Meeting of NHS Greater Glasgow and Clyde and St Margaret of Scotland Hospice
2 May 2008 at 8.30am

Present:

St Margaret of Scotland Hospice	**NHS GGC**
Professor Leo Martin - Chairman	Andrew Robertson - Chairman
Sister Rita – Chief Executive	Tom Divers – Chief Executive
Edward McGuigan – Vice Chair	
Jacquie Malcolm – Nurse Lecturer	
Elizabeth Thomas – Director Clinical Services	

Andrew Robertson

I think we will just start. I'm very pleased to welcome you here today. I am very conscious that there has been a whole series of discussions and correspondence going back over the years and I have come in at the tail end of it, really from 1 December 2007. As you know, I met with you Leo in January, in fact I think it was February, and then we had follow up correspondence when I wrote to you on 13 March 2008 and I suspect, and I think I have already heard from Tom, that you were distressed with my letter to the Herald after the public meeting and I think it is fair to say that I am extremely sorry if there is any continuing difficulty with this on a personal level and I did think that it was critically important that we should put forward how we saw the situation.

Leo Martin

I think that is a good introduction and from that it is good to hear your position. However, let's look at going forward because you have now confidently said to the Health Board and to the Press that decisions have been made and clearly the decisions have not been made, according to the minute we've got of your Board meeting. But what you have said the whole way through is that you will ensure the continuation of St Margaret of Scotland Hospice so clearly we need to hear from you what your proposals are for that and that's really what we want to hear because we are really at a point this morning where we would like to hear how the Health Board see that happening.

We know what we do, we know what we want to continue to do, we know the patients referred, we know where the patients have come from, we know how long they lived before they died, we know these things and we want to hear how you intend to continue St Margaret of Scotland Hospice.

Andrew Robertson

Leo, we are both lawyers. We can't say that we can ensure the continuation of St Margaret's. But what we can say is that we are very keen to see a continued relationship, a continued service and a continued contract. We can't say we can ensure the continuation of St Margaret's. You are your own masters but we are very keen to explore the various alternatives already put forward and see if there is a way

coming out of those or if there is some other way but we are determined to take this forward in a positive way with you. I'm just setting that in the context. Tom.

Tom Divers

At the point when we had first met before the Balance of Care document was published back in 2004, my objective has been to try and ensure that all the beds at St Margaret's had a continuing future.

The Palliative Care beds to continue as Palliative Care beds and the frail elderly beds meeting a role that was one that would fit with one or other of the Health Board strategies.

And when we met previously, the 2 options that we had discussed briefly and about which John Arbuthnott and I had written at that point, had been either in elderly care providing enhanced social care or, and you said right at the very end of your short introduction there Leo "funded through the Health Board" and that is potentially quite a significant comment and I'll come back to that in a second, because when you had made that comment previously, we had gone back to look again and see whether there was a service that could fit with one of our strategies that would see St Margaret's continue to be funded wholly through the Health Board and it was on that basis that, I think in our second discussion, we had come back and suggested continuing care for older people with mental illness because we have a reprovision programme that we will need to make over the course of the coming years for that. And we had gone back and looked at that as an option because both you and Sister Rita had I think shown a very very strong preference for continuing to be funded through the Health Board as opposed to working in contract, through a contract with Local Authorities. So, those were the options that we have put forward previously.

My team have gone back and had further discussions with their counterparts in Glasgow City, West Dunbartonshire and East Dunbartonshire Councils because as you know, we have elected members from both of those Health Boards on our NHS Board and we have been engaged in this debate over the course of recent months *[Andrew Robertson interjects to confirm they have elected members from both of these Local Authorities, not both of these Health Boards]* and from the most recent discussions between ourselves, Glasgow City, East Dunbartonshire and West Dunbartonshire, a further option which has been identified, which all 3 of those Local Authorities would support and probably support in equal measure, would be the provision of a care home with nursing that would mean that whereas the enhanced social care model that we had previously mentioned would not have involved the employment of nursing staff, a care home with nursing would involve the employment of nursing staff and those are the 3 options that we would see as being options that would fit with the strategies, both of the Board and the Local Authorities and would see us able to move forward in a way that we continue to make use of all of the ward accommodation and all support facilities at St Margaret's.

Leo Martin

Obviously you have investigated these things with the Local Authorities and have done some research – who do you think we actually look after Tom? What sort of patients do you think we look after?

Tom Divers

I know exactly who you look after.

Leo Martin

Tell me about those patients Tom.

Tom Divers

You look after patients who are properly in receipt of NHS continuing care and who are in the final months of their life. I do know that. I am equally clear that we are now on the point of having an overprovision of that accommodation within the west sector of the NHS Board area.

That we have already changed the profile in 3 of the 5 sectors within what was the former NHS Greater Glasgow in order to readjust the provision between NHS continuing care, care home with nursing and enhanced social care and in the west and south east, it remains for us to complete that transition.

The most recent study that has been undertaken leaves us in the position where we are certain that is the right way to plan for the future and we now need to make the changes by redesignating or reproviding 30 beds in the west and 30 beds in the South East, taking 60 NHS continuing care beds out of the city, having already reprofiled in other areas.

Leo Martin

In relation to other parts of the city, have you done any analysis of the type of patients in comparison to ourselves.

Tom Divers

Yes, because what is common about this Leo is that there is a group of Consultant Geriatricians who have the referral and admitting rights for all of these units. They work in a single Directorate, that is now our Rehabilitation and Assessment Directorate, and we have intelligence, and that is what has fed the Balance of Care report, from all sectors of the city so your Ed Spilg, there's Margaret Roberts, Paul Wright, John McDonald – there is that cluster of Geriatricians across the City who in essence have the referral and admitting rights to the NHS continuing care beds.

Now in terms of my reflection on our previous discussions and coming back together again this morning,

Part of the reason why, well we went back to look again at whether there were other options because that is what we always wanted to do and as I said, the last thing that I or the Board would ever want to happen was that there was actually a gap at St Margaret's where there was a Palliative Care ward and there wasn't anything else and I remain absolutely determined to try and ensure that's not where we end up and I restate that again this morning. And that's why we went back to look again and see whether there was another option.

Can I say just a little briefly about both of the options because I think what I would want to do beyond this morning is actually get some of this written up and presented so that it can be considered in more detail. Let me offer you a perspective on that, in terms of what the need is from the strategic work that we and the Local Authorities have undertaken, the provision of a care home with nursing would best meet that need in terms of our strategies. That's why I said that West Dunbartonshire and East Dunbartonshire Councils, as well as the City of Glasgow Council would almost be equal partners in that venture because each of the Local Authorities has identified that they have under provision within that particular part of the care continuum. That involves provision of care for a group of people who clearly are not as ill as the group St Margaret's currently looks after but a group who would require nursing care and so if like, a congruence between some of that St Margaret's currently provides for NHS continuing care and would require the ongoing appointment of qualified and unqualified nurses and so my sense is that that would almost bump the enhanced social care option off the table.

And sorry the other thing I should say about that is that the costs of providing that model would not be at the same level as the current costs of NHS continuing care because the staffing levels are not as intense and in the main this is because people are not in the final stages of their life and they will typically be inpatients for somewhere between 18 months and 2 years. So not as an intense a level in terms of staffing but the costs we would propose in terms of that agreement would, at the end of a transition period, would be the costs able to sustain that so that there would not be any gap in provision. So the current costs of just under £1.2m and the future costs were £800,000 or £900,000, then what would be available once the transition has been made would be the £800,000 or £900,000 but that would be put through on the basis that that was the costs of providing the future service and what we have done with the other providers is to bridge the costs in moving between either NHS continuing care and care home with nursing as we have done with some providers or enhanced social care so that there has not been a financial risk. That is one battle. The provision of beds for older people with mental illness, sorry I should say that that care home with nursing agreement would in essence be an agreement constructed between the 3 Local Authorities and the Health Board where in essence, the Health Board would pass the monies across to the Local Authorities for that contract and that would be the means of funding but it would be a contract with the Local Authorities as opposed to the Health Board.

If I move to the provision of continuing care for older people with mental illness, this is again a frail group of older people, not as near to the end of life as the current complement of older people who you care for, but with many care needs, which are similar. And if that was the option that we were taking forward, that would be an agreement with the Health Board. The value of that ongoing agreement would be at

the level of the current agreement for NHS continuing care and it might even be slightly more than that given that the care needs of that group do have some differences in staffing requirements. But that, in terms of what you said initially Leo, would be an option which would continue to be funded directly through the Health Board and wouldn't involve any contract with any Local Authority, either individually or together.

Leo Martin

Tom, I'm listening to this and I'm looking at some of the things you are saying which I think are very much in support of what we do just now and that is to provide these patients with Hospice care within a Hospice.

Tom Divers

No, I've said they are getting NHS continuing care.

Leo Martin

Okay, so NHS continuing care but in a Hospice and in essence these people are being looked after as they approach the end of their life and yet you are proposing to change that?

That is the part that I can't intellectually or rationally get to a point where I understand that. Here we have an example of 26 or 30 people, depending on the information at that particular time, who are requiring of a Hospice service, albeit it is NHS continuing care, they are getting that and are getting it in such a way as it is excellent by all comparators, but getting it in such a way that is right and efficient for the Health Service, provided in a way that supports the whole of the Hospice because as you know it is done in such a way that the commonality of care in both wards support each other and therefore if you want me to be specific, the question I ask is if we were to change and lose money coming in for the Mary Aikenhead Centre, how will we make that up in St Joseph's ward?

And the question then arises, why do we get per bed less than so many others?

Tom Divers

This has nothing to do with cost.

Leo Martin

I accept that but just now there is a very efficient model in place just down in Clydebank which works. Why would you want to change that? And I have still not heard any reason at all for that.

Tom Divers

There are 2 or 3 reasons and I think you have heard them Leo.

The first is that we are now at the point of having too many NHS continuing care beds.

Leo Martin

Then move something else into Blawarthill. Move something else into Blawarthill.

Tom Divers

Blawarthill currently has 60 NHS continuing care beds. That is a reduction on that site over the years of 50% of the NHS continuing care provision

Leo Martin

But we get patients from Blawarthill and we know the condition they are in. I accept that you are changing Blawarthill and I accept that there is a need to change Blawarthill. They question I have to ask you is and the question I have asked before and never got an answer to is why do it to the prejudice of something that is doing so well? Why do that and why would your Board do that? And perhaps that why your Board have asked for further information after the meeting and obviously you'll provide it to them and I'll provide it to them as well.

Why change something that is working for the sake of something that is novel and untested?

Tom Divers

It's not novel and untested.

Leo Martin

It's not built yet.

Tom Divers

We got for provision of continuing care on that site. Blawarthill has already been resized over the course of the past decade to cut down to 60 beds. In addition and within that same locality, we have taken out all of the continuing care beds that were provided at Knightswood Hospital. And the decision that the Health Board made back in 2000 was that the continuing care provision for that locality would be 60 beds continuing care provision on that site which it has now been reduced to, along side a provision for enhanced social care in a joint development with the Local Authority.

Leo Martin

But by your own admission Tom at your Board meeting, that did not impact on St Margaret's.

Tom Divers

Yes, that's right.

Leo Martin

I remember sitting down with you when you said no decision had been made so I hope you are being consistent.

Tom Divers

Yes I'm being consistent. I am being entirely consistent.

[Andrew Robertson interjects to tell Leo to let Tom finish]

Leo Martin

I think I have to explain the reasoning for my question Andrew. Why sit down and make that decision without consultation with St Margaret's, which had such a deleterious effect on St Margaret's? Why make that decision?

Tom Divers

The Balance of Care study that was published in 2005 had set out a further continuing change. I first came to meet you with Sir John before that Balance of Care study was published, about 5 months before it was published, to try to begin to open that dialogue because it was clear from the stage that that work had progressed to, but not just in the west of the city but across the whole of the city, there was going to be a further shift in the balance of that care.

Leo Martin

No, you came because Alex McKechnie had said to us the decision had already been made and you and Sir John when you came to see us had clearly said it hadn't. An Officer of the Health Board had stepped in and told us that decision had been made and you came back and confirmed to us that that decision had not been made and would not be made without consultation with us.

What has happened is that that decision has been made as part of a decision you have employed with Glasgow City Council which I am sure is an honourable way to move forward for Glasgow City Council. However, its impact on us is such that it is going to have a negative effect. Now, even by your own introduction to the care home with nursing care, you accept it will have a negative effect because it will reduce the level of service that we provide, that level of service is the commonality throughout the whole Hospice and it will reduce the income to the Hospice.

Tom Divers

There are 2 points in that Leo. First of all, I have been trying to get some dialogue for over 3 years and have not been able to progress these conversations so I don't feel

there has been a lack of effort on my or John Arbuthnott's part to try and prevent discussions from taking place. I have not got to a point where you have been prepared to consider the options that thus far we have shared verbally and that is why I said that following today I need to write this down so that it can be considered fully.

The second point is that …

Andrew Robertson

That's a very important point Tom. We haven't come here with something written down, the object of this meeting I hope would be to try and tease out the different strands and whether there were particular items that should be given consideration and then we do come to writing things down. But if there is that sort of failure to pursue this course and we do end up writing it down, it's not for the want of trying to have this across the table discussion, so that what does go down on paper does have a fair chance of meeting the expectations of both of us. But if you are just going to say no….

Leo Martin

We are not just saying no but what I am asking is the rationality of this decision which was made without consultation with us and the Board still have to test it. We have been told us decisions have been made and decisions obviously haven't been made and your Board are in position to make that decision.

