NHSGG&C(M)11/04
Minutes: 66 - 86

NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the
NHS Greater Glasgow and Clyde Board
held in the Board Room, Corporate Headquarters, J B Russell House,
Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH
on Tuesday, 16 August 2011 at 9.30 am

P R E S E N T

Mr A O Robertson OBE (in the Chair)

Mr R Calderwood	Mr I Lee
Dr B N Cowan	Councillor R McColl
Ms R Crocket	Councillor J McIlwee
Mr P Daniels OBE	Mrs J Murray
Ms R Dhir MBE	Dr R Reid
Prof A Dominiczak	Rev Dr N Shanks
Mr I Fraser	Mr D Sime
Mr P James	Mrs P Spencer
Councillor J Handibode	Mr B Williamson
Dr M Kapasi MBE	Mr K Winter
Councillor B Lawson	Councillor D Yates

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

Mr G Archibald	..	Director, Emergency Care and Medical Services (for Minute No. 77)
Ms I Barkby	..	Shadowing the Nurse Director
Ms Y Bronsky	..	Supervising Authority Midwifery Officer (for Minute No. 80)
Ms S Gordon	..	Secretariat Manager
Mrs J Grant	..	Chief Operating Officer, Acute Services Division
Mr J C Hamilton	..	Head of Board Administration
Ms A Harkness	..	Director, Rehabilitation and Assessment (for Minute No. 76)
Mrs A Hawkins	..	Director, Glasgow City CHP
Mr A McIntyre	..	Director, Facilities (for Minute No. 86)
Mr A McLaws	..	Director of Corporate Communications
Dr D Morrison	..	Honorary Consultant in Public Health and Director of the West of Scotland Cancer Surveillance Unit (for Minute No. 74)
Mr I Reid	..	Director of Human Resources
Ms C Renfrew	..	Director of Corporate Planning and Policy (to Minute No. 75)

ACTION BY

66. APOLOGIES

Apologies for absence were intimated on behalf of Dr C Benton MBE, Ms M Brown, Mr G Carson, Councillor J Coleman, Dr L de Caestecker and Councillor E Stewart.

67. DECLARATION(S) OF INTEREST(S)

No declaration(s) of interest(s) were raised in relation to any of the Agenda Items to be discussed.

NOTED

68. CHAIR'S REPORT

(i) Mr Robertson reported that he had now completed all of the non Executive NHS Board member appraisals. He thanked those members for their co-operation in this annual exercise.

(ii) The NHS Board's new governance structures (and office bearers) were now in place and the first meeting of the newly formed Quality and Performance Committee had been held on 5 July 2011.

(iii) On 4 August 2011, Mr Robertson had attended an Area Clinical Forum meeting; the second chaired by Mrs P Spencer. The Forum had a real sense of maximising its role for the benefit of NHS Greater Glasgow and Clyde clinicians and informing the NHS Board on key areas of decision making. Currently, it was preparing for the NHS Board's Annual Review scheduled for 17 October 2011. He looked forward to working with Mrs Spencer and the Forum in the future.

(iv) As part of the Board Members' visits, Mr Robertson had visited Skye House on 15 July 2011. This was a purpose built facility on the Stobhill Hospital site providing a range of dedicated services for young people aged 12-18 years, from across the West of Scotland, who had serious mental health problems.

Similarly, on 26 July 2011, Mr Robertson had visited the Diabetic Retinopathy Screening Service.

NOTED

69. CHIEF EXECUTIVE'S UPDATE

(i) On 11 July 2011, Mr Calderwood met with Ruth Davidson MSP to discuss a broad range of the NHS Board's business and ongoing activities.

(ii) On 11 August 2011, Mr Calderwood, accompanied by Dr Cowan and Mrs Grant, attended a meeting at the Vale of Leven Hospital to receive informal feedback from the Healthcare Environment Inspectorate (HEI). This had been a positive meeting with the Inspectorate Team leaving with a good impression which was an encouraging message particularly for staff.

NOTED

70. MINUTES

On the motion of Councillor D Yates, seconded by Mr K Winter, the Minutes of the NHS Board meeting held on Tuesday 28 June 2011 [NHSGG&C(M)11/03] were approved as an accurate record and signed by the Chair.

NOTED

71. MATTERS ARISING FROM THE MINUTES

The rolling action list of matters arising was circulated and noted.

NOTED

72. SCOTTISH PATIENT SAFETY PROGRAMME UPDATE

A report of the NHS Board's Medical Director and Head of Clinical Governance [Board Paper No. 11/33] asked the NHS Board to review and comment on the progress achieved by NHS Greater Glasgow and Clyde in implementing the Scottish Patient Safety Programme (SPSP).

Dr Cowan reminded members of the overall NHS Greater Glasgow and Clyde aim to ensure the care provided to every patient was safe and reliable. The SPSP's aim was to achieve full implementation of the core programme in the Acute Services Division by the end of 2012.

Dr Cowan described the core programme as including improved staff capability in all wards and the creation of reliable processes for every relevant element in every ward. He confirmed that the NHS Board had also developed SPSP style improvement programmes in Paediatrics and Mental Health Services in 2010 and was working towards Primary Care and Obstetrics in 2011.

Dr Cowan led the NHS Board through the key progress points as follows:-

- On 8 June 2011, a team from Healthcare Improvement Scotland visited Glasgow Royal Infirmary to review the progress being made in implementing the core programme in Adult Acute Services. A draft report had been received and was currently being reviewed for key learning, however, the general impression from the team was that they viewed progress positively. Dr Cowan briefly summarised some key points from this draft report and stated that the review team had found many examples of great internal sharing processes, with data and systems well connected among local teams and work stream leads.

