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, 16 December 2008 at 9.30 am

PRESENT

Dr C Benton MBE
Mr G Carson
Dr L de Caestecker
Mr R Cleland
Councillor J Coleman
Dr D Colville
Dr B Cowan (To Minute No 124)
Ms R Crocket
Mr T A Divers OBE
Mr D Griffin
Mr P Hamilton
Dr M Kapasi MBE
Mr I Lee
Councillor D MacKay
Councillor J McIlwee
Mr G McLaughlin
Mrs J Murray
Mrs R K Nijjar
Councillor I Robertson
Mrs E Smith
Mrs A Stewart MBE
Councillor A Stewart
Mr B Williamson
Councillor D Yates

IN ATTENDANCE

Ms H Byrne .. Director of Acute Services Strategy, Implementation and Planning
Mr R Calderwood .. Chief Operating Officer, Acute Services Division
Dr E Crighton .. Consultant in Public Health Medicine (for Minute No 126)
Ms S Gordon .. Secretariat Manager
Mr J C Hamilton .. Head of Board Administration
Ms S Laughlin .. Head of Health Inequalities and Health Improvement (for Minute No 122)
Mr I Reid .. Director of Human Resources
Ms C Renfrew .. Director of Corporate Planning and Policy/Lead NHS Director, Glasgow City CHCPs (To Minute No 125)

116. APOLOGIES

Apologies for absence were intimated on behalf of Mr J Bannon, Professor D Barlow, Mrs A Coultard, Mr P Daniels OBE, Ms R Dhir MBE, Councillor J Handibode and Mr D Sime.

117. CHAIR’S REPORT

(i) Mr Robertson reported that NHS Board Chairs met with the Cabinet Secretary on 15 December 2008. At this meeting, two presentations were delivered on financial planning and Board effectiveness. The Cabinet Secretary advised that a report would shortly be issued on the draft Commonwealth Games Legacy Plan. One of the themes within this Plan would be “health” and the Board would be looking at this in detail to identify areas of benefits realisation in the lead up to (and after) the Games particularly in improving health and reducing health inequalities within NHS Greater Glasgow and Clyde.
(ii) In progressing partnership working with neighbouring Universities, Mr Robertson met with representatives from Glasgow School of Art on 24 October 2008, the Principal and Executive Dean of the University of the West of Scotland on 13 November 2008 and attended a University/Board Strategy Group meeting on 8 December 2008. In addition, the British Heart Foundation had visited the University of Glasgow on 2 December 2008. Such continued dialogue heightened partnership working between further education establishments and NHS Greater Glasgow and Clyde and Mr Robertson commended work that was being taken forward jointly to improve the health of the population.

(iii) Mr Robertson continued to work closely with Local Authorities and had attended both North and South Lanarkshire’s Health and Care Partnership meetings, a meeting arranged by the City Council Leader on CHCPs and Children and Family Services and had attended a meeting with the Leadership of Inverclyde Council.

**NOTED**

118. CHIEF EXECUTIVE’S UPDATE

(i) Significant effort had been made with progressing the Vale of Leven Hospital consultation exercise. Mr Divers, Ms Byrne and Mr Calderwood had attended meetings with West Dunbartonshire Council and Argyll and Bute Council as well as four public meetings. A final round of public meetings would be held in January 2009.

(ii) On 7 November 2008, Mr Divers and the Chairman had attended the unveiling of a plaque at Glasgow Royal Infirmary to commemorate Professor Tom Gibson who had been a pioneer of plastic surgery and bioengineering and had died in 1993. As a co-founder of the Bioengineering Unit at the University of Strathclyde (a department oriented to apply the principles and techniques of engineering to surgery and medicine), the Unit, under his inspired guidance, grew into the international centre of excellence that it was today.

**NOTED**

119. MINUTES

On the motion of Mrs A Stewart, seconded by Mr P Hamilton, the Minutes of the meeting of the NHS Board held on Tuesday, 21 October 2008 [NHSGG&C(M)08/7] were approved as an accurate record and signed by the Chair.