Andrew Robertson

We'll have to cope with the Board as we cope with the Board in all things in putting forward well researched and well argued, well-presented papers. So, we'll cope with the Board, don't worry about that. I want to be sure that if there is further correspondence with the Hospice it is correspondence that takes place in the spirit of goodwill and with a shared understanding so that when things go into paper they have a fair chance of recording what we both want.

Jacquie Malcolm

I wonder if I could interject at this point and speak about the Balance of Care recommendations that sit, I think, within the wider context of Glasgow and Better Health Better Care. It is paradoxical to take a situation which you have described quite clearly is NHS continuing care within a Hospice setting that by your own admission cares for people in the final stages of life.

You have clearly stated in the Balance of Care that continuing care is no longer a matter of years, its not in multiples of years but months. St Margaret of Scotland Hospice is held as an exemplar of end of life care for older people across the board both in introduction of End of Life Care Strategies. We absolutely fly in the face of all recommendations that are made through Palliative Care Strategies, through the Manifesto of our Cabinet Secretary.

On I suppose the groups that I sit on, representing Palliative Care both as a Specialist Palliative Care Representative and an Older Person Representative, taking end of life care aware from a Hospice setting, from an exemplar, is paradoxical and I appreciate that in the opening statement to the Health Board you said that it is not driven by financial considerations but it clearly is. To jeopardise an exemplar end of life care model for something, which you believe, can be provided in a social care context, or the Hospice ethos being jeopardised by the introduction of mental health issues. Some of the patients that we care for have at some point in their life experienced that or in the tragedy they are about to face, may experience that. To jeopardise the Hospice ethos, something that the Health Board has benefited from for 58 years, is paradox.

Tom Divers

I take issue with almost every word of that, I regret to say. Nothing we are doing flies in the fact of Better Health Better Care. I understand what the dimensions of Better Health Better Care are, I understand where the Government is in terms of strategies in Palliative Care, I understand fully what the implications are of delivering long term conditions. What we are doing is not flying in the face of that.

Elizabeth Thomas

I am sorry, I don't agree with that.

Tom Divers

Well, we'll disagree about that. Can you come back to this point about funding. What I am trying to explain is that if the NHS continuing care was no longer at St Margaret's and there was instead a care home with nursing or older people with mental health issues, then what would be available would be the full funding that is required to run that.

Edward McGuigan

So, what you are basically saying here is, for the sake of the money, change the service?

Tom Divers

What I'm saying is we have too many NHS continuing care beds and we need to adjust that.

Edward McGuigan

But you are contracting to Blawarthill. We get patients from Blawarthill.

Tom Divers

We are not contracting into Blawarthill. We have the beds established at Blawarthill. They have been there and have been reduced in that locality.

Edward McGuigan

So what you are suggesting is that those patients are just going to die at Blawarthill.

Leo Martin

It is a removal of choice.

Tom Divers

Well, sometimes there is a removal of choice. In almost every major strategic decision we have had to take as a Board, there at times have been a removal of choice. When we changed the maternity provision from 3 to 2 maternity units in 2010 will in that sense, a removal of choice but it is us having to resize our provision in order to meet what the future strategic requirement is.

Elizabeth Thomas

You keep using the words strategy and strategic. You said you are very well aware of the Palliative Care Strategy and Elderly Care Strategy. If you were well aware of the Palliative Care strategy you would realise that there is a huge problem in elderly people accessing Palliative Care/Hospice care services. There is also a huge problem with people with diagnoses other than cancer accessing Palliative Care services.

Here we have a model which really it was visionary when you think about it. We have been delivering what everybody else is aspiring to and you are going to dismantle this service. We look after the elderly patients, we look after patients who have cancer and non-cancer diagnoses, end of life issues surrounding the patient. We look after them until the very death and I think you know that we deliver a very good standard of care. Why would you want to destroy all of that when it actually is meeting the strategy?

Andrew Robertson

I find it very difficult this sort of sense that we are trying to do something destructive here and there is an issue of resources floating around and clearly, I think ….

Leo Martin

I think you've got to be honest here.

Andrew Robertson

Well, you've got to be honest too Leo.

Leo Martin

I am honest Andrew and my words to you and anyone else is that if you remove the funding for the patients who we look after and who we give excellent Hospice care to

in the frail elderly continuing care beds, you will prejudice the whole existence of the Hospice.

Andrew Robertson

That is a funding issue and there is a funding response, okay. There are care issues and patterns of care. But insofar as you have a funding issue, there is an answer on the table that meets that funding issue. This is a funding issue and we have shown you a way for this to be met.

Now, there is the pattern of care issue.

Edward McGuigan

With the greatest respect, this model moves far away from what the Hospice does. It looks after people that are dying. Where are these people going to die? Are they going to die in a nursing home?

Tom Divers

No.

Edward McGuigan

Then where are they going to die? They go into a nursing home with some form of enhanced medical care and then end up in a hospital bed? That is what is going to happen.

Tom Divers

No its not.

Elizabeth Thomas

But that already happens.

Edward McGuigan

If that's not the case then why are we getting patients from Blawarthill?

Tom Divers

There are lots of older people who die in a whole range of care settings and we all know that. There are older people who die at home, older people who die in a continuing care bed, older people who die in hospital.

Sister Rita

Tom I'm, sorry but what we know is that the most complaints are around that very issue. We are the only people who provide Hospice care for the elderly and if you look at the complaints to the Health Board, it is all around end of life care for older patients.

Leo Martin

Which we don't have. We don't have any complaints. You will not be surprised to hear because I am not in anyway defending the medical team probably because of what my father did I have an abhorrence of hospitals.

I have had this checked and have checked all the pathology of the patients that have come into the Hospice continuing care in the last year, I have checked what hospitals they have come from and also checked which Local Authority they have come from and I would have to say that the information you gave to the Board is not backed up by the information we have.

We have people coming to us to die. They are coming to us to die from hospitals in Glasgow. They are coming to us to die with symptoms and disease which requires the same type of care as we provide for the other patients in St Joseph's ward and they are coming to us in proportions from the other Local Authorities, which does not stack up with the information you gave the Health Board. My analysis of that spread is 40% come from West Dunbartonshire and East Dunbartonshire and you represented that on one snapshot in December. Now those figures are for the last five years.

Tom Divers

Well, I'd need to look at them. We based our information on the figures you gave us.

Sister Rita

But that was a snapshot. That was only taken for one day.

Tom Divers

But the papers that went to the Board clearly set out 2 snapshot periods. As long as there is an analysis around that, then that's fine. I am happy to look at it.

Elizabeth Thomas

In the Balance of Care report it stated quite clearly that there should be a full and thorough review would be carried out in December. Now, two snapshot audits are not a full and thorough review. It is far from it. And the fact that you stated we have 3 patients from other areas and we have 40% of patients coming from East and West Dunbartonshire just shows how ridiculous it is to base a final decision snapshot audits.

Tom Divers

There are two things and they are quite separate and that is that the Balance of Care report looks at each of those parts of the care continuum across the spectrum of NHS continuing care, the snapshot audit looked at NHS continuing care of all sites across the city at a particular point in time. We are not saying the snapshot audit was a full review of the Balance of Care report.

Elizabeth Thomas

Well where was the full review that was stated in the Balance of Care report that was undertaken? There was to be a further review in December. In fact, the Balance of Care report states it is only a draft copy. Where is the final copy of the Balance of Care report and when was it ratified?

Tom Divers

The summary of what was in the Balance of Care report was presented to the Health Board in April.

Elizabeth Thomas

Yes but it's quite sad though that the figures do not marry with the figure that we would provide. There are a number of discrepancies in the Balance of Care report.

Tom Divers

Well again, you are telling me something that I don't know.

Elizabeth Thomas

Well I can assure you that there are a number of discrepancies in that report and there was no review carried out, as stated would happen. That didn't occur. There were two snapshot audits carried out and you indicated that we only had 3 patients from outwith Glasgow and in actual fact 40% of our patients were from outwith Glasgow and you didn't even consult with East and West Dunbartonshire Councils when making this decision.

Tom Divers

Which decision?

Elizabeth Thomas

The decision to remove the beds from St Margaret's. They were not party to the discussion.

Tom Divers

I'm sorry that is just wrong. They were part of the planning groups that were involved in the original Balance of Care report. Granted, we didn't consult formally with the two Local Authorities. And that's the truth of it.

Elizabeth Thomas

Well you should have because it impacts on their areas because we take their patients and you did not consult. You didn't consult with us regarding this particular subject. Granted you may have consulted with us in letters and meetings but these were on other subjects such as wanting more beds, but you certainly didn't consult with us about removing the beds.

Tom Divers

Read my letters from September 2004 and tell me that we have been trying to …. look, this is sterile. I'm not going to go over this.

Leo Martin

There are a few questions we have to ask. Have you now committed yourselves completely, as a Board, to removing the 30 beds at St Margaret's and taking them to Blawarthill? Is that cast in stone? Are there legal reasons around it as to why this has to happen? Why are you so taken by this, that it must happen? Because everything we have shown throughout, everything we have stated throughout has said that what we provide is Hospice care in a Hospice environment for people that are dying, referred to us by NHS hospitals just now by NHS consultants and get an excellent service. So why is this something which the only consultation you had with us is to change that? Now you have provided, in effect, a fait accompli. You are transferring these beds to Blawarthill. Now it's do you want to do this, or do you want to do this or, this morning, a third alternative. At no point have you said or ever asked us how can we try to maintain the service that is happening at St Margaret of Scotland Hospice? How can we try and maintain what is happening there, which the people want who are there, what the consultants who are referring in want, which we understand there is a waiting list still to come in. Where are they going to go after 1 April 2009? Andrew's letter to me says the decision has been made and we will not get referrals after 1 April 2009. Where do they go?

Tom Divers

They, it would, they, they will go to Blawarthill. We have the NHS provision there. We are not taking the beds from St Margaret's and putting them into Blawarthill.

Sister Rita

We are going round in circles here and I am sure you have a whole lot of other big headaches, but we provide Hospice care and that is what we are going to continue doing.

Now, at the moment, my understanding is that there are 87 patients waiting for Blawarthill and there is also some other hidden list as well. Why can we not have transparency and be upfront?

I have a note here from a Geriatrician which states quite clearly that our place, the Hospice, is a very unique situation and that I must keep saying that because otherwise you are going to deprive an awful lot of people.

Now I see a very easy solution here Tom, you have a Hospice providing absolutely excellent care, we have a proven track record of doing this you know it is only a couple of years ago that the Health Board, and this makes me terribly sad, the Health Board was saying "we are in partnership with St Margaret's – if you go there you will find exactly the kind of care we like to deliver" and suddenly there is this awful change, it is as if we are doing something we shouldn't do. I have absolutely no interest in politics or in playing games. I want to make sure these patients continue to have this kind of care and for me, it's a justice issue. Nothing else. I have nothing against you Tom, I have nothing against anyone here, I just want to be able to continue to do that which we have done for so long without complaint. There is a very easy solution Tom because the Geriatricians might be saying one thing to you but there are Geriatricians who cannot access Hospice beds. We have some of the most difficult patients sent to us. We have no say in that and you, or whoever did the figures, said we had a patient in there for 10 years. We have no say. If in the morning the Geriatrician said to us "I don't think this patient should be here" then we have to go with that. We have no say over the patients. I think you are not understanding this, we are about Hospice care and about delivering end of life care for patients. In the last 2 years, the patients coming in are in for a shorter period but that is up to the Geriatrician. One Geriatrician has always referred to the Hospice. Other Geriatricians have said they have not been aware they could refer into Hospice care. Maybe it should be opened up more to allow Hospice care to be given to these patients because the one big complaint into the Health Board is all around that area. You actually have a Hospice, and you should be very proud because you could turn this around for yourselves, this Hospice is there, delivering a very good standard of care for the Health Board.

Andrew Robertson

Sister Rita, are you saying that you have two wards effectively providing Hospice care and want to be funded on that basis?

Sister Rita

No, we couldn't be funded on that basis. These patients coming into the Palliative Care ward are paid fully in an NHS bed and suddenly when they come to us, we only receive half of it. That's a nonsense. These patients have paid their way all their lives.

I have nothing against either of you, I just want to see these patients protected. We could say, yes open it up to everyone needing it, and Tom could say well you are only getting 50%.

Tom Divers

I wouldn't say that.

Sister Rita

I am just saying, there are other options, other ways of doing it.

Andrew Robertson

That's one option and I understand that. What are the other options do you think?

Sister Rita

The option for us is that we use our expertise, we deliver end of life care. All of our staff are trained very highly, skilled, and we have a proven track record for this.

Edward McGuigan

The irony of this is that we have staff coming from NHS to be trained by us and are looking at what we are doing and saying "wow" we have no experience here. These are ward managers.

Leo Martin

[Reading from Evaluation form from NHS ward manager] "It was useful for me because of ongoing developments at Blawarthill to appreciate the excellent environment for frail elderly patients." A quote from someone we have previously trained for you.

Tom Divers

People you have trained as part of an ongoing agreement between us that you participated in.

Leo Martin

So, someone is now coming in to us and saying "that is an excellent way for us to learn, how to something from people who deliver it".

Jacquie Malcolm

These were ward managers. Yes, and that was a wonderful initiative that people from the hospitals to the Hospice to learn about end of life care. The anxiety of you saying that patients die in Blawarthill is the travesty of it because we know that there already is a professional group there who feel ill equipped to deliver this level of care at Blawarthill.