- The NHS Board had previously noted the difference of opinion over progress against the national trajectory. An in-depth report, providing examples of team's evidencing reliable processes had just been completed. This reconfirmed demonstration of sustained reliability in a pilot population for all elements in the programme and the spread of those tested reliable care processes was well under way. There were 35 currently applicable measures and the NHS Board had separately supplied charts of team based reliability for all 35, along with a spread plan update. Feedback was awaited.

- One of the key educational programmes, the SPSP Scottish Fellowship, had been keenly supported by the NHS Board and places had been successfully secured for NHS Greater Glasgow and Clyde staff in each of the three cohorts. The application period for the fourth cohort had just been closed and six staff had applied. This was the largest number so far.

- Good progress had been made in the ITU Teams with all seven achieving reliability in glucose control. Over 44% of sustained reliability aims for ITU core care bundles, across all locations, had been met; with a further 20% displaying the required level of data reliability.

- A Central Venous Catheter Policy Group had now been created to accelerate the standardisation and improvement of central line care within NHS Greater Glasgow and Clyde.

- Service redesign had affected data submission and reliability of processes in some areas. An adjustment to new environments and staff in teams had caused dips in reliability for a few areas but testing and adaptation to these changes had been established.

- The NHS Board had committed to working with NHS Lanarkshire in developing and deploying a web based data collection portal that would improve the efficiency of data submission and analysis.

In response to a question from Mr Robertson regarding the national assessment scale, as issued to the NHS Board by the National SPSP Team, Dr Cowan confirmed that the NHS Board currently sat at Level 3. It was believed that the NHS Board now, however, met the conditions for Level 3.5. This demonstrated sustained reliability in a pilot population. Mr Robertson commended this work given that the starting level had been 0.5.

NOTED

73. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the Medical Director [Board Paper No. 11/34] asked the NHS Board to note the latest of the regular bi-monthly reports on Healthcare Associated Infection (HAI) in NHS Greater Glasgow and Clyde.

Dr Cowan explained that the report presented data on the performance of NHS Greater Glasgow and Clyde on a range of key HAI indicators at national and individual hospital site level and the template used was revised as specified by the Scottish Government Health Directorates.

Dr Cowan highlighted four key Healthcare Associated Infection headlines for August 2011 as follows:-

- In 2007, the Scottish Government Health Directorates issued HEAT targets in relation to Staphylococcus Aureus Bacteraemias (SABs) in which NHS Greater Glasgow and Clyde successfully reduced by 35% in April 2010. This target was extended by an additional 15% reduction which was also successfully achieved by 31 March 2011.

The revised national HEAT target required all Boards in Scotland to achieve a rate of 0.26 cases per 1000 Acute Occupied Bed Days (AOBDs), or lower, by 31 March 2013. For the last available reporting quarter (January – March 2011), NHS Greater Glasgow and Clyde reported 0.347 cases per 1000 AOBDs with NHS Scotland reporting an average of 0.326 per 1000 AOBDs. The revised target would be a challenging one as analysis of these infections had highlighted that a significant number originated in the community. Dr Cowan confirmed that subsequent reports would update on the NHS Board's progress towards this challenging target.

Medical Director

- The national report published in July 2011 (January – March 2011), showed the rate of C.difficile infection within NHS Greater Glasgow and Clyde as 0.23 per 1000 occupied bed days in over 65s. This clearly placed the NHS Board below the national mean of 0.28 per 1000 occupied bed days in over 65s and also below the 0.6 per 1000 occupied bed days updated HEAT target for 2011. The revised target in patients aged 65 and over, to be attained by 31 March 2013, was 0.39 cases per 1000 total occupied bed days. Subsequent HAIRT Reports would update on the NHS Board's progress towards this target.

Medical Director

- The Surgical Site Infection (SSI) rates in monitored procedures in NHS Greater Glasgow and Clyde, (for the first quarter of 2011), remained below the national average for all categories.

- Cleanliness Champions Programme – the Cleanliness Champions Programme was part of the Scottish Government's Action Plan to combat HAI within NHS Scotland. To date, NHS Greater Glasgow and Clyde had supported 2386 members of staff who were now registered Cleanliness Champions.

Dr Cowan referred to two Healthcare Environment Inspectorate (HEI) unannounced inspection visits as follows:-

- Glasgow Royal Infirmary – 4 May 2011.
- Gartnavel General Hospital – 30 May and 1 June 2011.

He reported that from the Glasgow Royal Infirmary inspection, eight requirements and two recommendations were to be actioned. From the Gartnavel General Hospital inspection, five requirements and two recommendations were to be actioned. Two further "announced inspections" had been undertaken on 28 and 29 June 2011 (at the Western Infirmary) and 10 and 11 August 2011 (at the Vale of Leven Hospital). Details of these inspections would be published in subsequent reports.

Medical Director

Dr Kapasi asked about hand skin complaints arising as a result of the increased use of anti-bacterial alcohol liquids. Dr Cowan conceded that some alcohol liquids did dry the skin and the NHS Board had moved to a gel formula to reduce this. If staff had a particular skin problem with the gel version, they had been issued with their own sterilising agent for personal use.

Ms Dhir asked about the "best in class" approach taken by the Scottish Government Health Directorates in rolling out best practice across NHS Scotland. Dr Cowan clarified that once a Board had achieved the target as set by the Scottish Government Health Directorate, this formed the best in class target for one year for every other NHS Board so that constant improvements were taking place.