**NOTED**

120. MATTERS ARISING FROM THE MINUTES

(i) The rolling action list of Matters Arising was circulated and noted. Mr Divers highlighted two points:

- An audit of mortuary and viewing areas in hospitals within NHS Greater Glasgow and Clyde had been carried out and the outcome reported to Members in a letter dated 11 December 2008.
The outstanding work relating to progressing two alternative options with St Margaret’s Hospice (namely nursing home care or services for the elderly mentally ill) had not progressed and efforts continued to be made to engage with the Hospice around the two options which might contribute to the NHS Board’s declared strategy.

(ii) Mr Divers confirmed that there would be a further meeting with Sir John Savill, the new Chief Scientist for NHS Scotland, on Friday 19 December 2008. At this meeting, he would be discussing the priorities for research in Scotland, how finance could be directed to the four clinical academic centres and how future collaboration could be taken forward. This matter would also form part of the NHS Board Seminar in February 2009 and Sir John and his colleagues would be in attendance.

NOTED

121. NHS GREATER GLASGOW AND CLYDE – OUTCOME OF HER MAJESTY’S INSPECTORATE OF EDUCATION (HMIe) REVIEWS

A report of the Board Nurse Director [Board Paper No 08/53] asked Members to note a summary of the HMIe service reports to protect children, recognising that inspections were multi-agency.

Ms Crocket summarised the HMIe inspection reports specific to East Renfrewshire, Renfrewshire and South Lanarkshire, confirming that reports had yet to be received for Inverclyde and Glasgow City.

The inspections covered the range of services and staff working in each area who had a role to protect children. These included services provided by health, the police, the Local Authority and the Scottish Children’s Reporter of Administration (SCRA), as well as those provided by voluntary and independent organisations. As part of the inspection process, inspectors reviewed practice through reading a sample of files held by services that worked to protect children living in the area. Some of the children and families in the sample met and talked to inspectors about the services they had received.

Inspectors visited services that provided help to children and families and met users of these services. They talked to staff with responsibilities for protecting children across all the key services – this included staff with leadership and operational management responsibilities as well as those working directly with children and families. Inspectors also sampled work that was being undertaken in the area to protect children by attending meetings and reviews.

Ms Crocket summarised the lessons learned and noted that these were progressed through a comprehensive range of governance structures. She highlighted areas of strength that had been reported and confirmed that, overall, the inspectors’ reports concluded that they were either confident (or very confident) that children who required protection were known to services and prompt action was taken to ensure their safety. Children and their families were well supported by staff. That said, there was always room for further improvement, therefore, each Child Protection Group had developed an action plan specific to their report indicators on how they would address the main recommendations in their report. This would enable the Inspectorate, when they revisited, to assess and measure the progress.
Mr Williamson asked what evidence existed to show children safer and risks being better measured. Ms Crocket responded by confirming that better assessment tools were used to support the multi-agency assessment of children. As a result of this, risks could be better identified, vulnerability assessed and a more comprehensive approach used to tackle this. All risk registers were constantly monitored and the HMie visits included a detailed analysis of case conferences. Given enhanced integrated care services, there was, however, an urgent need for increased e-care developments which would support this interaction and give it a sharper focus.

Councillor MacKay was heartened by the good progress and proactive approach to child protection. He recognised that this was the beginning of the process and the real test would be in ensuring that mechanisms continued to be fit for purpose. Councillor Robertson confirmed that the HMie follow-through inspection reported on work undertaken to achieve any weaknesses they may have identified in their earlier report.

In terms of some of the quality indicators being scaled as “satisfactory”, Mr McLaughlin asked what measures would be put in place to ensure these were evaluated, in the future, as “good” or “very good”. Ms Crocket confirmed that “satisfactory” meant that strengths just outweighed weaknesses and agreed it would be helpful that the next monitoring report identify how areas of risk were identified and what actions were being taken locally to improve performance prior to follow-through inspections.