Andrew Robertson

Can I just clarify, for my own sake, there have been three options which have been put forward, the enhanced social care, the NHS mental health care or a care home with nursing.

If you took up any of these options, would people ever be being passed back into the NHS or anywhere else, or would they effectively be the ultimate responsibility of St Margaret's?

Leo Martin

I've thought that through as well and I've thought how ridiculous it would be if were to become a care home with nursing and that when people got to end of life care, they would leave a Hospice to go to Blawarthill.

Andrew Robertson

But I don't think they would be.

Leo Martin

Basically, what Tom is saying is that we have to dumb down. We wouldn't have the skills. So if we have people who develop the complex symptoms, the complex people we have just now, we wouldn't have the staff available to care for them and would have to send them to Blawarthill.

Sister Rita

Could I just read this paragraph please *[reading from Professor Brian Williams email]* "my 24 years of experience as a Consultant Geriatrician in charge of selection of continuing care patients and supervision of Hospice patients, taught me that the Hospice provided an almost unique, high quality of specialist medical and nursing care for highly selected continuing care patients. Standard nursing homes were unable to provide this care and this meant that when nursing home residents did develop more complex problems, they required admission to acute care facilities. You must make this point clear in any of your discussions."

Tom Divers

Yes, I know you got in touch with Brian Williams and he's spoken to me since then because as we all know, he has decades of involvement with the service.

Edward McGuigan

So are you just prepared to ignore that?

Tom Divers

No, I'm not saying that. I'm just saying that I know there was contact with Brian when for a long period there wasn't contact, that's all. There is a different spectrum of provision in terms of care homes with nursing from NHS continuing care, because as I said, the length of stay is longer, as was the case in NHS continuing care a number of years ago and NHS continuing care has moved as the balance of care has moved over the course of the past decade to become, in essence, that specialist care that is provided in the final months of people's lives but there are still many individuals who could die in care homes having spent the final 18 months.

Edward McGuigan

We have people who are desperate to come into this facility. Why is there a waiting list?

Tom Divers

Well I've just heard of 87.

Elizabeth Thomas

You are talking here about end of life care. There is no better place for end of life care than a Hospice. I would like to direct you to the CEL 6 (2008), "people should have their care provided by the right professional, in the right setting at the right time they require care." It also goes on "NHS continuing care will be provided in a hospital, a Hospice, or contracted inpatient bed, etc". The fact of the matter is, St Margaret's is the only Hospice who provide NHS continuing care for the elderly in Glasgow. And you are going to remove the choice and yet it states quite clearly in CEL 6 (2008) that patients are entitled to have access to NHS continuing care and a Hospice is one of the places for that.

Tom Divers

Yes, that's what it says. But what is says is that NHS continuing care can be provided in one of three settings.

Elizabeth Thomas

Yes, and you are removing the choice by removing the beds.

Tom Divers

No, no.

Elizabeth Thomas

You are indeed. You are removing continuing care from a Hospice.

Tom Divers

Yes the choice is reduced but for the majority of people within NHS continuing care in Greater Glasgow and Clyde there is not the choice of having NHS continuing care provided on the same site as Palliative Care. That choice is not available for the vast majority of people.

Leo Martin

So why are you trying to do away with it? Why are you trying to do away with something that works so well.

Tom Divers

I've told you. We have too much provision.

Leo Martin

Well I'll come back to what the whole essence of this discussion should be about. If you have too much provision, why change something that is working. Why change something that is working? And it is working very efficiently, not just for the Health Board but for the patients. Why prejudice yourselves. Why put your head on a block? Why do that because what you are doing is chopping us. You are putting your head on a block and we are being chopped and that just doesn't make any sense to me. I have struggled now for years to understand that, it keeps me awake at night, I can't understand it. I try to get my head around it and process it in every different way I can process my thoughts and it still comes down to why move something that works to something different?

Tom Divers

We are having to resize the provision. Do you accept that? If you can't accept that, then … [SHRUGS].

Leo Martin

We have to accept that because you say it but it may well be we will go back to the Government at some point but we have to accept that. But we have to accept that because you are saying it. We have to accept that because that is the position which we as the taxpayers pay you to make. So, if you have come to that decision, and it might be the wrong decision and it might be shown to be the wrong decision because Health Board policies have changed lots of times over the years, so we have to accept it but we accept it but we don't like it because we think you are depriving lots of people in society of a right that they should have. That's the charitable side and that's our Mission.

It makes no sense to take away something that works very well, that people want, that there is a waiting list for, that the Geriatricians want, that the families want, why do the Health Board not want it? And honestly, I've still not had the answer. Andrew you and I met in my office to try and explain it to me and at that point you felt you

deficient of information on it and you would go back and look at it. And today, I still don't have the answer to that question. Why remove something that works very well to something that isn't?

Andrew Robertson

Well, we are not moving it because it is already there. Blawarthill has already got the 2 wards. NHS continuing care is already at Blawarthill. We are not increasing the continuing care beds there. What I did share with you when we met was the experience which I had personally as Secretary of Erskine Hospital for years where we were very dependent on funding from the NHS and there were 30 contracted NHS beds and that was in the days when we ran a very tight ship and it was Nightingale Wards. As we saw that the contracted beds were coming out, it was a wake up call to the changes that we had to make to meet the emerging new standard of service, we had to rebuild Erskine, we have had to rechannel all of our funding, we are now onto largely enhanced social care, there are probably about 30% who are self funded and therefore dependent only on their top up of £210 for free care for the elderly to make up the difference and we just got on with it. If you went and looked at Erskine now and you saw it 10 or 15 years ago, you would recognise that we are looking after largely the same people and giving the same service but we have had to take account of strategic changes in the Government approach.

Leo Martin

And that's entirely honourable and I can tell you professionally I have been to Erskine 15 years ago and I have been there recently. It has to be said that the difference though is that your people are dying through a normal pattern, our people are dying because of pathology that kills them very quickly. There is a great difference in those examples.

Andrew Robertson

Yes but it's interesting to see that the pattern has changed dramatically. It used to be a big issue if you were taking in long term patients because basically that was a rehab hospital and the long term residents were there for some 20 years. We are now taking people in in the final stages with heart disease, respiratory disease, and they are not lasting.

Leo Martin

It's not called a Hospice. It's called the Princess Louise Hospital. It's not a Hospice. It doesn't have a Palliative Care ward which provides Hospice care at 50% funding under an HDL for society. It doesn't have that. It's very different even before we consider the funding of the place. I appreciate your example there are lots of other exemplars and I have spoken with other charities who have managed to change and deliver and survive the changes. Our position though is quite simple, we provide a service that people require and we provide it as a Hospice service. It falls within the guidelines of what should be provided. Why are you changing that? Why would you want to change that?

Tom Divers

Because we have too much provision. You have accepted at least on one level that that is a decision the Health Board takes and the second reason is the Health Board made the decision in 2000 that it was going to redevelop Blawarthill as a centre for NHS continuing care with the Local Authority developing enhanced social care on the same site. That was a decision that was made and commitments that were made that have been confirmed since then and that is why the subsequent changes that are taking place in other parts of the city around the balance of care and NHS continuing care have been got through on an individual basis.

But the Board and Glasgow City Council consider that that is a decision that we made then and that they are still bound by.

Leo Martin

One of the things I thought when I read through the minutes of the Board Meeting and something which brought it home to me and which made me, I have to say, very pessimistic and hopefully I am managing to get through that. But what it was was the comments you made regarding Darnley on the south side because they've got a contract and you took our contract away. We were getting a contract. That is what you and I spent years talking about, to try and get St Margaret's on to a firm footing, a stable footing under a five year contract. We got that contract and then you took it away. Were we given a five year contract by the Health Board, this meeting wouldn't be taking place. Fact.

Tom Divers

Leo I think that the discussions that I had started in that with Laurence Peterkin in 2003 are now almost five years old.

Leo Martin

Yes but over that five year period you would not have been able to make the decisions you have made.

Jacquie Malcolm

There is almost an essence of orchestration.

Leo Martin

There wasn't a contract Tom.

Tom Divers

There was a service level agreement between our two organisations.

Leo Martin

To provide a service.

Andrew Robertson

Is this an implied agreement?

Leo Martin

It was withdrawn Andrew. It was there and then it was gone.

Tom Divers

There was a draft contract.

Leo Martin

And we got the contract to the point where we thought it was going ahead Andrew and then it suddenly disappeared and it disappeared at the time decisions were being made, without consultation with the Hospice, and which impact on the Hospice.

Sister Rita

At that time, and I regret it terribly, Tom you asked me to approach our Congregation to remove £1.9m loan which the Accountants insisted we carry through in our accounts and I did exactly as you asked me to do and you never honoured the other side of the bargain. That contract as promised never came back to us. I didn't think for one minute our beds would ever be in jeopardy. Never. But I kept my side of the bargain and as you know, we serve in the poorest parts of the world, I regret that terribly to this day, that I went and actually begged the Congregation to remove that £1.9m I feel terribly sad I did so. I had asked for that money because Clydebank was a very deprived area and I wanted the patients to have more choice. We have tried upgrading the Hospice over the last 20 years and you are very well aware of that. So that makes me also very sad because we sat in that room and regardless of advice given to me by an awful lot of people who asked me not do it I did so. But that contract from you never came back to us.

Tom Divers

I think we are conflating here.

Sister Rita

You don't want to go back, do you.

Tom Divers

No, I do happily but I think we are conflating a number of conversations that have taken place.

Sister Rita

We are just going back on the journey, that is all.

Tom Divers

My very clear recollection of the context of the £1.9m was when John McLintock had produced a year end forecast of what the Hospice's outturn was going to be for that year, which was probably 2003/2004 it may have been 02/03 but I can check that, that showed that at the year end, St Margaret's was going to be overspent by £684,000. I found those figures difficult to accept in the context of the ongoing relationship that there had been between my finance people and St Margaret's. And we sat down with you as we did to look at what the elements were that were driving that year end outturn and a significant chunk of that was been driven by having to go back and, in essence, repay what had been put upfront by the Order and in the context of trying to get the Hospice back into a position of financial stability, I had raised the question whether that could be removed from the revenue operating account and that was the point at which the Health Board made a payment of £175,000 as an additional payment.

Edward McGuigan

I remember begging on the phone for money. Was about to go on holiday, we couldn't pay the PAYE, it is nothing to do with depreciation on a loan account. It's not Tom.

Leo Martin

You helped us out.

Tom Divers

And that was in the context of trying to get to a position of financial stability.

Sister Rita

Tom excuse me, you have had a lot to say. I don't deal with the financial side of things and I don't want anything to do with it. I have very very scrupulous people who do deal with the financial side. Every year we have major discussions with the Health Board and they agree with this and agree with that and then we just get a 2 liner to say you are getting an uplift of 2% regardless of the fact that nursing salaries have gone up, you know that, and should recognise that. But all we get is a 2 liner so we produce all the figures and everything we were asked for and the reply is a 2 liner. So although Tom you say we can't go back, you have to go back a bit to see where we are coming from, to see what happened and how we have arrived here. I am not

interested in the past, I am only interested in what is going to happen to these patients in the future. Why you would want to take away the right of these patients is a justice issue for me and I will do everything I can to make sure that it doesn't happen. The Hospice is there to deliver Hospice care. That's what we do and what we intend to continue doing.

Andrew Robertson

Sister Rita thank you very much. What I suppose slightly concerns me is that we do get into a stand off position with no room for discussion and I suspect that we have probably done about as much as we can do here now and I think we are absolutely of the understanding that there is a funding issue and that clear fact is intertwined of course with the strategies that we have to develop in terms of how we can assist you in meeting that. One of the clear issues that I am taking on board is the pattern of care that is of prime concern to yourselves and which you are reluctant to see jeopardised. There have been 2 proposals historically and you now have a third proposal that Tom has put on the table today but which he is going to work up further.

My concern is how we take this forward in the most constructive way. I would not like to think that there is a well thought out letter prepared and sent to you and we still get into a continuing stand off of correspondence. And therefore I want to consider whether this is actually the best thing to do now or whether we can both reflect on whether we should be seeking to meet again in 4 weeks time?

Leo Martin

Andrew, I think it is important before the letter comes out that we explore the possibilities you have put forward.

Andrew Robertson

Can we do that together?

Leo Martin

Something I always say is that I always enjoy teaching lawyers because lawyers tend to be clever people who are open to thought. You yourself have had to explore the consequences of the proposals put forward and immediately as you started to follow it through with a question that arose in your mind, which is a question that arose in my mind "what do we do with these people in the nursing homes once they get to end of life? Do we send them out of the Hospice?" That just doesn't make sense.

Andrew Robertson

Thank you but I think I am quite capable of containing my own questions. All the indications are that in my experience at Erskine which is enhanced social care, there are very, very, very few patients transfer out to the Royal Alexandria. The vast bulk are staying in Erskine and getting a degree of service and care which I am very conscious you are very well recognised for. So that was a rhetorical question and I really do not find that of great concern. If you are saying that we should be exploring

these a little bit further together before anything goes into print, then I think that is quite a worthwhile possibility. Tom, how comfortable are you with that?

Tom Divers

I think we need at least to write some of this down in terms of our experience of how this has operated in other settings, which are different settings from the setting in St Margaret's, and look at how things have operated there, what the financial consequences have been. I think we part the enhanced social care on the basis of the earlier discussions we have had and the fact that three Local Authorities are saying that for them, in terms of continuing care, and in terms of elderly care, their requirement is for a care home with nursing. But we need to map that out, at least broadly, so that that can form the basis of further conversations. I think it would be better if we have written some of that down so that there is some clarification around what the basis of that proposal would be.