In terms of rolling out the recommendations made from the HEI visits across NHS Greater Glasgow and Clyde, Dr Cowan explained that the requirements and recommendations were scrutinised, in detail, by the Director of Nursing (Acute Services Division) who then informed senior nursing staff. This resulted in best practice being communicated across the whole NHS Board's area. Over and above that, the NHS Board conducted self inspections. This was a form of inspecting ward areas to pinpoint weaker spots that needed to be tackled. This proactive and reactive approach to cleanliness in the healthcare environment was, so far, proving successful to prevent the spread of infections.

Mr Williamson referred to the Scottish Government's national plan to screen all elective patients for MRSA prior to, or on admission, and all emergency admissions to vascular, renal, dermatology and care of the elderly. He asked how, operationally, this was being implemented. Dr Cowan reported that the aim of the plan was to reduce the number of patients being admitted into hospital with colonised MRSA to prevent further cross patient colonisation or infection. The deadline set for implementation of the targeted screening was 31 January 2010. Since that time, however, the Scottish Government announced a new national minimum MRSA screening recommendation. Targeted MRSA screening, by specialty, would now be replaced by a universal Clinical Risk Assessment (CRA) followed by a nose and perineal screening (if the patient answered yes to any of the questions within the CRA). All NHS Boards had been asked to ensure local delivery by the end of March 2012. To clarify further, Dr Cowan confirmed that, in emergency situations, patient treatment would not be delayed to allow MRSA screening to be undertaken. This screening was useful for elective work in that it allowed staff to take necessary precautions but, in emergency situations, treatment of the patient would always take priority.

Councillor Yates asked about the peaks and troughs illustrated on the various HAI report cards. Dr Cowan reported that these presented data across a whole hospital site and were not specific to a particular ward. Any outbreak in a ward would be reported separately and he confirmed that no such outbreaks had been reported for NHS Greater Glasgow and Clyde other than suspected or confirmed norovirus.

NOTED

74. TRENDS IN CANCER INCIDENCE, PREVALENCE AND SURVIVAL: IMPLICATIONS FOR PUBLIC HEALTH

A report of the Director of Public Health [Board Paper No. 11/35] asked the NHS Board to note important patterns of cancer incidence, prevalence and survival as well as their implications for public health in NHS Greater Glasgow and Clyde.

Dr Morrison reported that cancers were the second most common cause of death in NHS Greater Glasgow and Clyde residents. Over the past 10 years, cancer incidence had risen in women but fallen in men. Beneath these total figures, however, were important differences between cancer types that reflected changes in risk factors and in the population at risk. Survival from most cancers had also increased so larger numbers of people were living with a diagnosis of cancer. This had implications for determining when to discharge patients from follow-up and for helping to prevent new cancers in survivors.

Dr Morrison led the NHS Board through information pertaining to the incidence of the most common cancers. He explored the socio-economic patterns of these cancer incidences highlighting that smoking remained the single largest preventable cause of cancer.

The incidence of most cancers increased steeply with age, particularly beyond middle ages. Successes in reducing deaths from other causes, such a cardiovascular diseases, as well as cancers, had led to an increasing number of adults surviving into older age and, therefore, being at risk of developing cancers. The NHS Board had been successful in meeting, or exceeding, relevant 2009 - 11 HEAT targets that reduced factors for cancers and other chronic diseases. These included Child Healthy Weight Initiatives, Alcohol Brief Interventions and Smoking Cessation Interventions.

Dr Morrison explained that patients who presented with cancers at an early stage were more likely to live longer or be cured. It was less clear, however, whether some patients presented with less advanced disease because it was slower growing and would be less likely to affect their survival while those with more advanced disease had more aggressive cancers. There was an ongoing debate, therefore, about the effectiveness of early detection and screening programmes on reducing cancer mortality. Any benefits of screening also needed to be weighed against over diagnosis, where asymptomatic cancers were detected in patients who would not otherwise have had symptoms of the disease for the rest of their lives.

In terms of treatment and quality of care, Dr Morrison confirmed that survival was a useful measure of quality of care for cancer, although survival also depended on stage of cancer at diagnosis, cancer type, general health of the patient and, in some cases, age, as well as treatment. Some broad observations for the most common cancers could be made and he led the NHS Board through the most common cancers showing what percentage of patients were still alive after five years compared to individuals of the same age and sex in the Scottish population.

In response to some concerns from analysis that showed cancer treatment to be poorer in the UK than the rest of Europe, Dr Morrison cautioned that it remained unclear whether this was indeed the case. He alluded to three main explanations for the poorer survival of cancer patients in the UK compared with the European average as follows:-

- Artefacts due to international differences in calculating cancer survival
- Later stage at diagnosis and poorer general patient health
- Differences in the quality of treatment.

Dr Morrison estimated that about 33,000 individuals in Glasgow were living after a diagnosis of cancer (not including non melanoma skin cancers). These largely comprised common cancers with a good prognosis. There were just under 9,000 female breast cancer survivors, 4,700 bowel cancer survivors, 3,700 prostate cancer survivors but only 1,400 lung cancer survivors. There were also about 1,400 female survivors of malignant melanoma in NHS Greater Glasgow and Clyde. Cancer survivors continued to be at risk of developing new cancers and there was also some evidence that health improvement (particularly stopping smoking and exercise) improved survival.

Mr Lee commended this paper particularly acknowledging the five year relative survival percentages for patients diagnosed between 1983 and 2007 which showed significant improvements in survival for cancers of the female breast, colorectal cancer and malignant melanomas.