**NOTED**


A report of the Head of Inequalities and Health Improvement [Board Paper No 08/54] asked the Board to review and discuss progress in implementing the NHSGGC Equality Scheme 2006 to 2009; note the specific improvements that would be made over 2009 and approve the second monitoring report.

Ms Laughlin explained that a single Equality Scheme and Strategic Action Plan had been produced for NHSGGC in order to harmonise the requirements of current Equality legislation. Public sector organisations had a requirement to produce an annual monitoring report and the NHS Board’s second monitoring report had been produced to build on the first report which was endorsed at the NHS Board meeting in December 2007.

Ms Laughlin led the NHS Board through the monitoring report summarising the extent of progress over the last year and identifying where further progress still needed to be made. The second monitoring report had been produced with a number of different audiences in mind, both internal and external, and included the Equality and Human Rights Commission which had a mandate to ensure that equality law was adhered to.

The overall conclusion of the report was that the response by the NHS Board to the legislation in the second year, following the Equality Scheme, was proportionate and relevant to the size and nature of the organisation and that there had been incremental progress since year one. The report did, however, reiterate the need to meet the challenge of implementing equalities legislation across an organisation of the complexity of NHSGGC and its substantial workforce. As such, Ms Laughlin identified areas where activity would be focussed for 2009.
In response to a question from Mrs Stewart, Ms Laughlin confirmed that work being conducted within CH(C)Ps was unified in that Local Authorities also had a single scheme. It was not the case, therefore, that there were two sets of expectations. It was, however, recognised that integration varied throughout the CH(C)Ps and Ms Laughlin confirmed that this area would be picked up in 2009.

Mr Carson referred to the NHS Board’s commitment to Equality Impact Assessments (EQIA). He noted that a database had been developed which captured progress of EQIAs across NHSGGC and this was updated on a six-weekly basis. Furthermore, a quality assurance tool was being developed and, once this was applied, approved completed EQIAs would be posted on the NHSGGC Equality In Health Website. At the moment, the various tools and fact sheets were available on this site. Mr Carson wondered whether it was possible to capture how many hits this site had received in an attempt to measure usage. Ms Laughlin confirmed that, at the moment, it was not possible to capture this but by next year it would be. She confirmed, however, that it was her understanding the site was largely used by those areas that members of the Corporate Inequalities Team were working with.

With regard to the development of the workforce and workplace, Mr Carson was disappointed to note that only 0.36% disclosed a disability. Ms Laughlin, in acknowledging that progress needed to be made, emphasised that staff needed to be willing to provide the information. Although the figure did appear low, this may not, in fact, reflect the total number of those with a disability in the workforce.

Councillor Yates commended the good progress made to date and recognised that this would be incremental and that progress was moving in the right direction. Mr Lee agreed and re-emphasised the importance of embedding this work in the organisation.

**DECIDED:**

(i) That progress in implementing the NHS Greater Glasgow and Clyde Equality Scheme 2006-2009 be reviewed and discussed.

(ii) That the specific improvement to be made over 2009 be noted.

(iii) That second monitoring report be approved.

**123. PROGRESS REPORT ON C.DIFF ACTION PLAN**

A report of the Board Medical Director [Board Paper No 08/55] asked the NHS Board to receive a further update to the NHSGGC C.Diff Action Plan.

Dr Cowan confirmed that the first progress report had been submitted to the Performance Review Group on 16 September 2008. A further update and outline of the progress report provided to the Scottish Government Health Directorate on 1 November 2008 was submitted to the Performance Review Group on 18 November 2008.

Dr Cowan led the NHS Board through the specific actions and provided the completion/target date as well as the current status for each. He reported that the Infection Team, chaired by Professor Cairns Smith, was due to revisit the Vale of Leven Hospital on 23 December 2008.
To date, the format and structure of that meeting had not been confirmed but it was expected that Professor Cairns Smith would look for evidence of improvements in processes and procedures and would seek to gather this from frontline clinical staff.

