

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 8YZ
on Tuesday, 20 January 2004 at 9.30 am**

P R E S E N T

Professor Sir J Arbuthnott (in the Chair)

Dr F Angell	Mr W Goudie
Mr J Best	Mr P Hamilton
Dr H Burns	Councillor J Handibode
Mr R Calderwood	Mrs W Hull
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	Mrs E Smith
Councillor R Duncan	Councillor A White

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

Dr S Ahmed	..	Consultant in Public Health Medicine (for Minute 9)
Ms E Borland	..	Director of Health Promotion
Ms S Gordon	..	Secretariat Manager
Professor I Greer	..	Deputy Dean, Medical School, University of Glasgow
Mr J C Hamilton	..	Head of Board Administration
Ms M Henderson	..	Chair, Spiritual Care Short-life Working Group (for Minute 8)
Mr A McLaws	..	Director of Corporate Communications
Ms D Nelson	..	Communications Manager
Ms C Renfrew	..	Director of Planning and Community Care
Mr C Revie	..	PricewaterhouseCoopers (for Minute 7)
Rev B Robertson	..	Chaplaincy Co-ordinator, South Glasgow Trust (for Minute 8)
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	..	Chairman, Area Nursing and Midwifery Committee
Mr H Smith	..	Chair, Area Allied Health Professionals Committee
Dr B West	..	Chair, Area Medical Committee

ACTION BY

1. APOLOGIES

Apologies for absence were intimated on behalf of Mr C Fergusson (Chair, Area Pharmaceutical Committee) and Ms G Leslie (Chair, Area Optometric Committee).

2. CHAIRMAN'S REPORT

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

- (a) The NHS Board was now in its final stages of consulting on the Maternity Services proposals (the closing date for consultation was 20 February 2004). Seven public meetings had been arranged throughout the city with the first one taking place this evening at the Radisson Hotel, Argyle Street. A meeting had been held on the evening of Monday 19 January 2004, arranged by the Evening Times, which had been well attended.
- (b) Interviews were ongoing for new NHS Board Members. The recommendations of the interview panel would be made to the Minister of Health and Community Care prior to any new Members being formally appointed.

NOTED

3. CHIEF EXECUTIVE'S UPDATE

Mr Divers made reference to the following issues:

- (a) The Minister of Health and Community Care had issued a news release in connection with NHS Scotland's Revenue Allocations for the next financial year – 2004/05. The NHS Board's Director of Finance and colleagues were working on the NHS Greater Glasgow share and detailed proposals would come to the NHS Board when this exercise had been completed.
- (b) As reported at the December 2003 NHS Board meeting, Ms Crocket would chair the NHS Greater Glasgow Child Protection Group. In addition, a meeting had been held with the Chief Executive, Glasgow City Council, Chief Constable, Strathclyde Police and Mr Divers to agree the criteria of a Chief Officers' Executive Group to provide clear visible support for the work of the Child Protection Committee.

NOTED

4. MINUTES

On the motion of Mr A Robertson, seconded by Dr F Angell, the Minutes of the meeting of the NHS Board held on Tuesday, 16 December 2003 [GGNHSB(M)03/13] were approved as an accurate record and signed by the Chairman.

5. MATTERS ARISING

- (a) The Rolling Action List of Matters Arising was circulated and noted.

NOTED

6. COMMUNITY HEALTH PARTNERSHIPS : BOUNDARY PROPOSALS AND PRINCIPLES

A report of the Director of Planning and Community Care and the Chief Executive, Greater Glasgow Primary Care NHS Trust [Board Paper No 04/1] asked the NHS Board to approve initial proposals on Community Health Partnerships as a basis for consultation.

Ms Renfrew referred to the good progress made by NHS Greater Glasgow's sixteen Local Health Care Co-operatives (LHCCs) in delivering their key objectives. The White Paper was not detailed or prescriptive in its propositions about Community Health Partnerships and the NHS Board was moving to accelerate progress in a number of areas and explore other opportunities as the development of Community Health Partnerships emerged. Alongside the NHS Board's work with each Local Authority, the NHS Steering Group had begun detailed discussions about the organisational form that the Community Health Partnerships should take, the resources they should manage and how they should exercise their wider influence. The consultation proposals had been developed through a continuing programme of work with each Local Authority and the Steering Group – they had also been shared with Argyll and Clyde and Lanarkshire NHS Boards.

