Minutes of a Meeting of the 
NHS Greater Glasgow and Clyde Board 
held in the Board Room, Dalian House 
350 St Vincent Street, Glasgow, G3 8YZ 
on Tuesday, 22 January 2008 at 9.30 am

PRESENT

Mr A O Robertson OBE (in the Chair)

Dr C Benton MBE
Mr G Carson
Mr R Cleland (to Minute 13)
Councillor J Coleman
Dr D Colville
Dr B Cowan
Mr P Daniels OBE
Ms R Dhir MBE
Mr T A Divers OBE
Mr D Griffin
Mr P Hamilton

Councillor J Handibode
Dr M Kapasi MBE (from Minute 6)
Councillor D MacKay (to Minute 13)
Mr G McLaughlin
Mrs J Murray
Mrs R K Nijjar
Ms A Paul
Mr D Sime
Mrs E Smith
Councillor A Stewart
Mr B Williamson

IN ATTENDANCE

Ms H Byrne .. Director of Acute Services Strategy, Implementation and Planning
Mr R Calderwood .. Chief Operating Officer, Acute Services Division
Ms S Gordon .. Secretariat Manager
Mr J C Hamilton .. Head of Board Administration
Ms A Hawkins .. Director, Mental Health Partnership
Mr A Lawrie .. Director, South Lanarkshire CHP
Mr A McLaws .. Director of Corporate Communications
Mr I Reid .. Director of Human Resources
Ms C Renfrew .. Director of Corporate Planning and Policy

1. APOLOGIES

Apologies for absence were intimated on behalf of Mr J Bannon MBE, Professor D Barlow, Dr L de Caestecker, Ms R Crocket, Councillor J McIlwee, Councillor I Robertson, Mrs A Stewart MBE and Councillor D Yates.

2. CHAIR’S REPORT

(i) Mr Robertson acknowledged the success of the NHS Board’s Communications Department in achieving excellent media coverage in a number of the NHS Board’s ongoing health initiatives. He summarised the eight key areas covered recently ranging from the NHS Winter Guide and the Smoke Free Initiative to the NHS Board’s Screening Programmes and advice on the Norovirus.
(ii) Mr Robertson referred to the Scottish Government’s consultation document on the Local Health Care Bill – comments on which were sought by 1 April 2008. He encouraged all NHS Board Members to consider this document and provide Mr J Hamilton with their comments by the end of February 2008 so that they could be incorporated into the NHS Board’s final response to the Scottish Government.

(iii) Mr Robertson alluded to recent confidential correspondence between himself and Mr Divers and the Cabinet Secretary and Chief Executive of NHS Scotland. To ensure NHS Board Members were fully briefed and kept up to date, information from Board officers had been shared with them via email. Unfortunately, it seemed that a confidential communication had been shared more widely and, as such, an investigation had been instigated into how this may have been leaked to the media. In light of this, senior officers were considering how best, in the future, to communicate confidential information with NHS Board Members.

(iv) Mr Robertson confirmed the re-appointment of six NHS Board Members from 1 April 2008 as recently confirmed by the Cabinet Secretary. The NHS Board Members were as follows:

Elinor Smith
Jessica Murray
Amanda Paul
Gerry McLaughlin
Rani Dhir
John Bannon

(v) Mr Robertson commended ongoing community engagement work taking place in relation to the new Children’s Hospital and the Art in Hospitals Project for the two new hospitals at the Victoria and Stobhill sites. He had recently participated in one of these events and had been impressed with the high level of engagement with local communities and service users.

NOTED

3. CHIEF EXECUTIVE’S UPDATE

(i) Mr Divers had been accompanied by Mr Calderwood and Dr Cowan to a seminar to launch the Scottish Patient Safety Programme. This had proved an interesting event with much debate surrounding the acute hospital sector as well as identifying issues covering all parts of the NHS system. He confirmed that a report would firstly be considered by the NHS Board’s Clinical Governance Committee and, thereafter, the NHS Board regarding how best to progress this programme of work throughout NHSGGC.

NOTED

4. MINUTES

On the motion of Mr R Cleland, seconded by Mrs E Smith, the Minutes of the meeting of the NHS Board held on Tuesday, 18 December 2007 [NHSGG&C(M)07/6] were approved as an accurate record and signed by the Chairman subject to the following amendments:
• Page 3, item 133, fifth paragraph, Mr Carson asked that his comment reflect his request to break down the number of “respondees” – rather than “non-respondees”.

• Page 7, item 136, after fourth paragraph, insert:

“Councillor Robertson stated that the NHS Board papers were critical of the Scrutiny Panel Report for not providing remedies to the difficulties faced in convincing the local community of the reasons for the transfer of services. He felt a more generous response to the Scrutiny Panel’s Report would have sent a signal of an NHS Board willing to listen and respect the views of the communities they served.

On the financial aspect of the NHS Board’s plans, Councillor Robertson stated that it was presented that the proposed changes in Clyde were not financially driven and yet a constant theme was that the recurrent deficit in Clyde had to be managed and restored without detriment to the services to those resident within the Greater Glasgow area. He believed the question of this funding deficit should be raised with the Cabinet Secretary for Health and Well-Being and that the plans to redress the recurring deficit should not only impact on services within “Clyde”.

