

Meeting of Community Council Reps with NHS Lothian (Reprovisioning of Services on the REH and AAH sites) Held at the Merlin - 17th November 2011 5.30pm

Present (for CCs): Jean Thompson (JT), Morningside CC (Chair)
Goff Cantley (GC), Morningside CC
Dianna Manson (DM), Morningside CC
Alastair Philp (AP), Marchmont Sciennes CC
Melanie Main (MM), Marchmont Sciennes CC
Mairianna Clyde (MC), Merchiston CC
Heather Goodare (HG), Tollcross CC
Stewart McGregor (SMc), Tollcross CC
Norman Tinlin (NT), Fairmilehead CC
Tom Crombie (TC), Craiglockhart CC
Jo Scott (JS), Southside Association
John Palmer (JP), Grange Prestonfield CC
Tony Harris (TH), Grange Prestonfield CC
Sue Tritton (ST), Grange Prestonfield CC

For NHS Lothian: Peter Gabbitas (PG), Director, Health and Social Care
Iain Gray (IG), Director, Capital Planning and Projects
Sheena Muir (SM), Acting General Manager AAH
Dick Fitzpatrick (DF) Project Manager, REH Campus Redevelopment

Apologies: Jackie Sansbury

1. Introduction

- 1.1. JT welcomed everyone and said that the CC representatives welcomed the opportunity to discuss possible changes to the REH and AAH. Morningside has had a long association with the REH and welcomes the decision for this hospital to remain in the area. She invited the NHS representatives to give a brief synopsis of the proposals
- 1.2. *DF. Plans to redesign the REH have been around for some time. Recently Jackie Sansbury had looked at the previous plans, spoken to stakeholders, considered the recent policy changes in Scotland related to Mental Health provision etc. The new proposals are in the large document which includes the Business Case, Masterplan, Feasibility study etc. – this was reported in mid-2010 and had been looked at by various committees. A phased development is the only reasonable way forward – to update the mental health services at the REH, services at the AAH, the opportunity to move services from the AAH to REH site. The move to more “fit for purpose” facilities had been warmly welcomed. It is possible that Liberton will move too.*
- 1.3. *DF. The document details 5 phases to be implemented over 10 years – these are not yet fixed in stone apart for Phase 1 – acute inpatient services for mental health patients.*
- 1.4. *DF. Phase 2 is the outline business case for each phase (a) do minimum £60m, (b) part refurbishment, part rebuild £142m (c) complete rebuild at REH £181m – been through hospital governance structures and has been well received – now with the Scottish Government Capital Investment Group. There will be a presentation on 1st December which may influence the SG’s decision.*

2. Questions

- 2.1. JT – Why amalgamate? IG – still early stages and details still to be worked out. Need to deliver fit-for-purpose and affordable provision.

- 2.2. HG – why move rehab from AAH without ancillary services? IG – *issue around existing site is fit-for-purpose and the overall state of the present facilities. SM – all ancillary services would move.*
- 2.3. Which facilities are not OK? IG – *details are still being worked on. Backlog of maintenance at AAH is approx £4m to bring facilities up to standard.*
- 2.4. AP – I understand the need to re-provision – but why do services have to move? PG – *remaining at AAH is an option – think preferred option will be to move but no consultation has happened yet – difficult to give firm answers. DF – this is only a statement of strategic intent and nothing decided yet.*
- 2.5. DM – this is a huge challenge – will this be affected by consultation? PG – *Capital Planning for REH – how much can be accommodated on the site. We are testing the feasibility but this doesn't mean it will happen. Understand locals want the REH redeveloped and that this is one site which NHS will retain – not sensible for NHS to have several partially used sites so need to consider what can move to REH.*
- 2.6. MC – Isn't the environment (e.g. all the space at the AAH) important as therapeutic value in recovery? PG/IG – *AAH is a beautiful site with beautiful grounds but awful buildings – this is a benefit which has been included in the plans.*
- 2.7. NT – I'm relaxed about the proposals – we need value for money and they are well thought out. With the normal scheduled service and buildings review procedures likely to take place over the next few years it is likely that there be nothing left at the AAH.
- 2.8. DM – Need for move of some services into the community – is the infrastructure sufficient? PG – *There has been major investment in the community and orthopaedic patients have been happy with rehab at home and the reduction in hospital stay. SM – Rehab is better at home if possible (OT, physio etc.) – need to reinvest in the community.*
- 2.9. DM – but is rehab in the community appropriate for mental health patients? There is considerable value of a drop-in centre for these patients.
- 2.10. JT – Has there been a shift of funds from NHS to Local Authority for this? PG – *I manage both budgets; it is a challenge transferring funds from the acute sector to Social Care. There is "Change Fund" with £70m nationally (£6m locally) available to invest in local facilities.*
- 2.11. AP – the sites are financial assets – can you retain any receipts if AAH sold? PG – *rules changed recently – previously receipts went to Lothian. IG – Capital receipts return to centre but elements remain locally – revenue reductions from efficiency savings. PG – if providing receipts we have a good case in asking for funds. MM/JS – is bid for new capital supported by AAH sale? IG – Difficult to know – need an affordable business case before doing anything. AP – Does the phased programme depend on AAH sale? IG – Business case assumes that developments are dependent on sale – sale can only happen after Board has declared properties surplus (line in the case that disposals will help the Capital programme) – capital is very tight and need to work at savings to be made in revenue funded streams.*
- 2.12. JS – is it simple to sell AAH – how do the Trusts work? IG – *properties are held by Scottish Ministers and all sites are problematic. PG There is a central Legal Service which supports all Health Boards.*
- 2.13. HG – What about the SMART Centre? PG/SM – *SMART Centre will definitely be staying at AAH – it's a regional centre and services have moved there from other areas. Also looking at more rehab for amputees at home therefore less need for beds. HG – why keep the SMART Centre and not the ancillary services? SM - the SMART Centre was recently built, fit for purpose and served a wider community.*