Leo Martin

Why are you removing these beds? Why are you so closed to the prospect of maintaining the excellent service of continuing care of the elderly who are actually dying. Why are your minds closed to the idea of the Hospice continuing to provide that care and to open your minds to the idea of providing other aspects of care at Blawarthill or wherever you want to do it? Why would you close your minds to that?

Tom Divers

Because as I have said, the extant position is that the Health Board made a decision in 2000 about what the future strategy for NHS continuing care would be and that is a decision that still stands.

Andrew Robertson

We haven't closed our minds. That all has come up because of your concern to see a continuing NHS funding stream and these are the alternatives that are on the table that wouldn't necessarily be put on the table otherwise.

Sister Rita

We know that these figures are fundamentally flawed and what you are trying to do is to change the whole Ethos, Core Values and Philosophy of the Hospice and I just do not understand where you are coming from. I also have a huge problem with the fact that Glasgow City Council and the Health Board got together and we were not included in that after 58 years of service. These are huge issues for us and I do think that we need to look at it very very seriously. As I said it is about these patients having access to Hospice care and that is the stand we will take. These patients are going to be deprived of Hospice care if we do not speak on their behalf.

Andrew Robertson

Tom, is it reasonable that we could convene a group in 2 or 3 weeks time where a paper could be presented, discussed, and not perhaps taken away because there might be things that come out of it, so that what does go out is something that has been the subject of a recent discussion.

Tom Divers

I would be happy to do that.

Sister Rita

Andrew, I would love it if when you took up your chairmanship you had phoned and asked to come down to the Hospice with Tom and said "Sister, can we sit down with Leo and yourself then have a walk around and have a look to see what you do". That hasn't happened and you are new to this post so you don't really know what our place is about.

Andrew Robertson

Fair point Sister - can we come back to that because I think it is fair point what you are saying and we can probably arrange something. That is something we can take outside this meeting.

Jacquie Malcolm

There were figures collected for the Balance of Care Report which clearly states in the reference they came from SMR50 from ISD and yet the figures from St Margaret's were never collected. Actually, it was almost as if St Margaret's was an entity providing care that was never recognised.

Tom Divers

Never collected or never supplied?

Sister Rita

No, never collected. They never asked us.

Jacquie Malcolm

Since 2004 there have been 16 different reasons provided through the documentation provided by the Health Board both in letters and reports as to why this decision is going ahead. 16 different reasons. One of which is as you have clearly indicated, there is a reduced need. There is a clear difference between removing beds and a reduced need and we experienced all of that when our Government removed Council housing. Just because they are not there, doesn't mean they are not needed.

And when you did the snapshot audit, the needs of the patient, their dependency and the complexity of their care was not collected, it was demographics that were collected.

And again, there is a clear difference between a body and a body that has needs. If we are going to look at the shape of care, and I want to go back to Better Health Better Care because I think that is important, we are on the brink of creating a new health service. This is a humanitarian response. In order to be able to provide some kind of meaningful health care, we have to put these financial decisions aside slightly. I do appreciate that finance is incredibly important but on your introduction to the Health Board you said "this is not driven by financial considerations"

Tom Divers

Yes, I said that specifically.

Jacquie Malcolm

You do have to recognise that when you have a facility that is providing all that is recommended, there is something clearly wrong when that has to be dismantled.

You moving people to Blawarthill will be absolutely not the right thing to do and I don't just say that because I work at St Margaret's, I say that because I am a professional working in that arena.

Sister Rita

Tom, Anne Harkness has said she "predicts less demand for continuing care". I just can't get my head around that. What tool has she used for predicting the complexities of patients in 6 months time? I just don't understand that. And she has said this quite clearly of the patients who come in to us, we can give you the conditions they come in under, they have absolutely multiple pathology. How then can anyone predict. I would love to see the tool she has for measuring that because I doubt there is one.

Tom Divers

That can be explored in subsequent discussions. To be fair, we thought the two of us were coming to meet a couple of you for a relatively high level discussion and I haven't got my professional team with me.

Sister Rita

The reason the others are here is that they deal with the admissions and number of patients, etc.

Andrew Robertson

Can we get people to arrange to a date perhaps at the end of this month or something.

Leo Martin

I am still asking what is open in this "paper"? If what you are saying to me is all that is open in this paper are the two options that are on the table, and you can't come back to me and say the Board is prepared to go back and rethink in the context of the delivery of care for elderly people that are dying and that that should be happening at St Margaret's, I still have to ask you why?

Andrew Robertson

We go on putting options forward, you now have three options, and there is a great reluctance to move from your position – here we stand and that's it. I would hope we can have a meeting and agree a shared understanding and that there can be an acknowledgement and let's see if we can find something together. I do not see that that is impossible. As you know and as I have discussed here today, I have seen these possibilities emerge elsewhere where you are meeting the same needs of people who desperately need care towards the end of their lives.

Edward McGuigan

All of the options you are putting forward involve change. Fundamental change of an excellent service. We are a Hospice.

Andrew Robertson

Yes and can you imagine all the change at Erskine. Change is difficult and we spent a lot of time with the people of Argyll and Clyde on staff modelling and how we actually took that forward. These are difficult times for us all and I do recognise that.

Leo Martin

But we have changed, that's the thing. We have changed throughout. We have changed to meet Care Commission requirements, we have changed to meet the patients requirements, we have, at no cost to the public purse, completed a state of the art facility which is there and at the same costs as the original facility, we don't have all these additional costs that you have with the private provision of hospitals. We have changed throughout and to take the Hospice into a situation where it is seen as reluctant to change is a tad unfair because we are not reluctant to change. What we are reluctant to do is to give up being a Hospice. We will not give up being a Hospice.

Andrew Robertson

That's quite a good point that you are not reluctant to change.

Leo Martin

We are absolutely not giving up being a Hospice.

Andrew Robertson

We are really going round in circles.

Elizabeth Thomas

Could I make one more point. Today we have said there are a number of discrepancies in the Balance of Care report, the draft report because we have never seen the final report and don't know if it has been ratified. It was news to many of your Board members, they had never seen the Balance of Care report, and yet the decision has been made. The fact that there are discrepancies, the fact that the indepth review which was asked for in that draft was not undertaken, the fact that the two snapshot audits have proven how useless these are for making decisions, I think the fundamental thing here is that the Balance of Care report on which the decision was made is flawed. I feel that someone should go back and look at this, particularly now where our figures were never included so the decision was made without the proper information.

Andrew Robertson

Tom, do you want to respond?

Tom Divers

I am interested that the SMR50 figures have not been included in the analysis and I would like to understand why that's happened. That's why I asked whether they had not been supplied or asked for because they should routinely have been returned as part of NHS continuing care facility. Should routinely be submitted.

Elizabeth Thomas

The ability to return them was withdrawn. We had pink slips that were filled in and then this was stopped and we were told not to make any more returns. So, for a number of years, our figures have not been included. The Balance of Care report is not based on the facts as they should be.

Tom Divers

If that's the case, it's 8% of the returns. I am not saying that is unimportant but it's 8%.

Sister Rita

You went back and changed a figure in a document that was produced in 2004 and put us in as having 26 beds and not 30. We have always had 30 beds for frail elderly.
The only reason we are working with 26 beds at the moment is because we are moving into a new building and the rest of the place has to be refurbished and then we will look at it. That document was actually physically changed which to my mind is totally unacceptable and appalling. A document that was produced in 2004 was changed. Now, I didn't think that was allowed.

Tom, our figures used to be returned and then it was suddenly stopped some years ago.

Jacquie Malcolm

You've went back and changed something that has already been circulated to people. That's wrong. Fundamentally wrong.

Tom Divers

Its overall significance is 1%.

Jacquie Malcolm

The percentage doesn't matter. It's the integrity behind it that matters.

Tom Divers

There are 2 or 3 things here that I need to find out.

Leo Martin

I think it would be nice to bring it to a conclusion in some what that we go back and consider all of the options, that we have pointed out to you that we think the figures are fundamentally flawed in the logic of the Health Board, removing the care of the elderly who are dying from St Margaret of Scotland Hospice, you want us to consider another 2 options

Andrew Robertson

I think there are three options.

Tom Divers

I think we've agreed to remove the enhanced social care option.

Andrew Robertson

Okay, so you want to stay with the NHS.

Leo Martin

For 58 years St Margaret of Scotland Hospice has provided service to the NHS in a very efficient way, that we have delivered Palliative Care to the NHS and we have just provided another building which has cost £4.7m of no cost to the NHS, I think it would be a nice idea if we kept the partnership there but what I would like is a commitment from you from this meeting that you are also considering the possibility of maintaining these beds at St Margaret of Scotland Hospice, the continuing care beds where people are in a unique environment, which is what the Specialists in the

field call it, an excellent environment, which is what the inspectors and regulators call it, for people that are about it die.

Andrew Robertson

I can't give you that commitment because it is all part of a much bigger picture.

Leo Martin

You can't give a commitment to consider it? It doesn't commit you to consider it.

Tom Divers

The NHS Board has an extant decision. The Board was keen that we should explore the options that were being set out in the Board paper and we have done further work on that as we have discussed this morning. I think the NHS Board would have an expectation that as part of exploring that and in trying to do that quite thoroughly, we would have the expectation that as part of your response you would come back, as you have done today, in essence, with a counter proposal. It would then be for the Board to consider that and determine whether it wanted to go back and re-visit a decision that was made in 2000 and re-open that with all of its consequences. I think that is where we are and that is where we left the Board meeting.

Andrew Robertson

And you would be asking us to do a huge thing.

Leo Martin

Yes well it's a huge thing you are asking us to do. But if the decision is wrong, then change it.

Andrew Robertson

I would hope that when we meet again, we look at the development of a proposal, and the various things that you have raised here today and I hope we will be able to give you clear answers on those, and if there is scope for finding someway that we can meet both our aspirations, let do it and get there. If you do remain absolutely adamant then it's not going to be easy for either of us. And I think that is where we leave it like that just now.

Jacquie Malcolm

The importance of today though was the open-mindedness and I think that is important that the consequence of everything is understood.

Andrew Robertson

Yep and that's absolutely taken on board.

Leo Martin

We are not approaching this from a defensive perspective.

Andrew Robertson

Neither of us want to be defensive. We both have to get on to the same picture. I am appreciative that this has been our first meeting with you all and I have been very taken with the openness and, I think, the friendliness and I do hope that we can keep that up and that we can get the next meeting fixed pretty sharpish and if there is anything you want to contact me about between now and then, well please do so. I would much rather that we spoke through the telephone than through the Letters page of the Herald, as I am sure you are. So I'll just finish by thanking you.

Meeting of NHS Greater Glasgow and Clyde and St Margaret of Scotland Hospice
11 June 2008 at 8.30am

Present:

St Margaret of Scotland Hospice	**NHS GGC**
Professor Leo Martin - Chairman	Andrew Robertson - Chairman
Sister Rita – Chief Executive	Tom Divers – Chief Executive
Edward McGuigan – Vice Chair	Anne Harkness – Director - RAD
Jacquie Malcolm – Nurse Lecturer	
Elizabeth Thomas – Director Clinical Services	

Sister Rita, Professor Leo Martin and Jacquie Malcolm provided Andrew Robertson, Tom Divers, Anne Harkness with a tour of the Hospice prior to the meeting.

Leo Martin

Thank you very much for coming down

Andrew Robertson

Well, I was very conscious that I haven't been here. I have been wanting to come at some stage and get a tour and to get that tour at the beginning was just great. It was nice to see. You have had my letter, you've seen the exchange between Des McNulty and Nicola in Holyrood and I think that that exchange did identify that we have a number of obligations; obligations in terms of health and social care policies and we have obligations in terms of working with Local Authority partners and it has to be said that we have our ups and downs with our Local Authority partners, but by and large we work to the general mutual satisfaction and I think that is a fair comment. And then together with our statutory partners working with the voluntary sector. There is that fairly complex matrix of National Policies, of Local Policies, with other private care services, social care services in the statutory sector and then providing services with the support of the voluntary sector.

So inevitably, it is not a straightforward process but what we want to get with everyone is a straightforward direction and outcome, understanding the balance that we all are concerned in achieving. So we have to be careful in all this process, there is a great temptation to speak to special interest groups and yet all of those special interest groups and what you represent are entirely valid within the terms of reference, but we have to fit that within the broader matrix. This is all known to you.

So I am hoping that following on from our last meeting and following on from the follow-up letter we can build a vehicle for communication that we can understand what we are each requiring to do. I have no doubt that we can find a way through; I am saying that but the Scottish Government and the Local Authority partners, they are also saying that and they are also signed up to finding this balance.

Now at a sort of personal level, I have appreciated that this is the third meeting, certainly for you and I Leo, I have not really known everyone else but it has been

great to have that just half an hour just now under Sister Rita's tutelage in getting round and getting a feel for not just the facilities, that is one thing but getting a sort of description of the services.

So I hope that as we take this discussion forward, we can have confidence in each other and we can seek to ensure that that confidence begins to get reflected in our wider constituencies. I would like to think today that we will do all that we can to clarify concerns for you, to explore what is the real underlying major aspects and we can keep those on the table and I think that we have got to believe that each other is seeking to be open and absolutely frank. So I suppose that comes down to seeking to ensure that you have got all the information but also that you are sharing with us all that information. I know that there are very very long stated financial concerns but there are also concerns about patient groups and I don't think you have raised this particularly but there are also concerns about staff. I can give you a commitment that I want to be in this process for as long as it reasonably takes to get an answer that we are both comfortable with. We may not get as far as we would like today and on the other hand we might, but I am not that concerned as long as we are not closing doors on either of us.