Councillor Robertson advised that the transfer of services from the Vale of Leven to the Royal Alexandra Hospital was not an acceptable solution to residents of West Dunbartonshire – this was acknowledged by the Scrutiny Panel and if the Greater Glasgow Acute Services Review could not be altered to accept these patients north of the river then there was an urgency to ensure the viability of the services at the Vale of Leven Hospital. The integrated model of care deserved a reasonable chance to prove its worth and it was disappointing that the NHS Board and its clinicians could not produce a workable model to support local clinicians.

Lastly, Councillor Robertson indicated that other than in general statements, the NHS Board had not offered any view of the future of the services at the Vale of Leven Hospital. The Scrutiny Panel had highlighted the absence of any vision for the hospital and this was part of the NHS Board’s difficulty in not communicating effectively with local communities. It would be essential to ensure that this was a part of the consultation in order to allow people to understand what the impact of the changes would be and to understand the future of the hospital”.

• Page 9, item 139, eighth paragraph, delete the words “stand along” and insert “stand alone”.

5. MATTERS ARISING FROM THE MINUTES

The Rolling Action List of matters arising was circulated and noted.

NOTED

6. OUTLINE BUSINESS CASE UPDATE – NEW SOUTH-SIDE HOSPITAL AND CHILDREN’S HOSPITAL

A report of the Director of Acute Services Strategy, Implementation and Planning [Board Paper No 08/01] asked the NHS Board to receive a progress report on the Outline Business Case (OBC) for the new South Glasgow Adult Hospital and New Children’s Hospital.
EMBARGOED UNTIL 19 FEBRUARY 2008 BOARD MEETING

Ms Byrne confirmed that a Project Team had been working over the past 18 months to develop the OBC for the new Adult and Children’s Hospitals. She summarised their progress to date identifying both internal and external factors:

- **Internal Factors** – Ms Byrne explained the key criteria considered in positioning the new hospitals on the Southern General campus. Benefits, risks, costs and deliverability of building the hospitals separately and as an integrated building had been subject to an option appraisal process. Although the preferred option identified was an integrated build, Ms Byrne confirmed that the hospitals would have distinct identities and separate entrances. In terms of design, through consultation with technical advisers and NHS stakeholders, a range of five options were initially reviewed; those which did not meet the full design requirements were deselected. Designs which did meet the full brief were then subject to further review and refinement until three preferred options emerged.

  An option appraisal was undertaken involving the design team, technical advisers and NHS stakeholders. A fourteen storey building was identified as the preferred configuration as it was most able to meet the criteria. Departments had been broadly agreed as meeting clinical needs and further refinement would continue in the next stage of the project.

  In terms of bed modelling, Ms Byrne explained that plans for the adult hospital included 1,109 beds and an emergency department with the capacity for 110,000 attendances per annum. The hospital would function as an acute hot site with an outpatient department serving the local population and would have a small medical day area. The surgical day case activity would take place at the new Victoria Ambulatory Care Hospital opening in 2009.

  The 240 bedded Children’s Hospital had emergency department capacity for 46,000 attendances per annum. The outpatient department would see an estimated 86,000 patients per annum and the day case facility approximately 11,000 patients per annum.

  It was the intention of the Acute Planning and Acute Divisional Teams to visit English hospital sites to compare and contrast their bed modelling with the NHS Board’s plans.

- **External Factors** – the new South Glasgow Hospitals Project was subject to Office of Government and Commerce Gateway Review. Projects which were considered ‘mission critical’ or deemed to be high risk projects were required to go through the six stages of the Gateway Review process from Gateway 0 to Gateway 5. This review represented Gateway 1. Ms Byrne summarised the outcomes from this independent assessment which had been carried out on 8 - 10 January 2008. As no “red” recommendations were issued which would require immediate action, the OBC could be submitted to the NHS Board and to the Scottish Government’s Capital Investment Group. The five “amber” recommendations and one “green” recommendation would be addressed before the Gateway 2 Review which was likely to take place in the summer of 2008.

  The Outline Planning Application submitted to Glasgow City Council was considered by their Planning Committee on 15 January 2008 and received conditional approval. Further discussion would be required on the Section 75 agreement.

  A socio-economic benefits analysis was carried out looking at the potential impact on the immediate area around the Southern General site, the wider City of Glasgow and the Glasgow metropolitan city region. Analysis identified potential benefits within the following categories:
● Economic
● Human and social
● Knowledge
● Place

It had been estimated that the future service configuration on the Southern General site would have a combined direct, indirect and induced economic impact of between £30m and £40m on the South-West Glasgow economy; between £110m and £140m on the City economy and between £240m and £290m on Glasgow City region by 2012/13.

In conclusion, Ms Byrne confirmed that the Southern General development was seen as a catalyst for the wider social and regeneration activity contributing to the creation of high aspirations for the physical development of the local area.

Mr P Hamilton noted that the bed modelling proposals for the Children’s Hospital reduced existing beds and in response Ms Byrne confirmed that the hospital had been designed flexibly to allow for increased capacity if required in the future.

Mr Carson welcomed the socio-economic benefits associated with the project and asked if it was the NHS Board’s intention to work with local people. Ms Byrne clarified that the NHS Board endeavoured to work with local people and communities as the project developed and necessary skills identified. A number of principles had been developed in Glasgow in relation to such workforce issues and the NHS Board would engage with industry and local regeneration partners to take this forward.

