

GGNHSB(M)02/11
Minutes: 109 - 122

GREATER GLASGOW NHS BOARD

**Minutes of a Meeting of the
Greater Glasgow NHS Board
held in the Board Room, Dalian House,
350 St Vincent Street, Glasgow
on Tuesday 22 October 2002 at 9.30 am**

P R E S E N T

Professor G C A Dickson (in the Chair)

Mr J Best	Mr T A Divers OBE
Dr H Burns	Councillor R Duncan
Mr R Calderwood	Mr W Goudie
Mr R Cleland	Dr R Hughes
Ms R Crocket	Dr F Marshall
Mr T Davison	Councillor D McCafferty
	Mrs E Smith

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

Dr A Bryson	Medical Director, Beatson Oncology Centre (to Minute 123)
Ms S Dean	Press Officer
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Mr J M Hamilton	Assistant Director of Finance
Mr A Lindsay	Head of Control and Support Services (from Minute 113)
Ms C Renfrew	Director of Planning and Community Care
Mr I Reid	Acting Chief Executive, Greater Glasgow Primary Care NHS Trust
Mr J Whyteside	Communications Manager

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

Dr F Angell	Chair, Area Dental Committee
Mr P Hamilton	Convener, Greater Glasgow Health Council
Ms M Nutter	Representative, Area Professionals Allied to Medicines Committee (AHPS)

G U E S T P R E S E N T E R S - N H S 2 4 (T O M I N U T E N O 1 1 1)

Ms C Campbell	Regional Project Manager for the West
Ms C Lenihan	Chairman
Ms E Muir	Deputy Director of Nursing
Ms M Regan	Director of Communications
Dr B Robson	Medical Director

109. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Councillor D Collins, Professor M Farthing, Councillor John Gray, Councillor J Handibode, Mrs W Hull, Mrs S Kuennsberg CBE, Mr A O Robertson, Mrs C Anderson (Chair, Area Pharmaceutical Committee), Ms E Borland (Acting Director of Health Promotion), Mr J Cassidy (Chair, Area Nursing and Midwifery Committee), Mr E P McVey (Chair, Area Optometric Committee), Dr J Nugent (Chair, LHCC Professional Committee), Ms S Plummer (Nurse Adviser to the Board) and Mr H Smith (Chair, Area Paramedical Committee).

The Chairman welcomed Mr Ian Reid, Acting Chief Executive of Greater Glasgow Primary Care NHS Trust to his first NHS Board meeting. He also welcomed the guest speakers from NHS 24.

110. MINUTES

On the motion of Mr J Best, seconded by Mr R Calderwood, the Minutes of the meeting of the NHS Board held on Tuesday 17 September 2002 [GGNHSB(M)02/10] were approved as an accurate record and signed by the Chairman pending the following amendment:

- The addition of Councillor D McCafferty to the list of Board Members present.

NOTED

111. NHS 24 PRESENTATION

Dr Brian Robson, Medical Director, NHS24, described the new clinical service for Scotland in terms of improved access to health information via telephone nurse consultations. There were three leading edge contact centres in Scotland – in Aberdeen, Clydebank and South Queensferry.

NHS 24 was not a replacement of any health service but a complementary service which was convenient to patients, equitable across Scotland and provided 24 hours a day. This provided an opportunity for people to get the most appropriate care maximizing the use of other health professionals (for example pharmacy) and reducing inappropriate workload on the NHS.

Dr Robson referred to the experience gained in Grampian where the service was provided to 575,000 people in urban, remote and rural areas. Much of the success of NHS 24 in Grampian could be attributed to the joint working between G-DOCS (the equivalent of Greater Glasgow's GEMS), Scottish Ambulance Service, two A & E Departments and 20 community hospitals. The centre received, on average, around 2,000 calls per week – 98% of which are answered in less than 30 seconds. The average call duration was 12 minutes and the outcome for out of hours calls could be broken down as follows:

- 3% referred to the Scottish Ambulance Service
- 6% referred to an A & E
- 60% referred to the GP G-DOC service

Dr Robson described how the service would work in Greater Glasgow by highlighting the following:

- night-time – all calls directed previously to GEMS would automatically be answered by NHS 24;
- day-time – people should still contact their GPs as normal;
- additional capacity – NHS 24 would bring an additional capacity of a 24 hour nurse consultation service and health information service.