So, thanks for inviting us here, I will enjoy my bacon buttie. I think we need to work out what is the best way forward. It may be that it would be helpful if Tom and Anne went through the proposal – because if you think about it, you had two proposals and it is a third proposal that we began to outline when we met in May and it now has a bit more substance to it. That might be a starting point, there may be points in relation to that that you want to raise pretty quickly, fine, and there may be wider points that particularly relate to the proposal. So, how do you want to play it Leo?

Leo Martin

I think we were a bit surprised to get your letter on Friday on the terms it came in. It was a very closed letter. The Board and I had understood from the closing of the last meeting that you had undertaken Tom to go back and rethink the whole thing and see if there was something else along the lines of what we had been suggesting to you. And that really hasn't even been factored into the letter. Now it may well be that you have come to the conclusion that that is not worth you doing anything but I have to hear Tom if that is your position. However one of the advantages of taking you around this morning Andrew was to show you that this is very much an integrated facility – that what happens upstairs in St Joseph's Ward for Palliative Care is affected and affects what happens downstairs in Mary Aikenhead Centre and is what we want to be. That is part of our mission, which is to look after people who are dying.

Our problem is 2 fold, firstly it is financial and we can't get away from that in no matter what discussions we have and we have to come back to that.

AR interjects to advise he is not dodging that

The first is ethos and it is about what we actually do here as a Hospice. Again, your letter of 6 June does not allow the Hospice care to continue. There is this shift towards either a care home with nursing or the care of people with mental health

issues. The actual idea of keeping us as an institution which looks after people who are elderly and who are dying, and in cases prematurely in terms of what people would expect of a life span. There was no mention of keeping us as a Hospice and I think we need to know Tom why you are not prepared to look at that because I thought when we left Dalian House the last time we met you were going back to look at that. You were going to look at the idea of this place being some sort of Centre of Excellence for Palliative Care for the Elderly and you were going to look at what the actual needs would be and what people were talking about in terms of reports that are being done just now and what people were talking about in terms of the provision that will be required in the future. There is none of that. What you have got in the letter is your proposal broken down.

Tom Divers

I made it quite clear to you that we would write. The very detailed note that you had prepared – a 32 page note of the discussions that we had – I think reflects what I had said accurately. That when you had raised specifically again the question of whether the Health Board would not go back and reconsider its earlier decision about Blawarthill, what I said was that it was my expectation that as part of what was discussed between us, you would come back with a proposition to that effect but that I did not begin to underestimate the difficulty of the Board going back and revisiting a decision that was made 7 years ago. That's what the note says.

Leo Martin

Presumably as officers of the Health Board you could go away and examine for the Board whether there should be a reconsideration of the strategy with regards to the 30 beds. The question is, did you do that?

Tom Divers

No, not yet.

Leo Martin

Although Andrew is quite rightly talking about reasonable timescales, the unfortunate thing from our point of view is that that timescale is finite because there is a meeting of the Health Board in 2 weeks time where it appears to be me that if you continue the consideration of a decision and if that decision is made then the impact of that decision would be entirely deleterious to what we do here.

Andrew Robertson

When we met with the Health Board at the end of April, we had not got this proposal. I think we are here to keep talking and to keep explaining and there are no immediately pressing timescales.

Leo Martin

But at your Board meeting it was proposed to stop the referrals to the Hospice on 1 April 2009 so time is clearly pressing.

Andrew Robertson

We can cope with that, the Board meeting on 24 June if it comes out of this meeting today that there is an understanding here of what we want to explore together, well we can report that to the Board. The Board are not going to insist we come back with a clear decision. It may be that we don't get very far and we would have to report that back. We don't want to report back a stalemate. So the opportunity is here today to look at this, to look at other aspects, and I am not quite clear how much you are expecting us to reopen the whole Balance of Care process, given that there are National Guidelines in terms of social care and there are other parties involved.

Tom Divers

Leo, as I was trying to say, what the members of the Board are expecting from the further discussions that we have had together, is that St Margaret's will have looked in a considered way, even although, even although Leo you do not at all favour that as a way forward, at what the implications are for the proposals set out and that that consideration as well as other points that you would want to make will form part of what we take back to the NHS Board.

Leo Martin

I think we can probably sum this up fairly succinctly, were we to accept any of these options – and we do not want to accept any of these proposals – but if we do accept any of these options, then we would have to close the Hospice. Because we would be in a situation Tom where even at best, I would be looking at a drop of £400,000 in income – at best. And that is accepting your figures. We have not done any analysis on this and we've not looked at it for 2 reasons, firstly because we don't have the figures that you have to do the analysis and secondly, we don't want to do it and that is perhaps the most difficult part.

Tom Divers

As a public body as the NHS Board is, it is not unreasonable in these circumstances that it is expecting that the change that has taken place over the years in the Balance of Care and its impact, that you would at least consider objectively the alternatives that have been set down.

And just to cut into that at that headline, because we have a different take on this and I think we need to try take discussion about this further. Our perception is that for a care home with nursing even although you don't see that sitting with your ethos, the charity, the care home with nursing model, the costs of that that Anne has set out in the annex to that paper would be what would be required. That we would be funding in full through the Local Authority or with the dementia option, we would be funding directly, the full value for what is required to run the service. That is of quite

different financial value from the just under £1.2m that sustains the continuing care just now but the actual cost of providing care home with nursing is of a quite different order of magnitude from the NHS continuing care option.

And so while I accept that there is a difference of £400,000 in the financial values of those options, in our view we are fully funding continuing care now and we would be fully funding care home with nursing in the future. And I am not clear where that financial risk is unless you are saying to us that you are producing a further cross subsidy of hundreds of thousands of pounds to the Hospice care costs from the elderly care agreement that we have between us.

Jacquie Malcolm

I wonder if I could just question you around the staffing element of this.

Andrew Robertson

Yes, yes, these are the things we should be getting into.

Jacquie Malcolm

Looking at the staffing in the Hospice just now, the way the staffing is utilised is based around the specialist needs of patients. The care home with nursing element, first of all it only has a 0.5 of a manager role. The way the figures have been set out, it would be helpful for us to understand how that analysis came about. What tool was used? Which model did you use in order to work out first of all the needs of these patients that are unknown. How do you determine how many staff are required and how the impact of that would be absorbed through staff turnover. Obviously, as people with great experience leave, people with less experience and less pay are absorbed in. I am struggling, from an educational perspective, to understand how we would sustain an educational balance but also how we would sustain the expertise and how we would sustain standards of care when there is 0.5 of a manager, less experienced staff, people on lower salaries. I am not quite sure that is a model that is acceptable for people near the end of life, for a group of people who potentially are desperately unwell. I'm not quite sure, unless these are people who are mainly residential who would be having bed and breakfast facilities?

Andrew Robertson

And these are all very valid questions and I'm not sure if we can answer them today

Jacquie Malcolm

So it is to become a bed and breakfast type service where people are dependent.

Andrew Robertson

Yeah, yeah

Jacquie Malcolm

Is this what this model is based on?

Anne Harkness

I think what we need to be clear about is that these are very indicative figures, they are not 100% black and white and the letter clearly states at the start that this was an indication to give you a rough guess about what the cost profile what it might look like because in reality the detail would be through direct discussion in the care home with nursing model with the local authorities. The costs are based on typical staffing and that varies because the way the care market works is that there is a guaranteed fee if you like in terms of weekly income and each individual care provider might have a slightly different staffing model based on their own experience, based on their own skill mix. These figures are based on a care home in Glasgow. The dementia option is based on the number of admissions we would expect to get based on examples.

Jacquie Malcolm

If a care home has increased an dependency of patients and decides to take more staff on board in order to meet that need, does the care home absorb that cost themselves? Is that how that works?

Anne Harkness

Yes. Well you know the way the Care Commission work, in a similar way to the way their regulate your staffing. Some local authorities if you take a particularly special interest group or a special type of client, they might have a top up fee but again that is the detail of discussions you would need to have with the local authorities.

Jacquie Malcolm

And that is where our concern lies because already there are care homes, and this is coming out through Glasgow City Council Development and Regeneration Department, there is incredible concern about the care that is delivered as we speak. If we then create more models like that, then we are then adding to that problem where there is under staffing, a high turnover of staff

Leo Martin

We couldn't do that Jacquie. We couldn't deliver that.

Jacquie Malcolm

This takes us back I suppose to the question that we posed on 2 May. When these patients came towards the end of their life, what do we do with them? We would no longer have the staffing with the expertise to care for them so where do they go? Currently, patients who are dying in care homes as we speak are not being cared for. We know that through Care Commission standards, we know that through reports and we know that ourselves. An analysis of education of these people tell us

professionally what their knowledge is what their expertise is, what the challenges are. We know that in Greater Glasgow and Clyde that is a problem.

Andrew Robertson

What is the scope for furthering these discussions then. We are not the sole parties. This would have to be discussed with the local authorities.

Anne Harkness

As the paper says, that would absolutely have to be through the local authorities but you know that the Care Commission have got standards around Palliative Care and we know that care homes are expected to work to those standards of care. Like any provider, there are a range of providers and a range of standards. You know that in Glasgow we have currently invested in a range of specialist nursing support, you know that through the Palliative care MCN. All that work is ongoing.

Jacquie Malcolm

Yes but we teach these people and it is fantastic that we are able to teach that but in many respects what you are asking us to do is to take a step backwards not forwards. You have an opportunity to have an excellent centre that advocates and demonstrates a palliative care model for the elderly.

Andrew Robertson

How are your teaching costs covered?

Anne Harkness

They are within the funding for the Hospice.

Sister Rita

This is like a marriage - the 2 units actually save money for each other because we have the expertise in one area that crosses over into the other so you are getting very good value for money. I think it is a shame because for years this has been described as a unique situation. I think what is very sad is these discussions didn't take place prior to now. And I am sorry Andrew because you have came into it but Anne never came down here to look around and to talk to us about the model we have here because it is a unique model and that is quite clear. The geriatricians keep saying that, they are saying that this is the model. In nursing homes they are not delivering palliative care, they are trying to do it because they are being asked to but it is not happening. They just put on a syringe driver and that's it. That's not palliative care.

Andrew Robertson

I am getting a sense of the service and I suppose what I would like, probably outside of this meeting, is to understand how that costing and that funding of your education side is. And there may be other aspects and how interlocked they all are because I

think the very clear message that I am picking up is that there is a degree of integration that certainly looking in from the outside, I wouldn't understand that financially because we would, and even know, I think we believe we are providing a discreet service with discreet funding.

Leo Martin

Andrew, Tom will try to hold himself back here but I am sure he will want to come in on me here because I have had this discussion before. The whole way we work is integrated. The bargain that the Health Board have had for years out of St Margaret's has relied on that integration. It can be put very simply by contrasting us with another hospice where we have 28 beds and we get £938,000 for the Palliative Care side. The Accord Hospice which has 8 beds receive £910,000 for Palliative Care. Now Tom has told me before that a bed rate is not a currency he is prepared to deal with. Unfortunately, Catriona Renfrew in her papers has used that as her currency and she is prepared to be honest Tom when she has been doing analysis. So for the Health Board to say now that they are not prepared to look at bed rates for the Hospice when they have previously is at best inconsistent. What I am saying to you here is, put very simply, there is a cross subsidy; there must be in here because if we were to charge you the level other Hospices charge to recover at 50%, then our figures for the Palliative Care side would be three times that.

Andrew Robertson

Let's understand that cross subsidy because it is unique. And this puts forward concerns for us that we have to look at and be able to address. Anywhere you commission services is that you commission a discreet service with discreet funding and that is how we are accountable down the line. But if there is a more complex structure here which you can share with us then we will be in a much better position to understand and this exchange I think probably doesn't do justice to these issues.

Tom Divers

I am not going to rerun the currency thing. I have been entirely consistent. What I have said from our first conversation is that our understanding from the work that was done 4 years ago was that the sub-analysis cost attribution between elderly care and Palliative Care that was carried out at that time was an accurate reflection of the way in which the costs were – and we didn't do that analysis, it was St Margaret's who did the analysis and provided that analysis to us. And our understanding was that that was an accurate attribution of what was the £1.somthing million that came from Greater Glasgow and Clyde which is now the £2.1m that now comes. So that is why I was asking the question Leo because I have had an understanding from that point in time that the cost attribution has reflected what is in your most recent set of accounts that there is just under £1.2m that supports the NHS continuing care and that the total costs involved in providing Palliative Care of £1.6/£1.7m of which we now contribute just over £900,000 reflecting the significant movement in 2006/07 to achieve the 50% contribution and that that represents an accurate attribution of costs.

That is why in coming back to your first point about, if you like, "we would be left with a £400,000 hole", I am not understanding how that would arise. We are happy

beyond today for folk to sit down *[indicates Anne Harkness, Jacquie and Elizabeth]* and go through the detail of this and explain more fully how it has been built up and to take comment back from that because it is important that we are able to do that as part of this process and to do that before we go back to the Health Board with another paper. What Andrew is saying to you is that we are not hide bound to go back to the Health Board with a paper a week on Tuesday. We are not hide bound to do that and the Board members know that we are in discussion, and in the second round of discussions taking place today.

That is why I raise the question Leo because we had an understanding at that point in time, given that you were pressing for a longer term contract as we reran last time, but also that the Health Department Letter recommitting to the 50% funding level then had a trigger date but we do need to understand the cost attribution.

