GGNHSB(M)02/12
Minutes: 123 - 135

GREATER GLASGOW NHS BOARD

Minutes of a Meeting of the Greater Glasgow NHS Board held in the Board Room, Dalian House, 350 St Vincent Street, Glasgow on Tuesday 19 November 2002 at 9.30 am

P R E S E N T

Professor Sir John Arbuthnott (in the Chair)

Mr J Best	Mr W Goudie
Mr R Calderwood	Councillor J Gray
Mr R Cleland	Councillor J Handibode
Councillor D Collins	Dr R Hughes
Mr T Davison	Mrs W Hull
Professor G C A Dickson	Mrs S Kuenssberg CBE
Mr T A Divers OBE	Dr F Marshall
Councillor R Duncan	Mr I Reid
Professor M Farthing	Mr A O Robertson

I N A T T E N D A N C E

Dr S Ahmed	Consultant In Public Health Medicine (for Minute 125)
Ms E Borland	Acting Director of Health Promotion
Ms S Dean	Press Officer
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Mr A McLaws	Director of Corporate Communications
Dr C Morrison	Consultant in Public Health Medicine (for Minute 130)
Ms C Renfrew	Director of Planning and Community Care
Mr J Whyteside	Communications Manager

B Y I N V I T A T I O N

Mr P Hamilton	Convener, Greater Glasgow Health Council
Mr E P McVey	Chair, Area Optometric Committee
Dr J Nugent	Chair, LHCC Professional Committee
Mr H Smith	Chair, Area Professions Allied to Medicine (PAMS) Committee

ACTION BY

123. WELCOME AND CHAIRMAN'S REPORT

Professor G C A Dickson opened the meeting by welcoming the new NHS Board Chairman, Professor Sir John Arbuthnott.

ACTION BY

Professor Sir John Arbuthnott advised that he was honoured to be appointed Chairman of Greater Glasgow NHS Board. By profession he was a Microbiologist with an interest in public health. He had spent five years working on the National Review of Resource Allocation for NHS Scotland (Fair Shares for All). He continued to be the Chair of the Committee on Resource Allocation as its work was continuous in reviewing unmet need in relation to health inequalities and deprivation. He had worked for 28 years in Glasgow in various roles which incorporated the social, educational and economic needs of the population of Greater Glasgow.

He was keen to see early implementation of the decisions taken on acute services in order to lead to improved services for patients. He recognised the importance of the health improvement agenda for the NHS Board and in particularly the need to tackle health inequalities. Also paramount was the importance of communication at all levels inside and outside the NHS in Glasgow.

Since taking up post on 4 November 2002, Sir John had been involved in the following:

- Attendance at the NHS Board's Annual General Meeting on 5 November 2002 which was held at Glasgow Dental Hospital and School.

- Had a meeting with Professor David Hamblen, former Chairman of the NHS Board, on 6 November. He paid tribute to the achievements of the NHS Board under the leadership of Professor Hamblen and wished him well in his retirement.

- Visited Ward 4C and the Tom Wheldon Building at Gartnavel General Hospital and the facilities within the Western Infirmary in a tour of the Beatson Oncology Centre on 7 November.

- Had a meeting on 11 November with representatives from Greater Glasgow Health Council.

- Met with the Trust Chairmen and Chief Executives on 11 November.

- Attended the Area Clinical Forum meeting on 11 November.

NOTED

124. APOLOGIES

Apologies for absence were intimated on behalf of Dr H Burns (Director of Public Health), Ms R Crocket (Nurse Director), Councillor D McCafferty, Mrs E Smith (Chairman, South Glasgow University Hospitals NHS Trust), Mrs C Anderson (Chair, Area Pharmaceutical Committee), Dr F Angell (Chair, Area Dental Committee) and Ms S Plummer (Nurse Adviser to NHS Board).

