

GGNHSB(M)03/3  
Minutes: 27 - 42

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 18 March 2003 at 9.30 am**

**P R E S E N T**

Professor Sir J Arbuthnott (in the Chair)

Mr J Best	Mr W Goudie
Dr H Burns	Councillor J Gray (to Minute 36)
Mr R Calderwood	Councillor J Handibode (to Minute 36)
Mr R Cleland	Mrs W Hull
Ms R Crocket	Mrs S Kuensberg CBE
Mr T Davison	Councillor D McCafferty
Mr T A Divers OBE	Mr I Reid
Professor M Farthing	Mr A O Robertson OBE (to Minute 33)
	Mrs E Smith

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

Ms E Borland	Acting Director of Health Promotion
Ms S Dean	Press Officer
Ms S Fitzgerald	Legal Adviser – Bevin Ashford and Shepherd Wedderburn (from Minute 34 to 35)
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Mr A McLaws	Director of Corporate Communications
Dr J McMenamin	Consultant in Public Health Medicine (from Minute 35 to 36)
Ms D Nelson	Communications Manager
Ms C Renfrew	Director of Planning and Community Care
Mr J Whyteside	Public Affairs Manager

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

Mrs C Anderson	Chair, Area Pharmaceutical Committee (to Minute 36)
Dr F Angell	Chair, Area Dental Committee
Mr J Cassidy	Chair, Area Nursing and Midwifery Committee
Mr P Hamilton	Convener, Greater Glasgow Health Council
Dr J Nugent	Chair, LHCC Professional Committee

**ACTION BY**

**27. APOLOGIES**

Apologies for absence were intimated on behalf of Councillor D Collins, Councillor R Duncan, Dr R Hughes and Ms G Leslie (Vice Chair, Area Optometric Committee).

**28. CHAIRMAN'S REPORT**

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

- (a) Scotland's Health White Paper "Partnership for Care" had been issued. Further detail on the content of the White Paper would be provided by Mr Divers at Paper No 03/16.
- (b) The new proposed GP contract had been announced and included a template which would enable practices to estimate their income. The consultation of the contract within NHS Greater Glasgow was being led by the Primary Care Trust.
- (c) A new policy paper had been introduced on Monday 17 March 2003 entitled "Improving Health – the Challenge". This made clear what the health improvement aims within NHS Scotland should be.
- (d) 120,000 copies of the NHS Greater Glasgow Health News Newspaper had been distributed. Furthermore, the new website had generated activity with a particularly impressive increase in the uptake of the Smoking Cessation Scheme.
- (e) The Minister for Health and Community Care would announce shortly the North and South Monitoring Groups to take forward the monitoring of the continuation of "named services" within Stobhill Hospital and the Victoria Infirmary, during the period prior to the rationalisation of inpatient services.
- (f) Two new Board Members had been appointed by the Minister for Health and Community Care; Peter Hamilton and Ravinder Kaur Nijjar. The Chairman congratulated both and looked forward to working with them as Non Executives from the 1 April 2003. A new Trustee had also been appointed to South Glasgow University Hospitals NHS Trust, Mrs Maire Whitehead.

Councillor D McCafferty had intimated his resignation from the NHS Board as it was his intention to stand as a Parliamentary candidate in the forthcoming elections. The Chairman thanked Councillor McCafferty for his contribution to the work of the NHS Board since his appointment on 1 October 2001. It was also the last meeting of Dr R Hughes (as his Term of Office as Chairman of the Area Clinical Forum expired on 31 March 2003) and Sir John thanked him for his input which had been greatly valued.

**NOTED**

**29. CHIEF EXECUTIVE'S UPDATE**

Mr Divers updated the NHS Board on the arrangements for the North and South Monitoring Groups to be set up by the Minister for Health and Community Care. The first meeting of these Groups would take place on 28 March at which Members would discuss and agree their remit. It had been proposed that each Group meet three times a year, with the Chair of both Groups holding monthly meetings with the NHS Board Chairman

**NOTED**

**30. MINUTES**

On the motion of Mr J Best, seconded by Mrs E Smith, the Minutes of the meeting of the NHS Board held on Tuesday 18 February 2003 [GGNHSB(M)03/2] were approved as an accurate record and signed by the Chairman.