In response to a question from Mrs Murray, Dr Cowan explained the revised infection control team structure. He was confident that the new structure was much clearer in terms of ownership and responsibility, emphasising that everyone knew their role in meeting policy guidelines with regard to control of infection. He confirmed that this was now high on all staff agendas with it being regularly discussed at directorate meetings and Performance Reviews. Over and above this, Key Performance Indicators (KPIs) for infection control had been applied to all levels from the ward to the Board based on the forthcoming national monitoring template. Mrs Nijjar welcomed this restructuring and thanked Dr Cowan and his team for providing reassurance that the NHS Board was responding positively in this area of great concern.

Dr Benton asked if figures of incidences could be made available for each hospital within the NHS Board’s area. Dr Cowan confirmed that information was regularly produced by Health Protection Scotland (HPS) and this would be provided to the NHS Board as part of the Healthcare Acquired Infection bi-monthly report to be introduced in the New Year.

Mr P Hamilton asked about the police investigation taking place. Mr Divers confirmed that the police team involved had now received the case notes for the Vale of Leven patients affected and were aware of the complexity of the evidence involved. In terms of preparing staff for the investigation, The Central Legal Office (CLO) had been engaged in providing staff with advice as had the Royal College of Nursing (RCN). Counselling services had also been made available to staff in anticipation of the police investigation.

Councillor Robertson registered his support of all the action being taken particularly with regard to assisting staff.

This further progress report had been provided to the Scottish Government Health Directorate on 15 December 2008.

**NOTED**

**124. JOINT WORKING WITH GLASGOW CITY COUNCIL**

A report of the Director of Corporate Planning and Policy/Lead NHS Director Glasgow City CHCPs [Board Paper No 08/56] asked the NHS Board to note progress in moving forward the development of CHCPs and in developing the approach to the review of joint working with Glasgow City Council.

Ms Renfrew outlined the arrangements which provided a platform to achieve positive progress with Glasgow City Council in relation to CHCPs and a clear framework to move forward the review of joint working. The NHS Board Chair and Glasgow City Council Leader had agreed that their respective Chief Executives would work together to develop and bring forward proposals to address the issues which were impeding delivery of the two organisations’ clearly articulated and shared vision. It was hoped this would be achieved by the end of January 2009. A series of discussions with CHCP Directors and management teams had, so far, enabled the development of an initial agenda which would now form part of the joint process with the Council. Ms Renfrew summarised these issues, which lay in four key challenge areas as follows:
• Finance
• Service integration and improvement
• Governance
• Human resources

NOTED:

125. MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003: LIST OF SECTION 22 APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No 08/57] asked that the NHS Board approve the list of Medical Practitioners employed by the NHS Board to be authorised for the purpose of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

DECIDED:

That the 5 Medical Practitioners listed in the NHS Board paper for the purposes of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003 be approved.

126. PUBLIC HEALTH SCREENING PROGRAMMES ANNUAL REPORT TO MARCH 2008


Dr de Caestecker introduced Dr Crighton, Consultant in Public Health Medicine, to present this report. Dr Crighton reported that screening was a public health service offered to specific population groups to detect potential health conditions before symptoms appeared. Screening had the potential to save lives and improve quality of life through early diagnosis of service conditions. The annual report presented information about the following screening programmes offered to residents across NHSGGC for the period 2007/08:

• Cervical screening
• Breast screening
• Communicable diseases in pregnancy
• Down’s syndrome and other congenital anomalies
• Newborn bloodspot
• Universal newborn hearing
• Diabetic retinopathy screening
• Pre-school vision screening

Dr Crighton reported that, in addition, the report also highlighted plans for:

• Bowel screening
• The replacement of the existing Pregnancy Screening Programme offered for Down’s syndrome and other congenital anomalies.
• Haemoglobinopathy screening both during pregnancy and for newborn babies.
• The extension of the newborn bloodspot screening programme to include screening for Medium Chain Acyl CoA Dehydrogenase Deficiency (MCADD).
Dr Crighton confirmed that, each year, approximately 250,000 NHSGGC residents were eligible for screening. As part of the NHS Board’s commitment to tackling inequalities in health, the Public Health Screening Unit engaged with voluntary and statutory services to identify effective ways to encourage and promote uptake of screening programmes.

