

GGNHSB(M)03/4
Minutes: 43 - 53

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 15 April 2003 at 9.30 am**

P R E S E N T

Professor Sir J Arbuthnott (in the Chair)

Mr J Best	Councillor J Gray
Dr H Burns	Mr P Hamilton
Mr R Calderwood	Mrs W Hull
Mr R Cleland	Mrs S Kuenssberg CBE
Councillor D Collins	Mrs R K Nijjar
Mr T A Divers OBE	Dr J Nugent
Councillor R Duncan	Mr A O Robertson OBE
Mr W Goudie	Mrs E Smith

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

Mr T Findlay	Greater Glasgow Primary Care NHS Trust (to Minute 50)
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
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

Mr S Bryson	Representative, Area Pharmaceutical Committee (to Minute 50)
Mr J Cassidy	Chair, Area Nursing and Midwifery Committee
Dr R Hughes	Chair, Area Medical Committee
Mr J McMeekin	Vice Convener, Greater Glasgow Health Council
Mr H Smith	Chair, Area Allied Health Professionals Committee

ACTION BY

43. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Ms R Crocket, Mr T Davison, Professor M Farthing, Mr I Reid, Ms E Borland, Mr A McLaws, Mrs C Anderson (Chair, Area Pharmaceutical Committee), Dr F Angell (Chair, Area Dental Committee), Mrs P Bryson (Convener, Greater Glasgow Health Council) and Ms G Leslie (Vice Chair, Area Optometric Committee).

The Chairman welcomed new NHS Board Members Peter Hamilton, Ravindar Kaur Nijjar and John Nugent. Mrs Pat Bryson had been appointed as Greater Glasgow Health Council's new Convener and was represented at the meeting by the new Vice Convener, John McMeekin.

44. CHAIRMAN'S REPORT

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

- (a) The procurement launch for the two Ambulatory Care Hospitals (ACADs) had been held at Hampden Park on 1 April 2003; this had been well attended. The Chief Executive would include the key milestones in the procurement plan in his next quarterly update to the Board.

A first meeting had taken place on 28 March 2003 of the two Monitoring Groups set up by the Minister for Health and Community Care to take forward the monitoring of the continuation of "named services" within Stobhill Hospital and the Victoria Infirmary, during the period prior to the rationalization of inpatient services. Both Monitoring Groups had agreed a remit of operation and a cycle of meetings.

- (b) At the request of Councillor Handibode, Dr Burns had contacted the Chief Executive and Director of Operations at Scottish Water concerning the transfer from Glasgow to Edinburgh of water testing functions. Dr Burns had been assured that the testing systems for cryptosporidium would remain at its present level and Scottish Water would ensure that the level of service was maintained with regular reports being carried out without interruption. To date there had been no schedule for the transfer but the NHS Board would be kept advised of developments.

- (c) Sir John and Mr Divers had had a series of discussions with providers of training and education in relation to taking forward Greater Glasgow's manpower requirements with Universities and education establishments. This series of events had started with Learning Direct.

Sir John had chaired several meetings in relation to the creation of a Centre of Population Health – working in partnership with Greater Glasgow's Universities and health care establishments. The remit of the Centre would be based on three components:

- research
- policy
- education and training

and all scientists and experts were committed to making it work. This was a positive reflection on what Glasgow had learned regarding social and health issues and provided a platform to build on this momentum.

- (d) Sir John asked the Board to note the Declaration of Interest of the three new Board Members.

NOTED

45. CHIEF EXECUTIVE'S UPDATE

Mr Divers advised that there had been an Area Partnership Forum Away Day on 9 April 2003 to discuss taking forward the partnership working implications in the recent White Paper – "Partnership for Care". The event had been facilitated by Frontline Scotland and an action plan formed. It would be passed to the Staff Governance Committee. A follow-up half-day seminar had been arranged for 30 May 2003 to take forward the action plan.

NOTED

46. MINUTES

On the motion of Dr H Burns, seconded by Mr A O Robertson, the Minutes of the meeting of the NHS Board held on Tuesday 18 March 2003 [GGNHSB(M)03/3] were approved as an accurate record and signed by the Chairman.

