resources in very large hospitals. Political pressures against hospital closures are playing a part in this re-evaluation. Communities do not welcome the closure of their accessible local hospital and will increasingly express their displeasure through the ballot box.[16]

Conclusion

NHSGG plans to build three very large hospitals in the city, including the largest hospital in Britain on the Southern General Hospital site. If fulfilled, these plans will saddle the south-side with a costly, inefficient hospital against the wishes of the electorate of south-east Glasgow. All community councils in south Glasgow and adjacent parts of East Renfrewshire in the Victoria Infirmary's catchment area have repeatedly expressed such opposition in public petitions, meetings and demonstrations. Informed expert opinion is moving away from the grandiose concept of very large hospitals in favour of dispersed "virtual" hospitals with close organisational links.

Plans for a very large south-side hospital should be replaced by planning for two south-side hospitals of moderate size to serve south-east and south-west Glasgow, linked by a common management, combining the benefits of scale with accessibility to their catchment areas. The last seven years have been a time of increasing uncertainty, confusion, and demoralisation for staff working in Glasgow's hospital services. Reversing this process with a more rational approach to forward planning and the provision of sufficient capital to replace the city's run down infrastructure is the most important task facing the Scottish NHS Executive and NHSGG's Chief Executive.

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5 IMPLEMENTATION BY NHS GG OF THE ACUTE SERVICES REVIEW 2002-2004

In January 2002, NHS GG Board approved its Acute Services Review (ASR). As noted, this involves the closure of three acute hospitals to inpatient services, concentration of Accident and Emergency Services on two sites and the replacement of the Victoria Infirmary and Stobhill Hospital by stand-alone Ambulatory Care and Diagnostic Units (ACADS). These proposals have attracted considerable opposition from community and professional groups concerned by the withdrawal of accessible inpatient hospital services, including Accident and Emergency facilities, reductions in acute inpatient bed capacity, and the wisdom of placing large ACADS at a distance from the acute resuscitation facilities available in a fully equipped acute hospital.

The Scottish Health Executive approved the ASR in September 2002. NHS GG projected the start of work on the two ACADS in 2004, with both fully operational in early 2007. Work on the construction of enlarged inpatient facilities in the Southern General and Gartnavel Hospitals is due to commence in 2006 with operational completion on both sites by 2011. Details of planned hospital bed numbers are stated to be “unlikely to change by more than five per cent”.

There has been considerable slippage in the implementation of the first phase of the timetable since its approval almost three years ago. This has been mainly due to the Outline Business Case (OBC) attracting only a single bid (from Balfour Beattie Construction), removing any element of competition from the ASR. As a result, financial closure of the Full Business Case (FBC), if approved by the Scottish Executive Health Department and Audit Scotland, is unlikely before Summer 2005. Construction of the ACADS cannot therefore begin until late 2005 or early 2006.

There are increasing concerns about the ability of present and projected acute bed capacity to cope with demand in Glasgow’s acute hospitals. NHS GG assumes that further shifts of inpatient care to day case and outpatient settings will permit further reductions in acute bed capacity in surgical specialties. Additional provision of long-stay capacity in private sector residential and nursing home accommodation and the provision of supported home care is also projected to reduce “blocked beds” in acute specialties. On the other hand, emergency admissions continue to increase, compounded by an ageing population, rising public demand for rapid access to expert medical care and investigation, and emerging pressures on acute hospitals created by the ending of the obligation on general practitioners to provide 24 hour medical cover.

Since January 2002, pressures on Glasgow’s acute bed capacity have increased. The city’s acute hospitals lost 29% of their adult acute beds between 1990-91 and 2000-01 (4264 to 3026 beds). Despite repeated winter bed crises, with postponements and delays in elective admissions, leading to rising waiting lists, NHS GG has pursued a policy of further reductions in acute beds towards its provisional 2001 target of 2708 acute beds. In August 2004, NHS GG had 2757 available staffed beds in acute specialities, a 9% reduction (269 beds) from the 2001 bed complement and a 35% reduction since 1990-91. Bed reductions were spread across most acute specialties with the greatest reductions over this period occurring in Ear, Nose and Throat (-41%), ophthalmology (-20%), orthopaedics (-20%) and general surgery (-11%). Bed managers now struggle to cope at all times of the year. Acute hospitals

have been closed to emergency admissions frequently, with patients being moved to hospitals outwith their catchment areas, and emergency medical patients boarded inappropriately in surgical wards, leading to cancelled elective admissions and long trolley waits for admission from overcrowded Accident and Emergency departments.

A report from the National Audit Office in December 2004 showed that Glasgow Royal Infirmary, the Southern General Hospital and the Western Infirmary had respectively the second, fourth and fifth longest A&E waiting times in the UK (Edinburgh Royal Infirmary had the longest waiting time).

Greater Glasgow Health Council has repeatedly recorded problems resulting from insufficient acute beds in its Casualty Watch Surveys during 2003 and has raised concerns about insufficient acute bed capacity with NHSGG Board on each occasion. A NHSGG-commissioned review of pressures on acute bed capacity in Glasgow's acute hospitals by Secta Consulting in 2003 concluded, "the present model of acute care delivery is not deliverable for much longer". On 3rd February 2004, bypassing NHSGG, the Chair (Dr B A K West) and Vice-Chair (Mr Tim Parkes) of NHSGG's Area Medical Committee, wrote directly to Mr Trevor Jones, Chief Executive of NHS Scotland, to protest about "a serious and sustained lack of availability of beds for emergency admission. This has resulted in large numbers of patients waiting for long periods in inappropriate areas for a bed, and, for the first time in Glasgow, a significant number of patients sleeping overnight in the A & E departments". They concluded "Failure to act will lead to further deterioration in standards of patient care, clinical safety and staff morale".

Despite these severe capacity problems, at its 16th December 2003 Board meeting, NHSGG set out modifications to the 2002 Acute Services Review which planned acceleration of the consolidation of acute services on three sites. Medical Director, Dr Brian Cowan, stated that the main drivers for change were staffing and financial pressures, particularly following the introduction of the European Working Time Directive for medical staff. Accelerated change involved the reorganisation of the emergency and elective workload between GRI and Stobhill, Gartnavel and the Western Infirmary, and the Victoria and Southern General hospitals. All emergency admissions would be admitted to Glasgow Royal Infirmary, Gartnavel General Hospital and the Southern General Hospital; the remaining three acute hospitals would deal only with elective admissions. Accreditation of the Admissions Unit in Stobhill hospital would be withdrawn by Summer 2005.