125. CHIEF EXECUTIVE'S UPDATE

Mr Divers updated the Board on the following issues:

ACTION BY

(a) Beatson Oncology Centre

Since the last meeting of the NHS Board, a new Medical Director had been appointed to the Beatson Oncology Centre – this being one of the key recommendations of the External Advisory Group. Professor Alan Rodger, currently Director of Radiation Oncology at the Alfred Hospital, Melbourne, Australia, had accepted the post and was expected to commence in May 2003. He would have a major hand in shaping Phase II of the Beatson Oncology Centre at Gartnavel General Hospital. The Board welcomed this news as a further strengthening of the Beatson Oncology Centre.

Mr Divers referred to the tabled West of Scotland Cancer Network Report 2001/2002 and commended the activities of the Network and its plans for the future.

NOTED

(b) Outbreaks of Winter Vomiting

Mr Divers welcomed Dr Syed Ahmed, Consultant in Public Health Medicine to update the Board on the outbreaks of the winter vomiting bug, the Norwalk Virus. It now affected many hospitals in Scotland and within Greater Glasgow. Currently, eight wards were closed in North Glasgow University Hospitals NHS Trust (five at the Western Infirmary and three at Gartnavel General Hospital) and there were single ward closures in the Southern General Hospital, the Victoria Infirmary and Drumchapel Hospital.

Dr Ahmed explained that the virus was air borne and very infectious and once it was in an environment such as a hospital ward, it would affect the whole ward very quickly usually leading to a ward closure of between five/six days to a maximum of two weeks. Prior to the ward re-opening, a cycle of rigorous cleaning and disinfection was required.

NOTED

(c) Pay Dispute in North Glasgow University Hospitals NHS Trust

Mr Divers invited Mr Davison to update on the pay dispute within North Glasgow University Hospitals NHS Trust.

Mr Davison advised that just over 300 administrative and clerical staff were taking unofficial strike action – this being their thirteenth day – in support of a claim for regrading of administrative and clerical staff on grades 2-5.

The action was being handled by the North Trust on a day-to-day basis but, so far, the commitment from other staff had meant that the Trust had been able to sustain its patient services; to date, only 33 out of over 50,000 outpatient episodes had been affected.

The Trust's responsibility of delivering services to its patients remained paramount and the Trust would be supportive of the staff who remained at work.

ACTION BY

Discussions were ongoing at a national level to develop a "concordat" between NHS employers in Scotland and the Trade Unions to ensure a consistent approach to address low pay and a number of pay and terms of conditions claims which had been raised by the Trade Unions. There was hope that a national agreement of the "concordat" might be imminent.

NOTED

126. MINUTES

On the motion of Dr F Marshall, seconded by Dr R Hughes, the Minutes of the meeting of the NHS Board held on Tuesday 22 October 2002 [GGNHSB(M)02/11] were approved as an accurate record and signed by the Chairman.

127. MATTERS ARISING FROM THE MINUTES

(a) Disposal of Land at the Former Lennox Castle Hospital

Mr Divers advised that Councillor Handibode and the Director of Social Work at South Lanarkshire Council had written to him in connection with the disposal of the Trust's land holding at the former Lennox Castle Hospital and its capital receipt. Mr Divers confirmed that his research into their issues raised was almost completed and he would respond shortly. **Chief Executive**

NOTED

(b) NHS 24

The Chairman advised that Councillor McCafferty had represented the NHS Board at the official launch by the Minister of Health and Community Care of NHS 24 in Clydebank on Monday 18 November 2002.

NOTED

128. UPDATING THE LOCAL HEALTH PLAN

A report of the Director of Planning and Community Care [Board Paper No 02/76] asked Members to consider a number of proposals which would enable the Local Health Plan to be updated.

Ms Renfrew explained that this offered the NHS Board an opportunity to generate ideas on the shape and the content of the draft plan which would then be considered by the Board at its December meeting. The plan would be updated to reflect progress and change rather than be completely rewritten.