In terms of working with NHS Greater Glasgow, Dr Robson confirmed that partnership working had taken place with GEMS, the Scottish Ambulance Service, Acute Services, Accident & Emergency, Primary Care and Dentistry in an effort to maximise benefit to patients. It was their intention to continue such close working with NHS Greater Glasgow when NHS 24 went live mid November. Prior to the service getting up and running, they were working on promoting public awareness and understanding of the service and this would be done via TV and radio advertisements as well various posters and leaflets distributed throughout the city. Dr Robson thanked NHS Greater Glasgow for its support, commitment and hard work, making it possible to launch NHS 24 in Glasgow in November 2002.

Professor Dickson thanked Dr Robson and his team for an interesting and informative presentation.

Mr P Hamilton asked how seamless the transfer would be from GEMS to NHS 24. Dr Robson confirmed that both GEMS and NHS 24 were committed to providing a seamless transfer and that members of the public would be informed via publicity campaigns that, out of hours, all their calls would be answered by NHS 24. Given that Dr Robson had referred to the average call duration time being 12 minutes, he further clarified that the centre would not operate to a “target call time” – there was a detailed system of questioning which would be tailored to fit the needs of individual calls regardless of how long they may take. Ms Regan highlighted the experiences learned from the introduction of the service in NHS Grampian in terms of communicating with the whole population including ethnic communities, deaf communities and raising awareness amongst the visually impaired. She was confident that given the NHS Grampian experiences this would be a smooth transitional phase in Greater Glasgow.

Professor Dickson referred to the valued relationship Greater Glasgow NHS Board had with Greater Glasgow Health Council and encouraged NHS 24 to build on this good relationship in Glasgow in terms of communicating with users of the service. Ms Regan confirmed that NHS 24 had already met with Greater Glasgow Health Council and would most definitely continue this dialogue.

In response to a question from Councillor McCafferty, Mrs Muir confirmed that the skill mix of nurses was very broad based and incorporated into their core training was dealing with mental health issues and critical decision making skills. Furthermore, referral of mental health issue related calls could be handed over to community psychiatric nurses (CPNs).

Dr Hughes voiced concern regarding the impact of nurse recruitment to NHS 24 from the acute sector. Mrs Muir advised that two-thirds of NHS 24's nursing staff had already been recruited and recognized that 51% of these nurses had come from the acute sector – this was largely due to their appointment criteria which stipulated that nurses should have at least five years general nursing experience.

In response to a question from Dr Marshall, Ms Regan confirmed that NHS 24 would provide a “call back” system in the event of patients calling from pay phones or mobile phones.

Professor Dickson and the Board looked forward to these services going live in Greater Glasgow in November and wished the team well for the challenges that lay ahead.

NOTED

112. BEATSON ONCOLOGY CENTRE – AN UPDATE OF ACTION PLAN

A report of the Chief Executive [Board Paper No 02/67] was submitted asking the Board to note the update of progress in implementing the action plan and to authorise production of a further quarterly update for the January 2003 Board.

Mr Divers referred to the detailed update of progress attached at Annex 1 of the Board paper. He led the Board through the key areas of development and introduced Dr Adam Bryson, Medical Director, Beatson Oncology Centre.

An interview date would be set for November 2002 with a view to filling the appointment of Medical Director. There had been a strong UK wide and international interest in this post. The overall staffing position within the Beatson Oncology Centre continued to improve with the total number of staff projected to be in post at 4 November 2002 being 439.78 WTE, some 73.14 WTE higher than the position at January 2002. Significant pressure continued on Consultant Clinical Oncologist staffing, however, with no applications received in response to the further recruitment exercise undertaken during the summer. Efforts continued to identify potential applicants for Consultant Oncologist vacancies through local and international recruitment agencies.

Work on the West of Scotland Plan for Specialist Oncology Services progressed materially during the last four months. The process completed its first stage in June 2002 and on the basis of that work, proposals for the future pattern of Specialist Oncology Services across the West of Scotland had now been shared with each NHS Board. Discussion would be ongoing so that a future pattern of Specialist Oncological care could be finalized by the target date of 1 April 2003.

The Phase II Business Plan Development was one of the first three critical projects in implementing the Board's Acute Services Strategy. As such, a final review of the project's scale and affordability (alongside the development of the two Ambulatory Care Hospitals) was in progress. The Board required to be assured that all three projects remained affordable and deliverable within the timescale set out in the Board's Acute Services Plan.

Dr Bryson highlighted other key areas of progress including the following:

- Meetings had taken place with site management tumour teams to move towards greater comprehensive use of IT.

ACTION BY

- Additional revenue requirements for April 2003 had been calculated in relation to the funding provided to address the deficits in staffing, facilities and other resources.
- Beatson Oncology Centre was continuing to actively recruit, retain and provide continuing personal development programmes for staff.
- Work was ongoing in the production of an education strategy.
- Significant progress had been made on producing a comprehensive IT strategy. This was being developed to ensure that the move to the new Cancer Centre in four years time would facilitate the IT strategy.