Since the modification to the ASR was announced, it has become clear that severe capacity shortages within the city's hospitals have rendered it unworkable. Limitations on acute bed capacity in the Royal Infirmary and Southern General Hospital make the concentration of emergency receiving on these sites impractical. In consequence, closure of the Stobhill Admissions Unit has been deferred to 2006, at least. The 966 acute beds, (including geriatric assessment beds) available on the Victoria Infirmary and Stobhill sites in August 2004 cannot be dispensed with until, and unless, major expansion of acute capacity is provided in the Royal Infirmary, Southern General and Gartnavel General Hospitals. This cannot happen until 2011 at the earliest.

At present, a combination of financial pressures, capacity constraints related to inadequate acute bed capacity, medical and nursing staff shortages (leading to ward closures), and limitations on theatre capacity raise serious concerns about the competence and planning

assumptions underpinning the ASR. The recent announcement that 10,000 patients are awaiting orthopaedic treatment in North Glasgow is only the latest manifestation of these multiple problems. In a letter to the Health Board in October 2004, Mr Tony Reece, a senior orthopaedic surgeon in the Western Infirmary stated, “many of my colleagues are seriously concerned that the orthopaedic service in Glasgow is about to collapse due to lack of planning, poor morale and inadequate support”.

The major difficulties in implementing the Acute Services Review outlined above indicate the need for substantial revisions to both the assumptions underlying the provision of capacity and the future configuration of Glasgow’s hospitals. The present Acute Services Review cannot provide the quality of acute hospital care, which the city expects and requires, for its own population and for a significant proportion of the population of the West of Scotland.

6 FUTURE TRENDS

Some trends are clear.

The plan must make provision for a major increase in elderly population.

In the UK as a whole, the number of people aged 75+ is expected to increase from 4.3m to 7m by 2036. This is the sector of the population, which is by far the heaviest user of the acute hospital services. [Reference: Candace Imison, Presentation at Cambridge Conference, 27th June 2001]

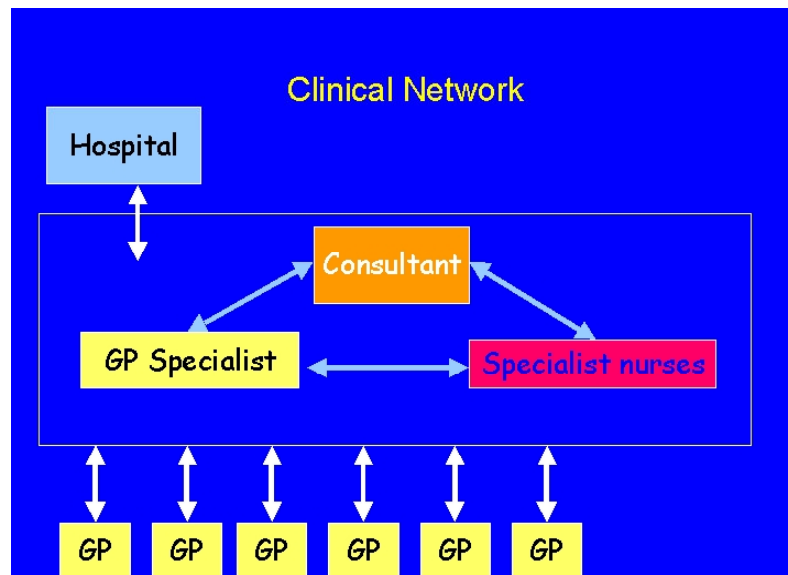
The plan must provide more staffed acute inpatient beds.

Between 1990-91 and 2004 Glasgow hospitals have lost 35% (1507) of all their staffed acute beds. The result has been increasingly severe difficulties in gaining admission for a rising number of emergency admissions and rising waiting lists for elective admissions who require inpatient beds. Day case accommodation cannot compensate for the severe bed shortages in the city's acute hospitals. The current bed model proposed by NHSGG does not acknowledge these increasing problems and instead proposes further unrealistic reductions to 2708 staffed acute beds by 2004-05 (see section 5).

Improvements in Information Technology will revolutionise the management, form and delivery of healthcare. Clinical Networking, not Hospital Centralisation, is the cost-effective way towards better healthcare.

The continuing trend in all branches of information technology is that the price approximately halves every 2 years. The NHS must take account of this major trend extrapolated over the lifetime of the hospital systems now under consideration. For example costs for equivalent technology in 2010 will be reduced to only approximately 3% of 2000 prices. The new technology is key to the re-organisation of healthcare by the establishment of Clinical Care Networks for managing patient care.

Clinical networks are seen as a key tool for improving quality of services in many countries.



The practical effects of this are the re-organisation of healthcare away from the basis of centralised individual hospitals, and to the establishment of clinical care networks for managing patient care.

The treatment of the patient is the responsibility of the network team. There is a better co-ordination and collaboration between Primary Care and the hospital service.

Clinical Networks are a key component of both Scottish and Welsh plans:

The emphasis in clinical networking is on connection and partnership rather than isolation and self sufficiency, on distribution of resources rather than centralisation, and on maximising benefits for all patients rather than a few.

Network-based models of working are already being developed in England in a wide spectrum of specialties:

- Nationwide for Cancer, Critical Care & CHD.
- In some areas for Paediatrics, Ear, Nose and Throat, Orthopaedics, Urology, Ophthalmology, Dermatology, Diabetes, Vascular Surgery, Renal services.

Network based approaches are developing in America, Canada, Australia, Denmark & Sweden.

Networks Permit Concentration of Surgical Specialties WITHOUT disproportionate centralisation

The Proposal is for a greater clustering of surgical specialties without at the same time requiring a disproportionate and disadvantageous centralisation of hospitals. It provides excellent utilisation of existing recent investments in Glasgow's hospitals. Construction carried out expeditiously with a stable and practical means of bridging services from their current facilities to the new buildings, which will become available as a result of this plan.

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7 RECOMMENDATIONS

7.1 The number of acute beds required must be established.

As a primary measure of requirement and of cost this is a basic initial step.