Ms Renfrew led the Board through proposed changes and updates including national guidance requirements for NHS Boards and staff, local communities and the Scottish Executive.

The current Local Health Plan had four key strategic objectives:

ACTION BY

- Improving health
- Reducing inequalities
- Improving health services
- Developing patient centred services

The main proposals for change to the Local Health Plan included:

- Acute Services – the current Local Health Plan had been criticized for lacking detail on acute services, however, the approval of the Acute Services Strategy enabled the updated Plan to focus on the programme of implementation and provide more detail on the key issues and priorities for 2003/2004.

- Local Authority Health Improvement Plans – it was important to ensure synchronization between the Greater Glasgow-wide Health Improvement agenda by feeding into the local authority planning cycle to capture local priorities.

- Consultation and Involvement – the Local Health Plan process must generate a range of material summarizing its content – with clear linkages to the large number of different planning processes thus enabling a wide range of interests to access information and connect to planning groups. It was intended that there would be a wide range of public involvement activity both on a continual basis and on particular issues or services.

- Performance Indicators – The updated Plan would include a report on progress against the Performance Assessment Framework and would show progress in the development of local key indicators.

- Trust Contributions – the plan would include a short statement setting out how each NHS Trust would contribute to the key objectives of the Plan enabling a more explicit connection between planning and delivery. This would also increase ownership of the Plan across NHS Greater Glasgow.

- Progress Update – each section would have a short update on progress in 2002/2003 on key outcome indicators, investment plans and new issues and priorities.

- Staff Governance – the updated Plan would set out, in more detail, progress on the National Staff Governance standard. It would also enable the presentation of actions taken as a result of the findings of the annual staff survey.

In accordance with the national priorities, the Board was also required to include specific and detailed implementation plans for these. It was anticipated that this material would form the basis of an agreement between the Scottish Executive Health Department and the NHS Board, an aggregation of which would form an NHS National Priorities Implementation Agreement. It would be important to reflect the balance between these national priorities and the Board's local priorities in the final Plan ensuring that resource allocation was in line with the implementation plan set out.

There were a number of key issues on which there would need to be decisions taken to update the financial section of the Local Health Plan to ensure that service and health improvement priorities were aligned with financial allocations.

ACTION BY

Ms Renfrew gave details of the sources of finance and their application. Furthermore, various scenarios around inflation were currently being modelled and work was in progress with Trust Chief Executives, planning leads and partners to enable these issues to be reflected in the draft Local Health Plan.

Councillor Collins referred to the section entitled "Working with Local Authorities" and re-iterated the importance of NHS Greater Glasgow working with its six Local Authority partners to improve the health of their population. Much work had evolved since the introduction of the last Local Health Plan and Councillor Collins emphasised the need to devise a better mechanism of ensuring the Local Health Plan was up to date with ongoing work taking place. Sir John stressed the importance of partnership working to deliver patient services across Greater Glasgow. Ms Renfrew advised that in promoting early discussion this should increase the influence of Local Authorities.

Professor Dickson encouraged staff involvement via the Staff Governance mechanism and referred to elements of risk other than financial risk. He considered that it was important to highlight risks in an open and transparent way at both macro and micro level.

In response to a question from Councillor Duncan, Ms Renfrew confirmed that changes would be made now that the new population census information was available – this was one area that would be updated as there were some significant differences from the last census in 1991. She recognised that defining and understanding the population was vital when it came to projections. Mrs Hull had prepared a detailed look at the census data and how the financial strategy would underpin this.

In response to a question from Councillor Handibode (in connection with page 16 of the Board papers, paragraph 4.4), Mr Divers confirmed that the general medical services funding had not yet been formulated as part of the national resource allocation formula – it was likely to form part of the primary care budget in relation to the new GP contract.

Dr Nugent sought clarity around resource allocations where there appeared to be dissonance between the financial strategy in the Local Health Plan and the actual allocation of resources.