47. MATTERS ARISING

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

Further guidance had been received from the Scottish Executive Health Department on establishing Service Redesign Committees. Councillor Collins asked that in considering Non Executive Members to new Committees, this be deferred until after the Local Authority elections on 1 May when it would become clearer which Local Authority Councillors would be Members of the NHS Board. Mr Divers agreed to take this on board.

Chief Executive

Sir John updated Members on the following appointments to vacancies on Standing Committees:

Charles Scott – appointed as Convener of the Audit Committee
Peter Hamilton – appointed as a Member of the Audit Committee
Ravindar Kaur Nijjar – appointed as a Member of the Research Ethics Governance Committee

NOTED

48. IMPLEMENTING JOINT FUTURES : OUTCOME OF CONSULTATION ON INTEGRATION OF SERVICES – EAST DUNBARTONSHIRE

A report of the Director of Planning and Community Care [Board Paper No 03/25] asked the Board to note the outcome of the above consultation and ratify the proposed way forward outlined by the Joint Planning Forum.

Ms Renfrew reminded the Board that at its December 2002 meeting it approved for consultation proposals to move to integrated service delivery arrangements within East Dunbartonshire Council.

Ms Renfrew led the Board through the responses to the consultation and highlighted the four recommendations already endorsed by the Joint Planning Forum:

- (i) The early establishment of a Shadow Joint Health and Social Care Committee.
- (ii) The recruitment of a Head of Health and Community Care.
- (iii) The establishment of a Project Steering Group charged with managing the initial change programme.
- (iv) Immediate and ongoing communication with stakeholders.

The outcome of the consultation had already been considered and approved by the Joint Planning Forum with East Dunbartonshire Council which brought together Board Members, Local Councillors, the voluntary sectors and Local Health Care Co-operative (LHCC) representatives.

From the responses to consultation it was clear that there was broad support for the further integration of services but a recognition that a significant amount of work remained to be done on the detail. The recommendations to the Joint Planning Forum would address the Council's need for capacity and leadership to direct the next stage of development.

East Dunbartonshire Council's objective was that the four recommendations would enable it to address, in final proposals, the key issues from consultation including:

- Achieving local accountability for mental health within a system-wide approach.
- A relationship of the structure to children's services.
- A balance of locality and East Dunbartonshire wide arrangements.
- Whether planning and commissioning was included in the joint head's remit as well as operational management.
- Evolution paths for LHCCs including cross boundary issues.
- Maintaining and strengthening devolution and delegation.
- Achieving best standards of governance and professional accountability.

In considering these recommendations, Ms Renfrew asked the Board to reflect on the three issues most significant to the NHS:

- (i) Had the consultation process been appropriate and engaging?
- (ii) Whether the issues raised by the responses of NHS interests had been adequately addressed by the recommendations?
- (iii) A desire to see much more detailed proposals on governance and professional accountability arrangements for individual staff.

The proposed way forward and these points outlined gave a firm commitment to reflect carefully on consultation responses in moving forward to implement an integrated structure. The essence of what was proposed was to create leadership and capacity to work through the detail of an integrated structure in a way which could address the issues and concerns people had raised. The full integration would be implemented at the end of this development phase, which would be steered by a Project Group bringing together the main constituencies of interest. Critically linked to that process would be a focus on communication and continuing engagement of key stakeholders.

Ms Renfrew assured the Board that it could be confident the consultation process had fully engaged health staff and that the issues and concerns raised in consultation could be addressed by the recommendations – without mitigating the Board's commitment to move to integrated service delivery which would improve the experience of patients and users.

Councillor Duncan confirmed that East Dunbartonshire Council was committed to the process of delivering a range of community based health and social services in its geographical area. The Council had been impressed with the outcome of the consultation and was optimistic to press forward.

Mr Robertson advised that the Primary Care Trust was committed to the principles and direction of travel but recognised the concerns expressed by staff. He was encouraged by the emphasis on the development process, particularly appointing a Head of Health and Community Care – to lead the development process with a fully representative project team.

Mr Robertson further noted the importance of a very inclusive further process before the transfer of operational management responsibilities to the Head of Health and Community Care. Ms Renfrew highlighted the detail of the four recommendations as covering the further development work to lead to a definitive final structure. Mr Divers confirmed that if the expanded recommendations covered the ground required, that would enable ratification of the Joint Planning Forum's conclusions.