Andrew Robertson

It may be that we will have a sensible discussion about all of that and we develop a mechanism of keeping it under review because I think what I am picking up is that there a sense of what seems to have been a couple of years ago, 3 years ago, there is now some sort of statements that it's not just like that now. Well, let's get that out on the table and let's make sure that if we can work together that we don't disappear into a blankness that and reaching a stage where we are looking at each other slightly oddly, and sort of what is this, why have we got this misunderstanding?

How would you take this forward Tom? Who would be the people to go into more detail about the breakdown and the cross subsidy?

Tom Divers

It seems to me that we are having a discussion of necessity on two or three different levels just now. There is the principal level about St Margaret's, its ethos and mission.

Sister Rita

And Core Values.

Tom Divers

And Core Values and that is one discussion. There is a second discussion about the implications of the alternatives that we are proposing and if we separate for a second the discussion from the Core Values and that other discussion and I know you are very unhappy about doing so but as I said we need to go back to the NHS Board having worked that through then I think that what we need is that there is a more detailed discussion which takes place around how that profile has been built up. I think as part of that, if the attribution that we have had over the years and which we have rolled forward is not or is no longer, I mean I am taking about an accurate attribution of the cost profile for the services that are provided and we need to be aware of that and that needs to be shared with us.

Edward McGuigan

We operate one unit. We don't operate 2 separate units with 2 separate sets of staff. So the practicality of actually saying that that individual on a salary of £10,000 spends 72.5% upstairs and the remainder downstairs. It is just physically impossible to do that.

Andrew Robertson

Can we not help you with that?

Leo Martin

Yes Andrew you can help us, you can go back to the Health Board and say that St Margaret's has been one of the best providing sources of Palliative Care and Care of the Elderly for the last 60 years shown throughout everything, throughout inspections, shown to be the best value for the various Health Boards over these years as well, exemplified in the money you pay for what we actually deliver and how can we sort this to make sure they sorted out. That's what you can go back to the Health Board and say. And if you want us to go down the road of saying this cleaner spends 5 hours in St Joseph's Ward and 8 hours in a fortnight in Mary Aikenhead Centre, that's really not helping us Andrew.

Sister Rita

We have done this exercise umpteen times and we have broken it down as far as we can. Every time we have gone back, now I'm telling you, hours and hours have been spent and I object to spending so much time on it because it takes us away from the patients.

Leo Martin

Sorry, Sister. Do you know what upsets me Andrew? I look at that board out there and see I have only been able to raise £600,000 for the new building because I have spent the last 2 years talking about this. I have spent all that time worrying about this. I should be doing that, that's the charitable part.

Sister Rita

Andrew, we got back to the Health Board and we work very closely with the Accountant – I don't do the accounts and I don't want to do them – but we go back every year and spend hours breaking down the staff and we go back and produce all of our figures and every year we do the same thing, we have done the same thing and then we're told, you're working on a bed rate across the board for our 55% beds and this is what you are getting, regardless. And what really crippled us and I know you have suffered this in the Health Board as well, is the increases in salaries for the nurses and the doctors. People at the Health Board have admitted that you have got very good value for money here over all of the years. Now the history of the Hospice is fantastic Andrew and you won't know about it, it started across the road,

[Interrupted by Andrew Robertson to confirm he knows the history and knows the quality of care – that is not in question]

The contribution is the historical thing. We got furniture from you first, and I have gone right back over the history. And that was how the Health Board helped us at first. And then it was gradually moved towards £5 per beds and since then it has been a gradual increase and we have been very badly affected as a result. Other Hospices came along and they have got the cost of the time, ours has been an historical thing and no-one has ever sat down like today. We have produced these figures but nothing happens after 1 April. We just get the standard letter telling us we are getting 1 or 2%.

Andrew Robertson

Yes and it would be lovely if Tom and I could go back to the Board and say St Margaret's is tremendous, a wonderful service and we should just sign another cheque to keep the thing going but we can't do that.

Leo Martin

That would be a very popular thing to do Andrew.

Andrew Robertson

You popularity comes with its problems. We can't just do that. You know we have Audit Scotland crawling all over us. We've got politicians all over us.

Sister Rita

And you'll have a lot more of them crawling all over you if you don't sort it out.

Andrew Robertson

We are fundamentally answerable to the Scottish Government. We are directed by the Scottish Government to work in partnership with Local Authorities and those are the key blocks. We are also directed, where appropriate, to work with voluntary organisations. And if we are going to satisfy all these requirements, we cannot just come up and say "hey, they're great, leave them alone".

Sister Rita

Nobody is expecting you to do that. All we have ever wanted is a fair, just and reasonable contribution. That's all that we have ever asked for.

Andrew Robertson

Well those are very complicated words Sister. Reasonable has to be backed up.

Sister Rita

It is backed up. You get very good value for money.

Anne Harkness

We're talking about Hospice funding now which is separate.

Leo Martin

Yes but it impacts directly on the whole Hospice. We were asked Anne if there is a cross over and Edward started to explain that there. Of course it crosses over. There are things that we have gone out of our way to try and recover from you and there are things perhaps in the past that we haven't tried to recover.

Andrew Robertson

Tom, do you not acknowledge that we have to try and understand from year to year how this cross over works? We need to understand that.

Sister Rita

Tom, you know we have provided anything we have been asked for over the years. We provided everything, breakdowns of figures, etc., etc.

Tom Divers

And I have accepted that and I accepted that that was an accurate attribution of costs. But I think that is not what I am hearing this morning. I acknowledge entirely there was an enormous amount of work put into that because we needed to do that work in order to get the best understanding that we could of the Hospice costs and what the impact was going to be in terms of the Health Department Letter. And that is why I am stuck on this £400,000 hole. We need to understand that.

Andrew Robertson

Did you have to look at that from the continuing care side of it or were you just getting the Hospice side of it?

Tom Divers

It was both sides. Sister Rita is absolutely right. There has been a detailed exercise done and I think we need to come back and revisit that. You still return in your annual statement costs against your specialist medical care as opposed to your Hospice care and the financial values that are in those accounts reflect that earlier analysis that was done.

Jacquie Malcolm

I suppose sometimes the more you look the more you see and the more confusing this is because an 8 bedded Hospice it just does not make sense that they actually get

greater income than a 28 bedded Hospice. It just doesn't make sense. I have worked in all three Glasgow Hospices at quite a senior level and I was so saddened when I came here and realised it was so impoverished in lots of ways. You can only spend what you are given. If you spend more than that, it is a debt that is incurred. It doesn't make sense to spend more than that, especially now when you have to prepare detailed accounts and you are right, everyone is audited in that you can't spend more than you are given.

Tom Divers

That's a different argument for discussion.

Leo Martin

But it's a fundamental discussion.

Tom Divers

Leo, it is a different argument from the discussion we are having about whether the current attribution of costs between the services is an accurate reflection of the expenses incurred. It wasn't Jim Hamilton and Alex McKenzie that produced that analysis; they asked for the analysis. The analysis was produced here.

Anne Harkness

I accept that some of your fixed costs have to be spread but at a very micro level if you are moving from having 9 staff on an early shift to having 5 staff then there is a clear cost saving.

Edward McGuigan

You are missing the point here. When I signed up to join this Board, I joined the Board on the basis that we would be moving the Hospice forward. I didn't sign up to be making people redundant and that is the implication of what we are doing here.

Leo Martin

Dumb down the staff.

Andrew Robertson

That's not actually the implication. It could be an implication if this was done in a clumsy fashion but what is absolutely clear and what has already been mentioned is if you did explore this more fully what are the terms, what is the likelihood of people moving on? So the question of redundancies is not the first question that would be involved in this. We have spent a lot of time with other services and redundancies is not necessarily a problem at all. Now Tom is saying that he thinks it would be worthwhile looking at updating the basis on which figures were prepared 2 or 3 years ago. Sister Rita, I am not sure if you are also signed up to thinking that is worthwhile.

Anne Harkness

Their figures are submitted every year.

Edward McGuigan

Could we go back to the last meeting. At the last meeting I think we made it pretty clear we were providing continuing care for older people and providing care for people with mental health problems would not be appropriate for us.

Tom Divers

What you commented at the last meeting Edward was that it remained preference to be working directly in contract with the Health Board and that is an option which was strategically left open for discussion.

Edward McGuigan

I appreciate that Tom so let's park that at the moment and go back to these 2 options of a 28 bed care home with nursing and a 19 bed one. We have to, as a Board, look at leaving our existing staff levels as they are, again let's park that up at the moment.

Tom Divers

But you can't do that.

Edward McGuigan

No, I appreciate that but let's just park that for the moment Tom. Leaving everything as it stands, we would potentially see a shortfall or a drop in funding of £430,000

(odd) and for 19 bed, £683,000. We have a unique skill base which nobody else does. Is there an option where we can effectively use our 30 beds in our new unit for a Palliative Care service because it has become obvious in the discussions that we have had that nobody really quite knows what is going to happen to the patients that we deal with at the moment, where there is a very high demand of care required. We don't know where they are going to go. So we are moving from a position of very heavy nursing to a very distinct palliative role for elderly patients. Now that then allows us to leave in place our skill base, it potentially would leave us with a shortfall in funding where we would go from, in crude terms, we would go from £800,000/£900,000 to £1.6/£1.7m. We are at £2.1m at the moment so we would somehow have to close that gap to leave us with the status quo position as far as overall funding is concerned. Now it could well be that there is a mechanism internally that where you can look at all the services that we provide, the education service that we provide and albeit we are bound by this HDL but there must be some mechanism we can find to provide some enhanced funding for us that to take us back up to £2.1m and to fit in with what you guys are trying to. Why can't we do that?

Elizabeth Thomas

That's the first bit of sense I've heard. It seems much better using the skills that are here and teaching as well other people about good palliative care.

Tom Divers

That essentially is another version of the status quo.

Elizabeth Thomas

And what's wrong with that?

Edward McGuigan

Perhaps a better-defined status quo. There are issues around the definition of what we do. Andrew has accepted I think that there is a uniqueness here. We have our role to fulfil in palliative care in the west of Scotland. Why would it not be a positive thing for the Health Board to embrace something which is recognised as not only highly efficient but also a Centre of Excellence. Look at our Care Commission reports, no criticisms at all, none at all. The fact remains this is a wonderful standard of care.

Elizabeth Thomas

It's value for money. It meets the Palliative Care Strategy in terms of equity of access for the elderly to Palliative Care services.

Andrew Robertson

Now there is a whole lot of work going on across Glasgow in Palliative Care and you are part of that.

Jacquie Malcolm

Yes but we are trying to actually implement the strategy but these discussions, and that's why I said earlier that that is a step back, when we are part of these discussions at no point did anyone ever say decommission a Hospice that is there to become a care home with nursing. This Hospice has been referred to as a care home with nursing since 2007 so in your letter Andrew when you said this was a new option, it's not a new option for us because we have been referred to as a care home with nursing since 2007 in letters from the Health Board. I think one of the things I find most difficult is St Margaret's figures were not included in the Balance of Care, you used Mearnskirk. In the last snapshot audit Mearnskirk provided continuing care for 40 out of 72 beds. This Hospice has always had 100% occupancy. So that's the bit that fools me, I don't see how those figures are. If we have somebody who has 100% occupancy and by your own admission Tom at our last meeting you said that I know all of your patients fully fit the criteria of NHS continuing care, none of these patients

have been placed inappropriately, they are all in the final phase of life. I am therefore not sure why our figures didn't matter and for someone not to collect the figures, for someone not to make sure that the figures were included, especially in the west of the city. You compared us to the south of the city. It would be almost me saying to you that because in Wishaw they don't play golf, we are going to close your golf club. It doesn't make sense. You cannot compare these two areas.

Tom Divers

I don't think at all we were saying that your figures didn't matter. Anne could you just deal with the Mearnskirk proxy that was used.

Anne Harkness

The reason I used Mearnskirk as proxy was that it is one of the few other NHS continuing care sites in the city that hasn't been used for delayed discharges. A lot of the other sites, as we know, we have used for delayed discharges patients so their admissions didn't give a reflection of that true continuing care cliental.

Sister Rita

Why didn't you come to us? Can I ask Anne why she never came down here and sat down with us. Tom will agree, and I know we have often disagreed, but Tom will agree that it is a complex situation, it is a unique situation, it's a difficult one. The Hospice has been going for years because of the two units. There's no-one else like that. Why didn't Anne make an appointment with us and come down and talk to us and say to us "what exactly do you do here" because she doesn't know.

Andrew Robertson

Okay but what can we do now?

Elizabeth Thomas

Why would you take figures from Mearnskirk rather than come and ask us for our figures? You have to give a reason for that.

Sister Rita

You know, we feel very hurt about this.

[Anne Harkness simply shrugged at this]

Anne Harkness

The Balance of care report is based on 7 years of SMR50s which St Margaret's for whatever reason, and I can't comment on what that was because I wasn't involved, but for whatever reason, was not submitting. It is not a case of and it's not as simple as just coming down and having a snapshot. I think you would accept that all the snapshots audits that we have done over the last, over the recent past, St Margaret's absolutely have been involved in that. And that is the information that was used and we have referred to that in part but the original Balance of Care report was based on the SMR returns and at the review, we took the opportunity to use the up to date snapshot which included everybody and you will know there was another snapshot done recently that was done as part of the national work surrounding continuing care and again we received your information in relation to that.

Elizabeth Thomas

Can I just clear up that we did not submit returns because we were told not to submit the returns. We were told not to. There was a pink form and we were told not to submit these.

