

GGNHSB(M)04/9  
Minutes: 127 - 149

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, 21 December 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	Mrs W Hull
Mr R Cleland	Mr G McLaughlin
Councillor J Coleman	Mrs J S Murray
Councillor D Collins	Ms A Paul
Dr B Cowan	Mr I Reid
Ms R Crocket	Mr A O Robertson OBE
Mr T P Davison	Mrs E Smith
Ms R Dhir MBE	Mrs A Stewart MBE
Mr T A Divers OBE	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 138)
Mr A Bishop	..	ECCI Project Manager (for Minute 134)
Ms E Borland	..	Acting Director of Health Promotion
Ms J Frame	..	Programme Manager (for Minute 134)
Ms S Gordon	..	Secretariat Manager
Mr J C Hamilton	..	Head of Board Administration
Ms S Laughlin	..	Women's Health Co-ordinator (to Minute 137)
Mr A McLaws	..	Director of Corporate Communications
Ms D Nelson	..	Communications Manager
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 C Fergusson	..	Chair, Area Pharmaceutical Committee
Mr H Smith	..	Chair, Area Allied Health Professionals Committee
Dr B West	..	Chair, Area Medical Committee

**ACTION BY**

**127. APOLOGIES AND INTRODUCTORY REMARKS**

Apologies for absence were intimated on behalf of Councillor J Handibode, Mrs S Kuenssberg CBE, Mrs R K Nijjar, Professor I Greer, Mr J Cassidy (Chair, Area Nursing and Midwifery Committee) and Ms G Leslie (Chair, Area Optometric Committee).

Mr J C Hamilton referred to the nomination process for the appointment of Vice Chair of the Board. One nomination was received, that of Mr Andrew Robertson. Dr Angell proposed and Mrs Stewart seconded Mr Robertson's nomination.

**DECIDED:**

That Mr A O Robertson be appointed Vice Chair of the NHS Board.

Sir John advised the Board that Elinor Smith had been appointed as Chair of NHS Greater Glasgow Audit Committee. He also congratulated the NHS Board's Director of Finance, Wendy Hull, on her recent appointment as Director of Finance to a large Acute Trust in England.

Sir John took the opportunity to thank NHS Greater Glasgow's 33,000 members of staff for delivering an excellent service across the city throughout 2004. This had included around five million primary care contacts, three hundred thousand inpatient/day care cases (acute) and two and half million outpatient attendances. He commended everyone's efforts in achieving the service offered to patients.

**128. CHAIRMAN'S REPORT**

The Chairman updated on the following:

- (a) The Minister for Health and Community Care, Andy Kerr, this week announced a new plan for NHS Scotland entitled "Fair to All, Personal to Each" which aimed to substantially cut waiting times over the next three years. Mr Divers would provide further detail of this new plan during his Chief Executive's update.
- (b) Professor Andrew Calder, whom the Minister had appointed as Chair of the Advisory Group to consider the future location of a new children's hospital in NHS Greater Glasgow, was currently clarifying the membership of his Group and its working arrangements with the Minister. Sir John envisaged a further update on progress in early 2005.
- (c) Sir John had accepted a petition prior to the beginning of the Board meeting objecting to any closure of inpatient beds at Glasgow Homoeopathic Hospital. He confirmed that an evaluation of the hospital's services was ongoing as were the various strands of work the NHS Board had previously agreed to.
- (d) The Joint Strategy Group with the University of Glasgow now met regularly and had established subgroups to take forward key areas of joint work. This was proving to be an excellent platform for progressing joint work.
- (e) Sir John was a member of the Workforce Committee looking at workforce issues throughout NHS Scotland. It was their intention to create a robust model looking at the supply and demand of the workforce across Scotland against the background of the Scottish economy.