Dr Nugent outlined the significant staff challenges that lay ahead and sought more clarity around the control outcomes of the integrated working. Ms Renfrew referred to the measurable outcomes on pages 33 and 34 of the Board papers particularly in relation to older people, mental health and physical disability.

Mr Goudie encouraged the Local Authority and Primary Care Trust to work in partnership to address any practical problems on the staff side – one way to alleviate this would be to ensure that a staff representative was a member on the Joint Planning Committee. In response to this, Ms Renfrew advised that there was a strong relationship between the NHS and East Dunbartonshire Council where partnership working was active.

Councillor Collins commended this as a fine example of joint working and encouraged a roll-out of the good practice arrangements throughout other Council areas.

Sir John echoed the views already expressed in terms of the challenge of joint working that lay ahead particularly now that the concept and plan had been devised – the delivery would remain complex but exciting.

DECIDED:

- That the outcome of the consultation on joint future implementation – integrated services for East Dunbartonshire Council be noted.
- That the proposed way forward outlined in the paper (already endorsed by the Joint Planning Forum) be ratified as follows:
 1. The proposal for the establishment of a Joint Health and Social Care Committee received widespread support. It was proposed, therefore, that a Shadow Joint Committee be established in line with the recommendations in the proposal. The Shadow Committee should be constituted as early as possible to oversee the change programme.
 2. The recruitment of the Head of Health and Community Care should be progressed. Without the capacity such a post would create the NHS Board could not address the agenda of detailed work, which the consultation process, quite rightly, highlighted as required and which must be completed to deliver the integrated services which most people supported. The postholder's initial focus, estimated over the first twelve months, would be to develop and refine the integration proposal in light of the feedback from the consultation, working with the Project Group. The operational management of services would remain within the current configuration during that development phase. Thereafter, the Head would assume management responsibility and accountability, for the agreed range of services and the structure established in the development phase, reporting to the Joint Executive Group and through that to the Joint Committee. The final service and structure would be subject to East Dunbartonshire Council and Greater Glasgow NHS Board approval before the transfer of management responsibilities.
 3. A small project steering group with senior colleagues to represent East Dunbartonshire Council (Social Work and Corporate Services), the Primary Care Trust, the LHCCs and GGNHSB should be convened to manage the initial change programme. Immediate priorities would include:
 - the establishment of the Joint Committee
 - the process of finalising the remit and recruitment to the post of Head of Health and Community Care
 - development of the concept and functionality of a joint executive group
 - consideration and establishment of a joint integration support function (including existing and additional capacity) to address issues from the consultation around:
 - human resources
 - information sharing and information technology
 - finance
 - performance and clinical governance
 4. To ensure immediate and ongoing communication with stakeholders. Initially this would involve the next edition of the joint newsletter and Joint Future Update Seminar planned for 15 April 2003.

**Director of
Planning and
Community
Care
Director of
Planning and
Community
Care**

49. PRIMARY CARE ACCESS STRATEGY UPDATE

A report of the Chief Executive, Greater Glasgow Primary Care NHS Trust [Board Paper No 03/26] asked the Board to:

- Note the progress being made on access initiatives within the Primary Care Trust and to endorse continuation of the approach adopted.
- Note that practice redesign and triage training costs were not directly funded by the Scottish Executive and, as such their financing would need to be considered in finalising the priorities for the Local Health Plan.

The Chairman welcomed Terry Findlay, Greater Glasgow Primary Care NHS Trust who described the aims of the strategy. These were to improve access to services across a range of measures and at the same time support the short-term goal of ensuring access to an appropriate member of the primary health care team within 48 hours by April 2004.

He updated on the short term initiatives designed to meet the 48 hour commitment and referred to the achievements in respect of the overall strategy that had been documented in the Primary Care Strategy Phase 2. In the longer term, the access strategy was concerned with a fundamental rethink and redesign of services within primary care towards streamlining ways that patients may access these services. The long and medium term initiatives in the Access Strategy were an integral part of this.

Mr Findlay described the current situation and the two major stages in meeting the April 2004 position, that of practice redesign and assessment and triage. He was confident that by April 2004, sixty GP practices would have completed the programme for practice redesign with a further sixty giving a commitment for the following year. Seventy practices would have conducted and instigated telephone triage which would change the dynamics of service provision.

