

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, G3 0YZ
on Tuesday, 16 September 2003 at 9.30 am**

P R E S E N T

Professor Sir J Arbuthnott (in the Chair)

Dr F Angell	Professor Michael Farthing
Mr J Best	Mr W Goudie
Dr H Burns	Mr P Hamilton
Mr R Calderwood	Councillor J Handibode
Mr R Cleland	Mrs S Kuenssberg CBE
Councillor D Collins	Mrs R K Nijjar
Dr B Cowan	Dr J Nugent
Ms R Crocket	Mr I Reid
Mr T Davison	Mr A O Robertson OBE
Mr T A Divers OBE (to Item 115)	Mrs E Smith
Councillor R Duncan	Councillor A White

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

Ms E Borland	..	Director of Health Promotion
Mr J C Hamilton	..	Head of Board Administration
Mr A McLaws	..	Director of Corporate Communications
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 P Bryson	..	Convener, Greater Glasgow Health Council
Mr J Cassidy	..	Chair, Area Nursing and Midwifery Committee
Ms G Leslie	..	Chair, Area Optometric Committee
Dr B West	..	Chair, Area Medical Committee

ACTION BY

109. APOLOGIES

Apologies for absence were intimated on behalf of Councillor J Coleman; Mrs W Hull; Mrs F Needleman, Chair, Area Pharmaceutical Committee; and Mr H Smith, Chair, Area Allied Health Professionals Committee.

110. CHAIRMAN'S REPORT

The Chairman intimated that this would be Professor Michael Farthing, Executive Dean of the Faculty of Medicine, University of Glasgow's last meeting of the NHS Board before taking up his new appointment as Principal, St George's Medical School, University of London. He thanked Professor Farthing for his contribution to the workings of the Board and Chairmanship of the Health and Clinical Governance Committee and Research Ethics Governance Committee and wished him well in his new appointment.

In reply, Professor Farthing stated how much he had enjoyed his involvement with the working of the NHS Board and wished the Chairman and Members well for the challenges that it faced over the coming years.

The Chairman welcomed Cllr. Andrew White, Council Leader, West Dunbartonshire Council, to his first meeting of the NHS Board and hoped he found his role as a Non-Executive Director both interesting and rewarding.

111. CHIEF EXECUTIVE'S REPORT

Mr Divers made reference to the following issues:-

- (i) An additional NHS Board meeting was being held at 10.30 a.m. on Tuesday, 7 October 2003 in the Community Central Hall, 304 Maryhill Road, Glasgow G20 7YE, to hear three Reports on Maternity Services:

- Report of the Maternity Working Group on the Future of Maternity Services in Greater Glasgow
- Report of the Midwives Forum
- Report from Glasgow's Maternity User Representation Group.

The normal monthly NHS Board meeting would be held at 9.30 a.m. on Tuesday, 21 October, also in the Community Central Hall, 304 Maryhill Road, Glasgow G20 7YE, and it would consider a consultation document on the Future of Maternity Services in Glasgow.

- (ii) A meeting had been held with the Chief Executive and Director of Social Work for South Lanarkshire Council to discuss Community Health Partnerships. Sir John Arbuthnott, Tom Divers and Catriona Renfrew had attended and further meetings had been planned with other Local Authorities – namely, East Dunbartonshire, East Renfrewshire and West Dunbartonshire.
- (iii) Mr Divers had been accompanied by Robert Calderwood, Tim Davison and Catriona Renfrew to a meeting with Argyll and Clyde NHS Board officers. This was part of a regular series of meetings to discuss issues of common interest. The recent meeting had considered Maternity Services, Mental Health Services, Adult Acute Services, Cancer Network and the development of Community Health Partnerships.