It is clear that:

- Historical data and trends are one important indicator.
- The demographic model, particularly the increasing numbers in the population aged 75+ must be addressed.
- A resource allocation model in which surgical beds are treated as an emergency reserve for medical emergencies is seriously flawed and must be abandoned. It leads directly to abysmal productivity for the expensive and highly trained surgical teams. This in turn leads to large waiting lists, and ultimately to patients' conditions deteriorating to reach emergency status, thus further aggravating the situation.
- Attempts to plan hospitals on the basis of very high bed utilisation must be abandoned. These inevitably lead to long waiting times and poor productivity by the surgical departments.

7.2 Two acute hospitals are required in south Glasgow.

- With two sites in operation both are well within the range of medium to large hospitals in the U.K. This size is found best by all other health authorities.
- The traffic impact of the two hospital strategy is approximately half that of a single hospital of equivalent capacity on the site of the present Southern General Hospital.
- Small surgical specialties must be re-organised using the clinical networking concepts so that each department is of appropriate size to enable 'out of hours' cover.
- The two-site strategy permits the full development of specialist day surgery units adjacent to ITU facilities, and hence within the safety guidelines enforced elsewhere (as in USA). The two-site strategy enables utilisation of the modern facilities built at the Southern General Hospital.

7.3 During the phase of building reconstruction, capacity must be retained so that hospital operation can continue and disruption to patients kept to a minimum.

Any new construction would most efficiently be carried out on a green or brown field site. Building on a site separate from existing facilities is much cheaper and faster. Extra expense of modifying an existing hospital arises from various sources:

- It is more costly to have to build-to-fit than to build from scratch.
- Maintaining existing services during construction is a difficult, time-consuming and expensive process.
- A separate construction site leads to a shorter construction phase.

This produces savings because:

- A new facility has to be paid for from the start of construction, a longer construction period is less cost/effective.

- The new facility can be put into use sooner, and thus its benefits in quality and reduced cost can be experienced sooner.

Appendix 1 TRANSPORT

The primary objective of medicine in general, and hospitals in particular, is the care of patients with the aim, where possible, of curing them so that they pick up and continue with their normal lives. Human beings are not automata. Their state of mind profoundly affects not only their immediate condition but also their will to survive and rate of recovery. When in hospital, support from family and friends, is important, as is freedom from worries about the family particularly when the principal next of kin may also be in poor health, elderly and without means of personal private transport.

Many aspects of improving technology in medicine and information technology now point to care for patients by a **decentralised** system in which all components of the service co-operate and share information and many more aspects are handled locally rather than via a massive centralised complex.

In contrast to Information Technology, the trends in transport are moving inexorably towards greater costs.

There are several reasons for this:

- The underlying cost of oil is predominantly upwards, approximately doubling every ten years; despite great advances in oil exploration and recovery technologies, the amount of drilling which has to be done for every gallon of fuel produced is steadily increasing.
- The costs of travel congestion are increasing.
- The impact of global warming is likely to cause governments to make increased fuel taxes a way of enforcing a reduction in the environmental impact of transport.

Transport costs are likely to escalate over the lifetime of the plan, from 2 times the year 2000 costs in 2010, to 8 times the year 2000 costs in 2030. A prudent and cost/effective plan for hospital services must take account of this.

Comparison of a Single Hospital Strategy (Southern General site) and the New Strategy that provides inpatient services on two sites in South Glasgow.

Increased journey times (in minutes) for a single large hospital

No of hospitals	1	2	% Increase for single hospital
Av. Time by public transport	53.3	36.4	46%
Av. Time by car/taxi	16.9	10.6	59%

The times shown in the table are average times for the non peak period calculated for the year 2006. Times during peak travel periods are substantially longer.

Reference: Average journey times computed from data for catchment areas extracted from Table 1 South Side Hospitals Time and Traffic Impact Study (Allan W. Drewette BSc MICE Chartered Civil Engineer, Consulting Traffic and Transportation Engineer). Simulation by CSTM3 traffic model owned by Scottish Executive

The traffic and environmental impact of centralising hospital inpatient services for South Glasgow on a single site at the Southern General Hospital

Local authorities are obliged to set targets for reduction in traffic growth in their areas under the Traffic Reduction Act 1997. If NHSGG proposals to centralise inpatient services on a single site at the Southern General were carried out, this would have an immediate and substantial effect on increasing road traffic in south Glasgow. The Drewette report (above) has investigated the traffic impact of the proposed change.

Traffic impact is represented by the number of vehicles on the road multiplied by the time they are on the road. Increasing the time of travel to hospital by 59% has the same effect as increasing the number of vehicles on the road by 59%. The traffic impact of centralising hospital services on a single Southern General site is made greater because of the higher proportion of journeys, which have to be made by car or taxi, to reach the southern general site compared to the Victoria Infirmary site. This is because the Southern General site is not well served by train, while patients from Croftfoot, Cambuslang and Rutherglen can readily reach the Victoria Infirmary site by rail. Drewette estimates that for every 10 of these rail passengers 9 will travel by car and taxi and 1 by bus. Taxi travel often implies two journeys for the vehicle where a car may make one. The overall traffic impact of hospital travel resulting from NHSGG's proposed centralisation is estimated by Drewette to be an increase of 70 to 80%.

The increased traffic impact of the proposed change would have to be paid for in terms of increased pollution and fuel costs as well as inconvenience and effects on patients.

Appendix 2 INFORMATION TECHNOLOGY AND THE NHS

Over the next 20-30 years we can expect the underlying costs of moving and storing information electronically to decrease and the relative costs of moving people and things to increase. Information Technology (IT) makes possible the policy of 'keeping the NHS local, ensuring national standards and national accessibility of healthcare patient records'.

In general the Forum supports the programme to make the NHS more IT-aware and to modernise its operations. We are acutely aware of the importance of the NHS acquiring an effective IT infrastructure, linking one hospital with another, GP practice with hospital and making research information available widely without loss of individual patient's confidentiality.

The Present Position In Scotland

The overwhelming majority of GP practices in Scotland (some 890) use the GPASS system. This means that at GP practice level there is already a single system, which has to be interfaced to local hospitals, and this task is to some extent undertaken. It would be a big mistake to abandon this software and the existing training of NHS staff. This is one of the 'islands of technology' already successfully integrated and adopted by the NHS in Scotland. Other 'islands of technology' exist in the subsystems which already support radiography and laboratory services.