Ms Renfrew explained the proposed Community Health Partnership boundaries which had been developed in partnership with the Local Authorities. It was expected that the Community Health Partnerships would have substructures within the primary boundaries to reflect different communities and neighbourhoods and the different population clusters for their varied functions. The proposed boundaries would raise significant issues for a number of LHCCs and Area Social Work Teams within Glasgow City. NHS Greater Glasgow was committed, through the consultation process and the detailed work on schemes of establishment, to ensure that the positive gains of LHCCs were acknowledged and developed in these new structures.

It was anticipated that Community Health Partnerships would directly manage all NHS staff and budgets provided in their areas unless there were good reasons to favour an alternative arrangement. Such reasons might include issues about critical mass, the relationship between community based and specialist services and the way patients flowed through services. It would be important that all Community Health Partnership budgets reflected their population and level of deprivation.

Ms Renfrew outlined the anticipated key roles for the Community Health Partnerships and the work in progress to conclude issues around their NHS management responsibilities. She set out the current thinking on other dimensions for further discussion and debate including:

- partnership with Local Authorities
- delivering health improvement
- contributing to service and strategic planning
- influencing the provision of specialist services
- playing a major role in community planning and acting as a local focus for regeneration
- engaging and involving the local community

The key proposition was that Community Health Partnerships had massive potential to deliver better services and decisions for their populations, anchored in local accountability and responsibilities which connected wider health improvement with service delivery. Community Health Partnerships should not only be seen as a better way of managing and integrating NHS services but also as offering an organisation which could be a partnership with Local Authorities, giving the opportunity to integrate services and drive a joint health improvement agenda.

The consultation proposals on boundaries and direct management responsibilities would enable the NHS Board to seek views on core propositions about the organisation and resources for Community Health Partnerships. It would also enable the six key areas highlighted earlier to begin to be thoroughly debated.

Clear public information would be developed for this consultation exercise which would run in partnership with each Local Authority.

Councillor Collins was encouraged by the consultation proposals and acknowledged the vast array of work undertaken so far particularly by NHS and Local Authority Planning Officers.

Dr Nugent recognised the work going on throughout NHS Greater Glasgow to take this forward particularly in relation to formalising the CHP boundaries. He was anxious that the proposals for Community Health Partnerships to hold their own budgets, as described in paragraph 3.5 of the Board paper, may be too soon for such new organisations. He was also concerned about the proposed need to create mutual accountability between Community Health Partnerships and the NHS Operating Divisions for specialist NHS services. Ms Renfrew recognised these concerns but suggested that as Community Health Partnerships would not come into being until April 2005, a staged responsibility package could be explored, however, ultimate control would rest with the Community Health Partnerships. She envisaged that the scheme of establishment would take stock of such anxieties.

Dr West agreed with Dr Nugent's point that devolution of budgets to Community Health Partnerships may be premature. Many issues particularly in relation to prescribing, were national issues not local issues and such national guidance had to be adhered to. This may result in different decisions being made by Community Health Partnerships. In relation to specialist enhanced services, she was unclear how this could be devolved to a local level when it should be carried out on a city-wide basis in accordance with the Local Health Plan.

Mr Robertson referred to the ongoing work being taken forward with regard to prescribing by Greater Glasgow Primary Care NHS Trust's Medical Director, Dr Iain Wallace. As a result of this, changes had been taking place and cost was not the only criterion – performance and financial sustainability also had to be considered. To alleviate these concerns, he pointed out that the CHP governance arrangements would need to be watertight.

Councillor Handibode referred to a seminar held on 16 January 2004 in the Rutherglen/Cambuslang area. This area was also within Lanarkshire NHS Board area and work was going on to determine how best this could be taken forward particularly in relation to the size of any Community Health Partnership.

