

GGNHSB(M)03/5
Minutes: 54 - 68

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 20 May 2003 at 9.30 am**

P R E S E N T

Professor Sir J Arbuthnott (in the Chair)

Dr H Burns
Mr R Calderwood
Councillor D Collins
Ms R Crocket
Mr T Davison
Mr T A Divers OBE
Mr W Goudie

Mr P Hamilton
Councillor J Handibode
Mrs S Kuenssberg CBE
Mrs R K Nijjar
Dr J Nugent
Mr A O Robertson OBE
Mrs E Smith

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

Dr S Ahmed
Ms E Borland
Ms S Gordon
Mr J C Hamilton
Mr A McLaws
Ms C Renfrew
Mr J Whyteside

Consultant in Public Health Medicine (for Item 63)
Acting Director of Health Promotion
Secretariat Manager
Head of Board Administration
Director of Corporate Communications
Director of Planning and Community Care
Public Affairs Manager

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

Dr F Angell
Mr J Cassidy
Ms G Leslie
Ms M Wilmot

Chair, Area Dental Committee
Chair, Area Nursing and Midwifery Committee
Chair, Area Optometric Committee
Vice Chair, Area Allied Health Professionals Committee

N H S 2 4 R E P R E S E N T A T I V E S

Ms M Brannan
Dr L Duncan
Mrs C Lenihan
Ms E Muir

Communications Manager
Associate Medical Director
Chairman
Deputy Director of Nursing

54. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Mr J Best, Mr R Cleland, Councillor R Duncan, Professor M Farthing, Councillor John Gray, Councillor J Handibode, Mrs W Hull, Mrs C Anderson (Chair, Area Pharmaceutical Committee), Mr H Smith (Chair, Area Allied Health Professional Committee) and Dr B West (Chair, Area Medical Committee).

The Chairman welcomed representatives from NHS24 who were in attendance to present to the NHS Board the progress since NHS24 was launched within Greater Glasgow in November 2002.

In noting Councillor J Gray's apologies, the Chairman acknowledged it would have been his last meeting representing Glasgow City Council. He thanked Councillor Gray for his valuable contribution to the Board and in particular his leadership in taking partnership working forward especially in Learning Disabilities and the relocation of patients from Lennox Castle Hospital.

55. CHAIRMAN'S REPORT

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

- (a) Both the national and local elections had been concluded and the Chairman had written to all elected MSPs within Greater Glasgow to confirm his intention to have quarterly meetings with them. This was welcomed by the Board.

With regard to the local elections, he congratulated the Councillors on the NHS Board who had been successfully retained by their local electorate. New Council nominations from Glasgow City and West Dunbartonshire were awaited.

- (b) The Chairman congratulated the NHS Board Corporate Communication Team and Partnership Co-ordinator for the production of NHS Greater Glasgow's Staff News – Issue 1. This was a new staff magazine inspired and written by staff for staff and had the full support of the Partnership Forum. Mr McLaws had received positive feedback about the newspaper. In response to a question from Councillor Collins, it was agreed that the magazine should be distributed to Greater Glasgow's Health Centres via the Primary Care Trust. In connection with the NHS Health Newspaper, Mr McLaws advised that the next edition was due mid June.
- (c) The Chairman had arranged a meeting with Professor Sir G Davis and colleagues from Glasgow University and external advisers in taking forward the creation of a Centre of Population Health in Glasgow.

NOTED

56. CHIEF EXECUTIVE'S UPDATE

Mr Divers advised that there had been a meeting of NHS Board Chief Executives to develop thinking on regional planning arrangements arising from the NHS White Paper 'Partnership for Care'. This had been a productive session with the group looking at the key issues to work through the formulation of arrangements.

NOTED

57. MINUTES

On the motion of Mr R Calderwood, seconded by Dr J Nugent, the Minutes of the meeting of the NHS Board held on Tuesday 15 April 2003 [GGNHSB(M)03/4] were approved as an accurate record and signed by the Chairman.