Difficulties exist in the integration of a patient's data and in preserving the patient's confidentiality, while allowing hospital (or other) specialists access to appropriate portions of the patient's personalised healthcare information. Systems must also permit access to de-personalised healthcare records for research and epidemiological studies.

There have been a number of medical records projects over the years (Oxford, Exeter and Aberdeen), all of which were 'heavyweight systems'. Each started anew but none progressed beyond the pilot project stage. By the time such systems were evaluated they were out-dated by progress in the real-world NHS. There was also an unresolved training problem in the NHS staff that would be required to use the chosen system.

The Forum supports an approach, which is in essence 'lightweight', using software tools of greater generality and longevity. Tools which could be used include e-mail and web-enabled IT services. Public key encryption with a suitably long key has already been developed. This enables the public-key of the recipient to be well known e.g. it could be made available via a document like a telephone directory, but only de-encrypted by the user's private key known only to specific users. It can also be used in reverse to effect a digital signature of the authorised persons i.e. the public-key can be used to de-encrypt anything encrypted with the user's private key.

Cost

Costs are enormous. There are around 60 million men, women and children in the UK. Contracts worth £2.3 billion have already been awarded out of a total budget of £5 billion. This huge investment represents approximately £170 per person.

Conclusion

There is a long history of problems in large scale public sector IT programmes in the UK. Not only is the NHS IT Strategy for Scotland very large in scale, it is also at the leading edge of technology. The sharing of confidential personal medical data across a wide area electronic network is one of the most sensitive, challenging and high profile developments ever undertaken.

The NHS is not one generation of technology behind, but at least two. We are expecting organisations such as NHSGG to implement successfully a large scale, high technology strategy when they are still using taxis to transfer paper records from one hospital to another. Key factors in implementation will include:

- the availability of sufficient numbers of staff with key IT skills
- the provision of adequate levels of training for staff at all levels in the NHS
- the availability of adequate support services to ensure that hardware, software, and the IT infrastructure function at all times
- the involvement of staff at all levels in the detailed design stages

All of these factors are the subject of criticism from staff within the NHS.

The present Scottish strategy seems sufficient, but it is successful implementation that is required.

References:

Extract from NHS National Programme for Information Technology Web site
www.npfit.nhs.uk/news/news_131004/
Extracts from Computing Company UK Web site
www.computing.co.uk/specials/1157250

Appendix 3 TECHNICAL GROUP REPORT ON ALTERNATIVE PROPOSALS FOR A NEW BUILD GLASGOW SOUTH HOSPITAL

NHSGG proposals for the Southern General site

The NHSGG proposals for this site involve seven stages in sequences of demolition and extensive construction including temporary re-siting of some existing units. In effect the entire central existing area would be more or less totally demolished and a complex of three densely designed, compact four to five storey blocks would be constructed.

The existing SGH of approaching 600 beds would be almost trebled to a size of some 1800 beds including the possible transfer of Yorkhill and the Queen Mother's to the SGH site and provision for a self-contained psychiatric unit.

This would appear to be a logistical nightmare to co-ordinate on the existing built-up hospital campus, whilst maintaining its operational capacity and integrity. Complex demolition work would have to be continuously undertaken involving biologically, chemically and radiological contaminated areas whilst ensuring power and services to existing and continuing hospital services.

Add to this the major construction works required for the new buildings right across the main avenue and concourse of the hospital site, which must involve upwards of ten years to complete and the full enormity of the proposals becomes all too clear.

Victoria Infirmary and Queen's Park Recreation ground sites

NHSGG summarily dismissed the QPR ground plus the adjacent former Queen's Park School site as being too small for an acute hospital. In fact, the overall area is greater than the existing restricted and heavily impacted site upon which Glasgow Royal Infirmary presently stands, yet the Board is planning to expand the Royal Infirmary to approximately 1200 beds.

The recreation ground site comprises some 30 acres inclusive of the existing hospital complex. As the accompanying sketch shows, this can comfortably hold a 750 bed hospital complex of gross area 75,000 square metres comprising 4 to 5 storey stepped central accommodation of 50,000 square metres and two storey ward blocks of 25,000 square metres as a discreet and independently functioning unit.

This complex can be built exclusively on the QPR site, independently of the existing Victoria Infirmary and totally without interference to its present functioning. Demolition of the existing Infirmary buildings can then likewise proceed without affecting the new hospital and frees up this area of the site for the self-contained psychiatric unit, or any other hospital requirements such as additional parking etc.

A shortage of medical staff is being used as an argument to close down hospitals and thus concentrate scarce resources into bigger and fewer units.

In January 2005 the Health Committee of the Scottish Parliament published a report entitled “Reshaping the NHS?: Workforce Planning in the National Health Service in Scotland”.

In the report it is stated (para 117)

“The evidence that the committee has received suggests that under almost any eventuality there will be a requirement for a large number of additional doctors within the NHS in Scotland in future.”

And para 110:

“To date this does not appear to have been quantified by the Executive of NHS Scotland and health boards are still grappling with some of the issues.”

