

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, 18 May 2004 at 9.30 am**

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**P R E S E N T**

Professor Sir J Arbuthnott (in the Chair)

Dr F Angell	Councillor R Duncan
Mr J Bannon MBE	Mr W Goudie
Mr J Best	Dr R Groden
Dr H Burns	Mr P Hamilton
Mr R Calderwood	Councillor J Handibode (to Minute 66)
Mr R Cleland	Mrs W Hull
Councillor J Coleman	Mrs S Kuenssberg CBE
Councillor D Collins (to Minute 65)	Mr G McLaughlin
Dr B Cowan	Mrs J S Murray
Ms R Crocket	Mrs R K Nijjar
Mr T Davison	Mr I Reid
Mrs R Dhir MBE	Mr A O Robertson OBE
Mr T A Divers OBE	Professor S Smith
	Mrs A Stewart MBE

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

Ms E Borland	..	Acting Director of Health Promotion
Mr J Cameron	..	Director of Human Resources, South Division (for Minute 67)
Mr J C Hamilton	..	Head of Board Administration
Mr D McCallum	..	Development Manager, North Division (for Minute 66)
Mr A McLaws	..	Director of Corporate Communications
Ms D Nelson	..	Communications Manager
Ms C Renfrew	..	Director of Planning and Community Care
Mr B Steven	..	Director of Finance, North Division (for Minute 66)
Mrs L Trendell	..	Senior Solicitor, Central Legal Office (for Minute 66)

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

Mrs P Bryson	..	Convener, Greater Glasgow Health Council
Mrs G Leslie	..	Chair, Area Optometric Committee
Mr H Smith	..	Chair, Area Allied Health Professionals Committee

**57. APOLOGIES AND WELCOME**

**ACTION BY**

Apologies for absence were intimated on behalf of Miss A Paul, Mrs E Smith, Cllr. A White, Mr J Cassidy (Chair, Area Nursing and Midwifery Committee), Mr C Fergusson (Chair, Area Pharmaceutical Committee) and Dr B West (Chair, Area Medical Committee).

The Chairman welcomed Dr Richard Groden, the new Chair of the LHCC Professional Committee, who was attending his first meeting of the NHS Board.

**58. CHAIRMAN'S REPORT**

The Chairman invited Dr Harry Burns, Director of Public Health to update Members on the tragic incident at Maryhill on 11 May, 2004 and to comment specifically on the role of the NHS and its staff.

Dr Burns advised that 9 people had died and just over 40 had been admitted to hospital.

At just about 12.30 p.m. on Tuesday, 11 May, 2004 he had received a telephone call advising that, following an explosion in Maryhill, the Chief Constable had enacted the Major Incident Plan. 2 site medical teams were immediately dispatched to the incident.

As the emergency services carried out their tasks it had been necessary to consider the safety of those involved at the site in relation to the possibility of toxic fumes from the Plastics Factory. The Environmental Protection Agency and the City Council's Scientific Services Department were able to give reassurances from monitoring the atmosphere that no specific hazard of this nature had been detected.

Dr Burns praised the efforts of all the NHS staff from NHS Greater Glasgow and neighbouring NHS Boards; the emergency services and, in particular, the Fire Brigade. Their efforts had been outstanding in attempting to minimise the loss of life and injury. The Major Incident Plan had worked exceptionally well and this was as a result of the regular rehearsals undertaken of the Plan, led by the NHS Board's Emergency Planning Officer, Alan Dorn.

The A&E Departments had coped well with the additional numbers of casualties and intensive care beds were available within the city throughout the incident.

There would be a review of the NHS response to the incident to learn any lessons for the future and this would be followed by a major review by all the emergency services involved in the Major Incident Plan.

The Chairman wished recorded the NHS Board's heartfelt condolences and sympathies to the families who had lost loved ones in the incident. He had written to all NHS staff who had been involved, thanking them for their outstanding efforts in responding to this dreadful incident and asked the Chief Executive to write to the other emergency services to formally thank them for the role they played in co-ordinating and collaborating in responding to the explosion at the Plastics Factory.