Mr Davison referred back to the GP Fundholding concept where prescribing budgets were devolved to practice level – nine Community Health Partnership budgets would give enough control and population base for local planning and delivery in an incremental and evolutionary way. It would maximise the potential for a locality with integrated health and social care. He was encouraged by the CHP concept.

Ms Renfrew referred to the flexibility in the formation of Community Health Partnerships particularly as work progressed with Local Authorities. It was anticipated that different arrangements and speeds of development would be seen with the nine Community Health Partnerships – it was not a case of “one size fits all”.

Councillor Duncan referred back to the cross-boundary concern with other NHS Board areas and welcomed the consultation period to resolve this.

Councillor Collins re-iterated that Community Health Partnerships would not operate in an isolated way but that community planning arrangements would be much more integrated with NHS and Local Authority involvement.

DECIDED:

That the initial proposals on Community Health Partnerships, as a basis for consultation, be approved.

**Director of
Planning and
Community Care
and Chief
Executive,
Greater Glasgow
Primary Care
NHS Trust**

7. ACUTE SERVICES IMPLEMENTATION : AMBULATORY CARE HOSPITALS PROCUREMENT PROCESS

Mrs Kuenssberg declared an interest in this item and, therefore, left the room for its consideration.

A report of the Programme Director (Acute Services), Chief Executive, Greater Glasgow NHS Board and Director of Finance, Greater Glasgow NHS Board [Board Paper No 04/2] asked the NHS Board to:

- (i) Consider the report on progressing the procurement of the Ambulatory Care Hospitals.
- (ii) Agree that the procurement should now include the provision of a new Day Surgery Theatre and Diagnostics Complex at Stobhill Hospital; and of 60 new-build rehabilitation beds at the Victoria redevelopment.
- (iii) Re-affirm the strategic imperative of progressing this procurement of the Ambulatory Care Hospitals as a crucial step in the NHS Board’s plan for modernising adult acute services care; and of ensuring that the forward financial plan supported the affordability of these developments, as an overarching priority, to be commenced in 2007/08, with full year costs to be met in 2008/09.
- (iv) Re-affirm the original funding of £15 million agreed for the provision of the Ambulatory Care Hospitals, updated to 2008/09 prices, together with additional revenue funding of £2.1 million, if required, to meet the additional costs of extending the brief, at (ii) above.
- (v) Amend its previous decision, in respect of the provision of “Soft” FM Services, to allow the development of an “in-house” bid, to be assessed alongside the bidder’s submission in order to ensure value for money was secured.
- (vi) Note the agreement for progressing with Glasgow City Council the outline planning and related issues.

- (vii) Receive verbal feedback from PricewaterhouseCoopers concerning key governance aspects relating to this paper.
- (viii) Authorise the Chief Executive and the Programme Director to release the FITN (Final Invitation to Negotiate) documentation to the consortium in February 2004.

Mr Divers outlined the background to the negotiated process with the single bidder based on the development of a robust process which would achieve best value for money with an appropriate set of governance arrangements. The development of these governance arrangements had had a number of strands. Firstly, PricewaterhouseCoopers, as external auditors, carried out a review of the project to the period ended 30 September 2003. This was presented to the NHS Board's Performance Review Group at its meeting on 22 October 2003 and provided additional assurance that appropriate arrangements had been put in place to obtain best value against the context of a single bidder.

The status review by PricewaterhouseCoopers also enabled the NHS Board Chief Executive to write to the Director of Performance and Finance at the Scottish Executive Health Department to ensure that the Health Department was content with the arrangements and that work with the single bidder should continue. A response was received on 3 December 2003 confirming that the Scottish Executive Health Department was content that appropriate governance arrangements were being developed and that work with the single bidder should continue. A further level of review of the project by Partnership UK (PUK), a consultancy which undertook key stage reviews of PPP projects on behalf of the Treasury, was also commended.

As the project was now nearing a point at which the Final Invitation to Negotiate (FITN) would be ready for issue, it was agreed that PricewaterhouseCoopers would undertake a further review of the project up to the current date so that it could offer the NHS Board its view of the robustness of certain of the best value considerations which had been developed further.