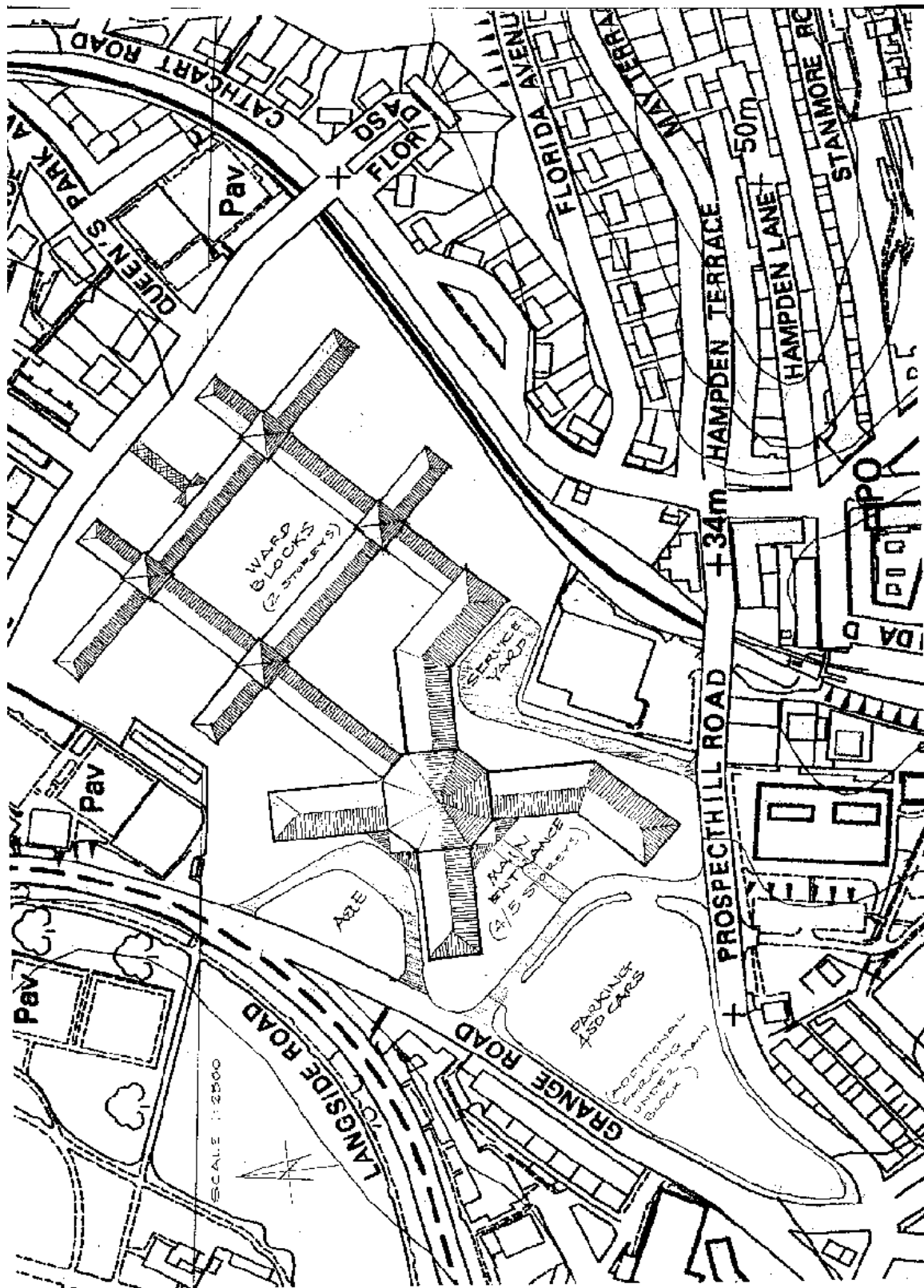
The staff shortages that are driving the centralisation plans will result in fewer hospitals across the city. If the Victoria Infirmary site is disposed of then another valuable piece of development land will be lost to the NHS. NHS GG is planning its flagship hospitals on the most impacted sites in the city and will be left with no room for manoeuvre. When the plans to recruit and train more staff come to fruition there will be no possibility of building local hospitals as suitable sites will no longer be available.

Concluding observations

The needs of the community must form the basis of the hospital design and service brief. An urban hospital must be accessible to the population it serves. It must be an integral part of that community. Both the Southern General Hospital and especially the Victoria Infirmary are such hospitals.

The option of retaining the Southern General Hospital with its established brain and spinal injuries specialties intact, together with the other units which have been invested on this site, and building a new hospital at the Victoria QPR ground is worthy of serious considered appraisal. This would seem to be the preferred option of the communities themselves. As it is the people in these communities who, through taxation, finance the health service and its managers’ salaries, surely the people have some democratic right to a determining voice, as they are also the ultimate users of the service.

ARCHITECTS' SKETCH PLAN



Feasible hospital on Victoria QPR site

ESTIMATED SCHEDULE FOR BUILD ON THE TWO SITES

Discussion programme for new build options at Victoria (QPR) and Southern General sites.

Item	Description	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
1	Financial Approval to proceed	↓									
2	Professional team										
3	QPR site consultation ACAD										
Southern General Site											
4	Block 1 approvals & design brief										
5	Stage 1 & 2 demolition temp works										
6	Main contract tender & awards										
7	Construction Block 1										
8	Block 2 temp. works, demolition										
9	Main contract tender & awards										
10	Construction Block 2										
11	Block 3 as 8, 9, & 10 above										
Victoria ACAD Site											
12	Victoria site ACAD approval										
13	Design Brief										
14	Contract tender & award										
15	Construction of ACAD										
Victoria hospital with ACAD											
16	Acquire land & consultation										
17	Authority approvals & design brief										
18	Contract tender & awards										
19	Construction										
20	Demolish & build at existing site										

This schedule was drawn up in December 2002 shortly after the decision on the building of ACADs in Glasgow had been endorsed by the Scottish Parliament. Please note that at December 2004 the very limited work which has taken place at the Southern General site falls far short of the scale of operation required to meet the above time schedule.

NEW HOSPITAL COMPARISON OF STRATEGIES

	<u>TWO HOSPITAL STRATEGY</u>			<u>SINGLE HOSPITAL (SGH) STRATEGY with ACAD at Queens Park Recreation site</u>		
	New Hospital	SGH		SGH Option		
Too large ?	700	900	3rd and 5th largest in Scotland	1600		50%Larger than largest in UK (Ref:Binleys Directory)
Too small ?	700	900	> UK average =500	1600		Notes 1
Decant site for build ?	Yes	Not required		No		
Design takes advantage of IT Clinical networks integration	Yes	Yes		No		
ACAD site meets VA 12345 safety regulation for day surgery	Yes	Yes		No		Day surgery repertoire limited (or additional risk to patients) Notes 2
Ambulance requirements				interhospital		
Patient/home increase	0%	0%		100%		
Meets NHS Emergency pick-up targets for heart attack, stroke etc.	Yes	Yes		No		
ACAD-hospital	No	No		Yes		
Inter hospital transfers	Yes	Yes		No		
Patient transport % By Car/Taxi	70%			>90%		
Car/Taxi distances increase	nil			60%		
CAR/TAXI traffic impact(time x distance x number)increase				78%		
Access by Public Transport Time increase				50%		As Per CSTM3 Transport Model
On-site rail station	Yes			No		
Attractive Open Design	Yes			No		5 storey ward blocks arranged around internal well
Parking Places Available	1100 off street					
Concentration of speciality staff	Yes	Yes		Yes		
Re-Build Disruption	None	None		Yes Massive		Throughout construction period (up to 10 years)
Rebuild Supplement cost	0%			40-100%		
Site Area	37 Acres	60 Acres		60 Acres		
Total Staff on site	3000	5000		8000		
In-Patient	700	900		1600		
In-Patient visitors / day (3 per patient)	2100	2700		4800		
Makes maximum use of existing facilities	New Build	Yes	Limited new /additional at SGH	No		Demolition/Reconstruction required
Complete Maintenance of existing services during construction	Yes	Yes		No		(at best with difficulty)
Stand Alone ACAD at QPR SITE	No	No		Yes		Cost est £103 million
Public Transport use estimated	30%	20%		<5%		
Additional Loading at GRI A&E	0%	0%		20%		
Additional Parking needed to GRI				10%		

Appendix 4 SUPPORTING EVIDENCE

Why the Forum says NO to a mega hospital.