112. MINUTES

On the motion of Mr A O Robertson, seconded by Mrs S Kuenssberg, the Minutes of the meeting of the NHS Board held on Tuesday, 19 August 2003 [GGNHSB(M)03/08] were approved as an accurate record and signed by the Chairman, subject to the following amendments:-

Minute 98 – Chairman's Report – (a) 5th line

Delete: “The Chairman also reported that a new Principal was now in place at the University of Glasgow

Insert: “The Chairman also reported that the new Principal would take up his post on 1 October 2003 at the University of Glasgow

Minute 102 – White Paper: Partnership For Care – Consultation Proposals (iv)
Developing Community Health Partnerships – Page 7:1 Access

Add: “enable patients to move more readily to their home or care in a community setting”.

113. MATTERS ARISING FROM THE MINUTES

Members were circulated with the rolling action list which updated on the progress and timescale of the outstanding matters. In particular -

Minute 102 – White Paper: Partnership For Care – Consultation Proposals.

Ally McLaws reported that the consultation documentation and the summary version had now been sent out to the list of consultees and the Involving People list.

Mr McLaws also reported that the Annual Report was now being prepared together with arrangements for an AGM. The distribution of the Annual Report would include distribution in a local daily newspaper, together with distribution to a variety of outlets as part of the Health News.

114. SERVICE RE-DESIGN COMMITTEE - PROPOSALS

A report of the Director of Planning and Community Care [Board Paper No. 03/55] was submitted setting out the progress in developing proposals to establish a Service Redesign Committee.

The Scottish Health White Paper had given strong encouragement that:-

- (i) frontline staff should be leaders of the change process; and
- (ii) service change should be driven from the patient’s perspective and grounded in everyday patient experience.

The Scottish Executive Health Department had created and distributed a Change and Innovation Fund to NHS Boards where a satisfactory Change and Innovation Plan was in place. The Service Redesign Committee would be a focal point for this work and a stated objective was to ensure that there was a strong clinical input into the development and delivery of change and innovation plans.

Two short workshops were arranged with a wide range of interests, including clinical staff managers and the Local Health Council to debate the issues around remit, membership and the connections and linkages which the Committee could most benefit from. It was recognised that the Committee needed to add value to the work of the NHS Trusts and their staff in driving service change and innovation across the massive range of services currently delivered.

A number of headline themes emerged from the two workshops, namely:-

- Resources
- Staff capacity
- Membership
- Developing the plan
- Programme of activity

and each was covered in detail in the NHS Board paper.

It was intimated that Dr John Nugent would be willing to Chair the Service Redesign Committee. He stated he was keen that the Committee was formed from a balance of membership between innovators and enthusiasts and other clinical and managerial staff. He wanted to ensure that the Committee added value: he would be keen to establish the Committee by the end of the year.

Mr Goudie expressed disappointment that the Area Partnership Forum and the Trade Unions had not been involved in the debate so far; this would have been a good opportunity to exploit partnership working in this area. He was encouraged at the Partnership Support Unit being established in the North Glasgow Trust and this was an encouraging mechanism to include as many frontline staff as possible in key decisions and their involvement would lead to greater ownership and support of proposals.

The Area Partnership Forum had taken stock of all Committees and Groups across the NHS Board and Trusts to see how best staff partnership could be played in to these Committees/Groups. It was clear that there would be a capacity issue in trying to be involved in all Committees/Groups. It was recognised that there currently was staff involvement in many Committees/Groups as well as staff representatives involved in others and it was important to draw the distinction between the two.

Mrs Kuenssberg explained the process of offering bursaries or grants to individuals or teams at Yorkhill for carrying out redesign or training. This work could be shared by Helen Ostrycharz, Director of Human Resources, Yorkhill NHS Trust, if necessary.

There was already much under way in the field of redesign and innovation across a whole range of services and in forming a Committee to add value, it had to be ensured that it was complementary to what was currently under way and had appropriate linkages with relevant Committees and Groups.

Mrs Bryson and Mr Hamilton saw benefit in staff, patient and public involvement with the Committee and would work with Dr Nugent to see how this could be achieved.

Cllr. Collins suggested that a future Board Seminar should review the range of current Committees/Planning Groups, their roles and remits and how they related to each other. This would also help to identify clear linkages, any support required toward service change and encourage innovation as it interfaces with patients.