The brief for the project had been re-examined to ensure that the content of both Ambulatory Care Hospitals was comparable and provided the best, long-term arrangements for the delivery of care. The preparation of the initial brief for the Stobhill Ambulatory Care Hospital was based on the premise that the existing, 30 year old theatre suite and the adjoining Day Surgery Unit, developed in the early 1990s, would be upgraded and retained as part of the future Ambulatory Care Hospital. In comparing both the level and facility of theatre, investigative and day case provision which this upgraded scheme would offer, in comparison with the modern purpose built facilities specified for the Victoria Infirmary development, the Programme Director (Acute Services) and his Project Team concluded, with strong support from the Professional Advisers, that both developments should include the provision of new, purpose built day case theatres and diagnostic facilities.

The NHS Board's overall plan for the modernisation of Adult Acute Services included the provision of the replacement of elderly care services currently delivered from the Mansionhouse Unit in two settings, within the South-East and South-West of the city. The provision within the South-East comprised 60 beds for rehabilitation which it was proposed to develop alongside the Ambulatory Care Hospital. Initially, it had been planned that the replacement of the Mansionhouse Unit would be carried out in 2009/10. The opportunity was available, therefore, to include the re-provision of these 60 rehabilitation beds in the ambulatory care procurement, thereby allowing the whole campus development plan to be completed in a single phase.

Maintaining momentum in this procurement process was key to the modernisation of acute services care in NHS Greater Glasgow. It both involved the first stage of implementation of the acute services plan and would contribute materially to addressing the service and workforce challenges of the years ahead. Allied to a major programme of Service redesign, the provision of modern, fit-for-purpose facilities, with enhanced day case and diagnostic capacity, would allow increased “one-stop” provision for patients and help to unblock the current bottlenecks in care pathways. There was also an important issue of credibility with the public, NHS Greater Glasgow staff and elected representatives. Given the duration of the public consultation process and the ensuing decision making process, there still remained doubt in a number of quarters whether the promised modernisation of acute services care would be delivered. It was crucial, therefore, to be able to demonstrate to the wide range of interests involved that the NHS Board was now moving definitively to implement these key first stages of the Acute Services Plan.

Mr Divers outlined the two aspects of value for money and affordability which had to be addressed. The first centred on whether the costs now estimated remained in line with the original financial envelope which the NHS Board approved. The second retested whether the NHS Board’s financial plan for the years ahead would meet the revenue required to support this project. The NHS Board, in approving the Acute Services Review in March 2002, identified a recurrent funding requirement of £19.4 million for the first three major projects, that was, the North and South Ambulatory Care Hospitals and the Beatson redevelopment Phase II. As reported in December 2003, the Beatson Phase II additional recurrent costs were in line with the original affordability assessment of £4 million. Since that meeting, each of the Scottish West of Scotland NHS Boards had confirmed their share of the recurrent revenue requirements. Consequently funding available for the two Ambulatory Care Hospitals was reconfirmed at £15 million at 2006/07 prices, uplifted to £15.8 million at 2008/09 price base.

A Public Sector Comparator had been developed which was key to understanding the value for money aspect of the project and this calculation enabled the NHS Board to proceed to issue the FITN. The detail of the Public Sector Comparator calculations had been reviewed by the project’s Financial Advisers, Ernst and Young and by PricewaterhouseCoopers, external auditors. In line with this, work was also ongoing to prepare a detailed shadow bid which drew on reliable average and contract specific benchmarks – this would form a key part of contract negotiations.

The assessment of the overall revenue requirement for the two Ambulatory Care Hospitals included a provision for equipment which would be excluded from the PPP scheme and would, therefore, be financed through the NHS Board’s capital programme. The overall financial assessment of the two schemes assumed that the funding required for soft FM services would be matched by equivalent monies released from existing budgets held by the North and South Trusts.

In summing up, Mr Divers highlighted:

- The inclusion of the Mansionhouse beds and replacement theatres at Stobhill had increased both the capital and the consequent revenue funding requirements by £2.1 million per annum.
- On the basis of a like for like comparison with the initial brief for the Ambulatory Care Hospitals, the updated cost estimate was in line with the financial provision which the NHS Board agreed in March 2002.