**Chief Executive**

**59. CHIEF EXECUTIVE'S UPDATE**

Mr Divers made reference to the following issues:

- a) The latest Joint Liaison meeting on 21 April, 2004 with Argyll and Clyde NHS Board which covered a range of issues, including the forthcoming consultation by Argyll and Clyde NHS Board on its Clinical Strategy.
- b) The tri-partite meeting that afternoon (18 May, 2004) with Argyll and Clyde NHS Board and West Dunbartonshire Council on the health care needs of that area.
- c) That he had forwarded to the Minister for Health and Community Care, a week after the April NHS Board meeting, the outcome of the consultation on Maternity Services and the NHS Board's recommendations. The covering letter to the Minister had been copied to NHS Board Members for information and the submission had included the supporting documentation which Members had previously received.

**60. MINUTES**

Cllr. Handibode stated that, again, he had received a number of “To Follow” papers on the Monday before the NHS Board meeting, the papers having been delivered to the Council’s offices on the Friday evening. He found this practice unacceptable as the papers required detailed reading and consideration. He asked that a deadline be set for papers being sent to the NHS Board – after which papers would be submitted to the next available NHS Board meeting.

Sir John indicated that he too had been disappointed to learn that a number of “To Follow” papers had to be sent to Members on Friday and he had discussed this with the Chief Executive.

Mr Divers accepted the point made by Cllr. Handibode and would be working over the summer with the Corporate Management Team towards a different way of working in order to achieve the reasonable request made by Cllr. Handibode about receiving NHS Board papers with adequate time to consider the issues raised.

On the motion of Mr R Cleland, seconded by Mr P Hamilton, the Minutes of the meeting of the NHS Board held on Tuesday, 20 April 2004 [GGNHSB(M)04/4] were approved as an accurate record and signed by the Chairman, subject to the following changes:-

- i) Minute 50 – Modernising NHS Dental Services in Scotland: Scottish Executive Consultation Paper – Page 10 – 3<sup>rd</sup> paragraph – 4<sup>th</sup> line: delete “such”.
- ii) Minute 56 – Modernising Maternity Services: Outcome of Consultation – Page 18 – 9<sup>th</sup> paragraph – 5<sup>th</sup> line: delete “some key groups” and insert “neonatal staff”.

**61. MATTERS ARISING FROM THE MINUTES**

The Rolling Action List of matters arising was circulated and noted.

NOTED

**62. EMERGING PRESSURES IN ACUTE SERVICES**

A report of the Programme Director – Acute Services Implementation [Board Paper No. 04/29] was submitted addressing the significant challenges faced by the NHS Board in sustaining the present pattern of services for the timescales envisaged in the Acute Services Review.

This issue had been discussed at the NHS Board meeting in December 2003 and Dr Cowan explained the key drivers for change as:

- Outdated buildings – unsuitable and unfit for modern health care.
- In-patient sites which were unable to provide one-stop/rapid diagnosis and treatment models for large volumes of patients.
- Fragmentation of care as patients were required to move around sites and different buildings, leading to an inevitable loss of continuity and difficulties in transferring information.

- Unsuitable diagnostic and imaging facilities which restricted capacity, created bottlenecks and inevitable delays in treatment.
- Increasing sub-specialisation within medicine – a move towards larger teams to ensure all patients could get access to appropriate specialists.
- Glasgow's role in teaching and research and their link with the Universities was critical for the service to attract and retain high calibre staff.
- Too many in-patient sites requiring emergency on-call rotas on each site with pressures going on both Consultants and junior staff.
- Changes in doctors' training – would mean Consultants were being called in from home more often or opting to do resident on-call to provide support to junior staff.
- Restrictions on the hours doctors could work – New Deal for Junior Doctors; limited number of hours; European Working Time Directives; restricted availability of Consultants due to compensatory rest requirements.
- Policy imperatives outlined in the Scottish Health Plan and Cancer Plan which included waiting time guarantees; reductions in waiting times; improved access to rapid diagnosis and treatment; the provision of services designated around the needs of patients; and improved integration with primary and social care.

In addition, Dr Cowan highlighted the most significant problems and pressures being faced by the NHS Board – New Deal for Junior Doctors; Consultants Contract; SIMAP – time spent in work being counted as working hours including sleeping time; Modernising Medical Careers – changes to the training of Senior House Officers from August 2006; and the European Working Time Directives. In addition, since the report to the December Board, there also had been the worsening financial position for NHS Greater Glasgow and the need to reduce costs of Glasgow's hospital services without compromising effectiveness or the safety of patients.