DECIDED:

1. That a seminar be held in November/December 2003 to consider the remit and structure of existing Committees and Planning Groups and how it can add value to innovation and redesign effort.
2. That a Service Redesign Committee reflecting the discussion be established.

**Director of
Planning and
Community Care**

**Director of
Planning and
Community Care**

**115. HEALTH AND WELL-BEING SURVEY OF THE GREATER GLASGOW
POPULATION**

A report of the Director of Health Promotion [Board Paper No. 03/56] was submitted asking that the Board consider:-

- (i) The impact of health inequalities and the effects of poverty and deprivation on health, with people in Social Inclusion Partnership (SIP) areas recording less favourable responses in all aspects of health.
- (ii) That there was evidence of improvements in health since the baseline survey in 1999.
- (iii) The encouraging indications that the policy of working in partnership and targeting resources and efforts to areas was resulting in positive changes in both lifestyle behaviours and life circumstances among people in SIP areas, and that in some aspects of health the inequality gap was closing.

The report summarised the main findings of the Health and Well-being Survey of the Greater Glasgow population carried out in September 2002. This was an important means of gathering information on the health status of the people in Greater Glasgow which complemented the mortality and morbidity statistics which were regularly collected. The survey collected information on aspects of people's lifestyles, their environment and personal and social circumstances that affect their health. The results were relevant to the NHS and the Local Authorities and their community planning partners in informing planning and activity aimed at improving the health and well-being and quality of life of people throughout the Greater Glasgow area.

A representative sample of 1,802 adults was interviewed about their perceptions, attitude and behaviour in relation to their physical, mental and social health. A response rate of 67% was achieved. A similar survey was carried out in 1999 acting as a baseline against which the results of the 2002 survey could be compared giving some indication of changes that had taken place in the last three years.

Thus far, the results had been analysed for the whole sample at a Greater Glasgow area-wide level only with an indication, where statistically significant, of differences between people living in SIP areas and non-SIP areas.

Key Results

(i) Perception of health and illness

Substantial differences in perceived health status were identified between SIP and non-SIP areas with those living in SIP areas consistently having a more negative view of their health than those living in non-SIP areas.

(ii) Use of Health Services

80% of respondents had visited a GP in the past 12 months and 50% had visited the dentist in the past 12 months. Residents in SIPs are less likely to be registered with a dentist (65% registered in SIPs, 75% in non-SIP areas).

The majority of health service users reported that they felt they had been given adequate information about their condition or treatment (80%); had been encouraged to participate in decisions affecting their health or treatment (70%); had a say in how the services are delivered (65%); and felt that their views and circumstances had been understood and valued (74%). 10% of people felt that they had not received adequate information and 18% of people had not been encouraged to participate in decisions affecting their treatment; 24% had not had a say in how services were delivered; and 14% did not feel that their views and circumstances were understood and valued

(iii) Health-related Behaviours

The results suggested that there had been a reduction of 4% overall in smoking. Whilst this may have been a proportional change and may not have been statistically significant at a confidence level of 99.9%, nevertheless, even a very small change in smoking rates would have had a significant effect on the health in Greater Glasgow and it was an encouraging finding.

There had been an increase in physical activity levels when compared to 1999 as well as an increase in the consumption of fruit and vegetables, a reduction in numbers of people eating high fat snacks, and a reduction in alcohol consumption. A cause for concern, however, was the high proportion of young women (16-24 years of age) who exceeded the recommended weekly limit of 14 units of alcohol.

(iv) Social Health

People in the SIP areas felt less connected and felt less of a sense of belonging and less valued as a member of their community. They also felt less safe in their neighbourhood and had a more negative view regarding problems and equality of services in their area.

Young people hanging around was the most frequently cited example of a common problem within an area (62%) and drug activity, excessive drinking, vandalism/graffiti were mentioned by around half as being very common/fairly common problems.

(v) Changes since 1999

The majority of change since 1999 had been positive in health improvement terms – the most positive change had taken place among residents in SIP areas, suggesting that measures to promote social inclusion and tackle health inequalities had been effective.