58. MATTERS ARISING

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

NOTED

59. NHS24 - PRESENTATION

The Chairman welcomed Mrs C Lenihan, Chairman, NHS24 who in turn introduced Dr L Duncan, Associate Medical Director, Ms E Muir, Depute Director of Nursing and Ms M Brannan, Communications Manager.

Mrs Lenihan explained that although NHS24 was a new member of the NHS family, it worked within the same policy context, providing 24 hour access to health information and advice over the telephone.

She described the NHS24 core services which centred around the needs of individual patients when their call was received. Tier 1 of the service involved the call handler assessing whether the patient required healthcare information and advice or a nurse led consultation. Tier 2 involved integration with other bodies such as the Scottish Ambulance Service, A & E Departments and the out of hours GEMS Service. Tier 3 comprised the aspirational connections for NHS24 and looked at services such as dental treatment, pharmacy, community nursing and midwifery.

In terms of service provision in Greater Glasgow, Dr Duncan advised that NHS24 received on average 5,000 calls per week – 99% of these calls were answered in less than 30 seconds and the total call duration was 10 to 12 minutes on average. In terms of out of hours outcomes, 3% were transferred to the Scottish Ambulance Service, 5% to A & E and 60% to the patient's GP.

Dr Duncan advised that NHS24 received regular feedback from partner organisations which often highlighted how improvements could be made particularly in relation to demography accuracy and inappropriate referrals. Furthermore, an analysis was ongoing on the IT systems with modifications being carried out currently. In terms of future developments, NHS24 were looking to expand into the areas of dental advice and referral, and protected learning time cover for GP practices.

Dr Duncan thanked NHS Greater Glasgow for working in partnership with NHS24 to support its learning as it sought to improve the quality of its service.

In response to a question from Sir John, Dr Duncan confirmed that the IT providers were fulfilling their contract albeit that there had been a few minor unexpected difficulties with the operating and communication links. NHS24 had a paper back-up system which they had relied on for short periods of time when the system had been down – at no time had there been an adverse effect to patients and system modifications were being made to remedy this.

Mrs Lenihan explained that NHS24 had looked at scenario planning anticipating strategies such as disaster recovery and were satisfied that calls could switch between the three NHS24 centres in Scotland ensuring full business continuity.

In response to a question from Ms Crocket, Ms Muir confirmed that direct referrals could now be made to Community Psychiatric Nurses (CPNs) via the NHS24 IT system. As it was at the moment, there was no planned date for further roll-out of NHS24 in the West of Scotland. Ms Muir confirmed that she was happy with the staff complement as it stood at the moment and 10% of staff who were working full-time now worked part-time in an effort to continue experience of clinical nursing.

In response to a question from Mrs Nijjar, Ms Brannan confirmed that NHS24 used a language line service which allowed them to access around 200 different languages.

In response to a question from Mr Reid, Mrs Lenihan advised that the NHS24 Board would be looking soon at the demographics of those using its service to establish if there were any pockets where further work could be done to raise awareness of NHS24.

In response to a question from Mr Goudie, Ms Muir advised that there was a national partnership group within NHS24 and furthermore a local one in each centre.

The Chairman thanked the NHS24 staff for attending the Board and giving a very informative update of ongoing progress.

NOTED

60. IMPROVING HEALTH IN SCOTLAND : THE CHALLENGE

A report of the Acting Director of Health Promotion [Board Paper No 03/31] asked the Board to note the main element of “Improving Health in Scotland : The Challenge” and the work underway in Greater Glasgow to address this challenge as well as considering the Local Health Plan Steering Group recommendations as contained in section 4 of the Board Paper.

