GGNHSB(M)03/1
Minutes: 1 - 12

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 21 January 2003 at 9.30 am

P R E S E N T

Professor Sir John Arbuthnott (in the Chair)

Mr J Best	Professor M Farthing
Dr H Burns	Mr W Goudie
Mr R Calderwood	Councillor J Gray
Ms R Crocket	Councillor J Handibode
Mr T Davison	Dr R Hughes
Professor G C A Dickson	Mrs W Hull
Mr T A Divers OBE	Mrs S Kuenssberg CBE
Councillor R Duncan	Mr I Reid
Mr A O Robertson OBE	

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

Ms S Dean	Press Officer
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Mr A McLaws	Director of Corporate Communications
Mr J Whyteside	Public Affairs Manager

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

Ms M T Hosey	Vice Chair, Area Dental Committee
Mr P Hamilton	Convener, Greater Glasgow Health Council
Dr J Nugent	Chair, LHCC Professional Committee
Mr H Smith	Chair, Area Allied Health Professions Committee

ACTION BY

1. APOLOGIES

Apologies for absence were intimated on behalf of Mr R Cleland, Councillor D Collins, Dr F Marshall, Councillor D McCafferty, Mrs E Smith, Ms E Borland (Acting Director of Health Promotion), Ms S Plummer (Nurse Adviser to the NHS Board), Ms C Renfrew (Director of Planning and Community Care), Mrs C Anderson (Chair, Area Pharmaceutical Committee), Dr F Angell (Chair, Area Dental Committee), Mr J Cassidy (Chair, Area Nursing and Midwifery Committee) and Mr E P McVey (Chair, Area Optometric Committee).

ACTION BY

2. CHAIRMAN'S REPORT

The Chairman updated on the following events which had occurred since the last NHS Board meeting:

(a) The publication of the NHS White Paper was due to be issued around 20 February 2003. It was not clear what the content would be although he surmised that the performance element of NHS Boards would be further enhanced to make them more accountable for all parts of the NHS within its area. He was attending a meeting with the Minister of Health and Community Care and NHSScotland Chief Executive on Friday 24 January when the document's content may become clearer. Nonetheless, he was keen that an away day be arranged for NHS Board Members following the White Paper's publication to discuss taking its implications forward. **Head of Board Administration**

(b) A national agreement on low pay had been concluded with UNISON's Scottish branches overwhelmingly accepting the terms. The Chairman thanked, in particular, Gerry Marr and Robert Calderwood for their intensive discussions in taking forward the resolution. As yet, the cost implications had not been finalised but given that it was a national issue, guidance was awaited on how this would be handled. It was understood that the main heads of the agreement would be backdated to 1 December 2002.

(c) Confirmation of the following Trustee re-appointments to the NHS Trusts in NHS Greater Glasgow:

North Trust	John Bannon and Ian Irvine (both from 1 February 2003 – 31 January 2005)
South Trust	Agnes Stewart (from 1 February 2003 – 31 January 2005)
Primary Care Trust	Bob Winter and Charles Scott (both from 1 February 2003 – 31 January 2005)
Yorkhill	Hazel Brooke and Asif Haseeb (both from 1 April 2003 – 31 March 2005)

John Thomson, Trustee, South Trust retired on 31 January 2003, and the Chairman thanked him for his contribution to NHS Greater Glasgow over the years of his appointments.

Two NHS Board Members, namely Professor Gordon Dickson and Dr Fiona Marshall were retiring at the end of February 2003 and a selection process was underway to seek replacements.

(d) Following his attendance at the Staff Governance Committee meeting on 3 December 2002, he was keen that the Employee Director explained to Members at the next NHS Board meeting the responsibilities of the Committee and the functions and structures in place to bring about an improvement in the management of staff. **Employee Director**

NOTED

ACTION BY

3. CHIEF EXECUTIVE'S UPDATE

Mr Divers updated the NHS Board on the following issues:

(a) Referring back to the Chairman's update on the low pay agreement, Mr Divers acknowledged the move to the implementation phase – Scotland-wide. In general terms, the Area Partnership Forum would look broadly at pay and conditions issues and associated prioritisation in accordance with the Board's overall financial plan.