- The forward financial plan would support the additional revenue requirement for the Ambulatory Care procurement. The financial envelope which the NHS Board agreed in March 2002 had been updated to reflect the current knowledge about future years' allocations and commitments. The revenue required for the Acute Services Review Phase I, including the additional £2.1 million (if required) for the Ambulatory Care Hospitals, would represent a first call against development monies available in the years preceding the first full year of operation, 2008/09. Since the NHS Board meeting in March 2003, there had been a series of further discussions which had resulted in a range of views on the arrangements for the provision of soft FM Services. The Project Team had explored whether use of a "best value" approach might be feasible but considered that the work involved in this would add three months to the timetable for implementing the project. Given that "value for money" could be delivered through the mechanism of the "variant bid", without extending the timetable, this was the preferred option.

Agreement for the sale to the South Glasgow Trust of the required portion of the Queens Park Recreation Ground was, in principle, in place. Additionally, detailed discussions about the mechanism by which a replacement relief road could be created to compensate for the closure of Annan Street were underway, such that each of the planning issues could be concluded within timescales consistent with the Consortium's development and submission of the final planning application.

Sir John confirmed the capital cost of expenditure of £190 million was broken down as follows:

- Stobhill Ambulatory Care Hospital - £83 million
- Victoria Infirmary Ambulatory Care Hospital - £108 million

Mr Revie, PricewaterhouseCoopers, summarised his findings under four key areas:

- affordability
- design fit for purpose
- public sector comparator
- shadow bid

- (i) Affordability – PricewaterhouseCoopers was satisfied that the reworked model was comparable with what the NHS Board had seen presented in March 2002. The NHS Board's Director of Finance had reworked the additional revenue costs and the external auditors had recognised the challenge regarding achieving an in-year balance but were comforted that the Acute Services Review Phase I would be given the first call on future years' development monies. On that basis, PricewaterhouseCoopers had concluded that the revisions made to Phase I were affordable.
- (ii) Design Fit for Purpose – PricewaterhouseCoopers was satisfied that there was lots of evidence regarding extensive consultation with clinical and user groups, special advisers and NHS colleagues to ensure that Phase I of the Acute Services Review was undertaken in a design fit for purpose.
- (iii) Public Sector Comparator – this would determine whether there would be value for money in the procurement process. Standard modelling techniques would be used to ensure a like for like comparison and PricewaterhouseCoopers were content that the procurement proceed along the current route.

- (iv) Shadow Bid – given that the NHS Board was in a single bid situation, Mr Revie re-iterated that the process had to be much more robust and this should be benchmarked with a commercial build to ensure that a good deal was being provided.

Mr Revie had been satisfied throughout his audit that all dealings had been open and transparent and throughout the process he had found no barriers from members of staff working on the process.

Mr Robertson commended all those involved for taking forward such a complicated process – he took comfort from the open and transparent manner of the information contained with the Board paper. He suggested that the fourth recommendation on the Board paper be changed to reflect that the Programme Director (Acute Services) would be charged with “a rigorous overhaul of the cost structure of the whole project in order to reduce this additional potential figure to the minimal level required”. Mr Divers agreed to this amendment.

Chief Executive

In response to questions from Dr Nugent, Mr Divers confirmed that there was a requirement for additional revenue sums given the enhancement of the services. The figures shown were, however, net figures and would take account of savings that could and would be made from moving away over time from other sites. The importance of the project was such that the additional £2.1m (if required) should indeed be a first call against development monies in the first full year of operation.

Mr Goudie highlighted the arrangements for the provision of soft FM services and the many discussions that had taken place with staff side interests who had accepted the recommendation of the “value for money” approach. Sir John thanked Mr Goudie for his role in assisting this process.

Mr Divers advised that the next step would be for the Programme Director (Acute Services) to issue FITN documentation in February 2004.