Ms Borland outlined the main elements of Improving Health in Scotland : The Challenge which had been issued by the Scottish Executive to provide a strategic framework for the delivery of a more rapid rate of health improvement in Scotland. She outlined the objectives of the Challenge document which was to be the first in a series and was aimed primarily at the period to mid 2004, at which point a second phase of the framework would be published. While work was expected to continue in all determinants of health, for the first phase of the Challenge, the main focus was on the following five key risk factors affecting health:

- tobacco
- alcohol
- low fruit and vegetable intake
- physical activity levels
- obesity

and working in the four following areas:

- early years
- teenage transition
- workplace (working-age people)
- communities

Work on the key themes within these four areas would be measured through the Performance Accountability Framework for health improvement. Ms Borland led the Board through examples of the extensive range of work currently underway to meet the Health Improvement Challenge in Greater Glasgow. She set this in the context of Glasgow being the most income deprived local authority area in Scotland with one-third of the worst 10% of wards for unemployment and nearly one-half of the worst 10% for health. The Board's health improvement efforts were, therefore, set firmly within the social inclusion framework.

At their meeting on 12 May, the Local Health Plan Steering Group discussed the potential to maximise some of the opportunities provided by the city's review and take a West of Scotland approach on a few key priority health issues with a view to achieving the "step change" required by the Challenge.

Smoking prevention was considered the area that would most benefit from such a focused and co-ordinated approach, particularly in achieving a situation where smoke free becomes the norm in all public places. This would require the concerted efforts of the relevant NHS Boards, local authorities and their community planning partners, as employers, service providers and policy makers in operating no smoking policies in all spheres of their activities.

Other areas of health improvement where the Steering Group considered a more focused and co-ordinated approach could make the difference were alcohol, nutrition and employment.

Councillor Collins welcomed the Challenge but highlighted a need to ensure that local priorities within different local authority areas varied. He referred back to the Chairman's commitment to meet Glasgow's MSPs quarterly and encouraged similar meetings with politicians in local authority areas who had responsibility for health and social work. Sir John welcomed this suggestion. Mr Divers confirmed that the Challenge would reflect local priorities particularly as the Local Health Plan Steering Group had input from all six of Greater Glasgow's local authority partners.

Mrs Kuenssberg welcomed the inclusion of the two areas of early years and teenage transition. She highlighted, however, the gap between the two and the importance in defining early years and teenage transition to ensure continuity of services particularly to vulnerable groups – narrowing this gap.

Mr Divers confirmed that assessment of progress within Greater Glasgow would be made prior to the NHS Board's Accountability Review meeting set for 25 June.

DECIDED:

- That the main element of “Improving Health in Scotland : The Challenge” and work underway in Greater Glasgow to address this Challenge be noted.
- That the Local Health Plan Steering Group recommendation (as contained in Section 4 of the Board Paper) be approved.

61. IMPROVING MATERNITY SERVICES – THE NEXT STEPS

A report of the Director of Planning and Community Care [Board Paper No 03/32] asked the NHS Board to approve the proposed process to establish a Working Group with a remit to:

- Comprehensively review and provide advice on how to provide modern, safe and sustainable maternity delivery services for the NHS Board’s population as the final stage of implementing the Maternity Services Strategy.
- Carry out its work in a fully engaging, transparent and accessible way.

The NHS Board was also asked to approve the establishment of a comprehensive effort, through the Maternity Services Liaison Committee’s (MSLC’s) consultation network, to engage consumer interests in maternity services to further inform its decisions.

Ms Renfrew explained that this was the final strand in implementing the Maternity Services Strategy, which was developed in partnership with women and had already achieved a number of the priorities they set for services. These included strengthened community services, innovative maternity centres, improved relationships with primary care and better information and support for pregnant women.

Ms Renfrew outlined the review of the Maternity Services Strategy which had been conducted under the auspices of the Maternity Services Liaison Committee (MSLC) in 1999. Following the MSLC report, the Board undertook a major consultation exercise in autumn 1999 and, in reviewing the outcome of the consultation in November of that year, approved a Maternity Strategy with a series of recommendations including a reduction in delivery units from three to two. In parallel to the extensive programme of public engagement around the Maternity Strategy and full consultation to debate the options for the future shape of delivery services, the Acute Service Services Review raised the question of the future siting of paediatric services – it was concluded that a combined process for paediatrics and the maternity services should be a core component of the further development of the Acute Services Strategy. By late 2001, that further development and consultation had concluded that decisions on the siting of paediatrics and the delivery component of maternity services should not form part of the overall Acute Services Review.