**31. MATTERS ARISING**

Members were circulated with the rolling action list which updated on the progress and timescale for ongoing matters arising.

**NOTED**

**32. PARTNERSHIP FOR CARE : SCOTLAND'S HEALTH WHITE PAPER**

A report of the Chief Executive, GGNHSB [Board Paper No 03/16] asked the Board to receive the report on the Health Department's Guidance on implementing the Health White Paper - Partnership for Care and discuss the next steps in taking forward the plans for implementation.

The main themes of the White Paper were:

- The challenge of health improvement.
- The importance of listening to patients.
- The delivery of consistent, safe, high quality care, supported by national standards and robust inspection arrangements.
- A significant emphasis on clinical reform and service redesign.
- The continuing emphasis on partnership working with staff and the need to equip staff with the tools and skills necessary to deliver high quality care.
- Arrangements for strengthening unified NHS Board working through a move to single NHS organisations, with clear lines of accountability.

Mr Divers aimed to focus on the key elements within the Guidance [NHS HDL(2003) 11] and on the processes of implementation which the NHS Board was charged with taking forward. The main areas for consideration were as follows:

- Moving to unitary NHS organisations.
- Devolution of powers; schemes of delegation from NHS Boards to and within operating divisions.
- A repositioning of NHS Scotland Management.
- The role of NHS Chief Executives in single system working.
- Changes to membership of NHS Boards.
- The Development of Operational Divisional Management Teams.

- The legal steps to Trust dissolution.

Mr Divers covered each in more detail:

(i) Moving to Unitary NHS Organisations

NHS Boards which operated with NHS Trusts were required to bring forward simple, practical proposals as soon as possible, but no later than April 2004, to enable the Trusts in their areas to be dissolved, with the Trusts' functions, staff and assets transferring intact to new Operating Divisions of the NHS Board. This evolutionary approach was designed to allow NHS leaders to concentrate on supporting improvements in patient care in order to take forward the key national priorities which were set out in the White Paper. The Guidance made it clear that the dissolution of Trusts would have no substantive impact on the employment of staff, since employers' obligations were transferred directly to the respective NHS Board.

Given that the timescale had been set at no later than April 2004, it was possible that Ministers would wish to see the single system working arrangements in place by April 2004. That timescale would require launch of the public consultation paper in August 2003 with decisions by the NHS Board by December 2003.

Mrs Smith recognised the role of existing NHS Trust Chairs being vital to ensure a seamless transfer but sought recognition of the high profile Chief Executives role in the four Glasgow NHS Trusts. For them to be proactively involved in the unitary NHS organisation, organised formal support would have to be provided at their respective Trusts should they be engaged elsewhere.

Councillor McCafferty sought clarification of the future of the Golden Jubilee Hospital delivering waiting time guarantees ensuring best use to maximise effect to delivery of local NHS plans. Given the plans for decentralisation, it was his view that the Golden Jubilee Hospital should be decentralized and not held under the ownership of the Scottish Executive.

Mrs Kuenssberg was re-assured that the transfer of NHS Trust employees would be straight forward in that staff would return to a single employer – that of Greater Glasgow NHS Board although there was an issue of harmonization of human resources policies.

In terms of the plans for development of the Community Health Partnership arrangements, Dr Nugent welcomed the less prescriptive but more flexible arrangements.

In summary, Sir John highlighted the following key areas which would be further discussed at a Board seminar:

- Ensuring support was available for existing Trusts particularly in the transitional arrangements.
- How would the Golden Jubilee Hospital fit into a devolved structure?
- Preparation for the Community Health Partnership arrangements.
- Ensuring the human resource management issues of harmonization did not throw up unexpected difficulties.