The pressures on services were building up and bringing forward some of the agreed changes would have significant advantages and lead to better and safer services to patients. Currently there was not always adequate specialist out-of-hours cover available and this was not an acceptable level of service for patients.

It was reaffirmed that there was nothing in the proposals which was at odds with the decisions taken in agreeing the Acute Services Strategy in terms of the number and disposition of services.

Mr Calderwood advised that a pan-Glasgow Acute Services Review (ASR) Acceleration Group was set up and it had been developing a number of themes for discussion. Mr Calderwood reminded Members that the principles of the Acute Services Strategy had been to develop locally accessible out-patient and day surgery services from 5 sites and to consolidate in-patient services at Glasgow Royal Infirmary, Southern General and Gartnavel General with Accident & Emergency/Trauma being provided from Glasgow Royal Infirmary, the Southern General and Acute Emergency Receiving from Gartnavel General.

In turning to Section 3 of the paper, he highlighted a number of imperatives which had been identified by the ASR Acceleration Group:-

1. Only an early reduction in the number of staffed emergency service sites would enable the NHS Board to address the pressures identified by Dr Cowan.
2. The Casualty service at Stobhill Hospital could not be sustained beyond August, 2005.
3. A consolidation in the number of smaller specialties was required sooner rather than later.
4. The limited availability of beds at Glasgow Royal Infirmary and the Southern General sites was a significant block to achieving early change.

He then described the detailed proposals for early change as follows:

- Aim to achieve single emergency and elective sites for each of the three sectors of the city – North and East, South and West meaning proposals would be developed to reorganise emergency and elective workload between – Royal Infirmary and Stobhill; Gartnavel and the Western; Victoria and the Southern.
- Consolidation of Orthopaedics from the present five sites to the two planned sites, with a re-profiling of emergency and elective activity to reflect the East and West split and distribution of clinical resources accordingly.
- Create capacity for emergency care at the Royal Infirmary and Southern General – this may include an early move of Cardiothoracic Surgery from the Royal Infirmary to the Golden Jubilee National Hospital (GJNH). This could be a first stage of the proposals to consolidate all West of Scotland Cardiothoracic surgery at GJNH.
- The Services, Beds and Capacity Sub-Group of the ASR Programme Board to finalise the disposition of smaller specialties should be re-framed to make recommendations on potential interim service moves as soon as possible.
- Work with senior clinical staff on how to put in place arrangements to avoid concerns over patterns of work, status, clinical leadership and management arrangements to avoid any obstacles to achieving the change necessary.
- Early consolidation would require the use of existing physical facilities and the restrictions on the short term availability of capital.

The objective would be to have achieved the changes outlined above by the end of 2007 which would be alongside the opening of the first phase of the new Beatson Oncology Centre and the new Ambulatory Care Hospital facilities at the Victoria Infirmary and Stobhill.

Mr Davison provided Members with a background to the Casualty service at Stobhill and the difficulties being experienced with achieving accreditation of this service for training purposes for junior doctors. The Casualty Department was staffed by five Senior House Officers (SHO), without on-site Accident and Emergency Consultant cover and therefore had inadequate clinical and training supervision. The accreditation bodies (the Royal College of Surgeons and the Royal College of General Practitioners) had previously indicated that they would withdraw recognition of the SHO posts for training purposes in February, 2004 and this would have led to a closure of the Casualty service at Stobhill.

Clinicians and management of North Glasgow had worked hard to put in place an interim solution and the Accreditation Committee had confirmed that it would give accreditation to these posts until August, 2005 to enable the NHS Board to plan and manage the transfer of service. This interim solution would involve the rotation of SHO's throughout North Glasgow departments, including Stobhill; Accident and Emergency Consultants within North Glasgow providing sessional cover at Stobhill; improving middle grade support and physical and equipment improvements to the department. The Royal Colleges had indicated that the extended accreditation to August, 2005 was only on the basis that the NHS Board committed to work to the closure of the unit by August, 2005.

The Accident and Emergency Sub-Committee had previously offered advice that the Casualty model at Stobhill was not a safe and sustainable service to deal with emergency patients. Two potential options would be developed for discussion: the first would see Stobhill continuing to provide acute medicine and surgery cases referred by their GP – all other patients would attend Accident and Emergency departments. The second would consolidate all emergency activity for North and East at the Royal Infirmary and fully utilise Stobhill to provide elective services and rehabilitation for a larger catchment population than is presently the case. A Minor Injuries Unit would also be provided.