**NOTED**

**129. CHIEF EXECUTIVE'S UPDATE**

Mr Divers made reference to the following:

- (a) “Fair for All, Personal to Each”, a new plan announced by the Minister for Health and Community Care, brought in a range of new waiting times targets for the service, many of which represented a considerable advance on existing targets. All of the targets announced in the plan were to be achieved by the end of 2007 and Mr Divers summarised these as:
- An eighteen week maximum wait for both outpatient and inpatient or day case hospital treatment. This extended and expanded the existing target of a maximum wait of six months for each by the end of 2005.
  - A specific target for cataract surgery of eighteen weeks from referral to surgery.
  - A four hour maximum wait from arrival at A & E until admission, discharge or transfer. This matched the existing target for the NHS in England.
  - A twenty-four hour maximum wait for surgery following a hip fracture.
  - The existing target of a maximum sixteen week wait for cardiac intervention was expanded to include the period following GP referral and to cover a wider range of treatments, including heart valve surgery.
  - Further new waiting targets for diagnostic tests would be announced in Spring 2005.

Mr Divers concluded by confirming that the NHS Board was working towards detailed capacity plans to deliver these standards.

- (b) Robert Calderwood, Catriona Renfrew and himself had met with counterparts in NHS Lanarkshire to discuss the regional dimensions of Lanarkshire’s strategic document “A Picture of Health”. They had taken the opportunity of picking up mutual topics of interest to ensure they worked together in parallel in taking forward their strategic planning.
- (c) Mr Divers asked Mr Calderwood to clarify the position in relation to Accident and Emergency Services as an article had appeared recently in the Evening Times which may have led to confusion. Mr Calderwood advised that there had been no change to the Board’s strategy in relation to A & E services and that the two monitoring groups (set up by the then Minister of Health and Community Care) met regularly to monitor the planned services at both Stobhill and the Victoria Infirmary. In addition, work was going on with the Royal Colleges to try and address training issues for junior doctors at Stobhill and the outcome of these discussions would be reported to the NHS Board when the discussions had concluded.

## **NOTED**

### **130. MINUTES**

On the motion of Mr G McLaughlin, seconded by Mr A O Robertson, the Minutes of the meeting of the NHS Board held on Tuesday, 12 October 2004 [GGNHSB(M)04/8] were approved as an accurate record and signed by the Chairman pending the following amendment:

Page 3, Item 12 (b), line 5, delete “Rankin” and insert “Brankin”.

### **131. MATTERS ARISING FROM THE MINUTES**

The Rolling Action List of matters arising was circulated and noted. Mr J C Hamilton updated Members on issues which had progressed since the publication of the Rolling Action List.

#### **NOTED**

### **132. CONSULTATION PAPER : IMPLEMENTING PARTNERSHIP FOR CARE – THE NEXT STEPS**

A report of the Chief Executive [Board Paper No 04/63] asked the Board to receive a consultation paper which set out the next steps proposed in implementing “Partnership for Care” and approve the issue of the paper, following consideration by the Board, to consultees.

In describing the next steps which the NHS Board proposed to take in implementing “Partnership for Care” Mr Divers advised that he had delivered presentations to four NHS Board seminar sessions, the Area Partnership Forum, over one hundred senior staff, professional advisory committees including the Area Clinical Forum, the GP Subcommittee and a series of meetings with representatives from Local Authorities. Over and above this, many briefing sessions had taken place at Divisional level.

He described the remaining aspects of the proposed organisational changes on which consultation had not yet taken place and summarised those areas where approval had already been granted by the Board following consultation. He described the context of the new organisational arrangements proposed and stressed, at the outset, the “Partnership for Care” priority which was to improve health and narrow the inequalities gap. He described how the Board was committed to strengthening the interface between the primary and secondary care sectors and how the organisational arrangements with the creation of CHPs and the proposed Acute Operating Division would specifically address this, both in the design of the respective structures, with appropriate cross-representation and in the development of shared objectives for senior managers working within the respective structures. In setting the scene for the next steps in moving fully into single-system working in NHS Greater Glasgow, Mr Divers detailed the new organisational arrangements in the context of “Partnership for Care” and noted the key outcomes which each part of the system would be expected to deliver. He led the Board through four schematics as follows:

- The formal Subcommittee structure which reflected the three key planks of governance as stipulated in “Partnership for Care” – corporate (audit/risk management), health/clinical and staff governance.
- The key dynamics and interactions which were designed to secure delivery both of corporate functions and of involvement therein of colleagues from other parts of the new structure.
- The potential acute services structure.
- The proposed Directorate of Rehabilitation and Enablement.

The focus of the public consultation was to move away from the current structure of four Operating Divisions to a new arrangement. Alongside this consultation, the detailed work of designing the new structures would be taken forward with full staff and staff partnership involvement. Mr Reid had drafted a paper on “Managing the Transition” which set out the key principles by which the process would be managed – this re-enforced the commitment to a partnership approach, the application of the policy of “no detriment”, an assurance that there would be no compulsory redundancies, a commitment to communicate with all directly affected staff as soon as possible when the details of structural arrangements became clear, and, whenever possible, to match any displaced individuals to new posts but, where competition was necessary, to endeavour to ensure that the number of interviews for any one individual was kept to a minimum.

It was intended to issue the consultation paper as quickly as possible following the NHS Board meeting and comments from consultees on all aspects of the consultation paper were welcome. As the specific issues for consultation were relatively few, it was proposed that the consultation run for just over six weeks allowing the NHS Board to consider the responses and make decisions at its February 2005 Board meeting.

This was bearing in mind that the start date for implementing the new arrangements was from 1 April 2005. That date signalled the move into the new arrangements; the expectation was that implementation would progress steadily through the 2005/2006 year as the new organisations developed their capacity to deliver the different roles which they would discharge. It would be important, however, in order to guard against a loss of momentum in continuing to take forward the Board’s key priorities for action to keep the period during which competition for posts was carried out as short as possible so that uncertainty for staff was kept to a minimum.

Councillor Collins welcomed the spirit of the consultation and recognised the much work that was in progress. In recognition of many of the issues to be worked through with Local Authorities and given the Christmas and New Year holiday period he wondered if this complex process would merit from a longer consultation period rather than a short six week period.

In response to this, Mr Divers outlined key planks of the proposals which had already been subject to consultation. He re-emphasised that this would be a gradual process of implementation. Given this and the other work which was being handled with Local Authorities and that the anticipated audience would be largely limited to the NHS, a relatively short consultation process seemed feasible.

Mr Robertson recognised the point made by Councillor Collins and sought clarification around what audience the consultation document was aimed at. He also referred to some areas in the paper which would require refining prior to it going out to consultation and sought clarity around where diversity and anti-discrimination work would fall. Referring to the diagram shown at paragraph 5.7 of the paper, it was not clear how the acute services planning team tied in with the acute services structure.

In response to a question from Mr Cleland, Mr Reid advised that the Staff Governance Committee would play a key role in taking forward the implementation arrangements and would receive regular reports on the process and how it was being managed. It was envisaged that the Staff Governance Committee would approve the overall process as, at the moment, the Area Partnership Forum had agreed most of the principles and had set up a Sub-group looking at the ramifications for CHPs. As such it was anticipated that the Staff Governance Committee would be the vehicle for approving the implications for staff.

In light of this, Mr McLaughlin recommended that the Board prioritise its HR structure as early as possible to ensure that this support was in place to progress the process of change successfully.

Councillor Collins referred to the Board paper on the agenda which was looking at Community Health Partnerships and their Model Scheme of Establishment. He saw many interlinking areas between the two papers and although both had different end points, there were many areas of joint working between the two.

Councillor White re-iterated that the six week consultation period may be rather tight time. Mr Divers suggested that the February NHS Board meeting scheduled for Tuesday 15 February 2005 could be put back a week to Tuesday 22 February 2005 and the closing date for comments be extended to 14 February 2005. This was agreed.