(ii) Devolution of Powers: Schemes of Delegation from NHS Boards To and Within Operating Divisions

A new duty on NHS Boards was introduced putting in place devolved systems of decision making. On the dissolution of NHS Trusts, NHS Boards would devolve duties and responsibilities for service delivery to new Operating Divisions. This would be achieved by converting the current Trust Management Teams into Committees of the NHS Board to be known as Divisional Management Teams.

The devolution of powers direct from NHS Boards to Operating Divisions was intended to ensure that Divisional Management Teams were as flexible as the current Trust Management Teams. These new arrangements were intended to ensure that NHS Boards preserved their status as strategic Boards of governance and that they were not unnecessarily drawn in to day-to-day management issues.

There was flexibility for NHS Boards to consider developing arrangements in ways that were different from the suggested model, provided that there was agreement achieved locally on this and that benefits of the different arrangements proposed could be demonstrated. It was crucial, however, that an appropriate balance should be maintained between the need to avoid the disruption frequently associated with organisational change and the over-riding aim of securing tangible benefits for patients.

In summary, the NHS Board needed to determine whether the expected pattern of migration to Divisional Management Teams would deliver the priorities within the White Paper. Formal Schemes of delegation needed to be prepared both between NHS Boards and Operating Divisions and within Operating Divisions. These were likely to be required to form part of the consultation paper.

Councillor McCafferty raised the issue of elected representatives being Members of Divisional Management Teams. Mr Divers confirmed that this was not the model described in the Guidance but that a Non Executive Director of the NHS Board carried the responsibility of Chair of the Management Team.

(iii) A Repositioning of NHS Scotland Management

The White Paper aimed to bring about a material repositioning of NHS Scotland management to reflect its critical importance in working with clinicians to enable service change and clinical reform. Working within unified NHS systems, Divisional Chief Executives would have key cross-system leadership roles in the drive to integrate, redesign and develop patient centred services. NHS Boards must ensure that all Chief Executives carried appropriate cross-system, regional or national leadership roles in terms of:

- a new duty of regional (and national) planning
- support for clinical leadership

Chief Executives and other senior members of the Executive Teams were already taking leadership roles across the local NHS system, in respect of the roll out of the acute services plan and other key areas, including workforce planning. Further rigour needed to be built in to the “rules of engagement” on regional planning, however, to avoid some of the current impediments to progress. There was an urgent need to put in place the Service Redesign Committee if it was to play a material role in the first Change and Innovation Plan.

ACTION BY

Professor Farthing regarded this as an exceptionally important component of the White Paper particularly as there had been a dislocation in the relationships between some clinical groups and some managers. It was paramount to have a pro-active plan to address this and revolutionary ideas to engage all key players.

Mr Goudie sought the representation of staff organisations on the Service Redesign Committee.

Mrs Kuennsberg was keen that discussion took place with patients on how they may be consulted in the future. She was also disappointed to note that no financial arrangements had been set for regional planning.

Ms Crocket saw the importance of ensuring medical colleagues were on board but re-emphasised the need for a multi-disciplinary approach ensuring the whole NHS Greater Glasgow workforce was involved in driving the plans forward.

Professor Farthing re-iterated Ms Crocket's view and suggested one approach may be to plan peoples' careers better across the clinical spectrum.

(iv) The Role of NHS Chief Executives in Single System Working

The role of NHS Board Chief Executives would be broadly unchanged – the major difference was that, instead of discharging responsibility for implementation through separate statutory bodies, the responsibility would be discharged through Operating Divisions of the NHS Board. Similarly, the roles of Divisional Chief Executives would match closely the current roles of Trust Chief Executives in that they would continue to be accountable for their budget, the performance of their organisation and leading the work of the Divisional Management Team.