In response to a question from Dr Hughes, Dr Bryson recognised that Consultant Clinical Oncologists were still working under pressure, taking on 450 new patients per annum per Consultant (the guidelines were 320 new patients). While this was not out of step with some other parts of the UK the pressures remained material.

Dr Bryson recognised the importance of demonstrating to potential candidates that the Beatson Oncology Centre was an attractive place to work and was reassured that out of the two appointment panels conducted for Oncologists at the Beatson, successful appointments had been made. This point was re-iterated by Councillor McCafferty who highlighted the importance of being self-analytical and being more innovative in encouraging applicants to come to Glasgow as a career move. This had to be seen in the backdrop of there being a shortage nationally of Consultant Clinical Oncologists.

In a response to a question from Mr P Hamilton, Dr Bryson confirmed that ongoing training was being given to developing management arrangements and skills and the Beatson Oncology Centre was working hard to improve its management structure.

Dr Burns referred to a visit carried out at the Beatson Oncology Centre by Cancer Research UK – it had given the highest possible grading to the Beatson Oncology Centre for quality of service in science and such academic developments were very positive and encouraging.

Mr Cleland sought clarity around the timescales for the development of the project involving the Phase II development of the Beatson Oncology Centre and the two Ambulatory Care Hospitals. Mr Divers confirmed that the next Acute Services Steering Group meeting was scheduled for the following week when Members would be looking at the totality of the plan and taking stock and revisiting the overall financial framework.

Professor Dickson thanked Dr Bryson for an encouraging update report and once again highlighted the importance of making Glasgow, in general, an attractive career option for both medical and nursing posts.

DECIDED:

- That the update of progress in implementing the action plan be noted.
- That a further quarterly update of the action plan be submitted to the Board meeting in January 2003.

Chief Executive

Chief Executive

113. WINTER PLAN 2002/2003

A report of the Director of Planning and Community Care [Board Paper No 02/68] was submitted summarizing the Winter Plan 02/03 and asking the Board to note the proposed resource allocation and areas of risk and pressure.

Ms Renfrew explained that each local health system was required to submit a Winter Plan to the Scottish Executive by the end of October 2002. The key objectives of winter planning were to ensure that:

- Patients could be admitted through assessment facilities to a bed in the appropriate specialty.
- Long delays for patients waiting for admission from Accident and Emergency were avoided.
- Restrictions on admissions to hospitals were minimised.
- Transfer of patients between intensive care facilities was minimised.
- Flu vaccination among vulnerable patients and staff was maximised.
- Appropriately rapid discharge and alternatives to admission, where appropriate, were achieved.
- Elective activity was maintained.

The development of plans to deliver on these objectives had two elements of process.

- Each Trust had its own Winter Planning Group, bringing together the key players, including Social Work and the Ambulance Service.
- A Greater Glasgow Winter Planning Group brought together the Chairs of Trust Groups with the Planning Directorate.

The Scottish Executive Health Department had traditionally allocated non recurring funding for winter pressures and the Board had been notified at the end of September 2002 of an additional £2.3M allocation – the allocation of which had already been endorsed by the Winter Planning Group. These resources were in addition to allocations of £600K and £400K to the North and South Trusts, respectively, made from the Board's additional delayed discharge funding. The planned allocation of additional funding from the delayed discharge monies, at the start of the year, coupled with the rapid release of the Scottish Executive's non recurring allocation against identified Trust priorities, had put the Board in the best possible position to address anticipated winter pressures.

In response to a question from Dr Hughes, Mr Divers confirmed that the Business Plan for the Glasgow Royal Infirmary, ICU development and, in particularly, the capital planning of this was a strategic priority.

In response to a question from Dr Marshall, Ms Renfrew confirmed that joint planning had taken place with the formation of the winter plan and Social Services were committed to its execution. This demonstrated integrated team working and joint team endeavours.

ACTION BY

DECIDED:

- That the Winter Plan 2002/2003 be noted.
- That the proposed resource allocation and areas of risk and pressure be noted.

**Director of Planning
& Community Care**

**Director of Planning
& Community Care**

114. GEOGRAPHICAL INEQUALITIES IN ACCESS TO CORONARY ANGIOGRAPHY

A report of the Director of Public Health [Board Paper No 02/69] was submitted asking Members to note the geographical equity of access to elective coronary angiography.