In response to his question about prostate cancer, Dr Morrison confirmed that the causes of prostate cancer and the steep rise in incidence were not well understood but were the subject of ongoing research in Glasgow. There was evidence that high cholesterol may increase the risk of prostate cancer. Greater detection of prostate cancer was also likely to explain some of the increase in incidence but it seemed probable that a true increase had also occurred. There was also considerable clinical uncertainty about how to manage men with lower grade disease which may not progress to become clinically important. Studies were being undertaken on prognostic factors for prostate cancer to try to help clinicians better manage the increasing number of cases.

In relation to speculation that cancer survival was poorer in the UK than in Europe, Mrs Murray asked why, if that was the case, the UK did not adopt European forms of treatment. Dr Morrison reported that later diagnosis and differences in treatment were most likely to explain international variances in cancer survival and the International Cancer Benchmarking Partnership (ICBP) aimed to identify which had the largest effect. Irrespective of such conclusions, efforts to both improve early detection and the quality of cancer care were required. In response to a follow up question from Professor Dominiczak regarding genetic testing, Dr Morrison outlined work that was ongoing with colleagues in Glasgow Royal Infirmary looking at biochemistry data to help with predicting prognosis.

Mr Williamson referred to the smoking ban introduced in Scotland in 2006. Dr Morrison confirmed that it would be some time before any reduced cancer incidence levels could be attributed to this ban but thought some analysis would be available from around 2020. In response to a secondary question concerning interventions in alcohol, Dr Morrison confirmed that evidence was convincing in reducing daily/weekly alcohol intake limits. By way of an example he reported that consumption of one unit of alcohol increased the likelihood of breast cancer by 9%.

In response to a question from Mrs Dhir about the representativeness of sources of cancer information, Dr Morrison described that the Cancer Registry data were the most complete record of all new cancers available and additional sources, such as data from the cancer Managed Clinical Networks' clinical audit, were linked to these to further increase the detail available. Locally, this information was linked with data obtained by the Managed Clinical Networks (MCNs). In response to a follow up question concerning people who survived one cancer but then had another, Dr Morrison reported that these were referred to as second primaries and work was starting shortly to quantify such instances.

Mrs Spencer highlighted how the outcomes, as described in the report, raised the profile of the social determinants of cancer. She asked what role physical activity had in improving cancer survival. Dr Morrison agreed that there was a lot of evidence linking physical activity and wellbeing. He noted that lack of exercise in some cancer patients may be more to do with their physical health than their mental willingness to take exercise, and we should remain sensitive to the variations in abilities to take exercise despite the overall advice that it is beneficial.

Mr Robertson thanked Dr Morrison for such an informative presentation which had resulted in an interesting debate.

NOTED

75. THE FUTURE OF CONTINUING CARE IN THE WEST AREA OF NHS GREATER GLASGOW AND CLYDE AND THE BLAWARTHILL HOSPITAL SITE

A report of the Director of Corporate Planning and Policy [Board Paper No. 11/37] informed the NHS Board of the outcome of the initial review of continuing care in West Glasgow, the current position on discussions with Glasgow City Council about the potential care home development and sought approval to proceed with the required process to end the provision of NHS services on the Blawarthill site.

Ms Renfrew reminded the NHS Board of the background to this review which was a result of original plans not being able to proceed because, in formal legal terms, the binding requirements and timescale of the concluded missive had not been met by the developer. As such, the NHS Board started the review process by issuing a discussion paper to nearly 500 individuals and organisations who may have an interest. In addition, briefing sessions were held with patients, relatives and staff and an open stakeholder event was held in Yoker. Ms Renfrew led the NHS Board through the issues raised and the NHS Board's responses to these. In essence, these centred around the following:-

- Bed numbers
- Location of continuing care beds
- Financing a development at Blawarthill
- Potential impact of a move of service and particularly the quality of care delivered by Blawarthill staff
- Delayed discharges.

Ms Renfrew explained that the review process had offered the opportunity to hear a range of views, however, it had not resulted in any substantive challenge to the NHS Board's first appraisal that:-

- a maximum of 30 continuing care beds would be required on the Blawarthill site.;
- there was a real clinical and service delivery issue about a single stand alone ward;
- there was very limited prospect of accessing capital for a site redevelopment and there was not the required certainty about continuing care bed numbers and models for long term capital investment;
- there were beds immediately available at Drumchapel which would offer a short term improvement in the quality of facilities while medium and longer term planning on the model and number of beds took place.

Ms Renfrew emphasised that it was clear, and generally accepted, that the option of status quo was not viable given the condition of the site infrastructure and the quality of the environment. The conclusion, which needed to be fully tested in the next stage of the process, was that redevelopment was not possible in terms of available capital funding and was not required in terms of the number of beds needed and the availability of alternative beds. Whilst the beds at Drumchapel were not ideal, as a long term solution, they provided a viable solution to offer an improved environment, co-location with synergistic clinical services and modern site infrastructure. It also meant that the service in the west of the NHS Board's area was retained enabling more extended consideration of the future model and number of continuing care beds as part of the NHS Board's Acute Services Review and further development of the change fund process.

In terms of the future of the site, Ms Renfrew reported that whilst the site did not appear to have a future for NHS continuing care, the NHS Board's preference remained that the site was redeveloped for care services, if that was possible. This commitment had been reaffirmed to Yoker Housing Association. The NHS Board was currently in negotiation with Glasgow City Council to structure a financial agreement which would enable disposal of land at the Blawarthill site to be achieved under the terms required by the NHS Property Transaction Handbook. There was commitment on both sides to reach an agreement which would see care services continue to be delivered from the site.