Private Sector 'Small is good': Public Sector 'Small is bad'. Are surgeons operating on double standards?

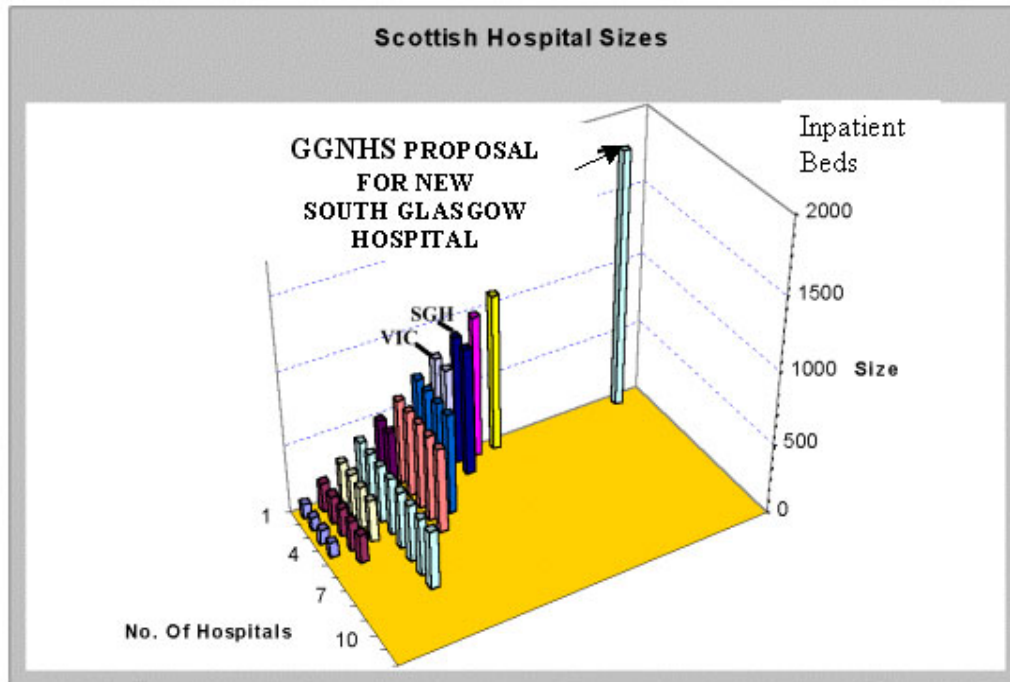
Very small hospitals are the norm in the independent private healthcare sector. The private sector in England is taking an increasing proportion of NHS elective surgical procedures as part of the government's concordat to reduce waiting lists. In Greater London, of 29 independent private hospitals, which provide acute medical and surgical services, 41% (twelve hospitals) have fewer than 50 beds, 31% (nine hospitals) have fewer than 100 beds, 24% (seven hospitals) have fewer than 200 beds and one hospital has 247 beds.

Private acute hospitals in Scotland are listed in Laing's Healthcare Market Review 2000-2001. [Laing and Buisson London] as;

Glasgow; Nuffield: 33 beds, Ross Hall: 101 beds. Edinburgh; Murrayfield: 50 beds.

Aberdeen, Ayr, Dundee and Stirling also have small private acute facilities.

Most of these hospitals carry out a wide range of surgical procedures. Several perform complex cardiac surgery, including paediatric surgery, and neurosurgery. Neither the Royal College of Surgeons nor the government has publicly expressed any reservations about the expansion of elective surgery in very small private hospitals, most of which have only a single medical officer on call for 24 hours. NHS hospitals with less than 400 beds are stated to be non-viable in the long-term while an increasing proportion of elective surgery is being hived off to small private hospitals, most with less than 100 beds.



Why the Forum says NO to a stand-alone ACAD

In November 2000 members of the Greater Glasgow Health Board visited San Diego, California to see at first hand a working ACAD and five ambulatory surgery centres. As a result the Board decided to proceed with their plan to establish two stand-alone ACADs in Glasgow.

Department of Veterans Affairs; Performance of ambulatory surgery

ACADs were a new concept to the Forum and we had to make enquiries to establish their functions and procedures. Our medical committee made contact with Dr Abbas Sedaghat, Professor of Medicine and Chief of the Veterans Hospital in San Diego, USA. Part of Dr Sedaghat's training took place in Glasgow and he is familiar with the poor record of health in the city. He accepted the Forum's invitation to address a meeting held in Glasgow City Chambers which was attended by members of the Greater Glasgow Health Board, medical doctors and members of the public.

The Veterans Hospital is a teaching hospital providing for the medical needs of those army veterans who cannot afford health insurance. It is our belief that this system of care is close to that provided in Glasgow under the NHS. Dr. Sedaghat explained that the stand-alone ACADs in San Diego, the only medical facilities visited by the Health Board, dealt specifically with those citizens who could afford medical insurance. Basically the patients were reasonably healthy individuals under the age of sixty with only minor health problems.

The purpose of the Veterans Health Administration (VHA) Directive 96-046 is to provide policy for the performance of ambulatory (same day) surgery. It rescinds VHA Directive 10-93-019 and its supplement.

It is the policy of the department of Veterans Affairs (VA) to provide patient care in the most economical manner possible without compromising the quality of care. Most diagnostic and the majority of surgical procedures can be performed on an outpatient basis, and ambulatory surgery is the norm for many of these procedures.

If these procedures are to be performed in a dedicated ambulatory surgery suite (ambulatory surgical centre), the operating rooms should be of appropriate size and equipped to the same standards as the main operating room suite. Use of general or regional anaesthesia in ambulatory care centres, not located in the operating room complex, must meet the requirements for communication, quick response, supplies and equipment as specified by the Joint Commission on Accreditation of Healthcare Organisations.