Two changes flowed from the move to single NHS organisations. Firstly, Divisional Chief Executives would not be appointed formally as accountable officers, but they would still have primary accountability for their budgets and would still be liable to be summonsed to give evidence to the Parliament. Secondly, the Chief Executive of the NHS Board would have overall accountability for the performance management of the whole NHS system and there would, therefore, be a direct line of accountability from Divisional Chief Executives to the NHS Board Chief Executive.

These formal changes would not, however, affect the status, authority or autonomy of Divisional Chief Executives. Other members of the former Trust Executive Teams would fulfill the same roles as before but as part of the Divisional Executive Team.

All the Chief Executives in the NHS Board area must operate in a strong, unified team providing leadership in agreed areas across the local NHS system, with specific operational results being delivered by Divisional Chief Executives and their Executive Teams. The NHS Board Chief Executive would be responsible for performance assessment of Divisional Chief Executives in consultation with the Chair of the Divisional Management Team.

In summary, Mr Divers commented that the relationship between Chief Executives should further be formalised by the early establishment of a Board level Executive Team and that the Board's Remuneration Subcommittee was already aiming to move substantially for the performance year 2003/2004 towards the arrangements set out in the guidance.

(v) Changes to Membership of NHS Boards

The current composition of Greater Glasgow NHS Board comprised twenty-three Directors (fifteen Non Executive Members and eight Executive Members). The guidance set out a number of changes:

- Creation of a new Non Executive position for the Chair of the LHCC Professional Committee – as Board Members, Chairs of LHCC Professional Committees would be expected to play a key role in the transition from LHCCs to Community Health Partnerships.
- Creation of the new Executive position of NHS Board Medical Director – this appointment was intended to complement the role of the NHS Board Nurse Director and the Chairman of the NHS Board was responsible for taking forward the appointment process. The pool of potential applicants eligible to be appointed as NHS Board Medical Director was limited to Medical Directors employed at Divisional level (currently Trusts).
- Transfer of Trust Chief Executive positions to Divisional Chief Executive positions.
- Replacement of the Trust Chair positions by an equivalent number of Lay Member positions – in order to maintain Non Executive capacity in each NHS Board, an equivalent number of new Lay Member positions should be created on each NHS Board concerned – these new lay positions would be filled by open public competition.
- The possibility to create additional Lay Member positions to compensate for the loss of Trustees on Trust Management Teams – a maximum of two additional Lay Member positions may be created for each Trust that was dissolved.

The overall number of Members of NHS Boards should reflect the balance between the desire for inclusiveness and the need to ensure that the Board was of a manageable size, consistent with the effective discharge of business. The arrangements set out in the guidance created a potential Board Member complement in Greater Glasgow of thirty-three.

Mr Divers advised that the Chairman would take early action to secure the appointments of the Chair of the LHCC Professional Committee and the Trust Medical Director as NHS Board Directors. The NHS Board needed to work through the scope and scale of Non Executive responsibilities to inform debate about the complement of Non Executives needed to deliver the functions required, consistent with maintaining a Board of a manageable size.

**Chairman**

Mr A Robertson saw the opportunity of further flexibility in working to deliver better services. He was anxious not to underestimate the challenge particularly at the consultation stage when it was paramount to ensure positive messages were given.

(vi) The Development of Operational Divisional Management Teams

The current appointments of Trust Chairs and Trustees would cease automatically on dissolution of NHS Trusts. The position of Executive Members of the Trust Management Teams was different since they were employees of NHS bodies.

**ACTION BY**

When Trusts were dissolved, the Executive Members would automatically transfer to Divisional Management Teams and would become employees of the NHS Board, in common with all former Trust employees.

Trust Chairs and Trustees whose positions ceased on dissolution of NHS Trusts would be welcome to apply as candidates in open competition for the new Lay Member positions which would be created on the local NHS Board.

The new Divisional Management Team would be chaired by a Non Executive Lay Member of the NHS Board. As the Divisional Management Team would be a Committee of the NHS Board, its chair would be appointed by the NHS Board rather than directly by Ministers.