Concluding, Ms Renfrew explained that there did not appear to be a future for the site providing a single ward of NHS continuing care beds. As such, the NHS Board needed to agree the required further process with the Scottish Government to test that conclusion and a proposed move of the ward to Drumchapel Hospital in public consultation. The next phase of process may depend upon whether such a public consultation process was required, if care services, albeit in the form of Local Authority (not NHS care) were to continue on the site. In this next phase of process, the NHS Board needed to be mindful of the impact on staff, patients and relatives and if change did not proceed, consideration would need to be given to the timescale based on ensuring the welfare of patients protected. That consideration also needed to reflect the immediate environmental, security and other site issues.

Mr Robertson, in referring to points raised at the stakeholder event on bed numbers, referred to a detailed paper, prepared by the relative of a patient, challenging this bed analysis which had separately been shared with NHS Board members.

Mr Williamson supported the proposals particularly as they were clinically safe and led to better clinical care (as well as being more cost effective) for patients. Rev Dr Shanks echoed this view.

In response to a question from Councillor McColl, Ms Renfrew confirmed that negotiations were ongoing with St Margaret's Hospice to establish a contractual arrangement for continuing care beds provided there. There was no intent to change current provision from the Hospice.

Mrs Spencer suggested that, at the consultation stage, further detail on the benefits of the change fund process be included. Ms Renfrew welcomed this suggestion.

Director of Corporate Planning and Policy

DECIDED

- That the outcome of the engagement process around the future of continuing care in West Glasgow be noted.

- That the establishment and completion of due process required to consult on a proposal to cease the provision of NHS continuing care on the Blawarthill Hospital site be approved.

  Director of Corporate Planning and Policy

- That the ongoing negotiations with Glasgow City Council on a potential future use of this site be noted.

  " "

76. REDESIGN OF REHABILITATION SERVICES - CONSULTATION ON THE CLOSURE OF LIGHTBURN HOSPITAL

A report of the Director of Rehabilitation and Assessment [Board Paper No. 11/36] asked the NHS Board to recommend to the Cabinet Secretary for Health, Wellbeing and Cities Strategy that Lightburn Hospital be closed (with in-patient rehabilitation beds being transferred to Stobhill Hospital and day hospital/out-patient services being transferred to Glasgow Royal Infirmary) and approve the recommendations of the Transport Needs Analysis (TNA).

Ms Harkness reminded the NHS Board that, at its August 2010 meeting, it agreed to move to a three month public consultation on the NHS Board's preferred option of transferring rehabilitation beds from Lightburn Hospital to Stobhill Hospital and the possible closure of Lightburn Hospital.

The closure of the Lightburn Hospital site was dependent on suitable alternative accommodation being identified for day hospital and out-patient clinics currently there. The three month formal consultation was launched on 30 August 2010. Alongside this, the NHS Board agreed to undertake further work to identify proposals for the relocation of out-patient clinics and day hospital activity and to undertake a Transport Needs Assessment to better understand the impact of any changes for patients, carers and visitors. Towards the end of the formal public consultation, Ms Harkness reported that it became apparent that, before final proposals could be put to the NHS Board, additional work would be required to better understand the individual patient experience at day hospital and out-patient clinics at Lightburn Hospital. This work had now been concluded.

Ms Harkness described the drivers for change that had led the service to review the location of longer term rehabilitation beds in North East Glasgow. In terms of in-patient services, the Board's preferred option (and the basis for public consultation) was service provision over two sites, namely, Glasgow Royal Infirmary and Stobhill Hospital. The NHS Board recognised that moving to a two site in-patient model located around specialist facilities at Glasgow Royal Infirmary and Stobhill Hospital would mean many relatives and friends who visited people in Lightburn Hospital may have a further distance to travel for visiting. The NHS Board also recognised the importance of visitors for in-patients, particularly those who may spend a number of weeks in hospital for rehabilitation. In this regard, Ms Harkness confirmed that to better understand this impact, the Transport Needs Analysis results had been considered in detail.

In relation to out-patient and day hospital services, it was recommended that these transfer to Glasgow Royal Infirmary. This move would deliver improved quality of care by improving access to diagnostic facilities and strengthening integrated working across a range of other services.

Ms Harkness described the formal public consultation and the various meetings and drop-in sessions that had been held. She summarised the themes and issues raised in the consultation reporting that a large majority of responses were opposed to the proposed changes although a small number of responses supported the move of in-patient rehabilitation beds to Stobhill Hospital. Analysis of the written responses and feedback from meetings and drop-in sessions raised the following issues:-

- Valued services and staff – many of the responses praised the quality of care provided by the staff at Lightburn Hospital. The service was clearly valued by respondents.

- Transport and access to hospitals – a large number of responses raised concern about transport and access issues covering visitor access to Stobhill Hospital and out-patient/day hospital access at the large Glasgow Royal Infirmary site.
- Concern for day hospital proposals – despite support in some meetings for a split site option for the day hospital providing some day hospital sessions in alternative NHS premises in the community, written responses were opposed to any transfer of day hospital off the Lightburn Hospital site and opposed to any split site operation of the service.
- Finance – a number of responses expressed a view that the potential for cost savings from the possible closure of the hospital site was driving the changes rather than improving quality of care.
- Concerns for the loss of a hospital in the East End of Glasgow – there was strong feeling that Lightburn Hospital was one of the last hospitals in the East End of Glasgow and that it provided local services to a significantly deprived population. For some people, the hospital provided a focus within the community beyond just the in-patient and out-patient service.
- Decisions had already been made – discussions in some meetings highlighted a perception, by some people, that a decision had already been made by the NHS Board and that people's views would not be listened to.
- Impact for staff – meetings with staff raised a number of issues surrounding the redesign of services in North and East Glasgow including impact on staffing levels and teams, rehabilitation facilities and wards, timescales for change and the HR process and change management.