Sister Rita

Dr Helen McKay was told not to and she was told they would come back with a new formula. We asked and asked but nothing was produced to replace the pink slips.

Elizabeth Thomas

There was no process put in place for collecting our figures. You must have realised that we would have figures. You should have come to us and asked us for our figures, not gone to Mearnkirk for a proxy.

Leo Martin

Regarding Mearnskirk, who does operate Mearnskirk? Who owns it?

Anne Harkness

Who owns the building or altogether? The nurses are NHS staff.

Leo Martin

NHS provided staff and for the building, so you just pay a rental for that. A PFI?

Tom Divers/Anne Harkness

Yes it is PFI. We pay for facilities and the care staff are by the NHS.

Andrew Robertson

So what are we getting to here?

Andrew Robertson

Go back to a 60 bed Palliative Care unit.

Andrew Robertson

Now I have understood exactly what you are saying and you have understood that Tom is very "hold on a minute" how much is this taking things forward in mutual territory and how much of this is a reworking of the status quo. I don't know but I think there is a willingness at this side of the table to go and look into that in more detail and for us to really understand if there is a case for what you are saying, that we can see stacking up and we can satisfy our statutory authorities. I am not sure if we can do much more today.

Anne Harkness

In our Palliative Care strategy it doesn't say about having a substantial increase in Palliative Care beds. Elizabeth knows that.

Elizabeth Thomas

This is crazy. We are delivering a Palliative Care service to the elderly, to these elderly patients who are at the end of their lives and now they are going to be taken out, I know not these patients we have at the moment, but new patients coming through are not going to have access to that. CEL 6 2008 stipulates that continuing care can be delivered within a Hospice setting, hospital or in the home setting. You are removing the choice and taking away a model of care, which is really inspirational. I said this the last time. You are changing it into something that is not meeting the requirements you are stating in all of your Scottish Executive documents and what is good practice for elderly care and Palliative Care. I really don't understand what the difficulty would be in allowing patients to come here for Palliative Care for elderly patients where we have the expertise, the knowledge, the facilities to deliver that and to give them access to good Palliative Care which they are entitled to. They are very vulnerable patients and they are entitled to Palliative Care.

Andrew Robertson

Elizabeth you are saying, and I don't know, but I expect it's a restatement of a valid view. Those wider discussions are having to look across the whole patch and I have no doubt that these issues have been borne in mind but Anne is there anything you can add as to how that discussion develops?

Anne Harkness

I don't think I have anything further to add other than that is not currently the model of Palliative care that we are trying to develop.

Jacquie Malcolm

Yet contrary to that, Professor Marie Fallon has written something for us today, unfortunately she couldn't be here, that shows there is a projected need for older people with Palliative Care needs because of treatment modalities and also tumoricidal. I think in lots of ways whilst Glasgow may not see a rise in the need for palliative care for elderly people but there will be a marked increase nationally and that will have an impact. Sometimes I am at a loss to work out who has looked at this. Who looks projects these costs? Not the cost but the patient need? Where does that come from when it is absolutely contrary to what we read.

Sister Rita

Tom, the documents are written and they tell relatives and patients exactly what they can expect and then we are not allowed to deliver it because what you are doing all the time is dumbing down, dumbing down, and its about having all the services just the same, just as long as it is just good enough. All the documents state quite clearly that patients should have a choice and they have paid into the system all their lives and they are entitled to a good death. We had 150 people here last night, relatives from both units, at our service. We deliver a very high standard of care for these patients, they are not going to go away. Don't write documents, and I have said this to the politicians, stop giving out these documents, and I know you don't write all of them but stop promising people things we can't deliver. I am not blaming you for it but do not put something on paper you are not prepared to deliver. We have a service here and this is what we want to continue doing. We look after the most vulnerable and that is what we hope to continue doing.

Andrew Robertson

I would like to spend time probably outwith this meeting in really understanding, so that you get a fuller crack of saying how this integration works and we get a fuller crack of how much we understand it. So that if we do draw apart we know precisely why we are drawing apart. I am not exactly sure that we understand the balance of

integration has shifted in the last 3 years, that's what I have picked up, and Tom and I are happy to see that more fully explored. Now is that something that you are prepared to do?

Leo Martin

What's happened here Andrew is that we are the fall out of decisions that were made in 2000. We are the fall out. I have papers here which were produced for the Health Board in 2000 talking about the redevelopment of Blawarthill. "In order to maintain the balance of institutional care, 60 existing frail elderly long stay places within partnership settings in the North and East will be converted to social care and places for elderly people with mental illness." The decisions that were made by the Health Board at that time in order to save Blawarthill, the fall out from that is that you are removing the Centre of Excellence. You are removing the ability for us to deliver what we do. Now what we are asking you to do is go away and reappraise it and think about it in whichever way you want to do but bear in mind the fact that what you are jeopardising is this whole place. You are jeopardising the whole place.

You can't charge £102 per week to stay here. I wouldn't have joined the Board if we were going to do that. If that is what we were going to do, I would have joined the Board of Southern Cross or something like that and earned money out of it. I don't want to do it as a charity, I don't want to do it as a person within a charity. We can't start charging people. That's not why we are here.

Tom Divers

And I understand that and I understand why Edward joined the Board as well. But the whole balance of care has changed over that period of time, it has changed more profoundly than was appreciated in 2000 and we need, as an NHS Board, to work through the consequences of that.

Jacquie Malcolm

It hasn't changed for us. It hasn't changed for St Margaret's.

Tom Divers

We need to work through the consequences of that. There are 2 different debates here, there is the debate as we were sharing a few minutes ago about Mission, Core Values, Ethos and there is a debate about the implications of a change in the balance of care for elderly and we need to be able to look at both of those elements. I cannot

go back to the Health Board and say sorry St Margaret's don't see this as being key to their ethos and continuing principles and so there is no analysis that I can bring you back of the implications of the alternative that we had written up and outlined and that just leaves the Health Board in the position where it is left to make what I would think would be a very stark decision.

Andrew Robertson

And we don't want to do that.

Tom Divers

I think the Health Board has a reasonable expectation that you will look at these 2 options with us and their implications and we will then go back to the Board when that piece of work between us has been concluded.

Edward McGuigan

Well, our instruction from Nicola Sturgeon was also to engage and produce for you other options. Now I have given you an ideal other option.

Tom Divers

I don't think you have given another option. That's a dressed up status quo.

What I am saying to you and to come to the point, the way in which a number of these strands is informed comes from a whole variety of different parts of work. Look, I would be interested to see what Marie Fallon has written if you would be willing to share that with us as further contribution. Because at a national level in 2000 and again in 2006, there was a huge piece of work done on cancer under the banner of cancer scenarios that looked closely over a 10 and 15 year period, incident levels. That work actually plotted out tumour site by tumour site what the expected incidents were, what the expected response to that was, both in terms of treatment therapies so it resized what radiotherapy capacity for Scotland would be but also looked at palliative care as well. So at that macro level, down to the work that you are part of, in turning that into a local strategy. That is the way in which we develop our assessments of our future requirements. We don't pluck numbers out of the air or just look at a trend. In these care groups we have sought to pick up worthwhile analysis that has been done at a National level and then translate that into a local content given an understanding of the make up of the age structure of our local population in each of our local authority areas.

Jacquie Malcolm

And that would be for cancer. And then on the other hand, we have a brand new document that has come out about heart failure and palliative care where we are now going to move towards more patients moving into the palliative phase than ever there was before because cardiologists refused to admit that people were dying. Now people are going to admit that they are dying, they are going to have access to palliative care. More palliative care provision is going to be required, as is the same for renal medicine. People are not going to be offered dialysis and they are going to be removed from dialysis which means that Palliative Care is again going to be on the increase.

Tom Divers

Whispering and gesturing – these are big issues. Big issues. Big issues

Leo Martin

We have to look at the consequence of that and again and I apologise if this doesn't flow through, but if there is a strategy that allows you to care for people with cancer in order to allow them to live longer, unless there is something else you've got there, at some time later on they are going to need Palliative Care eventually. They will need that care when they are actually dying.

Tom Divers

You are absolutely right, we are all going to "D" of something at the end of the day and for most of us it will be cancer, respiratory disease or heart disease. But the whole debate as we move forward, I mean, there are huge issues. There are huge issues in what is now being put forward as a potential way forward in relation to renal medicine. I have been involved strategically with the planning and provision of renal services within the west of Scotland since Laurence Peterken first put me in charge of developing a renal strategy for the west of Scotland in 1988. And the history of what has happened since then has been a relentless increase in dialysis capacity, there used to be an age issue, it was 55 in the 70s and now people well into their 80s are now dialysed. There are huge debates to be worked through about where that kind of policy indication might end up. I don't know where that sits, if anywhere yet, in a referral sense with local discussions about non-cancer.

Anne Harkness

This work has only just started and we have just appointed a project manager.

Jacquie Malcolm

You are looking to withdraw services for something that is unknown. Our renal colleagues, our cardiology colleagues and our respiratory colleagues are crying out for access to Palliative Care. They are asking for models to change in order that people who should be dialysed and who should be undergoing active treatment are given that option but there is an area where that active treatment is no longer suitable. There has to be an alternative and that alternative has to be Palliative Care. Now that is where I feel we start in Greater Glasgow in adminstering in the provision of Palliative Care where most people probably are, as you say, in the older age group.

Tom Divers

What is beginning to open out for the first time in a much more structured way is what the future arrangements should be for the provision of non-cancer diseases.

Leo Martin

We have always been available for non-cancer patients. That is part of our uniqueness. We have always been available for non-cancer Palliative Care.

Tom Divers

Others have too. I am not saying to what extent they have but I know from personal involvement in discussions about a particularly detailed care path.

Sister Rita

I know Tom but when we used to meet at the Health Board in the earlier days, in the good days when we all sat down and were very civil to each other. At that time, we were the only Hospice taking patients who didn't have cancer because other people had it written in their documents that they couldn't. Marie Curie, for example. Although now I think they are doing this, it is very new for them. We have always taken these patients, it has always been part of our philosophy and care.

Elizabeth Thomas

Within the Mary Aikenhead Centre, these patients who are requiring end of life care, they have non cancer and cancer diagnoses. So we are meeting the access for non-cancer patients and giving equity of access.

Jacquie Malcolm

And that's perhaps where the innovation lies in that what would be really said would be if the provision was removed but then once Jackie Caplin, the project manager has

done her analysis she could see that it is required. It would almost closing the stable door after the horse has bolted. I suppose to go back to Leo and Edward's point, if the provision is not required and if what we believe in and what we are working towards is not required, then Mary Aikenhead Centre is not be required but yet we know that's not the case. And that is not just through discussion, we are in an escalation of palliative care requirement. People are going to withdraw themselves from active treatment plans. We know that. So there has to be a provision in Greater Glasgow & Clyde for this increase of people who may not require specialist palliative care but the require is somewhere to die or somewhere to have this type of care.

Andrew Robertson

I don't think that's the bigger discussion for longer term. It will obviously have bearing on all sorts of services but we have got a very particular concern which we want to take forward. Sister Rita made reference to the old days when we were all very civil, well I think we are all very civil around this table and I would like that we get that discussion focussed on what are the issues, where we may be able to come further forwards towards you. I don't know what more we can be doing without that initial further discussion? Without their being a better draft for us of the implications of integration. Tom I don't know if you feel, or Leo if you feel there is an awful lot more we can say today other than to jointly express the commitment that we work through a bit more detailed process.

Tom Divers

We need to do that to go back to the Board. There are alternatives of the proposals that Edward described which I think is not hugely different to the status quo, in which we have moved into quite different conversations.

Edward McGuigan

Are you saying that these aren't vastly different?

Tom Divers

We need to get back to a discussion that is a developmental discussion about what the future shape and requirement for palliative care that recognises much more than typically happens with the current palliative care setting to meet the needs of non-cancer patients. But that is a developmental discussion.

Leo Martin

Tom, I think it is crucial to understand that is what happens here now.

Tom Divers

And that's your contention.

Leo Martin

No, we can give you examples, we can give you a detailed analysis of everyone that has died, we can show you.

Tom Divers

And is that different from the analysis that would come from those other NHS continuing care beds that are delivering NHS continuing care.

Elizabeth Thomas

The difference is the skills and expertise of staff. That's what the difference is.

Andrew Robertson

Tom, you are talking about developmental discussions and is that something that we want to pursue.

Sister Rita

I think we need to be clear Tom we have never been a care home. We are a Hospice. An independent health care provider. And this is where the problem has arisen because you have treated us as a care home which we have never been. We are not a care home. This is a matter of fact.

Andrew Robertson

Yes in terms of your core values.

Sister Rita

No, this is a fact.

Leo Martin

That's actually a matter of fact Andrew. We are a Hospice, not a care home.

Sister Rita

It's unfair to be looking at us as a care home. The geriatricians have sent us the most complex patients needing end of life care and they should be saying it but they want us to do it. So we have never been and we are not a care home. These are patients needing end of life care. This is what we do.

Edward McGuigan

When I stand up at a function and when I beg for money for the Hospice, I don't beg for money for a care home. I can guarantee you if I stood up to beg for money for a care home, the response would be "that's the state's responsibility".

Andrew Robertson

From my personal experience, that's not the case.

Sister Rita

You are talking about ex-servicemen, that is very different. And Andrew people will always support the ex-servicemen because they protect us.

Leo Martin

It's not hard to get support for ex-servicemen who protect us in times of war. That's not hard to do. What is hard to do and what I couldn't do is ask for money for the Hospice while anyone at all could turn round and say yes but you are charging people to stay in your care home.