Ms Renfrew proposed a way in which the Board should arrive at a fully informed view on the future pattern of delivery units in advance of formal public consultation. Key aims of that process were to enable all the clinical, professional and women’s interests to have their say in this important decision and to ensure that the Board was fully advised on all aspects of this matter prior to reaching conclusions. She also described the policy context, regional planning dimensions and the key clinical, service and financial issues.

The Princess Royal Maternity Hospital (PRMH) at present delivered around 4,800 babies against a probable capacity of 6,500 and, therefore, had unused facilities. The Queen Mother's (QMH) and the Southern General (SGH) delivered respectively, 3,400 and 3,000 babies each year operating at around 60% of their potential capacity. Both had ageing facilities which needed capital investment to provide a modern standard of accommodation.

There were a number of important issues which needed to be considered in determining the future pattern of delivery services. The primary concern must be to achieve the highest standard of care and safety for women and their babies. This meant the need to consider carefully the relationship between maternity services and the needs of women and babies who experienced complications or problems during delivery, recognising that for the vast majority of patients, this was an uncomplicated and happy event. The NHS Board also needed to ensure that it was providing care in modern facilities, properly used, and that those services were accessible to women and their families.

The question of which delivery unit should be developed as Glasgow's second centre for the future was a complex one, with a number of clinical, patient and financial factors which needed careful evaluation. Ms Renfrew outlined the intention to ensure that before the NHS Board developed its proposals for formal consultation all of the critical issues were carefully and transparently considered in a way which enabled strong public and professional engagement. As such, the paper proposed the establishment of a small Working Group which would consider all of the available evidence and information. This would include a number of sessions, open to the public, where key interests would have the opportunity to set out their views for discussion and debate. The Working Group would be independently chaired and would include four non Executive Board Members. In addition to this Working Group it was intended to identify the consumer interests and networks around maternity services and establish a process to brief those interests and networks on the key issues. This would enable a range of patient views to be fully included in the Board's evaluation. To this end, the attachment to the Board Paper provided further detail on this approach of communication. These two important strands of work should be completed by the middle of August 2003 to enable the Board to formulate propositions and embark on formal public consultation in October 2003.

Councillor Collins referred to the contribution that could be made to the Working Group from the Women's Policy Group and the six local authority partners who would be able to assist in the process.

Mrs Kuenssberg raised concern about the timescale but was assured by Mr Divers that in aiming to embark on formal public consultation in October 2003 this afforded plenty time for all key players to contribute to the process.

Mr P Hamilton suggested the involvement of the new Public Involvement Management Committee who would be another body that could actively contribute to this.

Mrs Smith welcomed such a thorough process of public consultation which may be regarded as a template in Greater Glasgow for future consultation exercises.

DECIDED:

- That the proposed process to establish a Working Group with a remit to:

**Director of
Planning and
Community Care**

ACTION BY

➤ Comprehensively review and provide advice on how to provide modern, safe and sustainable maternity delivery services for the NHS Board's population as the final stage of implementing the Maternity Services Strategy;

➤ Carry out its work in a fully engaging, transparent and accessible way

be approved.

- That the establishment of a comprehensive effort, through the Maternity Services Liaison Committee's (MSLCs) consultation network to engage consumer interests in maternity services to further inform its decisions be approved.

**Director of
Planning and
Community Care**

62. WHITE PAPER – PARTNERSHIP FOR CARE

A report of the Director of Planning and Community Care and NHS Board Chief Executive [Board Paper No 03/33] was submitted asking the NHS Board to endorse:

- the proposed development process for Community Health Partnerships;
- the arrangements to begin to establish a Service Redesign Committee;
- The proposal to establish a Performance and Resources Monitoring Group.