(b) In referring to the NHS Board Action List and in particular to waiting times and the information showing the spread of delivery where treatments were being carried out – Mr Divers confirmed that progress was underway to establish this retrospectively and as a forward look; as soon as the analysis was complete, this information would be made available to Board Members and others participating in the Board meeting. **Chief Executive**

(c) In connection with implementing the Acute Services Review, a further quarterly update report was due to be considered at the February 2003 NHS Board meeting. The Ambulatory Care Hospital (ACAD) Business Cases had been submitted to the Scottish Executive Health Department to be considered by their Capital Investment Group.

The West of Scotland Planning Group would consider the Business Case for the Beatson Oncology Centre at its meeting scheduled for 27 January 2003 – thereafter this would be submitted to the Scottish Executive Health Department in February. Professor Alan Rodger, the Beatson Oncology Centre's newly appointed Medical Director would be at this meeting.

A Head of Community Engagement had been appointed and was likely to take up post late March 2003.

The Board had been asked by the Deputy Minister of Health and Community Care to establish two monitoring groups; one looking at core acute medical services at Stobhill Hospital and the other looking at core acute medical services at the Victoria Infirmary. Mr Divers would report progress at the February Board meeting on these groups. **Chief Executive**

Bevan Ashford and Shepherd Wedderburn had been appointed as Legal Advisers supporting the implementation of the Acute Services Review. Interviews for the Financial Advisers were scheduled to be held on 21 February 2003.

NOTED

4. MINUTES

On the motion of Mr A O Robertson, seconded by Mr J Best, the Minutes of the meeting of the NHS Board held on Tuesday 17 December 2002 [GGNHSB(M)02/13] were approved as an accurate record and signed by the Chairman.

ACTION BY

5. PUBLIC HEALTH ISSUE – WHY DO AFFLUENT CANCER PATIENTS HAVE BETTER SURVIVAL THAN DEPRIVED?

A report of the Director of Public Health [Board Paper No 03/1] asked the NHS Board to note a new analysis which suggested that socio-economic factors influenced cancer survival independently of other lifestyle factors.

Dr Burns referred to the strong relationship between socio-economic deprivation and poor outcome amongst patients with cancer – Greater Glasgow being one of the first areas in the world to draw attention to this. Many studies carried out in a large number of developed countries in Europe, USA and Australia had confirmed this observation that cancer patients from affluent areas were more likely to survive. This observation had been shown to hold for cancers occurring at different sites of the body and it was reasonable to assume that there was an underlying process at work which was general to most, if not all, types of cancer.

The difference in survival between rich and poor was most marked amongst those cancers that tended to appear at a less advanced stage. This observation had led to the suggestion that the underlying effect of deprivation was to make recurrence of tumour more likely. Recurrences occurred either at the local site of the tumour (usually because the tumour had not been completely removed) or, more commonly, at a distant site due to spread of tumour within the bloodstream.

Dr Burns described the method and data collection using MIDSPAN datasets (a study that had been underway for the past 30 years in the Renfrew/Paisley districts of the West of Scotland). The study examined a number of questions, in particular, whether lifestyle characteristics and risk factors such as smoking, obesity or high alcohol intake, which were associated with deprivation, could explain the relationship between deprivation and cancer survival. The analysis had been carried out using a technique called Cox's proportional hazards model which estimated the strength of effect of a risk factor in influencing outcome. Dr Burns highlighted that affluent patients had about a 40% lower risk than deprived patients of dying from their cancer. After adding in risk factors such as smoking, alcohol consumption or obesity, the risk of death from cancer was not materially affected. It was, therefore, unlikely that deprivation was purely a marker for any of these other risk factors and deprivation appeared to have an effect independent of the pressure of these risk factors.

The second question examined whether cancers treated by "curative" resection were those in which the largest survival difference was apparent between affluent and deprived. If the survival difference disappeared amongst patients treated by curative resection, it could be said that the difference in survival across the entire patient group was simply due to the presence of more advanced cancers in the deprived. This could be a reflection of the fact that patients from poorer socio-economic groups either held onto their symptoms longer or were less likely to be treated urgently by the Health Service. Dr Burns illustrated that this was not the case. The difference in survival between affluent and deprived amongst all patients and those in whom the tumour was able to be resected and for whom the operation was thought to be curative was largely similar. The researchers also examined the distribution of stage at presentation amongst the patients. They found little evidence of any difference in stage distribution by deprivation for any of the tumours.