Trusts' current responsibilities for Clinical Governance would continue to be discharged at Operating Division level. Some former Trust Committees, such as the Audit Committee, would no longer be necessary following the dissolution of Trusts. NHS Boards would, therefore, be expected to review the Committee structures within their Board areas in order to determine how best to discharge the business of the local NHS system.

Mr Divers emphasised that the exercise to scope the responsibilities of Non Executive Directors across NHS Greater Glasgow needed to encompass the Non Executive roles required within Operating Divisions. In addition, there would be new Board level Committees such as the Service Redesign Committee and the proposed Performance and Resources Committee for whose creation the external auditors continued to press.

Mr Divers summarized the legal steps to Trust dissolution in terms of the public consultation which would be conducted in relation to dissolution of Trusts and the transfer of staff, property, rights and liabilities under the terms of the appropriate regulations.

Sir John welcomed the opportunity to do things in a new way – he did, however, acknowledge the challenges that lay ahead. On that point, Councillor McCafferty re-iterated the importance in ensuring the transitional arrangements were clear and precise particularly in terms of audit.

Mr Divers extended an invitation to engage in discussion with himself and the Chairman should any existing Board Member wish to do so.

**DECIDED:**

- That the report on the Health Department's Guidance on implementing the Health White Paper, Partnership for Care be received and noted.
- That the next steps in taking forward the plans for implementation be noted.

**Chief Executive**

**33. 2003/4 AND BEYOND CAPITAL ALLOCATIONS**

A report of the Director of Finance [Board Paper No 03/18] asked the Board to confirm the capital allocations proposed for 2003/4, totaling £68.9M. Furthermore, the paper sought outline approval for 2004/5, totaling £39.2M so that the allocation was balanced over the two financial years and to confirm the priorities used to determine the schemes proposed for inclusion in the capital programme.

**ACTION BY**

Responsibility for capital allocations was devolved to NHS Boards in 2002/3. Local approvals processes and procedures were agreed by the Board and the proposals set out had been prepared in line with agreed policy. In reviewing proposals from the Trusts, priority had been given to schemes that:

- Enabled the Acute Services Reconfiguration.
- Ensured ongoing commitments to previously agreed schemes and requirements for regular investment in medical equipment, maintenance, IT, Health and Safety and decontamination.
- Recognised Trust specific priorities.

The timing of schemes had also been scrutinized to ensure that the capital programme was balanced over the two years, 2003/4 and 2004/5.

In response to a question from Councillor Handibode about slippage on primary care developments, Mrs Hull clarified the slippage of £500,000 (page 32 of the Board papers, lines 254 to 257) recognised that the precise timing of completion dates was sometimes difficult to estimate, but over the years there was sufficient flexibility to reprovide for any such amounts.

In a response to a question from Mr P Hamilton, Mr Davison advised that the interim move of Gynaecology services to Glasgow Royal Infirmary was the preferred move for staff and would bring all Gynaecological services together.

Mrs Kuenssberg acknowledged that the Capital Planning Panel was working very effectively and the associated tables showing NHS Greater Glasgow's commitments had been well achieved.

**DECIDED:**

- That the capital allocations proposed for 2003/4, totaling £68.9M be confirmed. Director of Finance
- That outline approval for 2004/5, totaling £39.2M ensuring the allocation was balanced over the two financial years be approved. Director of Finance
- That the priorities used to determine the schemes proposed for inclusion in the capital programme be confirmed. Director of Finance

**34. IMPLEMENTING THE ACUTE SERVICES STRATEGY – PROCUREMENT PROCESS FOR THE AMBULATORY CARE HOSPITALS AT STOBHILL AND THE VICTORIA**

A report of the Chief Executive [Board Paper No 03/17] asked the Board to approve:

- that, in terms of the Public Procurement Regulations, the procurement of the Ambulatory Care Hospitals at Stobhill and the Victoria Infirmary should proceed as a Services Contract and that the Services Regulations should apply to the procurement of the project;
- that, in terms of the Services Regulations, the negotiated procedure should be the choice of tendering procedure adopted.