Coronary angiography was used to assess the severity of coronary artery disease so that informed decisions could be made about whether a patient required coronary revascularisation and whether this should be done by cardiac surgery or balloon angioplasty. In 1995/96, the Board demonstrated inequalities in access to coronary angiography across Glasgow with no obvious correlation between need and investigation. Furthermore, some areas with the highest risk of death from ischaemic heart disease had the lowest coronary angiography rates. As a direct result of this survey, additional resources were provided to Trusts to increase coronary angiography capacity. GPs were also encouraged to refer patients with CHD for investigation.

The survey was repeated using data from 1999 to demonstrate whether inequalities had reduced. In this survey, angiography was equitably distributed in relation to need.

Dr Burns highlighted four key conclusions.

- In 1995/96, access to coronary angiography was unequal and bore little relation to apparent needs. There was evidence of the inverse care law whereby those with greatest need were least likely to be investigated and, therefore, considered for coronary revascularisation.
- Across Greater Glasgow as a whole, the overall number of coronary angiograms had increased. This was in line with trends in other areas in Scotland and the rest of the UK.
- Targeted provision of resources and encouraging GPs to refer appropriate patients had achieved the desired effect of reducing inequalities in investigation.
- The overall increase in numbers and greater equality had not been achieved at the expense of waiting times – waiting times were now all within the twelve week maximum recommended by the Scottish Executive and most patients wait considerably less than twelve weeks.

In response to a question from Mr P Hamilton, Dr Burns confirmed that the figures used had been based on those patients attending the Western Infirmary and Glasgow Royal Infirmary. Figures were not used from the HCI and Ross Hall Hospitals as the majority of referrals were made, in Glasgow, to the Western Infirmary and Glasgow Royal Infirmary.

Dr Marshall commended the Chronic Disease Management Teams who had also worked hard, in parallel, to get rapid access teams in place throughout the city.

NOTED

115. COMMUNICATING THE ACUTE HOSPITAL SERVICES STRATEGY

A report of the Interim Chairman and Public Affairs Manager [Board Paper No 02/70] was submitted asking the Board to consider the issues and outcome from the Board Seminar workshop of 1 October 2002 and discuss whether there was scope to add more to the outline proposals that emerged. Furthermore, a communication strategy would be built and reported to the Board with certain aspects of it commencing immediately.

The Interim Chairman had hosted a Board Seminar workshop on 1 October communications on the Acute Services Strategy. This was seen in light of the £700M major programme over a ten year period to improve health care provision in Greater Glasgow and how best to inform and include members of the public in these changes.

Discussion had surrounded proposals to address each of the key groups with whom the communication was necessary:

- NHS Greater Glasgow's staff
- The general public
- Elected representatives
- The media

Councillor McCafferty re-iterated that the Board should genuinely try to involve people as the strategy unveiled. Given the ten year timescale, things may invariably not go as planned and it was important to be honest about wrong judgments as well as good ones – transparency, openness and honesty must be at the forefront of any communication strategy.

Ms Nutter sought inclusion of mention of the peripheral sites which formed part of the Trusts rather than simply referring to the Trusts by name.

Mr P Hamilton asked that the Board consider naming spokespeople when addressing the media rather than using the terms currently used - "spokesman/spokesperson".

Professor Dickson agreed to consider these points.

DECIDED:

That the issues and outcome from the Board Seminar workshop of 1 October 2002 be noted and the further points highlighted above be considered, and key elements be commenced immediately with the finalised Communication Plan being reported to the Board.

**Interim Chairman/
Public Affairs
Manager**

116. DISPOSAL OF LAND AT THE FORMER LENNOX CASTLE HOSPITAL

A report of the Chief Executive of Greater Glasgow Primary Care NHS Trust [Board Paper No 02/71] asked the Board to endorse the Greater Glasgow Primary Care NHS Trust's proposal to enter into an agreement with East Dunbartonshire Council and Lennoxtown Initiative in relation to the disposal of the Trust's landholding at the former Lennox Castle Hospital, Lennoxtown.

Professor Dickson outlined the Board's responsibility which was a governance role in satisfying itself that procedures had been complied with and the risks that had been considered were acceptable.

Mr Davison highlighted this proposal as a further example of partnership working involving a community led initiative alongside the NHS and the Local Authority which could achieve significant benefits. The NHS would benefit from minimizing the risks associated with a large vacant hospital site, participating in the re-investment and regeneration of a local community who had been dependent for many decades on the NHS for economic investment in the area and providing a capital receipt for the replacement of outdated existing facilities in Lennoxtown.

Councillor Duncan confirmed that residents and East Dunbartonshire Council welcomed this arrangement.