Mrs Dhir asked about the public engagement/consultation proposals. Mr Calderwood advised that any such proposals would be submitted to the NHS Board for approval prior to public engagement. They would clearly include the North and South Clinical Planning Forum, the Acute Strategy Monitoring Groups, Local Health Council and key stakeholders, including the public. It was reiterated that the Ministerial commitment to sustain services at Stobhill and the Victoria Infirmary for a 5-year period was based on the Monitoring Groups participating in discussions about any proposed changes to named services if this was required for reasons of clinical safety. The presentation by Dr Cowan had very clearly highlighted the clinical need and safety reasons for change and that current services were not sustainable and the changing pattern of these services required to be addressed.

Dr Burns advised that in terms of the preparedness for emergencies, the success in responding to major incidents was down to staff. It was essential therefore that staff had access to full and proper training in accredited facilities and this was also hugely important in terms of recruiting high calibre staff to the NHS in Greater Glasgow. For the longer term benefit of patients, there was no alternative but to recognise the need for the significant changes required in our services in order to deliver a modern, safe and sustainable service to patients delivered by a well-trained and motivated specialist staff.

Mr Robertson supported the direction and proposals contained within the paper and was pleased to see they were consistent with the Acute Services Strategy. Mr Cleland re-emphasised that, in consulting on proposals for change, the NHS Board had to take account of the Accreditation Committee's decision that Stobhill Casualty would not be accredited for training purposes from August 2005. What would be prepared for discussion would be the shape and pattern of services that would be required recognising the closure of the Casualty Unit.

Mr Hamilton raised the Ministerial commitment for the NHS Board to review Accident and Emergency services two years after the decision to move to two A&E/Trauma units. Mr Divers advised that a review of the robustness and appropriateness of the decisions relating to Accident and Emergency was required two years after the Ministerial commitment to undertake such a review, i.e. Autumn, 2004. This would test whether the NHS Board decision to move to two A&E/Trauma Units with Acute Emergency Receiving at Gartnavel General Hospital was still appropriate. There would be engagement with the Local Health Council and other key stakeholders to test that decision and a report back to the NHS Board on the outcome.

Mr McLaughlin enquired about the additional resources necessary to support the acute services implementation and Mr Calderwood advised that there would be shared resources across the Divisions and NHS Board and the continuation of the arrangements with the external advisers. A Project Team of 6/8 staff would be working on the implementation phase.

Sir John, in concluding the discussion, intimated that there would be regular reports to NHS Board Members either at the NHS Board, Performance Review Group or Seminars and these would assist in shaping the outcome of the proposals which it was planned to submit to the NHS Board in October for approval. Staff had been making huge efforts to sustain the current level of services and the NHS Board was grateful for their efforts during this difficult time.

DECIDED:

1. That the proposed approach to the acceleration of the Acute Services Review, with detailed proposals to be brought forward to future NHS Board meetings for approval prior to public engagement, be approved.
2. That the requirement to close the Casualty service at Stobhill by August, 2005 be accepted.
3. That the commitment to the major capital developments at the Southern General and Glasgow Royal Infirmary, approved as part of the Acute Services Review, be confirmed.

**Programme  
Director – Acute**

**Programme  
Director - Acute**

**63. BALANCING THE FINANCIAL POSITION IN 2004/05**

A report of the Chief Executive [Board Paper No. 04/30] was submitted and picked up on the further work of developing and implementing the Corporate Recovery Plan and gave a summary update on each of the key clusters of work within it. It sought Board approval to a range of actions within the Plan; identified how the plan was to be developed through further work with staff, partners and other interests and highlighted specifically where formal consultation was required on proposed changes to service delivery.

Mr Divers took Members through the main elements of the paper:-

1. How was balancing the financial position being taken forward?

There were two main strands to this work: firstly, a continuation of the tight budgetary control measures which were adopted in response to the financial pressures which developed during 2003/04. It seemed likely that the financial outturn for 2003/04 would have come within the lower estimates submitted to the NHS Board and the Performance Review Group during the second half of the financial year and this was helped by the release of a non-recurrent allocation by the Ministers to NHS Boards at the latter part of the year. It was vital therefore that across NHS Greater Glasgow the budgetary controls on manpower and on non-pay expenditure continued to be applied with the sensitive rigour which was applied last year. Secondly, the NHS Board had been developing a Corporate Recovery Plan which was aimed at reducing expenditure across the range of the Board responsibilities, through planned changes to enable the NHS Board to return to financial balance within a maximum of two years.