ACTION BY

The third main question examined was the extent to which other illnesses or co-morbidities played a role in influencing poor outcome. Such co-morbidities might include angina or other forms of ischaemic heart disease, high blood pressure, high cholesterol and the presence of bronchitis. They did, in fact, observe that patients with lower blood pressure, lower cholesterol and better lung function were more likely to be free of disease and survive their tumours although this was not true for patients with heart disease.

The study had been unable to establish that specific behavioural characteristics such as cigarette smoking and alcohol consumption were responsible for the deprivation differences seen in cancer survival outcome. They were important influences but so was deprivation which played an independent role in determining survival. The study results were consistent with, but did not definitely prove, the hypothesis that recurrence of tumour was more likely to occur amongst deprived populations. It was important to tackle lifestyle factors such as smoking, high alcohol consumption and obesity but these measures would be insufficient by themselves to narrow the gap in cancer survival between rich and poor. The precise mechanism by which deprivation led to poor cancer survival may be through impaired immunological status or a more sensitive stress response or some, as yet, unsuspected biological pathway.

Sir John referred to the large proportion of deprived areas within Greater Glasgow which was most likely to suffer from the outcomes of this research. Accordingly, the results had a significant impact on Greater Glasgow and it would be important to build in future research programmes.

In response to question from Mrs Kuenssberg, Dr Burns confirmed that it was the case that life circumstances of citizens was in part determined before they were born and that childhood deprivation played a significant role in an individual's future wellbeing.

Dr Burns confirmed that although cancer was being studied via this research, it was most likely that this played out across the other chronic disease management areas compounding the view that genetic background could be seen as the common driver.

Professor Dickson referred to the relationship between attitude and outcome and Dr Burns recognised this may warrant investigation in the future as there may be a connection. In response to a question from Mr P Hamilton, Dr Burns confirmed that lifestyle factors did not explain all the difference between rich and poor and poverty itself seemed to be an independent predictor of poor health when deprivation was taken into account.

Professor Farthing asked about the extent to which the genetics background of the population might explain the findings. Dr Burns felt that genetics might explain part of the picture but was unlikely to account for the size of the differences in survival between rich and poor.

Sir John saw a duty to address these issues further and was keen that this be taken forward with the Glasgow Universities particularly in areas of joint research to develop excellence. Furthermore, work would be undertaken with Greater Glasgow NHS Board's Local Authority partners regarding the social circumstances of its population. Dr Burns confirmed that the Board would look to other countries for statistical comparison.

DECIDED:

That the analysis on "Why do Affluent Cancer Patients Have Better Survival Than Deprived?" be noted and the partnership approach to taking such issues forward be endorsed.

ACTION BY

6. 2002/2003 REVENUE ALLOCATIONS YEAR END FORECAST

A report of the Director of Finance [Board Paper No 03/2] was submitted asking the Board to note the progress made by Greater Glasgow's Trusts in managing their in-year financial position and confirm the release of NHS Greater Glasgow in-year reserves and other contingencies as required to ensure overall financial break-even at the year end.

Mrs Hull led the Board through the report looking in-depth at the financial position across NHS Greater Glasgow at the end of November 2002. As required by the Scottish Executive Health Department, the position was then used to forecast the outturn at the year-end.

Analysis indicated that the Trusts continued to maintain financial break-even. A number of issues continued to require funding from NHS Board wide resources. No new or unforeseen factors had been identified and the extent of financial "exposure" appeared to be £2M to £2.5M and, therefore, remained within the flexibility available. West of Scotland issues, which may be resolved, accounted for £700,000 of this total. Consequently, year end financial targets would be achieved by releasing to the Trusts the equivalent funding held in:

- cumulative surpluses reported in Trusts' Annual Accounts
- reduced requirements for carry forward into the next financial year, 2003/2004
- other unspent remaining reserves

Mrs Hull confirmed that "capital to revenue" transfer requested from the Scottish Executive Health Department had been confirmed at £19.975M and this considerably reduced the risk associated with the financial management at the year-end, 2002/2003.