Dr Crighton led the NHS Board through a summary of each of the above-named screening programmes confirming that they stretched across the whole organisation and their successful delivery relied on a large number of individuals working in a co-ordinated manner towards common goals in a quality assured environment.

As such, it was essential that good information management systems were in place to monitor and evaluate each component and the overall performance of every screening programme offered.

In response to Dr Colville, Dr Crighton confirmed that laboratories and researchers were prepared for the increased samples they would receive from 31 March 2009 when the new bowel screening programme would commence.

Mr Lee referred to the disappointing uptake rate of pre-school visual screening in East Glasgow compared to the West. He was advised that there had been a shortage of staff in the area which had prevented the delivery of screening in nurseries. Resources were now being redirected to East Glasgow to remedy this situation.

Mr Williamson commended the programmes and paid tribute to all staff involved in their delivery. Mr Divers confirmed for Mr Williamson that there was capacity to offer all patients with diabetes diabetic retinopathy screening.

Dr Benton thought it would be useful to see a breakdown of the breast cancer screening statistics by CH(C)Ps. Dr Crighton confirmed that this could be made available.

In response to Mr Cleland, Dr Crighton reported that data was not analysed by ethnicity, therefore, it was not possible to analyse the uptake of screening programmes by ethnic minorities. In order to do this, improvements had to be made to the technology but, even with this technical issue resolved, the data could only be captured if individuals were prepared to divulge it. Dr Colville believed that GP practices were improving such recording and suggested this may help Dr Crighton.

127. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer – Acute Services Division [Board Paper No 08/59] asked the NHS Board to note progress against the national targets as at the end of October 2008.

Mr Calderwood reported that the target set by the Scottish Government was that by March 2011, the total maximum journey time for patients would be eighteen weeks from referral to treatment. The Government had set an interim milestone for March 2009 when the maximum wait for an outpatient appointment would be fifteen weeks and the maximum wait for admissions for inpatient and day case treatment would also be fifteen weeks. As at the end of September 2008, all inpatients, day cases and outpatients had been given an appointment within fifteen weeks, ensuring that the NHS Board had achieved this target six months early.
Mr Calderwood outlined how the Acute Division was now working towards delivery of the twelve week waiting time target for outpatients, inpatients/day cases.

As a milestone towards achieving the eighteen week referral to treatment standard, the maximum wait from referral to MRI scan, CT scan, non-obstetric ultrasound, barium studies, gastroscopy, sigmoidoscopy, colonoscopy and cystoscopy would be six weeks by the end of March 2009. Mr Calderwood confirmed that the Acute Division continued to make progress towards achieving this six week target.

The NHS Board discussed the delayed discharge statistics and noted that since the April 2008 target had been achieved, performance had fallen back. Mr Calderwood reported that discharge of four of the patients in Renfrewshire and South Lanarkshire had been delayed because of funding issues. Other patients were delayed, awaiting particular placements or for housing issues to be resolved. This situation was clearly of concern to the NHS Board and it was accepted that there needed to be a clear way forward to meet the target and that this may involve designing solutions that were not necessarily resource related. On this point, Mr Carson referred to the role of voluntary organisations who could provide support and advice. There were also independent living allowances and packages and some voluntary agencies would help with the arrangements around these. Mr Divers agreed that each delayed discharge should be tracked on a case by case basis to see budgetary movements. He also welcomed Mr Carson’s comments and agreed to explore this further.