The current state of knowledge about timely access to services was growing but still insufficient to adequately monitor performance against the 48 hour target. At best, the Primary Care Trust could assume that 25% of practices were unable to meet the access target. The two main short term strategies of practice design and triage would advance significantly in the course of the next year and would, if other UK experience was consistent in Greater Glasgow, be able to address this short-fall as well as providing more confident measures of performance.

Dr Nugent referred to the major redesign pressure and highlighted that although Primary Care Trust teams were working very hard, it was paramount to identify what could be done smarter and better.

Mr P Hamilton referred to the disappointing uptake of only 50% of practices who had responded to the initial GP appointment stock take undertaken in June 2002. In response to a question from Mr Hamilton, Mr Findlay confirmed that one alternative method of data collection being explored was the "mystery shopper" method when someone from the Primary Care Trust could telephone a practice and ask for their earliest appointment. He was, nonetheless, confident that the Primary Care Trust would receive the relevant information from the majority of practices once it had been made clear what the information was being used for. He also described how patient satisfaction was measured in relation to the pilot trials in that a survey would be undertaken to determine usefulness.

Councillor Collins sought alternative methods to encourage all practices to respond to the stock take to ensure that the data received was relevant and to determine the Greater Glasgow wide picture particularly as decisions would be made on the data – if it had not been accurately measured it could not be accurately managed.

ACTION BY

Mr Divers set the goals of the strategy in the strategic context of the White Paper and the GMS contract which would ensure robust ways of engagement and incentives with practices. Furthermore, there were qualitative standards to ensure practice participation and this was a further opportunity to extract the data.

Sir John referred to the enthusiasm to take forward the pilot although recognised the challenge in engaging practices to work with the Trust to obtain the relevant information. He highlighted that there were benefits and positive outcomes for practices and patients in the success of this strategy.

DECIDED:

- That the progress being made on access initiatives within the Trust be noted and the continuation of the adopted approach be endorsed.
- That as practice redesign and triage training courses were not directly funded by the Scottish Executive, financing issues would need to be considered in finalising the priorities for the Local Health Plan.
- That Dr Nugent discuss the issues raised further at the next LHCC Committee meeting.
- That a further update report be brought to the NHS Board in six months.

**Chief Executive,
GGPCNHST**

**Chief Executive,
GGPCNHST**

**Chair, LHCC
Committee**

**Chief Executive,
GGPCNHST**

50. PUBLIC HEALTH ISSUE – GGNHSB CERVICAL SCREENING PROGRAMME – ANNUAL REPORT 2001/2002

A report of the Director of Public Health [Board Paper No 03/27] asked the Board to note the above report which outlined the performance of the screening programme within Greater Glasgow.

This was the twelfth annual report of the screening programme and Dr Burns referred to the steady progress in improving uptake. Women were sent invitations to be screened at least every five years (although, in practice, it was usually within three years). The Board measured uptake within sequential 5½ year periods since this was agreed as the time limit within which women should be invited and should attend for smears. Within the 5½ year period to 31 March 2002, the screening uptake was 83%. Within the same period leading to 31 March 2001, uptake was 81%. Dr Burns explained that uptake was related to deprivation status and in the year ended 31 March 2002, uptake improved in each deprivation category, reaching 88% in DepCat 1 and 80% in DepCat 7. The number of GP practices reaching over 80% uptake had improved from 69% last year to 78% this year.

Recent review of the screening programme had suggested ways in which the Board could improve the effectiveness of its reporting arrangements. There were also national programmes for the introduction of new technology for assessing the results of smears. This should lead to a reduction in the number of unsatisfactory smears when women were required to attend for a second examination. The Board also awaited a national call/recall system which would standardize processes and protocols across Scotland to develop a single national IT system – it was hoped this would be introduced within the next year.

Dr Burns referred to the recent inspection undertaken by NHS Quality Improvement Scotland – the report of which was awaited.

In terms of extracting relevant information from the current IT systems, this matter had been raised with Greater Glasgow's NHS Trusts to ensure that maximum use was made of the data available. Furthermore, Mrs Hull referred to the ICT Strategy and the strategic direction of travel in abstracting information to address clinical needs.