Ms Harkness explained that the NHS Board's response to comments raised in the consultation had been themed into the six following areas and she summarised these alluding to the NHS Scotland Quality Strategy, which identified three key drivers for the NHS; patient safety, patient centred and clinical effectiveness:-

- Quality of healthcare services
- Transport and access
- Visiting times
- Responding to the health needs of the local population
- Listening to people
- Working with staff
- Finance.

Councillor Handibode understood the arguments made in the NHS Board paper and those presented in response to the consultation. He remained, however, concerned about the transport issues. Ms Harkness agreed that the perception in the local community was that transport did present a significant difficulty. As such, the NHS Board's Community Engagement Team would continue to work with Strathclyde Passenger Transport to take these issues forward. In a further question, Councillor Handibode sought clarity around the savings figure of £650,000 generated if all staff and services were moved from the Lightburn Hospital site. Ms Harkness confirmed that this was indeed the correct savings figure and that the previous figure quoted in the NHS Board paper from 17 August 2010 of £500,000 [Board Paper No. 10/37] did not include depreciation costs.

Mr Williamson commented that the clinical benefits to patients would be unquestionably better particularly as many services, such as diagnostics, could not be carried out at Lightburn Hospital. He was supportive of the proposals and particularly reassured that the Community Engagement Team continued to work with Strathclyde Passenger Transport in an attempt to resolve the local communities concerns.

Councillor Yates understood the passion of people in the area regarding Lightburn Hospital but, given that the proposals afforded better outcomes for patients, was satisfied that they were sound. Councillor Lawson agreed but recorded his concern that the transport problems (which had come up consistently during the consultation period) had not been addressed fully.

Dr Dominiczak agreed with Mr Williamson's earlier points and remarked that the medical/clinical improvements made, should the proposals be approved, could not be understated. She also pointed out that Lightburn Hospital would require so much upgrading, at a significant cost, to ever become a "modern" hospital.

In response to a question about the strategy being subjected to an Equality Impact Assessment (EQIA), Ms Harkness confirmed that it had been through this process as part of the Board's ongoing commitment to understand and tackle inequality. Similarly, the engagement and consultation process had also been subject to two EQIA's, one to design the process and one to review implementation of the consultation process. The EQIAs helped to identify gaps in provision and appropriate solutions.

The Chairman offered Councillors Simpson and McDougall, who had attended to observe the meeting, to make a statement and both re-emphasised the difficulties with public transport in the East of the city and confirmed their opposition to the proposal.

Councillor Handibode and Councillor McColl remained concerned about the transport issues and the fact that the Transport Needs Analysis did not have a clear answer. Given this, it was suggested that any decision be delayed until the transport issues had been resolved. In terms of timing, Mr Calderwood reported that, if the NHS Board approved the proposals, a submission would be provided to the Cabinet Secretary before the end of August 2011. It would then be for the Cabinet Secretary to consider the recommendations before responding to the NHS Board; this stage in the process had no stipulated timeframe. Mr Calderwood referred, however, to Ms Harkness's earlier commitment that ongoing engagement would continue between the NHS Board's Community Engagement Team and Strathclyde Passenger Transport.

Mr Williamson encouraged further promotion of the evening visitor scheme and monitoring of its usage to establish if demand increased. Ms Harkness confirmed that this would be the case.

DECIDED

- That Lightburn Hospital be closed and that in-patient rehabilitation beds be transferred to Stobhill Hospital and day hospital/out-patient services be transferred to Glasgow Royal Infirmary be recommended to the Cabinet Secretary for Health, Wellbeing and Cities Strategy. — **Director of Rehabilitation and Assessment**
- That the recommendations of the Transport Needs Assessment be approved. — " "
- That ongoing engagement, between the NHS Board and Strathclyde Passenger Transport continue in an effort to respond to the communities transport concerns. — " "

Councillor Handibode recorded his dissent from the first decision.

77. WINTER PLAN 2011/12 - PROGRESS REPORT

A report of the Director of Emergency Care and Medical Services [Board Paper No. 11/38] asked the NHS Board to note an update on Winter Planning for 2011/12.

Mr Archibald explained that the 2010/11 Winter Plan for NHS Greater Glasgow and Clyde was developed on a single system basis with all partners in the delivery of key services involved. The system-wide Winter Planning Group and Executive Group (with representation at Senior Level from across the key organisations) ensured a co-ordinated approach to the planning and delivery of services. This was being further developed with the 2011/12 Winter Plan. He confirmed that, since the update report to the NHS Board in February 2011, the Winter Planning Group and Executive Group had continued to meet to progress the winter planning process for 2011/12.

As part of the review nationally of the winter planning processes, all Boards were asked to complete a survey questionnaire on the effectiveness of winter plans. The outcomes of this were presented at the national winter planning event held in June 2011. The main focus of the winter contingency plan dealt with the period November 2011 to March 2012 and, in particular, detailed arrangements for the festive holiday period, 23 December 2011 to 3 January 2012. In planning for winter 2011/12, Mr Archibald reported that the plan would incorporate the lessons learned from 2010/11, along with guidance and outcomes from the national and regional winter planning events.