DECIDED:

That Greater Glasgow Primary Care NHS Trust's proposal to enter into an agreement with East Dunbartonshire Council and Lennoxtown Initiative in relation to the disposal of the Trust's landholding at the former Lennox Castle Hospital, Lennoxtown was in accordance with existing procedures and the necessary risks had been considered.

**Chief Executive,
Greater Glasgow
Primary Care NHS
Trust**

117. WAITING TIMES

A report of the Director of Planning and Community Care [Board Paper No 02/72] was submitted asking the Board to note progress on waiting time targets and to further note a draft reply to the Minister for Health confirming that waiting times were regarded as a very high priority.

September figures illustrated a small reduction at Yorkhill and the Acute Trusts, but significant reductions were required to meet the 2002 targets. It was anticipated the additional planned activity should begin to have an impact on this and Trusts were reviewing the durability of the December targets.

Professor Dickson highlighted one additional sentence to the draft letter to the Minister for Health and Community Care which reinforced the potential impact of current pay negotiations.

NOTED

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

A report of the Director of Public Health [Board Paper No 02/73] was submitted seeking approval of one medical practitioner employed by Greater Glasgow Primary Care NHS Trust to be authorized for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984.

DECIDED:

That the following medical practitioner be authorized for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984:

**Director of Public
Health**

Dr Kim Lim

119. 2002/03 FINANCIAL MONITORING REPORT FOR FIVE MONTHS ENDED AUGUST

A report of the Director of Finance [Board Paper No 02/74] asked the Board to note the results reported for the first five months ended 31 August 2002.

Mr J M Hamilton advised that Trusts were reporting a £241K deficit against the break-even target for the five months to August, against a planned surplus of £187K. Given the degree of risk inherent in Trust startpoint revenue allocations, the results for the first five months were encouraging.

Councillor McCafferty sought clarification on whether the underspend on staff salaries was part of a deliberate strategy. Mr Hamilton advised that no strategy existed and the underspends related to the difficulty in filling vacancies, particularly in nursing.

NOTED

120. GREATER GLASGOW NHS BOARD CORPORATE GOVERNANCE FRAMEWORK

A report of the Chief Executive, Director of Finance and Head of Board Administration [Board Paper No 02/75A] was submitted inviting Members to approve the documentation that made up the Corporate Governance Framework and agree that this was reviewed and submitted to the NHS Board annually in March.

The Audit Committee had held a workshop and a formal meeting on 1 October 2002 to discuss the Corporate Governance Framework. The Board papers had been revised to take account of the suggestions made at the workshop and the Audit Committee meeting. The Audit Committee, therefore, recommended the adoption of the following documents by the NHS Board:

- Standing Orders for the Proceedings and Business of the NHS Board.
- Committee Arrangements and Remits.
- Decisions Reserved for the NHS Board
- Ethical Standards in Public Life – Code of Conduct for Members.

ACTION BY

- Register of Board Members' Interests.
- Standards of Business Conduct for NHS Staff
- Standing Financial Instructions
- Fraud and Corruption Response Plan
- Diary of Governance Events

The Board was additionally asked to note Declarations of Interest made by Members.

DECIDED:

1. That the Declarations of Interest made by Members be noted and form part of the Board Minute as an Appendix.
2. That the following documents be adopted by the Board:
 - Standing Orders for the Proceedings and Business of the NHS Board
 - Committee Arrangements and Remits
 - Decisions Reserved for the NHS Board
 - Ethical Standards in Public Life – Code of Conduct for Members
 - Register of Board Members' Interests
 - Standards of Business Conduct for NHS Staff
 - Standing Financial Instructions
 - Fraud and Corruption Response Plan
 - Diary of Governance Events

**Head of Board
Administration**

**Head of Board
Administration**

121. RISK MANAGEMENT STRATEGY

A report of the Director of Finance [Board Paper No 02/75B] asked that the Board approve the Risk Management Strategy. This set out the Strategy of Greater Glasgow NHS Board for the management of risk. Implementation of the Strategy would allow the development of a co-ordinated and effective risk management programme for all services and activities. The NHS Board believed that by approaching the management of risk in a strategic and organised manner, the implications of risk could be reduced to an acceptable level.

Mr Goudie asked that on page 82 of the Board papers, paragraph 2.2, the series of bulletpoints highlighting the areas which the Board is required to focus on included "Organisational Development".

Director of Finance

DECIDED:

That the Risk Management Strategy be approved.

Director of Finance

122. MINUTES OF AUDIT COMMITTEE

The Minutes of a meeting of the Audit Committee [A(M)02/4] held on Tuesday 1 October 2002 were noted.

Meeting ended at 11.25 am