Mr Divers explained that it was the intention of the University of Glasgow to look at how it distributed its research and academic departments across the city in light of the new Southern General campus.

**DECIDED:**

- That the progress report on the Outline Business Case (OBC) for the new South Glasgow Adult Hospital and new Children’s Hospital be received.

7. **UPDATE ON PROGRESS TO CONSULT ON MODERNISING CLYDE MENTAL HEALTH SERVICES**

A report of the Director of Corporate Planning and Policy and the Director of Mental Health Partnership [Board Paper No 08/02] asked the NHS Board to note work underway to address a number of outstanding issues raised at the December 2007 NHS Board meeting prior to consulting on modernising Clyde Mental Health Services.

Ms Hawkins led the NHS Board through the Independent Scrutiny Panel’s suggestion that the qualitative option appraisal process be re-run with a quantitative dimension to determine the best option for public consultation in respect of inpatient services for West Dunbartonshire. For consistency and transparency, it was decided to extend this option appraisal process to cover Clyde inpatient services. The outcome and status of the various option appraisal events undertaken to date was summarised as follows:

- **West Dunbartonshire Adult and Elderly Psychiatry Acute Assessment Beds** – the option appraisal process was considering nine options, including options to improve ward environments and medical cover arrangements. It would clarify the preferred option(s) and whether there was a feasible basis for meeting the preconditions of retaining services at the Vale of Leven Hospital. It was intended that a process would be complete by the end of January 2008.
• South Clyde Adult and Elderly Psychiatry Acute Admission, IPCU and Intensive Rehab Beds – two option appraisal events had been held. With regard to IPCU beds, the favoured option of locating South Clyde IPCU beds at Inverclyde Royal Hospital (within upgraded accommodation in the current short-stay psychiatric unit) scored best in the numeric appraisal and, therefore, that option would be subject to consultation.

The option appraisal process also considered the merits of consolidating all of East Renfrewshire’s elderly psychiatry acute admission beds on the one hospital campus. This relatively small number of beds was currently split across Leverndale and the Royal Alexandra Hospitals, with both hospital sites considered able to accommodate the required capacity. No definitive outcome, however, emerged from the appraisal and further work and engagement would take place, led by East Renfrewshire CHCP, to determine a recommended option.

• Clyde Addiction Beds – two option appraisal events had been held, the appraisal process concluded that Leverndale Hospital was the recommended option for locating this service.

It was anticipated that outstanding work would be completed by the end of January 2008 which would enable a formal public consultation to commence for three months from mid February 2008. In addition to the elements which required formal consultation, extensive community, service user, relative, carer and staff engagement would take place on the entirety of the Clyde Mental Health Strategy proposals.

NOTED

8. UPDATE OF PROGRESS TO CONSULT ON CLYDE MATERNITY SERVICES REVIEW

A report of the Director of Corporate Planning and Policy and Director, Clyde Acute Services [Board Paper No 08/03] asked the NHS Board to note the proposed approach to, and timing of, public consultation on the closure of the delivery services within the Inverclyde and Vale of Leven Community Maternity Units.

Ms Renfrew reminded the NHS Board that it had agreed at its December 2007 meeting to move to formal public consultation on the closure of the delivery services within the Inverclyde and Vale of Leven Community Maternity Units. She briefly updated the NHS Board on the approach to consultation, building on the extensive pre-engagement process. The NHS Board would consult on the proposal to have a single Community Maternity Unit (CMU) birthing suite for Clyde located at the Royal Alexandra Hospital. The CMUs at Inverclyde Royal Hospital and Vale of Leven Hospital would retain all other antenatal and post natal services.

Ms Renfrew confirmed that included in the consultation papers would be the full option appraisal documentation detailing the four options for service delivery, the process and evaluation of relative benefits and risks cumulating in the preferred option of a single CMU birthing suite. The Independent Scrutiny Panel report, with its full conclusions, would be included in the consultation papers to ensure openness and transparency for public comment.
In line with the Independent Scrutiny Panel’s conclusions that further testing of choices made by women would be of value, an audit of all women booking at the CMUs during the consultation period would be carried out to elicit reasons for their choice of delivery unit. The outcome of this audit would be included for the NHS Board along with the outcome of the consultation.

In line with statutory requirements on public consultation, Ms Renfrew outlined provision of the following arrangements:

- Public information, including summary leaflets, would be produced providing clear detailed information on the consultation process, timescales and service options.
- Public events would be held in each locality providing opportunity for public comment and questions.
- Staff would be kept fully informed and involved.

It was proposed that the public consultation process begin on Monday 3 March 2008 for three months.

**NOTED**

9. **UPDATE ON PROGRESS TO CONSULT ON OLDER PEOPLE’S CARE AT JOHNSTONE HOSPITAL**

A report of the Director of Corporate Planning and Policy and the Director, Renfrewshire CHP [Board Paper No 08/04] asked the NHS Board to note progress towards formal public consultation on the proposed changes to NHS Frail Elderly Continuing Care Services in Renfrewshire.

At the NHS Board meeting on 18 December 2007, it was agreed that a series of next steps be taken to enable NHSGGC to move to formal public consultation on the proposed closure of Johnstone Hospital and the reprovision of the NHS Frail Elderly Continuing Care Service. The steps reflected the agreed objectives of the NHS Board in responding to the Independent Scrutiny Panel report, as it related to the proposed changes to the balance of older people’s care.