Ms Renfrew confirmed that in reaching decisions on the allocation of resources in 2002/03 a primary objective had been to rebalance acute services prior to beginning implementation of the Acute Strategy Review. Programme plans had been protected, but additional new resources were allocated to Acute Trusts.

Dr Marshall referred to the key performance indicators and, in particular, the difficulties in comparing Greater Glasgow to Scotland-wide indicators particularly as the data did not reflect modelling and targeting. Ms Renfrew confirmed that the indicators would be changed and refined and this would be included in the Plan.

Mr McLaws confirmed that it was his intention to provide summary versions of the Local Health Plan to encourage involvement and feedback from staff, community groups and patient groups who knew more about their own interest areas. Mrs Kuenssberg agreed with this and suggested short sections about what was happening at a Trust level in terms of work in progress.

The shape of the plan would give cognisance to the need to balance competing priorities and be clear about the choices to be made by the NHS Board.

ACTION BY

DECIDED:

- That the proposed approach to update the Local Health Plan be approved. **Director of Planning and Community Care**

- That the Board Seminar in December be used as a further opportunity to shape the Local Health Plan and Financial Strategy. **Director of Planning and Community Care**

- That the Local Health Plan be updated and presented as a draft to the Board in December 2002. **Director of Planning and Community Care**

129. IMPLEMENTING THE ACUTE SERVICES REVIEW

A report of the Director of Planning and Community Care [Board Paper No 02/77] asked the Board to note progress on implementing the Acute Services Review.

In August 2002, the Minister for Health and Community Care approved the Board's proposals for Acute Services. He subsequently confirmed:

- The establishment of a Monitoring Group to ensure connection to community and elected representatives' interests as the review was implemented.

- A review in 2 years of the key assumptions underpinning the disposition of Accident and Emergency services.

Implementation, to date, had focused on a number of critical areas and the Chief Executive led the Board through them as follows:

(a) Securing capital for Ambulatory Care Hospitals and the new Beatson Oncology Centre (BOC)

A process had been established to ensure that the two Ambulatory Care Hospital Business Cases were synchronized and completed to enable the capital procurement process to begin in January 2003. It was likely that these would be PPP (Public and Private Partnership) funded.

Final development of the Business Case for the publicly funded new BOC was underway, with the aim of achieving full Scottish Executive Health Department approval in January 2003.

(b) Community Engagement

Critical to the effective and credible implementation was the Board's ability to inform and involve local communities in the detailed programme of service changes which would take place over the next ten years. It was hoped that a Head of Community Engagement (Acute Service) would be appointed in December 2002 to lead on this.

(c) Communication

Mr McLaws was actively taking forward the compilation of a richer and more coherent strategy which would be operational early in the New Year.

ACTION BY

(d) Transport Study

This had been published and a Subgroup would be formed early in 2003 with the Local Authorities and Transport Executive to take this critical issue forward.

(e) Appointing Professional Advisers

Advertising for legal and financial advisers was underway.

(f) Reviewing Emergency Admissions

This major piece of work was well underway as a key Board commitment with an interim report anticipated early in the New Year.

(g) Planning Service Stability at Stobhill

A Planning Group was in place to establish what was required to continue core services at Stobhill.

(h) Project Management

The Chief Executives had agreed future implementation arrangements including the creation of a Project Executive Group with a structure of sub groups and the appointment of a single Project Director with overall responsibility for co-ordinating the implementation of the Acute Services Strategy.

(i) External Monitoring

This would be undertaken by Audit Scotland; an inclusive Monitoring Group and an Annual Report to the NHS Board.

Mr Divers confirmed that further updates on progress would be brought to the NHS Board at regular intervals.

In response to a question, Mr Divers confirmed the outcomes from the transport study had been published and copies were available. Further work would be done looking at current access arrangements for staff, visitors and patients and various models would be explored to maximise transport links. This was seen in light of the current transport arrangements mismatching services and a sub group would take forward the issues arising from the study with key community stakeholders being critically involved. Councillor Duncan appreciated the challenge that lay ahead in relation to the provision of transport but Mr Divers was confident of the Board's ability to work with others to address transport provision to services across Greater Glasgow.