- 2.14. JP- Ritson Centre – present has 12 beds but there is increased need? *PG – other centres and more investment in LEAP (Lothian and Edinburgh Abstinence Programme).*

3. Planning issues

- 3.1. AP- will Kennedy Tower stay? *IG – It's in the Masterplan owned by University who will continue to use it as a teaching resource. Need more refurbishment.*
- 3.2. JT – REH site – will there be any disposal – what will happen to therapeutic garden, bowling green etc? *DF – Community garden identified on masterplan and the intention is to keep these.*
- 3.3. MC – what about the community garden at AAH? *IG – Board is aware of community benefits and wants to maximise community engagement and interaction.*
- 3.4. JT – public access, recent walkabout had feeling that access is being restricted? *SM – risk assessment led to gates near waste bins being closed. JP – have contacted Jane Campbell about risk to public by having to walk round Blackford Brae – also “green access”?*
- 3.5. ST/MM – locked gates at night, more open access wanted? *SM – not relevant to this meeting – write to Jane Campbell. PG – hospital site, need to look after safety of patients not to help locals have access – not expected questions like this.*
- 3.6. JP/MC – need definition of “visitor” and “community” and recognition of how the community interacts with the hospital grounds. Not an acute hospital – access restriction now will lead to further restrictions. *PG – these are issues to be dealt with by the Planning process and when an application is considered.*
- 3.7. AP – How does “right to roam” apply to AAH? Assessment of health gains to general public of allowing access? *IG – Need legal advice about “right to roam”. A design principle is appreciating the value to the community. Patient safety must come first but NHS is committed to ensuring that the community has access to NHS sites for leisure and exercise purposes.*

4. Future Consultation

- 4.1. *DF – This will be on a service by service basis at the appropriate time – with stakeholders of that service. We are good at consulting – e.g. over mental health strategy. JT – all Neighbourhood Partnerships have “Health and Wellbeing” subgroups and we hope these would be consulted. Will consultation also be by phase? DF – Yes.*
- 4.2. *IG – CC engagement would be mainly as part of the Planning process.*
- 4.3. *DF – when the Initial Agreement is “done and dusted” by the Scottish Government we will then move to the outline Business case.*
- 4.4. AP – am nervous that we are catching up from behind – it's good to know what is happening and that we can be kept informed. *PG – suggest meeting every 6 months – but get in touch if there are immediate problems.*
- 4.5. AP – NPs have remit for planning and access and need to be informed (NT noted there are 3 local NPs)

5. Final Comment

- 5.1. In ending the meeting and thanking everyone for attending JT said she had one final question. Had the NHS considered that patients who might have gone to the AAH (e.g. stroke patients) might be unhappy at being sent to what is still referred to by many as the “Loony Bin” – had the NHS considered rebranding the site? *PG – REH wouldn't agree with this statement – there is a need to break down the perception that REH only deals with mental health patients.*

6. The meeting closed at 7.10pm