A series of organisational changes were proposed in the White Paper to deliver a series of imperatives for the NHS in Scotland and NHS Boards were required to deliver on a number of actions including:

- Developing proposals for the transition to Community Health Partnerships (CHPs).
- Establishing a Service Redesign Committee.
- The need for cross system, unified working and clear arrangements for corporate governance, including performance management.

Each one was taken in turn.

(i) Community Health Partnerships

The White Paper acknowledged the progress made by Local Health Care Co-operatives (LHCCs) in developing into responsive and inclusive organisations. It proposed, therefore, their evolution into Community Health Partnerships (CHPs) with an enhanced role in service planning and delivery.

The White Paper was neither detailed nor prescriptive in its proposition about Community Health Partnerships. Reflection on the NHS Board's local context should form an important part of the debate about what it wanted to achieve in moving to CHPs. Ms Renfrew set out how this might be organised and debated by proposing three strands of activity as follows:

- Establishment of a Board Wide Steering Group, bringing together the representatives of the main interests to take responsibility for leading the development and implementation of CHPs. Membership should include LHCC representation from the professional advisory committee, key PCT staff, representatives from public health, health promotion and planning at GGNHSB and of acute and children's services.

- An early event, under the auspices of the Steering Group, to bring together a range of frontline staff to contribute their thoughts at the formative stage of developing this approach.
- Early engagement with each local authority and its LHCCs to ensure they influenced and informed overall development of CHPs and, particularly, the development and implementation of the CHPs for their area. This was probably best achieved through existing joint structures.

These proposals reflected initial discussions with LHCC interests, local authorities and the Primary Care Trust – the objective was that they should enable the NHS Board to bring forward detailed proposals for the pattern, scope and organisation of CHPs by the end of 2003 enabling formal consultation in the early part of 2004. Consideration would be given to the timescales, which had been set nationally. There was a common view that additional time may be required to ensure a well developed and sustainable set of proposals. The work of the Steering Group would need to link into the wider process to consider future operational arrangements across the Glasgow NHS. It was critically important that during this development phase momentum of progress led by LHCCs and the work with local authorities was maintained.

Mr Robertson was encouraged with this direction of travel which had a very worthwhile outcome and was pleased to note that a wide range of stakeholders had been included in the process.

Mr Goudie saw an ideal opportunity to involve the acute sector at an early stage to ensure the development and full potential of CHPs was achieved.

To this end, Mr Divers suggested using the model of joint chair leadership and suggested Ian Reid and Catriona Renfrew. The process in itself was complex particularly in relation to local authority boundaries and as such it was paramount to launch it appropriately.

(ii) Service Redesign Committee

The Health White Paper included a very strong cross-cutting focus on service redesign and NHS Boards were expected to co-ordinate redesign activity by putting in place service redesign programmes and developing a Change and Innovation Plan that was specific, prioritised and resourced.

With the NHS in Greater Glasgow, there were wide ranging and significant programmes of activity which met many of the aspirations of the White Paper in that redesign and modernisation should be at the core of the delivery of healthcare.

It was proposed to establish a shadow Service Redesign Committee, chaired by a NHS Board non Executive and including membership from professional advisory structures and staff partnership arrangements. Given the plethora of redesign, change and innovation already occurring across the NHS in Greater Glasgow, it was proposed that the Shadow Committee should, in its initial phase, focus on four key areas enabling the NHS Board to sign off final proposals to establish a substantive Committee in the autumn of 2003.

ACTION BY

Over and above the membership proposed for the Service Redesign Committee, Mr Goudie suggested the inclusion of a human resource function. This was taken on board particularly in relation to an organisational development (OD) capacity that this role may bring. Furthermore, it was anticipated that the new NHS Board Medical Director would be involved in this process.

(iii) Performance and Resource Monitoring Group

Mr Divers outlined the focus on delivery of consistent, high quality care across NHS Scotland and the enhanced role for NHS Quality Improvement Scotland and Audit Scotland in monitoring the quality of clinical care and of other supporting services.