ACTION BY

Sir John welcomed Ms Sharon Fitzgerald, Legal Adviser from Bevin Ashford and Shepherd Wedderburn who had been appointed to assist the Board with the procurement process.

Ms Fitzgerald advised that in considering which set of Public Procurement Regulations should apply to the Project, it was recognised that the Project would constitute a “mixed” contract involving a combination of both works and services. In determining whether to apply the Public Works Contracts Regulations 1991 (as amended) or the Public Services Contracts Regulations 1993 (as amended) (the “Services Regulations”), the Board had to apply the “main object/primary purpose” test and the “relative value” test to determine the correct Regulations for the Project.

In applying the main object/primary purpose test, the Board acknowledged that it would identify the scope of the Project in terms of the service outputs required rather than focusing on the form of delivery of the Project. Given that the Board was looking for the delivery of a “serviced” accommodation over a 30 year contract period, the Board had concluded that the main object of the Project was the delivery of a service rather than the provision of works.

The test of “relative value” involved a comparison of the works/construction costs of the Project with the cost of the services elements. As part of the preparation of the Outline Business Case for the project, these costs were assessed over a contract term of thirty years. The assessment showed that the services element outweighed the works element over the thirty year life assumed for the Project.

On the basis of the outcome of the “main object/primary purpose” test and the “relative value” test, the Board had concluded that the Project was a services contract and that the Services Regulations should apply to the procurement of the Project.

The Board’s Executive Directors involved in taking this project forward concluded that it would not be appropriate to select the open or restricted tendering procedure for use on this Project. It was proposed that the Board should choose the negotiated procedure for the following reasons:

- The nature of the services or the associated risks did not permit prior overall pricing.
- The nature of the services was such that specifications could not be drawn up with sufficient precision to permit the award of the contract using the open and restricted procedures.

The decision to follow the negotiated procedure under the Services Regulations followed the advice of the Board’s Legal Advisers and was in line with Treasury Guidance.

The Board’s Legal Advisers had prepared the Official Journal of the European Community (OJEC) Notice for the Project on the basis that the Service Regulations applied and on the basis that the negotiated procedure would be utilised. The Board’s formal agreement to the recommendations would see the procurement advert appear shortly, ahead of an Open Day on 1 April 2003 which had been arranged for developers potentially interested in the project.

In response to a question from Dr Nugent, Ms Fitzgerald clarified the term “mixed” contract and “negotiated” procedure. The negotiated procedure was more interactive and allowed more flexibility particularly as the price was decided before the Project started and the Board would retain contractual control.

**ACTION BY**

In response to a question from Professor Farthing, Ms Fitzgerald confirmed that the Legal Advisers had already identified a number of potential bidders who would attend the Open Day on 1 April 2003 – as such they could only assume that the Project was attractive to bidders and that they could deliver on time.

Mr Calderwood clarified for Councillor Handibode the difference between soft FM and hard FM services. The procurement route recommended gave the NHS Board the most flexibility in determining the final shape of the contract and he did not anticipate any current staff suffering any detriment to their employment conditions. The OJEC advert at this stage included soft FM services. Mr Goudie and Councillor McCafferty indicated the concerns that they would have if soft FM services were included in the contract. Mr Divers briefly outlined the National policy framework which directed their inclusion.

Ms Fitzgerald confirmed that there were vigorous evaluation criteria which would be structured specifically to take account of all concerns raised.