In response to a question, Mr Archibald reported that the Winter Plan had seven key areas that described the contribution each partner agency would make to deliver an efficient and effective Winter Plan. He summarised these as follows:-

- Primary Care/General Practice
- Primary Care Out-of-Hours/NHS 24
- Acute Services
- Local Authorities
- Scottish Ambulance Service
- Whole system monitoring reporting and escalation
- Communication.

Detailed plans would be developed separately by each agency and a summary of these would be incorporated into the NHS Board-wide Winter Plan. The Winter Planning Group would continue to monitor this at the monthly planning meetings where main action areas included communication, information sharing, escalation plan/senior decision making rota, occupational health, public holidays and innovation.

In preparation locally, a winter planning meeting would be held at the end of August 2011 to ensure all partners had, in place, their Winter Planning processes for 2011/12. Following the regional event, amendments would be made, as appropriate, and the Winter Plan would be considered by both the Winter Planning Group and Executive Group before submission to the NHS Board in October 2011 for formal approval.

NOTED

78. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer (Acute Services Division) [Board Paper No. 11/40] asked the NHS Board to note progress against the national targets as at the end of April 2011.

Mrs Grant led the NHS Board through the report highlighting the actions being taken to deliver the waiting times and access targets. She referred to the new format of the report which, rather than reporting on individual stages of treatment targets, would now report against the 18 week Referral to Treatment (RTT) target, along with the 12 week national backstop guarantee for in-patients/day cases. This new format would advise of the monthly position being achieved by the NHS Board and would replace the stage of treatment format previously used.

The national target required the NHS Board to deliver 90% combined admitted/non admitted performance within 18 weeks by 31 December 2011.

Mrs Grant explained that within NHS Greater Glasgow and Clyde, this measurement process had essentially been manual in nature and was extremely complex relying on significant interpretation of data. Efforts over recent months would see the evolution of interim IT solutions being deployed across North and South Glasgow sectors, along with Yorkhill to improve pathway "linkage" and, therefore, more robust analysis, until the new patient management system was fully implemented. In Clyde, the patient management system roll out would take place prior to December 2011 and linkage there would be addressed through that route.

Mrs Grant explained that there were two main components which were routinely assessed in relation to the 18 week RTT standard as follows:-

- Combined admitted/non admitted performance – this measure outlined the NHS Board's performance against the agreed trajectory for both the admitted and non admitted pathways. The NHS Board was currently achieving 88% performance against an agreed trajectory of 81%, as an interim target towards delivery of the 90% position by December 2011.

- Linked Pathways – this was a measure of the percentage of patients where their total pathway was being linked at present. The NHS Board had achieved June's performance trajectory, however, there was significant complexity involved in improving performance for this key performance indicator due, in part, to the NHS Board's status as a tertiary provider for other NHS Boards and the cross boundary referral that occurred. Work continued nationally to develop more robust inter-Board processes to allow appropriate pathway linkage to be facilitated.

The national "stage of treatment" backstop guarantee of 12 weeks for in-patient and day cases had been met for all available patients. With the exception of orthopaedics, all specialties continued to meet the NHS Greater Glasgow and Clyde target of 10 weeks for new out-patients and eight weeks for in-patients and day cases. Orthopaedics remained within the maximum waiting of 12 weeks for out-patients and 12 weeks for in-patient/day cases. Mrs Grant led the NHS Board through the remaining measured waiting times including accident and emergency, cancer, chest pain, stroke and delayed discharges.

In response to a question from Mr Daniels concerning linked pathways, Mrs Grant reported that patients referred for more than one illness were measured separately in that each pathway was measured and recorded.

With regard to the measurement of delayed discharges, Mrs Grant explained that both the number of bed days and the number of patients were recorded. Mr Calderwood added that a ministerial task-force was currently debating how best delayed discharges should be measured and guidance was expected in late September/October 2011.

Mr Williamson was pleased to note the NHS Board's performance so far and the excellent progress made to reach the December 2011 targets. In response to his question regarding quality assurance, Mrs Grant outlined the process used.

Mrs Spencer noted some of the improvement work currently being driven on a site basis to drive change and improvement on the delivery of unscheduled care. She asked about the extended role of community support teams in facilitating earlier discharge of patients. Mrs Grant explained that much of this work surrounded the identification of patients (at appropriate times) to ensure community support teams had timely access to their needs.

NOTED

79. FINANCIAL MONITORING REPORT FOR THE 3 MONTH PERIOD TO 30 JUNE 2011

A report of the Director of Finance [Board Paper No. 11/41] asked the NHS Board to note the financial performance for the first three months of the financial year.

Mr James explained that the NHS Board was currently reporting an expenditure outturn £2.5m in excess of its budget for the first three months of the year. At this stage, the NHS Board considered that a year end breakeven position remained achievable.

The assessment was that expenditure was running between £1.2m and £1.3m behind its year to date cost savings target. Achieving the NHS Board's savings target of £57m for 2011/12 would be a key factor in determining whether the NHS Board would achieve a breakeven outturn for the year. In this regard, Mr James explained that, during the next few weeks, the NHS Board would work to confirm the extent to which its Acute Division and other Directorates could offset additional expenditure against budget through earlier implementation of existing cost reduction/cost saving measures. This work would be completed by the mid year point so that the NHS Board was able to assess, at that stage, whether it remained on track to deliver a breakeven outturn for 2011/12. Mr James explained, however, that it was assumed that the NHS Board would be able to identify and implement any necessary measures and reports to the Scottish Government Health Directorate and would, at this time, continue to forecast a breakeven outturn for 2011/12.