Ms Renfrew confirmed that work was now in hand to develop a consultation paper and this would be derived from the original NHS Board paper considered at the NHS Board meeting on 26 June 2007 (Paper No 07/26, Annex 4).

Ms Renfrew described the consultation process and referred, in particular, to a meeting that was planned for relatives and carers in late January and a meeting for staff on 1 February 2008. Consultation would commence on 4 February 2008 for a twelve week period ending 28 April 2008.

**NOTED**

10. **CHANGES TO CLYDE INPATIENT DISABILITY SERVICES**

A report of the Director of Corporate Planning and Policy and the Director of Rehabilitation and Assessment Services [Board Paper No 08/05] asked the NHS Board to note the proposed changes to specialist physical disability inpatient services and move to formal public consultation on the future service relocation.
Ms Renfrew explained that in recognition of the single NHS Board-wide arrangements, the Rehabilitation and Assessment Directorate had taken the opportunity to consider issues for all areas of the NHS Board’s specialist adult physical disability inpatient services. This process had involved engagement with staff, users and carers, health and social care colleagues and voluntary organisations. The NHS Board’s proposals had been shaped by a number of key principles drawn from policy context and shaped further by feedback from local stakeholder engagement events and included:

- Providing services as close to home as possible.
- Supporting people at home via improved community based services.
- Strong joint working between health, social care and the voluntary sector.
- Making best use of a valuable specialist inpatient resource.
- Supporting discharge from hospital through improved discharge planning.
- Ensuring specialist services were focussed on those with most complex needs.

The specialist adult physical disability inpatient service was a small service made up of three distinct areas, namely, inpatient specialist physical disability assessment and rehabilitation, NHS continuing care and NHS respite. Ms Renfrew explained that over the past year, the NHS Board had had detailed discussion with a wide range of stakeholders, the result of which had highlighted a number of challenges that required to be addressed.

In order that the NHS Board proposals for future bed numbers were robust, a detailed analysis of the use of beds since April 2005 had been undertaken. This analysis included admission and discharge rates, occupancy levels, lengths of stay, pathways through inpatient beds and discharge destination. Ms Renfrew summarised the conclusions from this analysis highlighting that the data showed that, with some redesign of current practice and consistently achieving 80% bed occupancy levels, the specialist inpatient service now required fewer NHS inpatient beds. This analysis of bed numbers would be made available as part of the consultation material. The Consultant responsible for the service had concerns about the proposed bed numbers which also needed to be worked through during the consultation process.

Taking this into account, the NHS Board proposed a model of future service provision that recognised the shift to community based care over recent years, with intensive assessment and rehabilitation provided through a specialist inpatient physical disability rehabilitation service, supported with physical disability rehabilitation services in the community. Community services would be further developed with health and social care colleagues to provide integrated multi-agency services to adults with a physical impairment.

A reduction in bed numbers would be achieved most efficiently by the closure of beds at Islay Cottage with the transfer of four assessment/rehabilitation beds and two NHS continuing care beds to another location and rebalancing NHS continuing care/respite. In view of the isolation of the current service at Merchiston Hospital, the status quo was not considered a viable option.

As part of a pre-consultation process, comments were sought on three possible locations for the transfer of the rehabilitation beds – the Southern General, the Vale of Leven and the Royal Alexandra Hospital. The process also proposed the provision of all NHS continuing care for the NHS Board at the Southern General Hospital.
Ms Renfrew summarised the assessment of each of these locations in terms of its viability and ability to meet the key principles of shifting the balance of care and supporting people at home with improved community based services. Given that the proposal was to transfer just two NHS continuing care beds, the only viable option was to increase capacity within the current NHS continuing care facility within Ward 53 at the Southern General Hospital. Future capacity requirements could be met by reassessing the balance of NHS continuing care beds with NHS respite beds and opening an additional two NHS continuing care beds within the current ward. Discussion with the Consultant in charge of Ward 53 had indicated this option was achievable with a continuation of the current flexible approach to the use of beds. It was, therefore, proposed to consult on the transfer of services from Merchiston Hospital to the Southern General with the following bed configuration:

- Physical disability rehabilitation unit, Southern General Hospital – thirty assessment and rehabilitation beds.
- Larkfield Unit PDRU, Inverclyde Royal Hospital – eight assessment and rehabilitation beds.

Ms Renfrew touched on the finance and workforce issues, conscious that staff were a specialist and scarce resource and, as such, clinical staff had been given the undertaking that they could all continue working within disability services if that was their wish.

A process of formal public consultation would be taken forward building on the engagement that had been ongoing since November 2006 – this would include a range of materials, meetings and briefings, a single staged event in the Renfrewshire area as well as a specific consultation response page on the NHS Board’s website.

In response to a question, Ms Renfrew confirmed that as the consultation proposed a site closure, Ministerial approval required to be sought following the consultation period and decision by the NHS Board.

Councillor MacKay sought clarity around the information provided on bed numbers and highlighted the importance in the setting up of the community infrastructure.

Mr Williamson wondered what the current waiting list was for rehabilitation and assessment of patients and whether the NHS Board’s proposals would induce an increase in this. Mr Calderwood reported that currently, there were five patients on the waiting list. Of these, some had declined assessment over the Christmas/New Year period with others awaiting further tests. Mr Williamson encouraged the NHS Board to monitor the bed number and waiting times issues.