It remained the role of the NHS Board itself to define and determine key strategic and policy issues. It was proposed that the Monitoring Group carried delegated responsibility on the NHS Board's behalf for the monitoring of organisational performance and of resource allocation and utilisation.

Mr Divers outlined the key responsibilities for the Group in relation to resources and organisational performance and one potential model would see the Group meeting on a two monthly cycle.

The NHS Board Chairman would chair this Group. Potential membership of up to ten members may include a spread of non Executive interests within the NHS Board, including the Employee Director, and a spread similarly of Executive representation from the NHS Board and NHS Trusts.

In response to a suggestion from Mr Robertson, Mr Divers related the Group's relationship to the NHS Board as formal in that Group reports would be submitted to the NHS Board, all papers sent to Group Members would be sent to all NHS Board Members for information and an open invitation to all NHS Board Members to attend this Group would be standard practice.

Councillor Collins raised concern that the Group could "approve annual financial allocations and investment plans as part of the update of the Local Health Plan". It was agreed that the word 'approved' be changed to 'consider'.

Chief Executive

Councillor Collins was reassured to note that the membership would first of all derive from those who expressed an interest.

Mrs Kuenssberg welcomed the formation of such a Committee which linked strategy and action at NHS Board level.

Ms Crocket recognised the status of the Group in terms of the business it was expected to undertake and suggested that the Clinical Governance Committee also link in.

DECIDED:

1. The proposed development process for Community Health Partnerships be endorsed.

**Director of
Planning &
Community Care**

ACTION BY
Director of
Planning &
Community Care
Chief Executive

2. The arrangements to begin to establish a Service Redesign Committee be endorsed.
3. The proposal to establish a Performance and Resources Monitoring Group be endorsed.

63. GENERIC INCIDENT MANAGEMENT/OUTBREAK CONTROL PLAN

A report of the Director of Public Health [Board Paper No 03/34] asked the Board to note the Generic Incident Management/Outbreak Control Plan.

Dr Burns welcomed Dr Ahmed, Consultant in Public Health Medicine, who explained that the Plan had been developed to form the basis of the NHS Board's response to incidents and outbreaks irrespective of source (deliberate or accidental). It formed part of the overall NHS Board's response to major incidents and should be read in conjunction with the NHS Board's Major Incident Plan and the Communications Strategy.

The Plan had been developed by Greater Glasgow NHS Board in consultation with its local authority environmental health departments following Scottish Executive guidelines issued in February 2003.

It aimed to provide a framework for the management of a co-ordinated response to any incident or outbreak within the NHS Board's area in order to protect the health of the public and outlined the actions to be taken by the NHS Board, local authority environmental health departments and other agencies in the event of suspected or actual incident or outbreak with potential public health implications.

Dr Ahmed advised that Greater Glasgow NHS Board was the lead agency in co-ordinating incidents and as such the communication about risk as well as advice was vital.

Dr Burns referred to the fine balance between communicating to the population to protect the public health and the legal and ethical responsibilities of the NHS to protect patient privacy. It was paramount to balance the two imperatives and this message would be taken forward with key interested parties and hopefully the media.

In response to a question from Councillor Collins, Dr Ahmed confirmed that the draft plan would go out to all Greater Glasgow's local authority partners for approval.

NOTED

64. ACCOUNTABILITY REVIEW 2002/03 : YEAR END UP-DATE OF PROGRESS

A report of the Chief Executive [Board Paper No 03/35] asked the Board to receive the year end up-date of progress in taking forward the priorities agreed at the 2002 Accountability Review Meeting with the Scottish Executive Health Department and note the arrangements for the 2003 Accountability Review Meeting which was to be held on 25 June 2003.