Mr Lee was pleased to note the NHS Board's progress at this time of the year. He asked about the challenge of meeting the Vale of Leven Public Inquiry legal costs and wondered how much this would total. Mr Calderwood responded by confirming that the NHS Board had an obligation to support the Inquiry and to be legally represented while it met. This would be an ongoing commitment during 2011/12.

NOTED

80. ANNUAL LOCAL SUPERVISING AUTHORITY MIDWIFERY OFFICER (LSAMO) REPORT 2010/11

A report of the Board Nurse Director/Supervising Authority Midwifery Officer [Board Paper No. 11/42] asked the NHS Board to note the Annual Nursing and Midwifery Council (NMC) Local Supervising Authority (LSA) report for 2010/11.

Ms Crocket explained that it was the responsibility of each NHS Board (LSA) to ensure that it complied with the LSA standards and that the activities of the Supervisors of Midwives were such that they promoted safe and high quality of care for women and their babies, achieved through a robust system of monitoring standards of midwifery practice and by actively promoting a safe standard of midwifery practice.

Ms Bronsky reported that the NHS Board had discharged its responsibility, in part, through the joint appointment of a single Local Supervising Authority Midwifery Officer (LSAMO). She highlighted the main points of activity as undertaken through the Statutory Supervision of Midwives during the practice year 1 April 2010 to 31 March 2011. In particular, she drew members attention to the evidence which demonstrated how NHS Greater Glasgow and Clyde had achieved compliance with the 54 standards as set within the NMC Midwives Rules and Standards (2004). The full report prepared by the LSAMO would now be submitted to the NMC for their scrutiny. During the coming year, the LSAMO would continue to work closely with maternity services to support the ongoing compliance with the 54 standards ensuring they were integral to provision.

In response to a question from Mrs Spencer concerning audit outcomes, Ms Bronsky confirmed that these would be available in future years reports.

Mr Robertson asked about one of the findings from the audit visit undertaken in March 2011 around little evidence of service user involvement in the Statutory Supervision Framework. Ms Bronsky highlighted that she was aware focus groups were being held with maternity users and this improvement would be reported in next year's annual report.

NOTED

81. 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. 11/43] asked the NHS Board to 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 one Medical Practitioner listed in the NHS Board paper for the purposes of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003 be approved.

Director of Public Health

82. AREA CLINICAL FORUM MINUTES: 2 JUNE 2011

The Minutes of the Area Clinical Forum meeting held on 2 June 2011 [ACF(M)11/03] were noted.

NOTED

83. PHARMACY PRACTICES COMMITTEE MINUTES: 16 JUNE 2011

The Minutes of the Pharmacy Practices Committee meeting held on 16 June 2011 [PPC(M)11/11] were noted.

NOTED

84. AUDIT COMMITTEE MINUTES: 21 JUNE 2011

The Minutes of the Audit Committee meeting held on 21 June 2011 [A(M)11/05] were noted.

NOTED

85. QUALITY AND PERFORMANCE COMMITTEE MINUTES: 5 JULY 2011

The Minutes of the Quality and Performance Committee held on 5 July 2011 [QPC(M) 11/01] were noted.

NOTED

86. PROPERTY ASSESSMENT MANAGEMENT STRATEGY (PAMS)

A report of the Director of Facilities [Board Paper No. 11/39] asked the NHS Board to note the Property Asset Management Strategy 2011-2016 as submitted to the Scottish Government Health Directorate.

Mr McIntyre explained that the Scottish Government Health Directorate's Property Management Policy (MEL)(1994) 44 required that all NHS Board's had property strategies and that these were reviewed annually.

Mr McIntyre reported that this was the first such document in NHS Greater Glasgow and Clyde and it was the combination of both physical site surveys and desktop reviews. The document was, however, a "live" document and would be continually reviewed and updated by the property team.

Mr McIntyre led the NHS Board through the report highlighting the ongoing investment in new and refurbished facilities for the Acute, Mental Health and Community Service Strategies and the positive impact in real time (and in the near future) these initiatives were having on the physical estate owned and leased or operated by the NHS Board. Although the present investment would significantly improve the asset base, there remained a challenge to ensure that all premises continued to meet current legislation standards and provide positive environments for the delivery of patient care.

The PAMS documentation would, therefore, be a key element used in determining future capital investment strategies by the NHS Board and the Scottish Government Health Directorate.

In response to a question from Mr Daniels regarding the backlog maintenance figure, Mr McIntyre reported a realistic figure of £98m (of which £71m was considered high priority in the context of risk profiled backlog maintenance) had been estimated. He was hopeful that this should marginally improve in 2013 when detailed surveys of all health and safety matters would be completed.

Mr Winter welcomed this illustration of the Board's property assets. He asked how such information was collated with community services. Mr Calderwood confirmed that each CHP/CHCP has been asked to provide an estates strategy for 2011/12. Following receipt of these, the NHS Board's strategic direction for property would be clearer.

In respect of a question, Mr Calderwood reported that modernisation of GP premises was undertaken within the auspices of the modernisation fund and, as a Board, there were limited steps to influence how these funds were allocated.

Given the depth of interest and discussion around this paper, it was agreed that members would benefit further from an in-depth seminar session to understand more fully the strategy. This was particularly welcomed as Mr Calderwood reported that all Public Sector organisations had been asked to compile a Property Asset Management Strategy and it would be the NHS Board's intention to align this with Local Authority partners' strategies at a future date.

Head of Board Administration

DECIDED

- That the NHS Greater Glasgow and Clyde Property Management Strategy 2011/2016 be noted.

- That a seminar session be arranged to discuss this in further detail.

Head of Board Administration

The meeting ended at 12:45 p.m.