Mrs Hull advised that all Glasgow Trusts had been able to manage most of their in-year pressures with a limited number of issues requiring action on a pan Glasgow basis. It was disappointing that there remained unresolved issues with other West of Scotland NHS Boards although these were acknowledged as complex.

The position for the South Trust reflected the need to undertake further waiting times target cases over and above those funded by Scottish Executive Health Department additional money. The year-end spend relative to allocation had yet to be finalised.

The net 2002/2003 year-end position did not adequately reflect the impact of GP prescribing in year. The early response by the Primary Care Trust and the agreement to a multi-component programme to improve cost effective prescribing should off-set some of the growth patterns on several drug categories.

Both the North and South Trusts had indicated further year end spend which may result from non-compliant rotas for Junior Medical Staff and the resolution of the industrial action – both of these issues were difficult to quantify.

The overall risk would, in part, be mitigated by further detailed work in hand to try and finalise the extent to which remaining in year reserves and other funds held for in year developments would be spent before the year end. Initial indications suggested that the overall position at the end of 2002/2003 for NHS Greater Glasgow would continue to break-even.

ACTION BY

In response to a question from Professor Dickson, Mrs Hull clarified two distinct components regarding the unresolved issues with other West of Scotland Boards as follows:

- Clarity was required on the process of funding new developments proposed by Glasgow-based tertiary services.

- The process required to define how West of Scotland Boards uplifted costs year on year of those tertiary and specialized services.

Alternative ways of dealing with this were being explored particularly given the sheer volume and time consuming nature of these negotiations.

Mr Davison highlighted that within North Glasgow University Hospitals NHS Trust, 65% of its income came from Greater Glasgow NHS Board – the rest was received regionally or direct from the Scottish Executive. He suggested that for all regional services, there should be a single commissioner to avoid tension with local NHS Boards seeking to apply a price tariff.

In terms of areas of future risk, several were identified including post graduate teaching, pay, waiting times, GP prescribing, acquired healthcare infection and Partnership Information Network (PIN) Guidelines.

DECIDED:

- That the progress made by Glasgow's Trusts in managing their in year financial position be noted. **Director of Finance**

- That the release of NHS Greater Glasgow in year reserves and other contingencies as required to ensure overall financial break-even at the year end be confirmed. **Director of Finance**

7. 2002/03 CAPITAL ALLOCATIONS

A report of the Director of Finance [Board Paper No 03/3] was submitted asking the NHS Board to confirm the final 2002/03 Capital Allocations and note the aspects of risk identified in the management of the in year position and the resultant implications for 2003/04.

The in year capital spend remained dynamic in that:

- Further allocations of funds to be spent in year had been made by the Scottish Executive Health Department – to date, NHS Greater Glasgow had received:

  - IM&T £1.5M
  - Decontamination £1.0M estimated

- The "capital to revenue" transfer request for £19.975M had been confirmed by the Scottish Executive Health Department.

ACTION BY

- Some slippage with local in year schemes was still anticipated, prompting considerations of whether such funds should be re-released or brokered (if approved by the Scottish Executive Health Department) into 2003/04. This was influenced by the 2003/04 capital requirements profile. An initial review had been completed, with a supplementary exercise to re-prioritise proposals to establish what scope existed to both:

  - Accelerate the various "enabling" aspects of the major PFI/PPP Acute Services Reconfiguration.

  - Fund from Treasury Capital the estimated £84M required for the Beatson Phase 2.

Mrs Hull referred to the tables attached to the report which set out the final iterations of the 2002/03 Capital Allocations against which the year end forecast could be monitored.

There remained outstanding decisions on two major schemes proposed in 2002/03 namely to upgrade to Intensive Therapy Unit (ITU) at Glasgow Royal Infirmary and upgrade to High Dependency Unit (HDU) at Yorkhill.