DECIDED:

- (i) That the report on progressing the procurement of the Ambulatory Care Hospitals be noted.
- (ii) That the procurement should now include the provision of a new Day Surgery Theatre and Diagnostics Complex at Stobhill Hospital; and of 60 new-build rehabilitation beds at the Victoria redevelopment be agreed.
- (iii) That the strategic imperative of progressing this procurement of the Ambulatory Care Hospitals as a crucial step in the NHS Board’s plan for modernising adult acute services care; and of ensuring that the forward financial plan supported the affordability of these developments, as an overarching priority, to be commenced in 2007/08, with full year costs to be met in 2008/09 be re-affirmed.
- (iv) That the original funding of £15 million agreed for the provision of the Ambulatory Care Hospitals, updated to 2008/09 prices, together with additional revenue funding of £2.1 million, if required, subject to a vigorous overhaul of the cost structure of the whole project in order to reduce this additional potential figure to the minimum level required to meet the additional costs of extending the brief, at (ii) above be re-affirmed.
- (v) That its previous decision, in respect of the provision of “Soft” FM Services, to allow the development of an “in-house” bid, to be assessed alongside the bidder’s submission in order to ensure value for money was secured be amended.

**Programme
Director – Acute
Services**

**Chief Executive
/Programme
Director – Acute
Services**

**Programme
Director – Acute
Services**

**Programme
Director – Acute
Services**

- (vi) That the agreement for progressing with Glasgow City Council the outline planning and related issues be noted.
- (vii) That verbal feedback from Pricewaterhouse Coopers concerning key governance aspects be received.
- (viii) That the Chief Executive and the Programme Director (Acute Services) release the FITN documentation to the consortium in February 2004 be authorised.

**Chief Executive
/Programme
Director – Acute
Services**

Mrs Kuenssberg returned to the meeting.

8. SPIRITUAL CARE POLICY

A report of the Director of Nursing, South Glasgow University Hospitals NHS Trust and Head of Board Administration, GGNHSB [Board Paper No 04/3] asked the NHS Board to:

- Note the outcome of consultation on developing a Spiritual Care Policy for NHS Greater Glasgow.
- Approve the Spiritual Care Policy for NHS Greater Glasgow.
- Approve the setting up of a Spiritual Care Committee as a Subcommittee of the Health and Clinical Governance Committee, under the chairmanship of Mrs R K Nijjar, Non Executive Director.

Ms Henderson explained the background to the formation of the Spiritual Care policy which had undergone a four month period of consultation between 25 June and 24 October 2003. She highlighted the main themes from the consultation and the amendments which had been made to the draft policy as a result of the consultation.

In response to a question from Mr P Hamilton, Rev Robertson confirmed that the chaplancy service at Stobhill Hospital was covered in the figures in Appendix C under North Glasgow Chaplancy.

Mrs Nijjar advised that she was looking forward to chairing the Spiritual Care Committee and the challenges that this brought.

DECIDED:

- That the outcome of consultation on developing a Spiritual Care Policy for NHS Greater Glasgow be noted.
- That the Spiritual Care Policy for NHS Greater Glasgow be approved.
- That the setting up of a Spiritual Care Committee as a Subcommittee of the Health and Clinical Governance Committee, under the chairmanship of Mrs R K Nijjar, Non Executive Director, be approved.

**Head of Board
Administration
Head of Board
Administration**

9. AIDS (CONTROL) ACT REPORT 2002/03

A report of the Director of Public Health [Board Paper No 04/4] asked the NHS Board to approve the submission of this year's Aids (Control) Act Report 2002/03 to the Scottish Executive and that it be published and widely distributed in accordance with the 1987 Act.

The Chairman welcomed Dr Syed Ahmed, Consultant in Public Health Medicine, to the meeting to present this paper.

During the year, there had been 85 newly diagnosed cases of HIV infection among Greater Glasgow residents. Of this 85, 28 probably resulted from sexual intercourse between men, 47 from sexual intercourse between men and women, 3 from mother to child transmission, 7 from other or uncertain routes and none from drug injecting. As last year, heterosexuals had the highest number of cases of any group – 55% of the total new cases reported.