Dr Burns referred to the "did not attend (DNA)" rate and ways of looking at reducing this and ensuring women took the opportunity to look after their health.

Dr Hughes referred, in general, to the increasing DNA rates across all specialties in Greater Glasgow which presented significant problems across the board. Any incentive/sanction to alleviate this would be difficult to enforce. Dr Nugent referred also to the fact that smear tests were not compulsory and that women did have a choice on whether to attend. It was recognised, however, that in exploring ways to reduce DNA rates, there were implications for effective management and secretarial services in terms of resources and organisation.

DECIDED:

That the GGNHSB Cervical Screening Programme – Annual Report 2001/2002 be noted.

51. WAITING TIMES

A report of the Director of Planning and Community Care [Board Paper No 03/28] noted progress towards delivering the Board's agreed over nine-month waiting time reduction. There had been a reduction of 37% in NHS Greater Glasgow residents with a guarantee waiting over 9 months between February 2003 and March 2003 – this showed significant progress towards meeting the December 2003 target. Furthermore, the March guarantee position reflected a 50% reduction since April 2002.

Ms Renfrew referred to the planning processes in place to ensure that the Board continued to move towards these commitments including:

- Maximum wait for inpatient and day case treatment of 9 months by December 2003.
- Maximum wait for inpatient and day case treatment of 6 months by December 2005.
- Maximum wait for outpatient appointments of 26 weeks by December 2005.

NOTED

52. 2002/03 FINANCIAL MONITORING REPORT FOR ELEVEN MONTHS ENDED FEBRUARY

A report of the Director of Finance [Board Paper No 03/29] asked the Board to note the results reported for the eleven months ended 28 February 2003.

Trusts were reporting a £2.557M deficit against the break-even target for the eleven months to February 2003. It was still forecast that a break-even position would be achieved for the full year and the reported overspend at the Primary Care Trust would be funded from brought forward reserves.

ACTION BY

Sir John referred to the significant effort of financial management on the part of the four Greater Glasgow NHS Trusts and NHS Board staff – he congratulated all for their efforts.

Mr Robertson sought clarification around the figures shown for health promotion/other services and Board Headquarters. Mrs Hull agreed to report back on the detail of these figures.

**Director of
Finance**

DECIDED:

That the results reported for the eleven months ended 28 February 2003 be noted.

**53. ETHICAL STANDARDS IN PUBLIC LIFE – CODE OF CONDUCT FOR
NHS BOARD MEMBERS**

A report of the Head of Board Administration [Board Paper No 03/30] asked the Board to:

- Note the requirement that Members re-familiarise themselves with the Code of Conduct for Members of Greater Glasgow NHS Board.
- Agree to the appointment of the Head of Board Administration as the “Standards Officer” under Section 7.1 of the Act.
- Approve the amendment to Standing Order 11.
- Note the requirement associated with the completion of the Declaration of Interests and that the Head of Board Administration would write to all Members shortly on the completion of their Declarations.
- Note the additional guidance provided by the Standards Commission for Scotland on the Ethical Framework – Relationship between Standards Commission and Public Bodies, Duties of Public Bodies and to Promote High Standards of Conduct and the Register of Interests.

Mrs Smith referred to the Guidance issued by the Standards Commission for Scotland and the Act which introduced a new ethical framework for public life in Scotland.

The model code of conduct had been adopted by the NHS Board in July 2002 and its impact on the Register of Members’ Interests had been referred to in the review of the Corporate Governance Framework which was submitted to the October 2002 and March 2003 NHS Board meetings. Now that the Code of Conduct had been formally agreed by Ministers, there were a number of actions which needed to be put in place.

DECIDED:

- That the requirement on Members to re-familiarise themselves with the Code of Conduct for Members of Greater Glasgow NHS Board be noted.
- That the appointment of the Head of Board Administration as the “Standards Officer” under Section 7.1 of the Act be agreed.
- That the amendment to Standing Order 11 be approved.

**Head of Board
Administration**

**Head of Board
Administration**

**ACTION BY
Head of Board
Administration**

- That the requirement associated with the completion of the Declaration of Interests be noted and that the Head of Board Administration write to all Members shortly on the completion of their Declarations be agreed.
- That the additional guidance provided by the Standards Commission for Scotland on the Ethical Framework be noted.

The meeting ended at 11.15 am