**DECIDED:**

- That, in terms of the Public Procurement Regulations, the procurement of the Ambulatory Care Hospitals at Stobhill and the Victoria Infirmary should proceed as a services contract and that the Services Regulations should apply to the procurement of the Project. **Chief Executive**
- That, in terms of the Services Regulations, the negotiated procedure should be the choice of tendering procedure adopted. **Chief Executive**

**35. NHS HDL 2002 (82)**

Dr Burns opened by referring to the recent case in Manchester of respiratory problems which had originated in the Far East. Symptoms included high temperature and severe muscle pains and had been fatal in a significant number of cases. Furthermore, it had been apparent that nursing staff had gone on to get the symptoms indicating that the virus may be infectious. It was not known yet what kind of organism this was although it may have arisen from the Middle East where a high density population live close to domestic animals. So far, this had not been an issue for Greater Glasgow but all medical staff had been asked to be vigilant

A report of the Director of Public Health [Board Paper No 03/19] asked the Board to note the response sent to the Scottish Executive, prepared by the Area Control of Infection Committee, on behalf of Greater Glasgow NHS Board, in collaboration with all the Trusts in Greater Glasgow. Dr McMenamin, Consultant in Public Health Medicine, introduced the report.

NHS HDL 2002 (82) highlighted recommendations from two reports for the management of health care associated infection:

- Ministerial Action Plan on Care Associated Infection.
- Watt Group Report on the Outbreak of Salmonella Infection at Victoria Infirmary.

The Watt Group Report included 47 recommendations for action by the NHS Trusts/Boards and other bodies including the Scottish Executive, to improve the efficiency and effectiveness of infection control arrangements and of hospital cleaning services. The Ministerial Action Plan contained further recommendations as well as endorsing the conclusions of the Watt Report.

The Board's response to the Health Department Letter highlighted the increasing emphasis on staff education, audit and updating of various outbreak plans, as well as progressive investment in infection control nursing staff. All Glasgow Trusts, in response to the Watt Group Report, also requested additional resources to improve the infrastructure of their infection control teams including additional medical microbiology support, clerical support and surveillance nurse support.

The Area Control of Infection Committee had agreed a standard formula based on international recommendations, however, it had not completed its review of other resources required by Trusts in Greater Glasgow for infection control infrastructure. Once this had been completed, the Area Control of Infection Committee would produce a further report for the NHS Board highlighting any other deficiencies in infection control staffing in NHS Greater Glasgow.

In response to a question from Mr Goudie, Dr McMenamin confirmed that the hand hygiene audit did not refer to the facilities but to auditing individuals.

In response to a question from Councillor Handibode, Mr Divers confirmed that in terms of the negotiated procedure agreed for the procurement of the two Ambulatory Care Hospitals, the Board could impose such new hygiene and other regulations on contractors.

Dr Nugent emphasised that in terms of hand hygiene, this also related to a cultural change emphasising the importance of good practice as for other more high profile issues. Furthermore, Dr McMenamin confirmed that there were implications for ward design and the Scottish Executive Health Department had issued guidance on minimal bed space that was appropriate. Overall, there were vast implications for implementing the new culture of hygiene across NHS Greater Glasgow, putting in place associated training and budgets and ensuring that management systems and audit systems were in place to counter balance these.

**DECIDED:**

That the response sent to the Scottish Executive Health Department Letter be noted.

**36. WAITING TIMES**

A report of the Director of Planning and Community Care [Board Paper No 03/20] noted progress towards delivering the Board's agreed over nine month waiting time reduction.

There had been a reduction of 23% in NHS Greater Glasgow residents with a guarantee waiting over 9 months between January 2003 and February 2003 – this showed significant progress towards meeting the December 2003 target.

Various pressures on both North and South Trusts which had a potential impact on waiting times included theatre maintenance, compliance with the recommendations of the Glennie Report, nursing vacancies, temporary closure of beds and delayed discharges. These continued to affect progress towards the December 2003 target.

Allocation of activity at the Golden Jubilee National Hospital and within the private sector in Glasgow would help to alleviate some of these pressures.

**NOTED**

**37. 2002/2003 FINANCIAL MONITORING REPORT FOR TEN MONTHS ENDED JANUARY**

A report of the Director of Finance [Board Paper No 03/21] asked the Board to note the results reported for the ten months ended 31 January 2003.