There were some areas where things appeared to have become worse:-

1. The number of people registered with a dentist had reduced by 7%
2. The number of people eating 5 slices of bread per day had reduced by 5%
3. The number of people belonging to a club had reduced by 10%
4. The number of people expressing a positive view of their local area had reduced by 6%.

In all of these areas the changes had taken place mainly in non-SIP areas.

There had been a number of positive changes in lifestyle, namely:-

1. The number of people eating five portions of fruit and vegetables a day had increased by 10%.
2. The number of people eating more than two high fat snacks had decreased by 22%.
3. Overall, the number of people exceeding the recommended alcohol limit had decreased by 5%.

4. There had been an increase of 12% in the number of people taking at least 30 minutes moderate activity five times per week.
5. There had been an increase of 9% in the number of people living in SIP areas who felt they had control over decisions that affected their lives.

(vi) Positive Change in Life Circumstances

1. 19% more people in SIP areas felt their area was a good place in which to raise their children.
2. There was an increase overall of 9% (16% in SIPs) in people saying they felt safe walking in their area, even after dark.
3. There had been a reduction overall of 14% (21% in SIPs) in the numbers of people without educational qualifications.
4. There had been a reduction of 8% overall in the numbers of people living in a household where no-one is employed.

The results of the survey, whilst requiring to be treated with due caution, highlighted encouraging signs that positive change had been achieved in the health of the whole population and, more significantly, in relation to the policy context of those living in SIP areas. The results of the survey suggested that the policies and programmes that had been implemented had laid the groundwork for further efforts to be successful.

Dr Burns welcomed the news of the improvements within the SIP and non-SIP areas and the fact that in some aspects of health the inequality gap was closing. He remained concerned, however, that in comparison with the health of the rest of Scotland we remained a long way behind and the morbidity statistics were not giving any indication of the narrowing of the gap and that remained a major challenge for the NHS Board. Dr Burns spoke about the Scottish Life Survey which was carried out every five years and the overall picture it can provide for all of Scotland and different parts of Scotland and it would be possible to extend that survey, at a cost, to a greater number of people and with a range of additional questions. The health promotion interventions were making a significant impact; however, almost a third of people living within SIP areas reported having a long term condition or illness that interfered with their day-to-day activities. Important issues of loss of control of their lives and low self-esteem affect a person's health and a major challenge facing all the bodies involved in social policy was to see how this could be challenged and improved.

Mr Robertson was encouraged by the recorded change and reminded Members that there were deprived areas within NHS Greater Glasgow that were not confined to the SIP areas and, therefore, some of the results in the non-SIP areas were also equally encouraging. It was an important piece of work that would assist the NHS Board in working with our Local Authority partners to continue to improve matters that affected health.

Cllr. White asked if there was any further analysis and whether the survey could be extended into other areas. For this survey additional information would be available for Glasgow City, East Dunbartonshire and South Lanarkshire. There was the potential to extend this to other areas in future surveys. The survey would also be reported to the Joint Community Care Committees and Community Planning Committees with the Local Authorities.

Mrs Nijjar asked about the population of the ethnic communities who had been included in the survey. Whilst they were proportional to the ethnic population within NHS Greater Glasgow's area, they were not significant enough in size to draw any particular conclusions as the sample size had been too small. Particular studies would look at this in more depth in the future.

Mrs Bryson said she had read in the local media that the North Glasgow Trust had amended its No Smoking Policy to include smoking areas within hospitals. Mr Davison replied that the North Trust was still committed to reducing smoking; however, they had taken steps to deal with a practical problem of hospital entrances being crowded with people smoking and giving a bad impression to visitors and others on entering hospitals. A discrete area adjacent to the main areas had been created to allow people to smoke and, in doing so, had improved the appearance of the front entrance of hospitals, dealt with some health and safety issues which had been raised and also complaints that had been received by management about people smoking at the entrances to hospitals.