Ms Renfrew took on board Dr Kapasi’s concerns regarding providing a service close to patients’ homes. Nonetheless, this was a challenge for a small number of patients as such a small specialist service could not always be localised.
Mr McLaughlin referred to the suite of Clyde consultation proposals considered by the NHS Board. He emphasised the importance of looking at these not only independently but in ensuring equity of access to them across the whole of NHSGGC. He thought it would be helpful to set out a vision on what the overall picture of service provision would look like following the outcomes of these various consultations. Ms Renfrew agreed with this point and proposed that Corporate Communications produce a comprehensive report on Clyde progress.

On a similar point, Ms Nijjar wondered how all the consultations would be considered by respondents. Ms Renfrew confirmed that each had a different target audience and it was for that reason that they had been set up individually rather than as one consultation with various strands. She assured the NHS Board that each consultation would be constructed according to its target group.

Mr Carson referred to the Independent Living Fund particularly as the criteria had been changed recently raising the ceiling of allowance per week. He asked what impact this may have on the NHS and Ms Renfrew advised that the Director of Rehabilitation and Assessment would clarify this.

**DECIDED:**

- That the proposed changes to specialist physical disability inpatient services be noted.

- That the NHS Board move to formal public consultation on the future service location.

11. **VALE OF LEVEN HOSPITAL : CHANGES TO UNSCHEDULED MEDICAL CARE**

A report of the Director of Corporate Planning and Policy [Board Paper No 08/6] asked the NHS Board to reconsider its decision not to publically consult on the transfer of the unscheduled medical care service from the Vale of Leven and, subject to approving that recommendation, discuss how the initial findings on community engagement could inform a consultation process.

Ms Renfrew reminded the NHS Board of the outcome of the Independent Scrutiny Panel (ISP) process in relation to unscheduled medical care at the Vale of Leven Hospital. At the 18 December 2007 meeting, the NHS Board noted the Independent Scrutiny Panel’s clinical conclusions supported the Board’s proposal to transfer the unscheduled medical care service from the Vale of Leven Hospital. At that time, the NHS Board further noted that the Panel’s recommendations on options for consultation did not sit comfortably with those clinical conclusions which, in effect, left only one sustainable option – the transfer of the service. The NHS Board had, therefore, concluded that on the basis of safety and clinical governance, plans should be developed, as soon as possible, to transfer unscheduled admission services, in a planned and managed way, from the Vale of Leven Hospital to the Royal Alexandra Hospital, with a process of community engagement rather than formal public consultation.

The NHS Board had also recognised the continuing issues for the local community and agreed to review, at its January 2008 meeting, proposals for that detailed programme of local community engagement to explain why these changes were necessary. Local staff would be fully involved in the development of the planning and community engagement process.
Since the December 2007 NHS Board meeting the NHS Board Chairman and Chief Executive had had a number of face to face and written exchanges with the Scottish Government about the above points and the Cabinet Secretary had asked the NHS Board to re-engage with the Independent Scrutiny Panel to discuss its clinical conclusions and how these related to their recommendations for consultation. Mr Divers and Dr Cowan were scheduled to meet the Independent Scrutiny Panel Members on 28 January for this purpose and to draw this engagement to a positive conclusion, with the minimal possible delay, given the real issues about the present service arrangements.

In addition, the Cabinet Secretary had instructed the NHS Board to conduct a formal public consultation and, on that basis this paper asked the NHS Board to reconsider its previous decision that public consultation was not appropriate where there was only one viable option particularly in light of the concerns about the current service. This meant that rather than a process of community engagement during which the plan to transfer the service was implemented, the NHS Board would accept that, after public consultation, Ministerial approval would be required for such a transfer to take place and that the action to achieve a planned and managed transfer would be delayed.

During a detailed discussion the following points were made:

- Mr Williamson asked whether the NHS Board was now being asked to consult on all options and where did responsibility for safety now lie? Mr Divers clarified by explaining that it was his intention to discuss on 28 January, with the Independent Scrutiny Panel Members, the contradiction between their clear clinical conclusions that there was no sustainable option to continue to provide the service at the Vale and their recommendations for consultation on a number of options. In terms of clinical safety for service provision at the Vale of Leven, responsibility rested with him as Accountable Officer.

- It was recognised that the NHS Board’s December 2007 conclusion had not changed in terms of its accountability and clinical governance responsibilities – what had changed was the Cabinet Secretary’s intervention instructing the NHS Board to conduct a formal public consultation. Mr P Hamilton was concerned that the NHS Board would then be consulting while there were service issues which required transfer as soon as possible, and only one option for the future provision of this service. That had not previously happened in his time as a NHS Board Member. Ms Renfrew noted the difficulty caused by the contradictions between the Independent Scrutiny Panel’s endorsement of the clinical elements of the NHS Board’s proposals and its recommendation to consult on options which were at odds with those clinical conclusions.

- Ms Dhir asked what the public consultation process would involve and how it differed from the earlier proposal of public engagement. Ms Renfrew explained that a public consultation would normally last around twelve weeks and during the consultation period, the NHS Board would not make any decisions or commence any changes in service. A public engagement process, on the other hand, would have allowed the NHS Board to go ahead and make decisions and associated changes during the period whilst engaging with communities.