Mrs Hull confirmed that Greater Glasgow's Trusts were reporting a £1.019M deficit against the break-even target for the ten months to January 2003. Overall, therefore, the position remained in line with that forecast and it was still anticipated that the total estimated £2M overspend against Trusts' startpoint allocations could be offset by reserves available at the year end.

**NOTED**

**38. QUARTERLY REPORTS ON COMPLAINTS : OCTOBER - DECEMBER 2002**

A report of the Head of Board Administration and Trust Chief Executives [Board Paper No 03/22] asked the Board to:

- Note the quarterly report on NHS complaints in Greater Glasgow for the period 1 October to 31 December 2002 (Appendix A).
- Note the extract from the Information Service Division's (ISD) Annual Report entitled "NHS Scotland Complaints Statistics – Year Ending 31 March 2002" (Appendix B).
- Approve the extension to the Terms of Office of ten Lay Chairs and six Lay Conciliators (Appendix C).
- Approve the NHS Greater Glasgow Habitual and/or Vexatious Complaints Policy (Appendix D).
- Note the attached draft consultation document "Reforming the NHS Complaints Procedure" issued by the Scottish Executive (Appendix E).

Sir John noted that no Trust met the national target of 70% of written Local Resolution complaints to be completed within 20 working days of receipt.

Mr J Hamilton referred to the consultation document issued by the Scottish Executive Health Department "Reforming the NHS Complaints Procedure". Comments were invited by the Scottish Executive by 2 June 2003 and the consultation document had been widely distributed throughout NHS Greater Glasgow. A seminar for all those interested in complaints had been arranged for Thursday 15 May 2003 (9.00 am to 11.00 am) in order that the proposals within the consultation document could be presented and feedback received. This would allow the Board to finalise its response to the consultation document.

Sir John asked that the draft Board response be considered by the Board at its meeting scheduled in May 2003 prior to submission to the Scottish Executive.

**Head of Board Administration**

**DECIDED:**

- That the quarterly report on NHS complaints in Greater Glasgow for the period 1 October to 31 December 2002 be noted.

**ACTION BY**

- That the extract from the Information Service Division's (ISD) Annual Report entitled "NHSScotland Complaints Statistics – Year Ending 31 March 2002" be noted.
- That the extension to the Terms of Office of ten Lay Chairs and six Lay Conciliators be approved.
- That NHS Greater Glasgow Habitual and/or Vexatious Complaints Policy be approved.
- That the draft consultation document "Reforming the NHS Complaints Procedure" issued by the Scottish Executive be noted and the arrangements to respond to the document be endorsed.

**Head of Board Administration**

**Head of Board Administration**

**Head of Board Administration**

**39. CORPORATE GOVERNANCE FRAMEWORK**

A report of the Head of Board Administration [Board Paper No 03/23] asked the Board to note that in its annual review there were no changes proposed to the Corporate Governance Framework (with the exception of the amendments to the Register of Members Interests) and authorise the Board Chairman to approach and appoint, where necessary, NHS Board Members to vacancies on Standing Committees ensuring the smooth and effective operation of the Board's business.

**DECIDED:**

- That the annual review of the Corporate Governance Framework and amendments to the Register of Members Interests be noted.
- That the Board Chairman be authorised to approach and appoint, where necessary, NHS Board Members to vacancies on Standing Committees to ensure the smooth and effective operation of the Board's business.

**Head of Board Administration**

**Board Chairman**

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

A report of the Director of Public Health [Board Paper No 03/24] was submitted seeking approval of two 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.

**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 John Khaukha  
Dr Colin Preshaw

**41. MINUTES OF THE AUDIT COMMITTEE**

The Minutes of a meeting of the Audit Committee [A(M)03/1] held on Tuesday 28 January 2003 were noted.

**42. MINUTES OF THE RESEARCH ETHICS GOVERNANCE COMMITTEE**

The Minutes of a meeting of the Research Ethics Governance Committee [NHSGGREGC(M)03/1] held on Friday 31 January 2003 were noted.

The meeting ended at 12.20 pm