Mrs Borland indicated that the NHS Board was still working towards the Tobacco Strategy which indicated working towards a smoke-free environment on an incremental basis and that we had to be careful, as Sir John reminded Members, not to send out mixed messages on this very important issue. Some hospitals and Trusts had very clear and explicit policies that smoking was not acceptable within hospital premises and this was reinforced by the message that smoking damaged health and the NHS should not be seen to be supporting its staff or visitors smoking within its premises.

Mrs Borland indicated that there was no shortage of challenges highlighted in this Health and Well-being Survey and in reducing smoking and that health promotion interventions would continue to strive towards making impacts into the various health targets and objectives. The results shown in this second Health and Well-being Survey had been an encouragement not only to her and her staff, but to the wide range of partners involved in work to improve health.

DECIDED:

1. That the Health and Well-being Survey of the Greater Glasgow population carried out in September – December 2002 be noted.
2. That the impact of health inequalities in the effect of poverty and deprivation on health with people in SIP areas recording less favourable responses in almost all aspects of health be noted.
3. That the evidence of improvements in health since the baseline survey in 1999 be noted.
4. That the encouraging indications that the policy of working in partnership and targeting resources and efforts to SIP areas was resulting in positive changes in both lifestyle behaviours and life circumstances among people in SIP areas and that in some aspects of health inequality gap was closing be noted.

**Director of Health
Promotion**

116. WAITING TIMES

A report of the Director of Planning and Community Care [Board Paper No 03/57] asked Members to note the provisional waiting list position as at 31 August 2003.

The data was presented in two formats:

- Table 1 showed all NHS Board residents without availability status codes (ASCs).
- Table 2 showed all NHS Board residents with availability status codes (ASCs).

Currently, 1,059 patients waited over nine months at the end of August with no availability status (ASC) codes and it was planned to reduce this figure to zero by 31 December 2003. To achieve this:-

- (i) It was planned to deliver an additional 3,200 in-patient and day case admissions to ensure that there were no waits in excess of nine months by December 2003 and sustained to March 2004.
- (ii) An in-year performance review and risk assessment of specific specialties that offer the greatest challenge, e.g. Orthopaedic Surgery, be carried out.
- (iii) The change in waiting time patterns on a weekly basis be monitored so that corrective action could be taken where necessary to improve performance.

Dr Nugent asked if the capacity was available to carry out the additional 3,000 in-patient and day case procedures. It was explained that between in-house initiatives, utilising the Golden Jubilee Hospital and the private sector should ensure that this level of patients is treated by the end of the year, thereafter the challenge would be to sustain the nine-month waiting time.

NOTED

117. QUARTERLY COMPLAINTS MONITORING REPORT – 1 APRIL TO 30 JUNE 2003

A report of the Head of Board Administration and Trust Chief Executives [Board Paper No. 03/58] was submitted setting out the Quarterly Report on Complaints in NHS Greater Glasgow for the period 1 April to 30 June 2003.

It was reported that the consultation period on the Reform of the NHS Complaints Procedure had now been completed and the Scottish Executive Health Department were considering the responses to consultation. Any new procedure was likely to be implemented from 1 April 2004.

NOTED

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

A report of the Director of Public Health [Board Paper No. 03/59] was submitted seeking approval of three medical practitioner 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 Brian Gillatt
Dr Rosemary McCaffery
Dr Myra David

119. MINUTES OF THE NHS GREATER GLASGOW ACUTE SERVICES COMMUNICATIONS MONITORING SUBGROUP: INVOLVING PEOPLE GROUP – 3 JUNE 2003

The Minutes of the meeting of the NHS Greater Glasgow Acute Services Communications Monitoring Subgroup: Involving People Group held on 3 June 2003 were noted.

120. MINUTES OF THE AREA CLINICAL FORUM MEETING – 18 AUGUST 2003

The Minutes of the meeting of the Area Clinical Forum held on 18 August 2003 were noted.

121. PERFORMANCE REVIEW GROUP MEETING – 29 AUGUST 2003

The Minutes of the meeting of the Performance Review Group meeting held on 29 August 2003 were noted.

The meeting ended at 11.10 a.m.