- Mr McLaughlin agreed that the NHS Board remained concerned around sustainability and safety of services at the Vale of Leven but to gain public confidence could not see how the NHS Board could ignore an instruction from the Cabinet Secretary. Councillor MacKay agreed with this point.
Dr Cowan referred to the relative nature of clinical safety and explained why it was difficult to define. Dr Cowan confirmed that the NHS Board’s Clinical Governance Committee had looked at risk and governance arrangements at the Vale of Leven and a series of service changes had been made to ensure the service was as safe as possible. He added that the service currently being provided at the Vale of Leven Hospital did not match that which was being provided in other parts of NHSGGC and, as the Independent Scrutiny Panel report confirmed, there were significant problems in providing emergency medical care in the absence of intensive therapy and emergency surgery, which could not be provided at the Vale of Leven. The service could continue to be sustained for a few more months and he would advise the Board that medical receiving was as safe as it could be, but was provided at the Vale of Leven Hospital in circumstances which had serious limitations.

Ms Renfrew noted the importance of the continuing concern that there were serious limitations in providing the service at the Vale of Leven. Mr Divers believed that, on balance, the NHS Board should press to move to a short, formal consultation period while recognising that the service did not meet standards elsewhere and it was unsustainable.

Mr Cleland thought it important to understand the logic in the Independent Scrutiny Panel recommendations. Mr Divers explained that the aim of the meeting with Panel Members was to understand the Panel’s clinical conclusions and how these related to their recommendations for consultation. He expected all four Panel Members to be in attendance at the meeting along with himself and Dr Cowan. The outcome of this meeting, therefore, would be helpful in framing the consultation material.

Councillor Handibode referred to Dr Cowan’s earlier comments and quoted from the Independent Scrutiny Panel report that service at the Vale of Leven Hospital was currently “significantly less than ideal”. He was concerned that any formal consultation period would mean that the NHS Board would be required to sustain this service, with its acknowledged serious limitations, during that period and he could not support that position.

Mr Sime wondered what was required of the NHS Board in terms of its Standing Orders and whether the NHS Board had to comply with this instruction from the Cabinet Secretary, particularly when it was contrary to medical advice. Mr J Hamilton confirmed that the Standing Orders were silent on this point.

The NHS Board considered the challenges for staff at the Vale of Leven. Dr Cowan commended staff at the Vale of Leven for doing as good a job as they could within existing limitations with no intensive care or surgical services. Although staff were under continuing pressure and scrutiny, at the moment, particularly with ongoing locum arrangements, he was of the opinion that services could be sustained for a short consultation period. Mr Divers agreed with this point.

Mr Williamson recognised that if the service was sustained for a consultation period, the Cabinet Secretary would then be required to consider the outcome from the consultation and, thereafter, approve, or otherwise, the NHS Board’s final recommendation. He noted there was no definitive timescale on this additional period required by the Cabinet Secretary to come to a decision. Mrs Smith echoed this point and as Chairman of the NHS Board’s Audit Committee recognised the role in managing risks associated with sustaining this service.
Mr Calderwood explained that operationally, the NHS Board wished to re-align medical receiving away from the Vale of Leven Hospital. This had to be undertaken as quickly as possible and in a planned way. Although the end point would remain the same, there was now a consultation process which the NHS Board must go through. Dr Kapasi emphasised that at the December NHS Board meeting an important part of the consideration was safety.

Councillor Mackay stated that the Cabinet Secretary required the NHS Board to undertake consultation and the NHS Board should proceed with that. However, he wondered about the timescale of that process and what would happen if any of the risk factors changed significantly during that time. He was advised that if this happened the Medical Director would bring these to the Chief Executive’s and NHS Board’s attention for further consideration.

On the issue of public consultation, whilst the process was different from public engagement, the information and process described in the NHS Board paper were noted as providing a good basis for consultation material. The issue of the ambulance services would be explored in a meaningful way in the consultation document and the experiences of patients at the Royal Alexandra Hospital would be considered.

Mr Robertson explained that the Cabinet Secretary was clear that a public consultation must be undertaken. He agreed with earlier points that the outcome of the meeting with Independent Scrutiny Panel Members would be helpful in shaping the consultation. He recognised the NHS Board Members’ need for reassurance regarding timescales but as the ultimate decision lay with the Cabinet Secretary, the NHS Board itself was not in control of this. He assured Members that following the meeting with Independent Scrutiny Panel Members, an update report would be made available to them. Mr Robertson also agreed to write to the Cabinet Secretary to report the Board’s continuing concerns about the delay in transferring the service, to raise the possibility of a shorter consultation period and to highlight the need for a rapid decision at the end of that process.

**DECIDED:**

- That the NHS Board’s decision not to publically consult on the transfer of the unscheduled medical care service from the Vale of Leven be reconsidered and a period of formal public consultation be initiated as soon as possible
- Councillor Handibode recorded his dissent from the decision.

That the consultation materials be framed around the initial findings on the community engagement process.