Mr P Hamilton referred to the transport study report and sought a summary of the document to make the options clearer and more user friendly for readers. **Chief Executive**

Professor Farthing drew attention to the enthusiasm from the Universities as key stakeholders in the modelling of acute services in Greater Glasgow and sought their involvement to play an active role.

ACTION BY

Professor Dickson sought clarification of the responsibility of the NHS Board in exercising its governance and over-arching responsibilities as the Acute Strategy was implemented. Mr Divers agreed to provide Members with a note of the NHS Board's responsibilities in discharging its functions during the implementation of the Acute Services Strategy. **Chief Executive**

Mr McLaws confirmed that the communication staff across NHS Greater Glasgow were currently working together to devise visual packages and information regarding the Acute Services Strategy. Similarly, work was ongoing to start interfacing with community groups to ensure communication links were localised.

Mr Divers confirmed that a proposed Constitution of the Monitoring Group had been drafted; its draft membership included a representative from Greater Glasgow Health Council.

DECIDED:

- That progress on implementing the Acute Services Review be noted. **Chief Executive**
- That further updates on progress and on specific issues would be brought to the NHS Board at regular intervals. **Chief Executive**

130. GEOGRAPHICAL AND SOCIO-ECONOMIC VARIATIONS IN REFERRALS FOR DEXA SCANNING

A report of the Director of the Director of Public Health [Board Paper No 02/78] was submitted for information.

Dr Caroline Morrison, Consultant in Public Health Medicine, advised that osteoporosis was a condition in which calcium was lost from bones leading to thinning and increased risk of fracture. Although osteoporosis was more common in women than in men, there was no evidence that the risk of osteoporosis varied with socio-economic status.

She tabled a map of osteoporosis/falls prevention work currently being undertaken in Greater Glasgow which highlighted various projects and pilots, both funded and unfunded. Bone Densitometry using axial DEXA scanning could identify individuals at increased risk who may benefit from bisphosphonate treatment and lifestyle management. In 1998, a GP Direct Access Densitometry Service (DADS) was established in Greater Glasgow. DADS was a collaborative venture between GPs and all GGNHSB DEXA providers. All four Glasgow hospitals used a uniform referral form which GPs completed and sent to their nearest facility. A criterion had been set up identifying patients at a higher risk of osteoporosis recommending they should have a DEXA scan. Data on every patient was recorded.

Dr Morrison referred to the referral rates by practices and LHCCs where there were wide variations. There was a trend in rates according to socio-economic status which was not simply due to age differences as the trend was still apparent when the analyses were repeated by age subgroups.

Dr Morrison highlighted the following conclusions:

- The vast majority of GP practices had referred at least one patient to DADS since its establishment.

ACTION BY

- Referral rates varied considerably between LHCCs and individual practices.

- Referral rates were generally higher in the South than North-East of Greater Glasgow.

- The variation by practice seemed to be due, at least in part, to variations in socio-economic status.

- Residents in the most affluent areas were more than twice as likely to be referred – this may reflect increased awareness of osteoporosis amongst affluent women.

- The variation in referrals by socio-economic status could not be attributed to variations in the prevalence of osteoporosis.

Councillor Collins referred to the Osteoporosis Working Group and Dr Morrison advised that the Care Commission was represented. This in turn should ideally feed into the local planning process as the Care Commission was the umbrella responsible for registering and monitoring all nursing residential homes. In relation to the Free Living Subjects Falls Prevention pilot within East Dunbartonshire, there were close links with the community in relation to Social Work, culture and leisure services.

In response to a question from Dr Marshall, Dr Morrison advised that ad-hoc screening services for osteoporosis had not been recommended due to the very diminishing return in comparison to targeted screening.