Patient safety requirements described must be met. For purposes of patient safety all satellite ambulatory surgery centres must have:

- (1) Adequate emergency back-up services (in VA or non-VA hospital) available within 15 minutes rush hour driving time from the satellite facility.
- (2) Ambulance services must be readily available.

We do not believe that the planned stand-alone ACADs in Glasgow can meet these two essential requirements. The ACAD at the Veterans, San Diego, is situated on the fifth floor of the hospital next to the operating theatres, surgical units and intensive care wards.

Alternatives are being trialled elsewhere

In December 2004 the Scottish Health Minister announced that sections of the Golden Jubilee Hospital in Clydebank would be leased out to private healthcare providers who could then be contracted to carry out specialised elective health treatments for the NHS. This raises serious questions. First and foremost where are the medical staff to come from?

Three pilot sites in England with innovative plans are currently being evaluated in England at Central Middlesex Hospital, Bishop Auckland General, and Penzance. The first of these, the **Brent Emergency Care and Diagnostic Centre (BECaD)** is particularly relevant to South Glasgow as it aims to develop a local hospital able to deal with emergency and routine cases on a 24-hour basis. The redesign of accident and emergency services will combine a nurse and general practitioner led service for minor illnesses and injuries while those with more serious illnesses and injury will be seen and treated by a small consultant led team. The services provided at the BECaD for a population of 220,000 will include acute medicine, surgery, gynaecology, trauma and orthopaedics. Elective in-patient Urology will be provided. Short-stay and day surgery will be provided from the ACAD.

If such an arrangement is possible at the Central Middlesex why not in Glasgow?

The proposals in the Department of Health's consultation document "Keeping the NHS Local: A New Direction of Travel. 2003" point in the same direction as the Forum's hospital strategy. "Configuring Hospitals Evidence File" of July 2004 provides a clear endorsement of the Forum's views.

Reference: The Configuring Hospitals Evidence File: Part Two. DoH, England July 2004.

Appendix 5 CAN A SINGLE BID FOR THE ACADs ASSURE VALUE FOR MONEY?

Summary

- NHS Greater Glasgow (NHSGG) received only one bid to construct two Ambulatory Care and Diagnostic Units (ACADs) on the Stobhill Hospital and Victoria Infirmary sites at a present provisional capital cost of £180million.
- The decision to proceed with a single bidder, resulting from a poor contract specification and diminished interest by the private sector in large PFI contracts, removes competition from the project. It greatly increases the risk of poor Value for Money (VFM), despite the alleged safeguard provided by a “shadow bid” prepared by NHSGG’s project team and its advisers.
- A single bid may be judged illegal under current and forthcoming E.U. Procurement law if challenged in the European Court of Justice.

Introduction

NHSGG is compelled by government policy to use the Private Finance Initiative for the construction of its new hospitals. In this process, a Public Sector Comparator (PSC), which assumes the use of public funding to construct the hospital, is compared with the costs of a number of private bidders who finance the project via a consortium of banks and construction companies over a 25/30-year leaseback period. The consortium owns the hospital over this period, maintains its infrastructure and provides non-clinical services for an annual availability fee. This comprises the cost of maintaining these services together with capital and interest repayments over the loan period. Since privately available finance is more expensive than publicly available finance, the higher cost of PFI is adjusted by applying a Treasury discount rate (initially 6%, now 3.5%) to the cost of the 30-year loan from the private sector. This still leaves the PFI cost significantly more expensive than the PSC; a further reduction (risk transfer) in the relative cost of PFI is then factored in by estimating the cost of the risks transferred from the public to the private sector and adding this to the PSC. Both financial mechanisms have been heavily criticised since their adoption. The concept of risk transfer is at odds with the reality that the cost of failure of PFI/PPP schemes such as the Passport Agency, IT projects and Railtrack, and of reductions in service delivery from PFI hospitals is borne by their users and the public purse.

A key concept enshrined in all PFI/PPP schemes is the introduction of market forces via competitive bidding to secure the contract and ensure value for money (VFM). This concept is embodied in European Community (EC) Public Procurement Directives. For example, Article 27, Point 3, of Council Directive 92/50/EEC (18th June 1992) relating to the co-ordination of procedures for the award of public service contracts states “where the contracting authorities award a contract by negotiated procedure as referred to in Article 11 (2) (i.e., referring to the competitive negotiated procedure used in UK PFI projects), the number of candidates admitted to negotiate may not be less than three, provided that there is a suitable number of candidates.” The National Audit Office (NAO) Report “Procurement of Vaccines by the DoH” (HC625 Session 2002/3: 9th April 2003) also states that the negotiated procedure with a call for competition “requires an OJEC advert and the purchaser is required to negotiate with at least three bidders.” These rulings are in keeping with everyday

commercial practice, which seeks to ensure that contracts for projects are based on the widest possible range of competitive tenders.

Response to NHSGG's Invitation to tender for two ACADS

NHSGG's invitation to tender for two ACADs in Spring 2003 received twenty expressions of interest but only a single formal bid from Balfour Beattie Construction, effectively eliminating competition and choice from the project. This presented the Board with the choice of re-advertising the project or going ahead with a single bid. The Scottish Executive decided that a single bid was acceptable, if supported by a satisfactory "shadow bid", to ensure competition. This shadow bid is currently being prepared by NHSGG's Commissioning Team, as detailed in guidance provided by Ernst & Young's "Strategy for Proceeding with Single Bid Documents". On 18th June 2003, the Board's legal advisers, Price Waterhouse Cooper, confirmed, "there were no public procurement issues from a legal perspective in proceeding with a single bidder". The process of preparing a shadow bid commenced in October 2003. The Scottish Executive Health Department, NHSGG and the Board's legal advisers (Price Waterhouse Cooper and Ernst & Young) believe that the use of this further financial instrument will ensure Value for Money (VFM).