Sister Rita

And we are not a care home.

Andrew Robertson

The great dilemma is you are taking all beds as Hospice beds and yet some of the beds are funded by as NHS continuing care. You have excellent PR.

Edward McGuigan

One of the things you said at our previous meeting was that this was not a funding issue.

Leo Martin

It is not excellent PR, it fits in with Scottish Government policy. People in continuing care with complex medical needs and who are dying have a right to go to a Hospice, to go to a hospital, to go to a care home, or to remain in their own house. You are removing option one. It is not PR Andrew, it is actually about delivering Government policy.

Andrew Robertson

What would happen with this model you have as to what is described in the letter? How different would the pattern of care become?

Tom Divers

It's a different care group, with a lesser level of dependency and at a different point in the care continuum.

Jacquie Malcolm

Can I ask something about the waiting list for continuing care in the west of Glasgow. We, in lots of documents that have come through from yourself there is this figure of four. Yet, we are acutely aware the waiting list is much longer than that. What we wondered is if it would be possible, and maybe Anne you are the best person to help us with that, is from a waiting list that may have 87 names on it, why has St Margaret's only got 4. Surely it would be as a bed becomes available in an NHS continuing care setting in the west, a patient would be admitted. What we are not sure of is why, out of 87, there is only 4 for St Margaret's. What's the criteria for St Margaret's?

Anne Harkness

Where are you getting your information from. I don't recognise that number and I know you mentioned it last time. Where is that information from and I will check that because that is not a number I recognise. Where did you get that information? Was it from a clinician? Our admissions for continuing care in the west is administered by one of the Geriatrician's secretary's.

Elizabeth Thomas

In actual fact, I contacted that secretary and asked for the full list because we were only party to those that had been selected out to come here. Initially she said there was no other list and when I pressed her on it she then said that there was a list but she wasn't allowed to give it out to bed managers and I asked her why and she said because it would be used against her. I said I don't think so. Then she said she would go back and speak with the geriatricians and get back to me and she didn't. We then contacted her again by phone and asked again and she said she discussed it with the geriatricians and Dr Spilg had said that we did not need to see the rest of the list because we only needed to know the patients that were coming here.

Dr Spilg said it is because he selected out the most complex patients for here. He said that's all you need to know.

How does that work? We are being told constantly that more difficult complex patients and more complex families are selected out for us because they can't be cared for in an NHS bed in a care home. That is what was said.

Tom Divers

I don't think that is a straightforward message. As Anne has said, there are a number of designated NHS continuing care beds around the city just now which are not housing NHS continuing care patients. There is no doubt about that. What the snapshot had shown at those points in time the number of patients who were in continuing care beds who did not fit the continuing care criteria because they were awaiting placement.

Elizabeth Thomas

And by your own admission at our last meeting, you accepted and acknowledged that all our patients meet that criteria. Why then is it that you are taking our beds when we have full occupancy and meet the criteria and there are others that do not have full occupancy and do not meet the criteria. This is crazy to me.

Sister Rita

There is a geriatric unit down in the Vale of Leven and the geriatricians there are very concerned about those patients, and where those patients are going. I do honestly think Andrew, the transparency is, I don't like to use the word unsavoury but I can't think of another at the moment, unsavoury. If everything is out front and it all should be, we shouldn't be having to use the Freedom of Information to get something. We have been told consistently by the geriatricians that they need these beds, that they choose the most complex patients for here. Last week even we were told. So why then are we sitting here with yourselves when we have had 100% occupancy all the time. All the time. That is not the case in other places. I know this is very difficult for you sitting there but it is also difficult for us. All I am interested in is protecting the rights of these patients to have this care and I have no other interest and will continue to pursue this.

Andrew Robertson

There are issues of finance and there are issues of continuing care and when we met earlier, trying to understand how they intertwine with each other. We acknowledge there is a financial issue here but we also acknowledge there is a continuing care issue. This issue of transparency, we are signed up for that. Let's have this developmental discussion and lets get it going and let us be able to report back to the Board that we are fulfilling what the Cabinet Secretary hoped would be a constructive discussions which will allow this institution to be funded to support the Board, the Hospice and the patient group.

Leo Martin

That suits us Andrew and I don't hide from that. We provide everything so it suits us. Because of that we then come back to looking inevitably at the different elements of the round where there are things that are wrong for us. The HDL is wrong for us. We are quite clear about that and the Scottish Hospices Forum might not like us saying that but we are being consistent. The HDL doesn't work for us because what it is doing is it is actually punishing a model of efficiency, a model of excellence. It is punishing us for that. Had we been a situation where we were being funded in such a way that would allow us to invest in this place, I even look at other Hospice accounts and look at the joy of them getting interest put through their figures, well we don't have that because we have been very lucky. This part of society has been very lucky that there has been an organisation that has been happy to fund capital costs in here. I said to you before Tom, it was very foolish of us to have taken notional interest of our accounts. It was foolish of us to do that because had I been sitting here with a

notional 4 or 5% recovery of capital interest in these accounts, then I would be sitting asking you for £100,000 or £200,000. Now, whether you'd give me it or not is another matter but anything like that that we don't have just now punishes us. What actually happened it seems to me from my analysis of this over the years is that people starting at year zero are better off than people who have been going for 58 years. And because of that everything that we do impacts upon the whole delivery here, whether it St Joseph's ward, the education centre and what we do there, or whether it is palliative care for the elderly in the other hospice beds we have in the Mary Aikenhead Centre. We need you to take that back to the Health Board. We have to make sure this place is maintained as a Hospice. Now I accept you can't do anything about the HDL because the Scottish Government tells you that, we'll be doing things about that. We will continue to be doing things about that and who knows how that will work out in the longer term. But we have to work on it because it doesn't work for us. If you compare us to other Hospices, it doesn't work for us.

Tom Divers

I understand that and Leo recognises that that is a debate in another forum. What we now need to do next in order that we can go back to the Board, not later this month but in the future although not too many months away, is to get involved in this further round of detailed analysis and create the opportunity as well for you to be able to engage in a response back to us on a number of the points that were discussed today.

That was where, I believe, I left our last meeting. I know its painful, I know it's difficult and you would rather not be doing it but need to work through this next stage and particularly understand what the financial implications of such a move would be and whether that does indeed and I know I am separating out in a way that you will say is entirely artificial and unfair, the core values and ethos and principals from the implications of a potential change. The implications of that need to be understood by us as well in terms of getting back to the Board.

Leo Martin

What would be terribly helpful for us both and what would send out a good message, would be for you to formally remove the 1 April 2009 date that you will stop sending patients here. I think that would be of great assistance in the interim if you were to say, and that you and I could say together, that we are fully reviewing these things and Andrew and I could get together and the date for stopping referrals of 1 April 2009 is no longer a definite timeline. I think that would show real a measure to everybody that we are working together.

Andrew Robertson

I would like to do that at a stage when we are on common ground.

Leo Martin

I think we should do that soon Andrew because the timeline is too short.

Andrew Robertson

We've got things to do with you over the next couple of months.

Leo Martin

I think at the very least what you should be doing is to say that that is not a definite date. At the very least. You see Andrew it's not fair. You are saying to us that we must do this, we must do that, we must talk.

Tom Divers

Let's reflect on that and come back to you and I'll give you a shout and see if we can put the next steps of this in a timeframe as well.

Leo Martin

I would like to think that you and I would have talked about that before a week on Tuesday then before you have your Board meeting.

Tom Divers

Yes, I'll speak to you before that. Okay

Andrew Robertson

Now, we have this developmental discussion. I get the sense that Jacquie is very much signed up to it and am looking at Sister Rita – are you signed up for it? Would you feel comfortable with it?

Sister Rita

I need to go away and meditate and pray about these things. I'm not signed up to anything at the moment, I'm being very honest. There are things here I'm not comfortable with. So I need plenty of time to go away, pray and reflect. I couldn't give you an answer about how I feel at the moment.

Tom Divers

The next steps of this is that we need to be able to work through the implications of that as a change and what happens with the funding stream just now and whether there is a cross over dependency or not. There is also a developmental discussion that has been picked up this morning that looks, potentially, a little further down the road at what is beginning to emerge more as a National Policy sense although part of what has been fed back to us this morning is that you believe you are at least in part on the way down that National Policy.

Elizabeth Thomas

No, not in part. We deliver.

Jacquie Malcolm

What is important is that something is not been removed that is then going to be required in the future and that why you say I am signed up to that agreement, what I want more than anything is that what is provided here is fully explored. It has become apparent the system that works for St Margaret's, the system that the Geriatricians use St Margaret's for maybe hasn't necessarily been fully known to yourselves. Whether the waiting list is 87 or 10, there is this magic number of 4 that we would like to explore a bit further and maybe that is work that Anne then does with the Hospice where we do a full analysis of what the Hospice provides. Then and only then can you make an informed decision that you don't want it.

Tom Divers

The other thing that would be good is just to be clear about to conclude this morning is just who is going to participate in the next rounds of conversation. Because Anne and her head of finance will head that up from our side so that we can get that engagement under way. So if you need to reflect on that and let us know. It would be good to know rapidly whether it is going to be the head of finance plus Jacquie and Elizabeth so that we know.

Andrew Robertson

I think that is right and I am sort of quite reluctant to get involved in more correspondence unless you think it would be quite helpful if we did confirm today's discussion in writing.

Sister Rita

Andrew, you said at the last meeting you were not going to put anything to paper and then we got your letter on 6 June. I got a shock having returned from York at 9.30pm and was told there was an urgent message for me and a letter had been a hand delivered at 5.45pm which also had to be signed for. I then phoned Leo at that time of the night, which I hate doing.

Andrew Robertson

Sister Rita you are right, that I did say we did not want there to be correspondence going back and back. Tom I think quite rightly reflected on the last meeting and thought to write.

Tom Divers

In page 25 of your own note, it quite clearly states that I wanted to write some of this down.

Sister Rita

I know and then Andrew said no to you.

Post meeting note – whilst Tom Divers correctly quoted from Page 25 of the previous minutes that he wished to write some of this down, Andrew Robertson subsequently stated, from Page 26 of the minutes, "is it reasonable that we could convene a group in 2 or 3 weeks time where a paper could be presented, discussed, and not perhaps taken away because there might be things that come out of it, so that what does go out is something that has been the subject of a recent discussion" to which Tom Divers agreed.

Andrew Robertson

Yes I know and there you are, we are all over the place just now and let's try and get all this together.

Sister Rita

Now we won't be getting something else on paper, will we? Is that what you are saying?

Andrew Robertson

I am offering to put something on paper as to where we go from here unless you think that we are sufficiently clear and you will come back to us Sister Rita when you have reflected and we begin to get that discussion going with Anne's team.

Tom Divers

Listen, I think we should write down and share what the next steps are. Not as a letter but just, if you like, a terms of reference on this next piece of work.

Andrew Robertson

It will come as a draft.

Tom Divers

And then we can agree who will participate in that piece of work.

Andrew Robertson

Sister Rita are you comfortable with that?

Sister Rita

I am but don't go giving me a shock when I come in from somewhere at 9.30 at night and get a letter and then I have to ring poor Leo, which I never like doing on a Friday night and I apologise Leo.

Leo Martin

Anne, while I have you here and I don't want to bombard you with questions but I just wonder if you could advise, because there are other hospices in Glasgow under development just now – Marie Curie obviously which is moving into Stobhill and the P&P about what is happening there? We would like within these discussions a complete openness about what is happening in other Hospices and what is going on.

Anne Harkness

Tom and I went to the P&P last week.

Tom Divers

First time I have been there in 12 years.

Anne Harkness

And they shared with us their proposed development. It is currently being endorsed by their staff. It was made clear that all such discussions would be going through the MCN.

Sister Rita

Tom could I ask you, you read out my minutes there. Where did you get that?

Tom Divers

Pardon?

Sister Rita

You read out my minutes there. Where did you get that?

Tom Divers

Oh that – someone sent it to me.

Sister Rita

Someone sent it to you. Who sent it to you?

Tom Divers

Eh?

Sister Rita

Who sent it to you? It was our Minutes. I just wondered who sent it.

Tom Divers

When you send your minutes by email as widely as you did, then …

Sister Rita

But I didn't send it to you.

Tom Divers

No of course you didn't but when you send it as widely as you did, the only surprise was that I hadn't got it 24 hours earlier!

Sister Rita

Well I intended to send it to you when it was completed but I thought it was quite a good reference for both of us.

Tom Divers

Well, it's okay you don't need to. We got it, okay.

Andrew Robertson

Now do we have anything else we want to say at this side of the table? Are you Leo content or are there any other outstanding things to reflect on?

Leo Martin

I would like you to get back to me on the 1 April 2009 date and to do that fairly shortly because people will be asking me, as you know, within hours how the meeting went today. I am sure people will be asking you as well. I've not doubt my phone will be ringing for the rest of the day, as will Sister Rita's. I would like to be able to say something positive.

Andrew Robertson

We will think it's fair to say we are working our way forward and we will make an appropriate report to the Board as and when we have got some common ground.

Tom Divers

One of the things we don't do is just take a line like that on the hoof. By the back of lunchtime today we will have developed a crisp, short line that will be available if we are asked about it which will reflect what the next steps are in the process. That will take just a little bit of time because I have another meeting and Andrew has a meeting in Clydebank. I'll just go back and get a short standby statement in place which I will be happy to send to you and it will just reflect the next steps in the process.

Andrew Robertson

Well thank you very much.