Ms Renfrew highlighted this pilot as being a good illustration how investment in non acute services could directly and positively impact on pressures in hospitals. This could also impact on delayed discharges and it was, therefore, paramount to consider such pressures within the joint planning process.

NOTED

131. WAITING TIMES

A report of the Director of Planning and Community Care [Board Paper No 02/79] asked Members to note progress made in relation to delivering the agreed waiting time target of a 50% reduction in over 9 month waits by March 2003.

Ms Renfrew advised that risks and pressures had been identified and to date the waiting times figures did not demonstrate as significant a reduction as had been expected.

NHS Greater Glasgow was some distance from delivering the intermediate position estimated for December 2002 anticipated position although new activity was due to impact in the next 2 months. There was anticipation of National Waiting Times Unit additional funding as a result of a further bidding process.

This paper covered Greater Glasgow patients only – there were issues about cross-boundary flow and the Trusts were working with other NHS Boards across Scotland to address these.

A mid year review against the NHS Board's target would be considered at the December meeting of the NHS Board.

ACTION BY

Professor Dickson had written to the Minister confirming that the NHS Board would consider monthly summary reports on progress of its performance against the accountability review target.

NOTED

132. 2002/03 FINANCIAL MONITORING REPORT FOR SIX MONTHS ENDED SEPTEMBER

A report of the Director of Finance [Board Paper No 02/80] was submitted asking the Board to note the results reported for the first six months ended 30 September 2002.

Trusts were reporting a £537K deficit against the break-even target for the six months to September, against a planned deficit of £28K. Given the degree of risk inherent in Trust startpoint revenue allocations, the results for the first six months remained encouraging. The overall forecast for the year end remained break-even, but there were issues emerging that would be more fully analysed in the Mid Year Review, due to be presented to the December 2002 meeting of the Board.

The commitment of Trusts to monitor the overall balanced results through a series of individual and specific initiatives was acknowledged.

Mrs Hull made specific reference to the overspend forecast on GP prescribing budgets. This reflected similar trends nationally. A series of indicators in the Primary Care Trust were focused on targeting key spend areas. This approach dovetailed with the implementation of the Pharmaceutical Strategy.

Mrs Hull highlighted additional funds that had been allocated in year by the Scottish Executive Health Department for specific initiatives including waiting times targets and delayed discharges/winter pressures.

Confirmation of further tranches of non recurring funding was awaited. This had led to some uncertainty in Trusts, particularly:

- The South Trust had agreed cases to be undertaken by the private sector in anticipation of further funding becoming available.

- The North Trust was exploring proposals to help relieve "bed blocking", again in anticipation of additional funding.

Ensuring break-even in year had important implications for next year's financial strategy.

NOTED

133. MENTAL HEALTH (SCOTLAND) ACT 1984 – LIST OF APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No 02/81] was submitted seeking approval of five medical practitioners employed by Greater Glasgow Primary Care NHS Trust to be authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984.

ACTION BY

DECIDED:

That the following medical practitioners be authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984: **Director of Public Health**

Dr Bernard Stein
Dr Bernard Sanchez-Capuchino
Dr Krishna Rohatgi
Dr Matt Al-Mousawi
Dr Ian Clarke

134. MINUTES OF NHS GREATER GLASGOW RESEARCH ETHICS GOVERNANCE COMMITTEE

The Minutes of a meeting of the NHS Greater Glasgow Research Ethics Governance Committee [NHSGGREGC(M)02/3] held on Friday 25 October 2002 were noted.

135. MINUTES OF NHS GREATER GLASGOW HEALTH AND CLINICAL GOVERNANCE COMMITTEE

The Minutes of a meeting of NHS Greater Glasgow Health and Clinical Governance Committee [GGNHSB(HCGC)(M)02/03] held on Tuesday 29 October 2002 were noted.

Meeting ended at 11.30 am