2. Developing the next steps in the Corporate Recovery Plan

The Corporate Management Team tested the reliance and durability of the Plan in a half-day Workshop which was facilitated by the Board's external auditors, PricewaterhouseCoopers. Further sessions would be held shortly with other key stakeholders such as the Partnership Forum and groups of clinical leaders.

To assist in monitoring the project, there would be a common set of project documentation which would be prepared identifying the Project Leader, key objectives of the project, milestones and timescales for delivery and this would be managed by a Project Manager – Douglas Griffin, Director of Finance, Primary Care Division.

He would co-ordinate the work of the individual projects and support the Chief Executive and Corporate Management Team in executing the Plan. Monitoring implementation of the Plan would be reported routinely to the Performance Review Group and, through it, periodically to the NHS Board.

3. Taking action in moving the Plan forward

There were several clusters of actions which comprised the current Plan and these saw pan-Glasgow reviews in Finance and Supplies, Human Resources, Pharmacy, Laboratories, Catering, Medical Illustration and Management Costs.

Following the earlier public consultation exercises, the plans to implement in-patient Dermatology onto a single site at the Southern General and the in-patient Gynaecology for North-East Glasgow within Glasgow Royal Infirmary would now proceed.

There would also be consideration to closing the 15 in-patient beds at the Homoeopathic Hospital and continuing the service through day and out-patient services. This proposal would be the subject of a consultation exercise carried out during the next two months. There would also be a review carried out of stand-alone rehabilitation sites and if integration with a major adult site was feasible and desirable those proposals would then become subject of formal consultation alongside proposals for the future use of any affected sites



The benchmarking of the performance of adult acute hospitals against an extensive range of comparative hospitals across the UK suggested there was significant scope for achieving greater efficiency in the use of beds in several acute specialties. This would be taken forward in discussions with lead clinicians.

Yorkhill Division had been analysing the potential to reduce beds in areas where occupancy levels were relatively low.

Planning Groups responsible for reviews of elderly continuing care and mental health beds and day hospitals were to complete their reviews shortly.

4. Engagement with key interests in taking forward the Plan

Two initial sessions had been held with staff partners (one with full-time officials and the other with the staffside members of the Area Partnership forum). Monthly meetings with these two groups together had been set for the rest of the year and there would be ongoing dialogue with each Local Partnership Forum. An initial meeting had taken place with members and officers of the Local Health Council, with a further meeting proposed. A meeting with MSPs had been offered. Discussion on the implications of the Plan were being taken forward with Local Authority partners, through the Local Health Plan Steering Group and the local Council-based planning structures.

Cllr. Handibode welcomed the very detailed report and asked about how confident the officers were in achieving the savings target and the potential additional income of £10 million due from West of Scotland Health Boards. Mr Divers advised that it would be important to demonstrate to the Performance Review Group whether the savings target was deliverable and if any elements were not, what plans would be put in place to fill that gap. In relation to the cross-subsidisation, he indicated that Catriona Renfrew and Wendy Hull had prepared a paper for the West of Scotland Health Boards identifying the cost that NHS Greater Glasgow believed should be paid for West of Scotland patients accessing national and specialist services within NHS Greater Glasgow. This dialogue was also being pursued with the Scottish Executive Health Department and, whilst it was important to include within the plan a target to be achieved, if the sum was to be made good it was likely that this would be over a timeframe that would be subject to debate and negotiation. Sir John emphasised that regional planning and cross-subsidisation issues were now being discussed at the NHS Board Chairmen's meeting and also with Scottish Executive Health Department officials.

Mr Robertson advised that at the next Performance Review Group it would be reviewing the strands identified in the Chief Executive's paper and also the progress in developing a single Corporate Recovery Plan. Whilst pleased to see that the financial outturn for 2003/04 may come within the lower estimates submitted to the NHS Board and Performance Review Group, he was particularly concerned that the recurring element of the Board's financial positions still required to be addressed urgently and all steps identified in the Chief Executive's paper were a necessary part of that process.