NOTED

128. FINANCIAL MONITORING REPORT FOR THE 6 MONTH PERIOD TO 30 SEPTEMBER 2008

A report of the Director of Finance [Board Paper No 08/60] noted the NHS Board’s financial performance for the first six months of the financial year.

Mr Griffin reported that the NHS Board and its Operational Divisions were currently reporting a close to breakeven position against its revenue budget after the first six months of the year. The NHS Board continued to forecast a revenue breakeven position for 2008/09.

Mr Griffin detailed expenditure to date against the NHS Board’s 2008/09 capital allocation and highlighted progress on achievement of the NHS Board’s 2008/09 cost savings targets. He commented on the financial outlook for 2009/10 and set out the extent of the savings targets that would be required to deliver a balanced financial plan.

NOTED

129. QUARTERLY REPORT ON COMPLAINTS : 1 JULY – 30 SEPTEMBER 2008

A report of the Head of Board Administration, Chief Operating Officer – Acute and Lead Director (CHCP), Glasgow [Board Paper No 08/61] asked the NHS Board to note the quarterly report on NHS complaints in Greater Glasgow and Clyde for the period 1 July to 30 September 2008.
Mr Hamilton confirmed that he had written to all Directors asking that there be an increased focus on the handling of complaints in order to bring about an improvement in their performance of responding to at least 70% of complaints within 20 working days. The CH(C)P Committees, Mental Health Partnership Committee and Senior Management Team for the Acute Service Division had been asked to review regular reports on the handling of NHS complaints to ensure a more local focus. Future Organisational Performance Review Group meetings would also include reviewing the performance in handling complaints against the national target.

Mr Hamilton recorded that this quarter’s complaints report showed an 8% improvement in performance and the Acute Services Division’s likely figure for October 2008 would be near 68%.

Mr Carson welcomed the improvement in the response rates and noted that, set in context, Members should recognise the volume of patient activity undertaken across NHS Greater Glasgow and Clyde.

In response to a question from Mrs Stewart, Mr Hamilton confirmed that the NHS Board wrote and confirmed the steps taken to implement the Ombudsman’s actions/recommendations and any other action taken as a result of their report. In each case, it was also necessary to notify the Chief Executive, NHS Scotland, of the actions taken in connection with their possible attendance at the Scottish Parliament Health Committee. Furthermore, each recommendation made by the Ombudsman was submitted to the Clinical Governance Committee with an action plan showing appropriate action against each item. The Clinical Governance Committee had the responsibility, on behalf of the NHS Board, to ensure that each recommendation was implemented in the interests of effective and safe care delivered to the population served.

**NOTED**

130. CLINICAL GOVERNANCE COMMITTEE MINUTES : 5 AUGUST 2008 AND 8 OCTOBER 2008

The Minutes of the Clinical Governance Committee meetings held on 5 August 2008 [CGC(M)08/4] and 8 October 2008 [CGC(M)08/5] were noted.

**NOTED**

131. INVOLVING PEOPLE COMMITTEE MINUTES : 6 OCTOBER 2008

The Minutes of the Involving People Committee meeting held on 6 October 2008 [IPC(M)08/05] were noted.

**NOTED**


The Minutes of the Pharmacy Practices Committee meetings held on 27 October 2008 [PPC(M)08/20], 3 November 2008 [PPC(M)08/21], 10 November 2008 [PPC(M)08/22] and 21 November 2008 [PPC(M)08/23] were noted.

**NOTED**
133. RESEARCH ETHICS GOVERNANCE COMMITTEE MINUTES : 17 NOVEMBER 2008

The Minutes of the Research Ethics Governance Committee meeting held on 17 November 2008 [REGC(M)08/3] were noted.

NOTED

134. PERFORMANCE REVIEW GROUP MINUTES: 18 NOVEMBER 2008

The Minutes of the Performance Review Group meeting held on 18 November 2008 [PRG(M)08/06] were noted.

NOTED

The meeting ended at 12.20 pm