**12. THE FUTURE ARRANGEMENTS FOR PRIMARY AND COMMUNITY SERVICES IN CAMBUSLANG/RUTHERGLEN AND THE NORTHERN CORRIDOR**

A report of the Director of Corporate Planning and Policy, the Director, South Lanarkshire CHP and the Director, North Lanarkshire CHP [Board Paper No 08/07] asked the NHS Board to accept the conclusion and next steps outlined and formally agree to the further transfer of responsibility from NHSGGC to NHS Lanarkshire of the directly employed staff and GMS contracts within the Cambuslang/Rutherglen locality and receive a formal report in regard to the Northern Corridor with North Lanarkshire Council at its February 2008 meeting.
Mr Lawrie reminded the NHS Board of the background and rationale for considering change in the Cambuslang/Rutherglen and Northern Corridor areas. Discussions had been ongoing since August 2007 when both Boards of NHS Greater Glasgow and Clyde and NHS Lanarkshire received a paper from the South Lanarkshire CHP outlining proposals for the future arrangement of the primary and community care services within the Cambuslang/Rutherglen locality. Since then, work had been (and continued to be) undertaken to more closely align both areas into the CHPs (Cambuslang/Rutherglen into the South Lanarkshire CHP and the Northern Corridor into the North Lanarkshire CHP). Both NHS Boards had a duty to ensure that the CHPs were working optimally and that they were best able to look after the health of the people of Cambuslang/Rutherglen and the Northern Corridor now and into the future.

In terms of the Northern Corridor, a further paper would be presented to the NHS Board in February 2008 as there was a need to create a formal engagement process within the Northern Corridor to build on the informal engagement already taking place.

In relation to the Cambuslang/Rutherglen locality, it was considered that a way forward which would alleviate a number of issues would be to formally transfer responsibility for the locality from NHSGGC to the South Lanarkshire CHP, operating within NHS Lanarkshire.

Mr Lawrie led the NHS Board through what these changes would mean emphasising that the physical areas of Cambuslang and Rutherglen would still remain within the NHSGGC boundary, however, the full financial and operational responsibility for staff and independent contractors (where this was legally possible) would pass to the South Lanarkshire CHP which would fully manage the services on NHSGGC’s behalf as an integrated part of the wider CHP. This would allow the locality to work more efficiently, sharing best practice more easily and communicate with ease with the rest of South Lanarkshire CHP.

Mr Lawrie summarised the discussion and consultation that had taken place with stakeholders, staff and patient groups to progress this. For Rutherglen and Cambuslang, the breadth of meetings that had been held was felt to fulfil the requirements set out by the NHS Boards in August 2007. The meetings with staff were planned to be undertaken through the Locality Partnership Group. It was made clear, however, that NHSGGC procedures were required to be adopted and, as such, further meetings in line with the procedures were organised. For the Northern Corridor, the meetings to date provided a platform for the circulation of a formal discussion paper and a report to the February NHS Board for decision.

Mr Lawrie highlighted some of the issues that had come up during discussion and consultation and provided an overview of the transfer options discussed with staff. The proposals that were initially put forward were aimed very clearly at improving upon the governance, planning and accountability framework under which the localities in question operated. Clear legal advice had been taken in regard to the actions that could and could not be taken by the NHS Boards in terms of further transfer of responsibility. The outcome of this was that both directly employed staff and GMS contracts could be transferred but that Community Pharmacy, General Dental Practitioners and Optometrists could not. As such, it was considered that the transfer of both staff contracts and GMS contracts to the South Lanarkshire CHP was legal and that the majority of concerns and issues raised by these groups could be addressed and accommodated.
Dr Colville raised several operational questions to which Mr Lawrie responded. He was reassured that NHSGGC could intervene if it was dissatisfied with the performance of South Lanarkshire CHP or if it considered the new regime was not operating effectively. It was apparent that GP contractors would be covered by Lanarkshire’s Local Medical Committee (LMC) under these proposals while there may be informal arrangements with the Glasgow LMC.

Councillor Handibode welcomed the proposals and viewed them as a blue-print for future arrangements.

In response to a question from Dr Benton, Ms Renfrew confirmed that there was no requirement for a public consultation exercise as there were no proposals to change services. Discussions had, however, taken place with the Patient Partnership Forum (PPF).

In response to a question from Mr Sime, Ms Renfrew confirmed that reassurances had been given to staff and staff representatives that, in the event of the transfer being approved, appropriate processes would be put in place to allow staff to have a better appreciation of the changes for them both collectively and individually, reflecting the transfer option deemed appropriate. This would include the establishment of an implementation team to facilitate effective communication with all members of staff.

**DECIDED:**

- That the conclusions and next steps outlined in the report be accepted.

- That the further transfer of responsibility from NHS Greater Glasgow and Clyde to NHS Lanarkshire of the directly employed staff and GMS contracts within the Cambuslang/Rutherglen locality be formally agreed.

- That a formal report in regard to the Northern Corridor be received at the NHS Board’s February 2008 meeting.

13. **INDEPENDENT SCRUTINY CONSULTATION : DISCUSSION PAPER**

A report of the Director of Corporate Planning and Policy [Board Paper No 08/8] asked the NHS Board to discuss the issues outlined to respond to consultation on independent scrutiny.