DECIDED:

1. That the progress report on balancing the financial position in 2004/05 be received.
2. That the steps proposed in further developing and implementing sections of the Plan, as described in the paper, be approved. **Chief Executives**
3. That the significant changes in services proposed within the paper should be the subject of formal consultation – in particular, the proposal to close the in-patient beds at the Homoeopathic Hospital. **Chief Executives**
4. That the Corporate Management Team and Performance Review Group review urgently investment proposals which currently sat within the financial plan for 2005/06. **Chief Executives/  
Director of  
Finance**
5. That the arrangements for the submission of regular reports to the Performance Review Group and the NHS Board itself, be approved. **Chief Executive**

**64. PAN-GLASGOW DECONTAMINATION SERVICE**

A report of the Chief Executive, Yorkhill Division [Board Paper No. 04/31] was submitted seeking NHS Board approval to the development of a fully compliant decontamination service centralised within a single industrial unit at Cowlares under a lease agreement for an initial period of 23 years.

Mr Best took Members through each section of the paper, reminding Members that the Outline Business Case had been approved by the Board at its November, 2003 meeting and also by the Scottish Executive's Capital Investment Group.

None of the six Decontamination Units (TSSU) serving Glasgow's acute Divisions were capable of upgrade to comply with the new national and technical standards as recommended by the Glennie Group Report (2001) and Medicines and Healthcare Products Regulatory Agency (MHRA). The project was a new development for the NHS and there had been significant input from advisers. Both Scottish Healthcare Supplies and the Scottish Centre for Infection and Environmental Health had been involved in regard to process flows, design layout of the new unit and equipment requirements.

Mr Best detailed the timetable and key milestones and anticipated that, if approved, the building conversion works could be completed with equipment installed and commissioned between February and March, 2005. The transfer of the existing decontamination services into the new Cowlares unit would then commence in April/May, 2005 with completion by December, 2006.

It was proposed that the Board lease the premises for a minimum of 23 years at an annual rental of £108,000. Indicative cost of conversion of the premises was £8.9 million – building works £6.2 million and equipment £2.7 million. The total revenue impact of the preferred option was £5.4 million, representing an increase of £1.9 million to the existing recurring revenue costs and, together with a further £0.5 million cost relating to unfunded costs, this would bring the additional sum required to fund the project to £2.4 million. These figures did not include the transitional cost, in particular the one-off capital required to purchase theatre instrumentation to support an off-site service (possibly £3 million), together with additional transitional costs mainly relating to training. This would result in a £4.393 million additional costs over the four financial years of the implementation of the project.

Mr Best explained the contingency plans and developments since the Outline Business Case had been approved by the NHS Board.

Mr Cleland enquired about the position with regard to staffing and Mr Best advised that a human resources group, including staffside representation, was taking forward the migration of staff and it was likely that providing a centralised service would lead to an increased need for staff.

Mrs Stewart enquired about the maintenance arrangements and contingency plans and Mr Best confirmed the issues highlighted in the paper around these arrangements.

In responding to Dr Groden's comment about primary care contractors and dental services, he advised that general dental practitioners made their own arrangements for sterilisation of their equipment and the Glasgow Dental Hospital and School operated a separate local scheme. Dr Angell advised Members of the requirements for increased instrumentation of general dental practitioners if they were required to move away from their existing arrangements.

Mr Best agreed to keep Members advised of the progress with regard to the creation of a centralised decontamination service for NHS Greater Glasgow.

DECIDED:

1. That the requirements to comply in full with the new national quality and technical standards for the provision of Decontamination Services within agreed timescales be noted.
2. That the proposals to achieve full compliance with the development of a pan-Glasgow Decontamination Service centralised within an NHS managed industrial unit, located at Cowlairst in the North-East of the city, be approved.
3. That the signing of the lease for the industrial unit at Cowlairst for an initial period of 23 years, be approved.

**Chief Executive,  
Yorkhill Division**

**Chief Executive,  
Yorkhill Division**

**65. 2004/05 AND BEYOND – CAPITAL PLAN ALLOCATION**

A report of the Director of Finance [Board Paper No. 04/32] was submitted to the NHS Board seeking approval to the Capital Allocations for 2004/05.

Mrs Hull introduced her paper by indicating that capital allocations had been devolved to NHS Boards in 2002/03 and that local approval processes and procedures had been agreed by the Board and the Audit Committee in October, 2002. The proposals set out in this report had been prepared in line with that agreed policy. Priority had been given to schemes that:-

1. allowed the completion of legally committed schemes;
2. enabled the acute services reconfiguration;
3. ensured ongoing commitments to previously agreed schemes and requirements for regular investment in medical equipment maintenance, IT, health and safety and decontamination.