The first year of managing the delegated capital allocation had been challenging. At the beginning of the year, the Scottish Executive Health Department indicated that levels of capital carried forward experienced in previous years, particularly last year 2001/02, were not acceptable. Local policy in agreeing approvals attempted to reflect this objective; some subsequent relaxation had allowed brokerage of up to £4M into 2003/04. Beyond that, and given that further funds were being made available, it seemed prudent to plan to spend the balance of remaining funds. Consequently, a modest level of over-commitment was recommended against yet to be reported in year slippage.

DECIDED:

- That the final 2002/03 Capital Allocations be confirmed. **Director of Finance**

- That the aspects of risk identified in the management of the in year position and the resultant implications for 2003/04 be noted. **Director of Finance**

8. WAITING TIMES

A report of the Director of Planning and Community Care [Board Paper No 03/4] noted progress towards delivering the Board's agreed over nine month waiting time reduction.

Provisional numbers represented an improvement over November 2002 but continued progress was required to reach the March 2003 mid-point target. The Board was previously advised of additional investment to secure extra one-off and recurring elective activity to achieve this. This included surgery to be carried out at the Golden Jubilee National Hospital. The agreed number of electives undertaken at the hospital was significantly lower than originally agreed in the period to December 2002 and redressing the balance between January and April would be important if targets were to be delivered. Extra sessions had been agreed with the hospital for both North and South Acute Trust patients to help achieve that goal.

ACTION BY

The South Trust had secured further elective capacity via an agreement with BUPA to utilize available capacity in other locations. This was at an advanced stage and patients involved had agreed to travel. In North Glasgow, the second plastic surgery initiative was now underway and this would provide over 140 cases and would eliminate over nine month waiters.

Mr Davison advised that within Glasgow Royal Infirmary essential maintenance and upgrading work was required in the Theatre Sterile Supply Unit (TSSU) and maintenance work was required to a number of theatres. This was an associated risk which would be factored in when considering plans to meet the March mid-point target.

Mr P Hamilton sought further information on the waiting times for specialties across the city and, in particular, patients with no guarantees. Mrs Kuenssberg suggested also including the numbers of patients who were being treated within the waiting times targets. Mr Divers agreed to take these comments on board and to include the numbers of patients with a guarantee exception in the following month's figures. **Chief Executive**

NOTED

9. MEMBERSHIP OF THE GREATER GLASGOW HEALTH COUNCIL

A report of the Head of Board Administration and Convener of Greater Glasgow Health Council [Board Paper No 03/5] was submitted asking the Board to note the revised membership of Greater Glasgow Health Council and approve offering the ten members whose appointment was to 31 March 2003 a twelve month extension to 31 March 2004.

The Head of Board Administration commented that a consultation paper on the future structure of public involvement organisations was awaited and the proposals were likely to have an effect on the future role, remit and make up of Health Councils. The consultation document was due shortly from the Scottish Executive Health Department with a three month consultation period. As such, the Health Council, by a majority view, had supported the option of offering the existing members whose term of appointment was to 31 March 2003 a twelve month extension in order to try and ensure the smooth continued operation of the Health Council's work and responsibilities.

DECIDED:

- That the revised membership of Greater Glasgow Health Council be noted. **Head of Board Administration**

- That the ten members whose appointment was to 31 March 2003 be offered a twelve month extension to 31 March 2004. **Head of Board Administration**

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

A report of the Director of Public Health [Board Paper No 03/6] was submitted seeking approval of six medical practitioners employed by Greater Glasgow Primary Care NHS Trust to be authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984.

ACTION BY

DECIDED:

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

Dr Neill Simpson
Dr Paul Forrester
Dr Esther Abein
Dr Lynne Steele
Dr Malcolm Cameron
Dr James Lewis

11. MINUTES OF THE STAFF GOVERNANCE COMMITTEE

The Minutes of a meeting of the Staff Governance Committee [GGNHSB SGC(M)02/2] held on Tuesday 3 December 2002 were noted.

12. MINUTES OF THE AREA CLINICAL FORUM

The Minutes of a meeting of the Area Clinical Forum [ACF(M)02/04] held on Monday 11 November 2002 were noted.

The meeting ended at 11.45 am