Diagnosing HIV in a mother before birth enabled interventions that could prevent infection in the baby. The Scottish Executive recommended that all NHS Boards in Scotland introduce routine antenatal HIV screening for pregnant women. Antenatal HIV testing had been offered to all women receiving antenatal care in Glasgow since July 2003.

There were 24 new cases of AIDS reported during the year. Most of these were people who were unaware that they had HIV infection until they became seriously ill. There were 6 deaths during the reporting year which, despite the increase in new AIDS cases, reflected the efficacy of the drug treatment known as highly active anti-retroviral therapy (HAART).

Specialist services for people with HIV infection in Greater Glasgow were provided at the Brownlee Centre, the purpose built infectious diseases unit at Gartnavel Hospital. During the year, 443 patients were followed up of whom around 70% were treated with HAART.

The cost of HIV related treatment was nearly £2 million in the reporting year. As the number of patients being treated was expected to continue to increase, the cost of drug treatment was likely to rise in the foreseeable future.

The main targeted preventive measures continued to focus on reducing transmission between men who had sex with men and drug injectors. During the reporting year, approximately 1 million needles and syringes were issued. This number, although large, fell well short of the estimated 7 to 12 million needles and syringes that would be required to ensure that drug injectors used clean needles and syringes every time they injected.

Prevention of transmission due to heterosexual sex was addressed through the improvement in generic sexual health and family planning services in Greater Glasgow.

In response to a question from Sir John, Dr Ahmed advised that the NHS Board was taking a guide from the Scottish Executive Health Department on how to progress a sexual health campaign locally. Furthermore, within NHS Greater Glasgow, the Health Promotion Department was looking at the design of a sexual health campaign to commence end March/early April.

Dr Ahmed confirmed that the Brownlee Centre was under increasing pressure as the number of cases rose but that he was in liaison with North Glasgow Hospitals NHS Trust to take forward other options of attendance and support at the Centre such as running evening clinics.

DECIDED:

- That the AIDS (Control) Act Report 2002/03 be approved and submitted to the Scottish Executive Health Department.
- That the report be published and widely distributed in accordance with the 1987 Act.

Director of Public Health

Director of Public Health

10. WAITING TIMES

A report of the Director of Planning and Community Care [Board Paper No 04/5] asked Members to note that there were currently no patients waiting over 9 months at the end of December 2003 with no availability status code (ASC) applied, compared to 968 in December 2002.

All of the Glasgow Trusts, therefore, achieved the national target of no waits in excess of 9 months by the end of December 2003. This was now a guarantee.

The national targets now to be addressed were:

- No inpatient/day case waits in excess of 6 months - to be achieved by December 2005.
- No outpatient waits in excess of 26 weeks – to be achieved by December 2005.
- To continue to deliver and sustain all existing targets and guarantees.

In conjunction with the Trusts, the NHS Board was now preparing plans for incremental performance improvement in waiting times in 2004/05, towards achieving these December 2005 targets.

Sir John thanked all NHS Greater Glasgow staff involved in getting to this end point and meeting this target.

NOTED

11. PERFORMANCE REVIEW GROUP MINUTES – 18 DECEMBER 2003

The Minutes from the Performance Review Group held on Thursday 18 December 2003 [PRG(M) 03/05] were noted.

12. STAFF GOVERNANCE COMMITTEE MINUTES – 16 DECEMBER 2003

The Minutes from the Staff Governance Committee meeting held on Tuesday 16 December 2003 [SGC(M) 03/4] were noted.

Mr Goudie referred to the new Staff Governance Standard which was due to be considered by the Scottish Parliament this year which would thereafter be embedded in legislation.

He also referred to the parental leave policy which had not fully met the PIN Guideline. This may be a matter to be considered further at the NHS Board's Accountability Review meeting with the Scottish Executive Health Department.

13. AREA CLINICAL FORUM MINUTES – 17 NOVEMBER 2003

The Minutes from the area Clinical Forum meeting held on Monday 17 November 2003 [ACF(M) 03/4] were noted.

Dr Angell thanked the NHS Board for its continuing support to the Forum.

The meeting ended at 11.20 am