In response to a question from Mr Robertson, Mrs Hull advised that the Corporate Management Team would be tasked with approving the schemes contained within the total formula allocation of £12 million.

Mrs Dhir and Cllr. Handibode enquired about Table 1 and the sale of properties. Sir John asked that Members receive a briefing paper on the surplus land and buildings within NHS Greater Glasgow and the up-to-date position with regard to disposal arrangements. Mr Davison advised that the site of the former Belvidere Hospital had indeed been on the market and had been withdrawn for a period of time during its inclusion within the options for the proposed Secure Unit. Discussions had been held with the City Council about whether a joint venture was possible, however, the site had now been re-marketed and the extent of interest in the site was now being appraised.

DECIDED:

- |    |  |                            |
|----|--|----------------------------|
| 1. | That the capital allocations proposed for 2004/05 totalling £67.177 million be approved.   | <b>Director of Finance</b> |
| 2. | That approval for 2005/06 totalling £29.43 million (so that the allocation was balanced over the two financial years) be given outline approval.                                   | <b>Director of Finance</b> |
| 3. | That the priorities used to determine the schemes proposed for inclusion in the capital programme be confirmed.  | <b>Director of Finance</b> |
| 4. | That the inclusion of receipts from anticipated land sales in future capital funding available be agreed and a briefing paper on land disposals be prepared for NHS Board Members. | <b>Director of Finance</b> |

**66. GLASGOW ROYAL INFIRMARY – CONTRACT FOR CAR PARK MANAGEMENT SCHEME**

A report of the Chief Executive, North Division [Board Paper No. 04/33] was submitted seeking the NHS Board's approval to entering into the contract for the car park management scheme at Glasgow Royal Infirmary.

Mr Davison introduced Mr Brian Steven, Director of Finance, North Division; Mr Duncan McCallum, Development Manager, North Division; and Mrs Lynne Trendell, Senior Solicitor, Central Legal Office, who were attending and would answer Members' questions.

The provision of a car park at Glasgow Royal Infirmary remained an obligation under the original planning consent for the recently built Princess Royal Maternity Hospital and a new A&E Department. The Full Business Case had been approved by the NHS Board at its July meeting and by the Scottish Executive Capital Investment Group in August, 2003. There had been some delay in completing the contract negotiations with the preferred bidder, Impregilo. These delays had been around the road construction consent for improvements to the main access from Alexandra Parade, a land title issue and a congestion charges element of the contract.

As a consequence of these delays, contract close had not been reached prior to the dissolution of the North Glasgow Trust and a Minute of Authorisation was now required as the NHS Board would now be entering this contract with Impregilo.

Car parking space numbers with the scheme had been finalised at 1,408 although during the construction phase car parking at the Royal would reduce from 440 spaces to 294.

Due to excess demand, the price of steel had increased by close to 20% since the Final Business Case (FBC) stage and it was expected again to rise at the end of May, 2004 and therefore time was of the essence in completing the Contract.

DECIDED:

1. That Members were re-appraised by the information provided and approval given to the Glasgow Royal Infirmary Multi-Storey Car Park Full Business Case in July 2003.
2. That the relevant changes which had taken place between the FBC approval in July 2003 and subsequent contract finalisation, be noted.
3. That the current situation regarding the price of steel and the potential for this to terminate the contract be recognised.
4. That the NHS Board Chief Executive and other duly authorised Directors be authorised to sign the PFI Contract for the provision of a multi-storey car park at Glasgow Royal Infirmary.
5. That the NHS Board Chairman be authorised to sign the Minute of Agreement to allow the Central Legal Office to complete the legal formalities.

**Chief Executive/  
Director of  
Finance**

**Chairman**

**67. NHS GREATER GLASGOW DRAFT CAR PARKING POLICY**

A report of the Chief Executive, Yorkhill Division [Board Paper No. 04/34] was submitted enclosing a draft Car Parking Policy for formal discussion and engagement with NHS patients, public and staff.

Mr Best introduced the paper in his capacity as Chairman of the Acute Services Strategy Transport and Access Group and introduced Mr Jim Cameron, Director of Human Resources, South Division, to take Members through the principles contained within the paper.