Mr Divers set out the six key action points agreed at the conclusion of the Accountability Review Meeting in June 2002 and provided a year-end up-date of progress ahead of the 2003 Accountability Review Meeting scheduled for 25 June 2003. The six key action points were:

- Managing within available resources
- Managing the Capital Programme to sustain implementation of the Acute Services Review
- Delivering the targets for waiting times
- Maintaining Progress on Developing the Beatson Oncology Centre
- Working to reduce the incidence of health care acquired infection
- Developing the staff governance agenda

The format of the Accountability Review Meeting would be based on a plenary meeting between NHS Board and Trust Chairs and Chief Executives and the Health Department's Senior Team, preceded by a discussion with members of the Area Partnership Forum. In addition, there would be a meeting with representatives of the Area Clinical Forum as part of this year's process. A full report on the outcome of the Review, with the agreed Action Plan, would be brought to the NHS Board at its August 2003 meeting.

DECIDED:

- The year-end up-date of progress in taking forward the priorities agreed at the 2002 Accountability Review Meeting with the Scottish Executive Health Department be received.
- That the arrangements for the 2003 Accountability Review Meeting scheduled for 25 June 2003 be noted.

65. WAITING TIMES

A report of the Director of Planning and Community Care [Board Paper No 03/36] noted progress towards delivering the NHS Board's agreed over nine month waiting time reduction.

Ms Renfrew explained that there was no longer a deferred waiting list and that all patients were now on a unified list which was made up of two categories:

- Patients without Availability Status Codes (ASCs)
- Patients with ASCs

The Availability Status Code removed the concept of guarantees and associated exceptions and replaced them with codes that described availability for treatment. Each patient whose circumstances prevented them from receiving an offer of admission for the specialty or procedure would have an ASC code applied. In terms NHS Greater Glasgow, there were 20,967 inpatient/day case patients waiting as at 30 April 2003. Of this, 667 patients were waiting over nine months at the end of April with no ASC code applied – it was planned to reduce this to zero by 31 December 2003.

Planning processes were in place to ensure that the NHS Board continued to move towards:

- Maximum wait for inpatient and day case treatment of 9 months by December 2003.

ACTION BY

- 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.

In response to a question from Mr P Hamilton, Mr Calderwood advised that work was ongoing to clear waiting lists in an attempt to treat patients with equal priority. Mr Davison advised that two specialties provided the longest waiting times, that of Orthopaedics and Plastic Surgery. It was agreed that future reports differentiate between the different ASC codes to provide further information.

**Director of
Planning and
Community Care**

NOTED

66. REFORMING THE NHS COMPLAINTS PROCEDURE : PATIENT FOCUS AND PUBLIC INVOLVEMENT - CONSULTATION

A report of the Head of Board Administration [Board Paper No 03/37] asked the NHS Board to note a tabled paper detailing the responses received to the consultation on the Complaints Procedure.

The consultation period ended on 2 June 2003 and a seminar had been held on 15 May 2003 in order that the proposals within the consultation document could be presented and feedback received from all NHS Greater Glasgow key complaints personnel.

Mr J Hamilton led the Board through the main outcomes deriving from the seminar which would form part of the Board's overall response to the consultation document. He encouraged any Board Member to feed in further comments to him for inclusion in this response.

**Head of Board
Administration**

NOTED

67. NHS GREATER GLASGOW AUDIT COMMITTEE - MEMBERSHIP

A report of the Head of Board Administration [Board Paper No 03/38] asked the Board to note the revision in the membership of the NHS Greater Glasgow Audit Committee and agree the two revisions to the Composition of the Committee.

DECIDED:

- That the Constitution, in relation to the appointment of a Convener, be amended to read:

"The Convener will be appointed from the membership of the Committee"

- That the revision in the membership of the NHS Greater Glasgow Audit Committee be noted.
- That the two revisions to the Composition of the Committee be agreed.

**Head of Board
Administration**

**Head of Board
Administration**

**Head of Board
Administration**

**68. MINUTES OF THE MEETING OF THE GREATER GLASGOW NHS
BOARD HEALTH AND CLINICAL GOVERNANCE COMMITTEE**

The Minutes of the meeting of the Greater Glasgow NHS Board Health and Clinical Governance Committee [GGNHSB(HCGC)(M)03/2] held on 6 May 2003 were noted.

The meeting ended at 12.15 pm