Ms Renfrew referred to the Scottish Government’s consultation on the introduction of independent scrutiny. She provided a basis for the NHS Board to discuss its response with the underlying assumption that independent scrutiny would be introduced and, therefore, the focus was on examining and commenting on the options and rationale presented, considering the position with independent scrutiny elsewhere in the UK and articulating a model which might be the most effective way forward.
Ms Renfrew presented key extracts from the consultation paper and provided a commentary. She summarised the Scottish Government’s three options – decision conference, a scrutiny body or an expert panel. In considering the consultation paper, the NHS Board could reflect upon its own experiences so far and those from England. At headline level, the NHS Board would suggest that any independent scrutiny panel should offer advice to the Cabinet Secretary on making decisions on controversial proposals – and that the focus of that advice should be on the decisions made by the NHS Board at the end of the planning, review and public consultation processes, given the Scottish Health Council’s role on public consultation and engagement.

From the point of view of governance and wider credibility, it was important that any panel processes commanded the confidence of NHS staff and NHS Board Members as well as of the general public and wider professional interests and were genuinely independent. The NHS Board noted the potential conflicts between public and community opinion and patient interests which should be reflected in the consultation response.

The issues which would be considered by scrutiny panels would be complex and a consistent approach would be required. The volume of scrutiny required was likely to be small and, therefore, it was suggested that a single standing panel, of a mix of interests be appointed by the Cabinet Secretary. The NHS Board would suggest that to tailor its approach to particular issues and local circumstances, the panel should commission an appropriate group of expert advisers on clinical, financial and planning issues. Furthermore, the panel would need a properly organised and appropriately senior secretariat.

In response to a question regarding the model in England, Ms Renfrew confirmed that the consultation document made very little reference to this. She advised, however, that Local Authorities in England had the power to review and scrutinise on matters relating to the planning, provision and operation of local health services. Local Authority scrutiny committees must be consulted on any proposed substantial reconfiguration or development of health service provision for their area. These scrutiny committees could refer matters failing to be resolved locally to the Secretary of State for Health. Where such a referral was made, the Secretary of State may ask the independent reconfiguration panel to advise on the issue. This panel had a standing group of members appointed from across the UK, the membership of which was a mix of voluntary sector, lay members, councillors, NHS managers and clinicians. The Secretary of State received the panel’s advice on arriving at decisions.

Ms Dhir sought inclusion in the NHS Board’s response of re-emphasising that NHS Boards were accountable to the Scottish Government and that with the introduction of independent scrutiny, the role of Non-Executive Members should be reflected upon.

Councillor MacKay expressed a different view on the trigger point for scrutiny. He agreed with the consultation proposal that independent scrutiny would take place at the early stages of the decision making process and before full public consultation. It was the NHS Board’s view, however, that triggering independent scrutiny at this point was not at the early stages of the decision making process but generally at the end of a long process of pre-engagement and planning.

**DECIDED:**

- That the issues outlined in the NHS Board paper to respond to consultation on independent scrutiny and NHS Board Members’ comments be noted and reflected into the response to consultation.

**ACTION BY**

[Director of Corporate Planning and Policy]
14.  **FINANCIAL MONITORING REPORT FOR THE 8 MONTH PERIOD TO 30 NOVEMBER 2007**

A report of the Director of Finance [Board Paper No 08/09] asked the NHS Board to note the financial performance for the 8 months of the financial year and comments relating to performance against the 2007/08 Financial Plan.

Mr Griffin confirmed that at 30 November 2007, NHSGGC was reporting a close to break-even position against a year to date budget of £1,701m. This confirmed that the NHS Board continued to manage its expenditure levels in line with budget.

In 2006/07, the NHS Board reported a revenue surplus of £27.3m which arose as a result of the impact of property disposals that were concluded during 2006/07. It was agreed with the Scottish Government Health Department (SGHD) that this one off benefit could be carried forward into 2007/08 and deployed on a non recurring basis to support the achievement of national waiting time targets by the required date of 31 December 2007. At this stage of 2007/08, the year end outturn was forecast to be a break even position against the overall revenue budget.

During November/December, a detailed mid-year financial review was undertaken covering all service areas and funding sources – Mr Griffin summarised this mid-year review which confirmed that it was reasonable to forecast that the NHS Board would manage its total expenditure within available resources in 2007/08. In relation to Clyde there was a residual funding gap of £8m in 2007/08. It was reasonable to anticipate that this could be resolved with the Scottish Government Health Department following the same approach as in 2006/07 and that during January/February, joint discussions would continue with SGHD colleagues to finalise an agreement for achieving this.

**NOTED**

15.  **CLINICAL GOVERNANCE COMMITTEE MEETING MINUTES : 18 DECEMBER 2007**

The Minutes of the Clinical Governance Committee meeting held on 18 December 2007 [CGC(M)07/5] were noted.

Dr Cowan confirmed that as of 5 February 2008, the Clinical Governance Committee would have completed a range of presentations from all Directorates and Partnerships on their respective clinical governance arrangements.

**NOTED**

16.  **PHARMACY PRACTICES COMMITTEE MEETING MINUTES : 13 DECEMBER 2007 AND 14 DECEMBER 2007**

The Minutes of the Pharmacy Practices Committee (PPC) meetings held on 13 December 2007 [PPC(M)07/21] and 14 December 2007 [PPC(M)07/22] were noted.

**NOTED**
17. AREA CLINICAL FORUM MEETING MINUTES : 13 DECEMBER 2007

The Minutes of the Area Clinical Forum meeting held on 13 December 2007 [ACF(M)07/7] were noted.

NOTED

The meeting ended at 12.30 pm