Value for Money (VFM) issues in relation to single bids for PFI/PPP projects

The Public Accounts Commission (PAC) disapproves of the single bid procedure. For example, in commenting on the PFI contract for Dartford and Gravesham Hospital (HOC Session No. HC131), the PAC comments "we find it disturbing that the Trust ended up with one final bidder on this major pathfinder project for the use of PFI in the NHS. Active competition is essential if VFM is to be achieved. We therefore recommend that NHS Trusts assess carefully the risks to achieving an effective competition and manage these risks carefully." The Treasury Minute on this project stated "the NHS Executive agrees that the withdrawal of one of the two short-listed bidders made the final negotiations more difficult for the Trust and prevented competitive tension in the later stages of procurement. The NHS Executive agrees that maximising competitive pressures amongst bidders at an earlier stage is the best means of optimising VFM under PFI contracts."

In HOC Session No. HC764 (Delivering Better Value for Money from the PFI), PAC Recommendation 13 states, "Competition is essential if VFM is to be achieved. But on a number of deals we have examined, the Department received only one bid. The receipt of just one bid may indicate, for example, that the proposed project has been poorly designed. Where only one bid has been received, Departments should consider redesigning the project or starting the procurement again."

NHSGG's Outline Business Case (OBC)

Scrutiny of NHSGG's Outline Business Case (OBC) for its two ACADs, in comparison with two comparable Outline Business Cases for University Hospitals of Leicester and an ACAD on the Birmingham City Hospital site confirms the inferior specification of the Glasgow OBC. For a project with an estimated capital cost of £140million, the 52-page specification in the public domain describes the project in general terms with three tables describing the areas of the component parts of the ACADs and two tables providing incomplete projections of clinical activity. Financial data is excluded on grounds of commercial confidentiality and

workforce requirements and architectural specifications are absent. The comparable Leicester and Birmingham OBC's are over four times as long and provide detailed specifications of the scope of each project. NHSGG's Chairman and Chief Executive insisted at interviews with the Health Service Forum South East and with Dr Jean Turner, MSP and Dr Robert Cumming that the specification issued to prospective bidders contained no more detail than available in the publicly available document. If so, it is in keeping with the National Audit Office's comment that a single bid may indicate a poor design specification.

To provide an authoritative view on the VFM and legal aspects of a single bid from a European perspective, the Health Service Forum South East obtained the views of Professor Christopher Bovis, Jean Monet Professor of European Law in the University of Lancaster. A summary of his opinion follows: -

“Legally, any procurement procedure which results in a single bidder lacks competitiveness, as a demonstrable principle of dispensing public services. The European Directives stipulate the need to have at least three candidates in negotiated procedures (the standard UK model) and at least five candidates in restricted procedures. The fact that there is a single candidate after the selection and qualification process may indicate a number of points: first that the contracting authority has not done the preparatory work properly (market testing, sounding of suppliers and services providers). It might also show a manipulation of the selection and pre-qualification process, so a single candidate (consortium) could emerge. If you have only one bidder in a PFI project, there is something wrong with the procurement process, or something more cynical. Logically, the contracting authority ought to abort and reconsider the options. If only one candidate has emerged from the procurement process, I would question the relevance of the business case (I have seen a few which are very poor). If the contracting authority proceeds with only one candidate (single negotiation), the risk (likelihood) of achieving Value for Money decreases dramatically. Two reasons support this assumption: (I) with a single candidate, the contracting authority does not have any price/quality benchmarking and (II) the specifications for the delivery of the project are subject to negotiations which violate directly and overtly the principles of competitive tendering (the single candidate will be able to write their own specifications and price them accordingly with no comparison!) My biggest concern is that the single candidate scenario will inevitably result in the lack of any risk transfer between the public and private sectors, which is the fundamental requirement for the project to go ahead. How can the contracting authority demonstrate risk transfer to the Audit Commission and the relation between risk transfer and pricing for the services? The “Should Cost Model” (Shadow Bid) is nothing more than the Public Sector Comparator case, submitted by the contracting authority to the Treasury for notional credit approval.”

The claim that a shadow bid can compensate for the absence of normal competition fails because, like the discount rate and relevant risk transfer adjustments made to ensure that the PFI bid is comparable with the PSC, it is a purely financial comparison. In normal commercial practice, and as every consumer purchasing a car or making a contract to have his/her house decorated knows, price is only one of several criteria governing final choice. Reliability, prompt delivery, aftercare, and a reputation for design and build quality are equally or more important in a context of wide consumer choice. None of these criteria operate in a shadow bid limited to artificially generated in house cost comparisons. The single bid situation is the reductio ad absurdum of the open competition which PFI is

supposed to bring about. NHSGG currently faces a situation in which the first phase of its ASR is neither competitive nor can assure value for money.

European Procurement Law does not favour the selection of a preferred bidder from three to five bids in the standard competitive negotiated procedure employed in U.K. PFI/PPP contracts since this is deemed to reduce the level of competition. A forthcoming E.U. Directive may veto the system of naming preferred bidders. The legality of the single bid procedure currently being followed by NHSGG for its two ACADs could then almost certainly be challenged at the European Court of Justice (See Private Eye, No. 1120, 26th November, p6, "HP Sauce," for a recent update on this situation). The Scottish Health Executive and NHSGG should think carefully before committing themselves to such a costly project in the absence of effective competition.

The present situation

At present (December 2004), NHSGG has not yet received the Shadow Bid, which is being prepared jointly by Ernst & Young and the Board's Commissioning Team. No explanation has been offered in the Board's minutes for this prolonged delay of over a year in presenting what the Scottish Health Executive and the Board's Auditors consider an essential part of the assessment of VFM in this complex procedure. Once the Shadow Bid is received, it must then be considered and approved by the NHSGG Board, the Scottish Executive Health Department, and Audit Scotland. NHSGG believes that preparation and approval of the Full Business Case (FBC) for the ACADs (assuming approval of the Shadow Bid) may be completed by Summer 2005. Only then can construction of the two ACADs proceed. If Audit Scotland or the Scottish Executive Health Department were to consider VFM for the single tender unsatisfactory, NHSGG would have no option but to re-tender for this project.

The present ACADs project, the first phase of NHSGG's ASR, offers poor value for money on grounds of poor specification, the absence of competition and the presence of commercial confidentiality, which conceals the true costs of the project. Based on past experience of PFI contracts from the award of preferred bidder status to final cost, the costs of this project will escalate; the presence of a single bidder makes cost control difficult. The single bid procedure negates the concept of a competitive market in which VFM is ensured by genuine competition. In the present procedure the sham of ill-understood financial instruments of doubtful efficacy provide only an illusion of a level competitive playing field.