Mr Cameron advised that the NHS Board had been facing increased pressure and difficulties in managing the rising number of patients, visitors and staff seeking limited car park spaces on NHS sites and this had led to a high degree of congestion and environmental problems for the local surrounding population. Scottish Executive guidance required the development and implementation of green travel plans when new developments were due to take place and the granting of planning permission could be dependent on agreeing a satisfactory Green Travel Plan.

The draft Policy had been developed by a Working Group including staffside representatives and remitted to develop arrangements for a fair and equitable access for patients, visitors and staff to existing car park spaces. The draft Policy had been produced as a key component of a Green Transport Strategy which was currently being developed. It was also integral to the implementation of the Acute Services Strategy.

The draft Policy was a framework document setting out the principles which would underpin any implementation plan for car parking charges and the NHS Board's approval was being sought for the policy framework to be issued for comment and discussion with patients, visitors and staff with the intention of implementing new arrangements from 1 April, 2005.

Mr Calderwood sought clarification to the hospital sites listed in paragraph 1.4 of the draft Policy. Mr Cameron advised that this was an indicative list and did not include Primary Care/Community Health Clinics. These two points would be made explicit within the consultation document.

Mr Goudie raised an issue in relation to paragraph 2.1 and the ability of staff to be able to pay car parking charges. He would prefer to indicate that the Policy would reflect staff's ability to pay as opposed to may reflect. This would be altered and would obviously form part of the consultation process.

In response to a number of questions raised by Members, Mr Cameron advised of the national guidance being considered by the Transport and Access Group as it considered transport access issues to health care facilities; the draft Policy would be more explicit around green transport alternatives and he explained the shuttle-bus arrangements from key public transport hubs.

Mrs Stewart asked whether it would be possible to be more explicit about the criteria whereby free parking permits could be made available to patients under exceptional circumstances. Dr Groden asked if consideration could be given to the charging policy when situations may arise where patients had been delayed within out-patient clinics.

Sir John asked that if Members had other points they wished to raise with Mr Cameron they should do so direct and this would then allow the draft Car Parking Policy to be finalised and submitted for discussion and engagement with patients, public and staff.

DECIDED:

1. That the draft Car Parking Policy framework and principles which underpinned it, subject to the amendments above, be approved.
2. That the amended draft Policy framework be issued for formal discussion and engagement with patients, public and staff be approved.
3. That, subject to the feedback from the engagement process, the NHS Board receive a further paper in 2004/05 seeking formal approval and implementation of the Car Parking Policy.

**Director of  
Human  
Resources, South  
Division**

*Director of Human  
Resources, South  
Division*

*Director of Human  
Resources, South  
Division*

**68. WAITING TIMES**

A report of the Director of Planning and Community Care [Board Paper No. 04/35] asked Members to note the progress on meeting waiting time targets.

Ms Renfrew highlighted the change in reporting from specifically monitoring patients waiting under nine months to patients waiting under six months for in-patient and day case treatment. Reporting still differentiated NHS Greater Glasgow patients without availability status codes and those with. This report would be further developed in the coming months to include out-patient targets and performance against these targets. She highlighted that the variance of 55% for Yorkhill was, in fact, only an additional 43 patients for March to April, 2004.

The initial investments to deliver the targets set for December, 2005 had now been implemented and adverts had been placed for the appropriate staff.

Mr McLaughlin enquired as to whether consideration had been given to setting an initial 31 December, 2004 target. Mr Divers advised that as the monthly monitoring reports indicated, reduction in patients for treatments was not a straight line reduction or trend. The waiting time target of six months for in-patient and day case cases by December, 2005 was a huge challenge for NHS Greater Glasgow and involved many thousands extra treatments. The NHS Board, through its initial investment plans, had begun to gear itself for reaching this target and had thus far resisted attempts to determine any interim target by the end of this calendar year. Mr Davison added that with the new out-patient waiting time target it was necessary to fully understand and predict the impact on in-patient waiting times of shortening the out-patient waiting time period and this was still currently being worked through.

Sir John indicated that the strategic financial and clinical element of meeting the out-patient and in-patient waiting time target would be a useful topic for a future NHS Board Seminar.

NOTED

**69. HEALTH AND CLINICAL GOVERNANCE COMMITTEE MINUTES**

The Minutes of the Health and Clinical Governance Committee held on 27 April 2004 [HCGC(M)04/2] were noted.

NOTED

The meeting ended at 11.50 a.m.