Mr McLaws confirmed that the Communications Team had drafted an information leaflet for patients and staff summarising the consultation document.

**DECIDED:**

- (i) That the consultation paper which set out the next steps proposed in implementing Partnership for Care be received. **Chief Executive**
  
- (ii) That the paper be issued, following the suggested amendments being made, to consultees and the outcome reported to the Board meeting re-scheduled for Tuesday 22 February 2005. **Chief Executive**

**133. COMMUNITY HEALTH PARTNERSHIPS : PROGRESS REPORT AND MODEL SCHEME OF ESTABLISHMENT**

A report of the Director of Planning and Community Care [Board Paper No 04/64] asked the Board to note work in progress in establishing Community Health Partnerships (CHPs) and their Schemes of Establishment to be submitted to the Scottish Executive Health Department by December 2004.

Ms Renfrew described the NHS Board's objectives for CHPs and how these aspirations and objectives had driven the work in developing Schemes of Establishment with each Local Authority. The purpose of the model scheme was to provide a framework within which the detailed work with Local Authorities was being undertaken so that there was a degree of consistency on key principles. This had also enabled the NHS Board to engage with key professional interests and to ensure the NHS CHP Steering Group, which included substantial partnership representation, had been fully involved in discussing key policy issues.

During the development of national guidance and regulations in relation to CHPs, NHS Greater Glasgow had consistently sought to ensure that there was flexibility to construct the organisation and governance of CHPs to reflect the extent to which they were full partnerships with Local Authorities rather than a relatively limited NHS organisation. Ms Renfrew advised that the final guidance and exchanges with the Scottish Executive Health Department indicated that this flexibility was potentially available.

Ms Renfrew went on to briefly outline the position as it stood currently with each Local Authority and she described further work required to finalise the Schemes of Establishment. It was hoped to finalise the Schemes of Establishment for Board and Local Authority approval during January 2005 for submission to the Scottish Executive Health Department by the end of that month. There would also be a further round of dialogue on the migration arrangements for services and functions presently managed by the Primary Care Division (PCD), the outcome of which would illustrate how the highly effective operation of the PCD would be delivered in the revised working arrangements. It was recognised that the substantial change which CHPs represented alongside the rest of the NHS re-organisation meant that, although aiming for establishment at April 2005, there would need to be a coherent programme of development and migration of responsibilities over the following twelve months.

Councillor Collins referred to the work ongoing with East Renfrewshire Council and sought clarity, in particular, around the agreement that children and families Social Work be included within the CHP. Mr Divers confirmed that this could be picked up at the meeting taking place that afternoon with representatives from East Renfrewshire Council.

Councillor White re-iterated that any re-organisation should be about improving the services provided to patients and therefore it was important that close working relationships be fostered between the NHS Board and Local Authorities recognising the close service arrangements already in place. Mr Robertson and Dr Groden both welcomed the amended report and commended the revisions that had been made which had clarified many of the concerns already raised. He also agreed with Ms Renfrew's earlier point that April 2005 was the start of a journey and should not be seen as a definitive end of many good ways of working with the PCD and at LHCC level.

Ms Dhir was unclear what areas of delegation Local Authorities would bring to a CHP. Ms Renfrew clarified that these roles had yet to be defined as they had not been signed off yet at Local Authority level and they would differ across the CHPs in NHS Greater Glasgow.

Ms Borland welcomed the renewed emphasis on health improvement and encouraged that the officer designated to lead health improvement in CHPs should be a member of the CHP senior management team and in a position to provide advice and guidance on health improvement matters directly to the CHP board; that he/she should be required to be competent in terms of the national competencies for public health specialists and practitioners and that the Schemes of Establishment should allow for appropriate linkages and reporting arrangements between core health improvement staff in CHPs and elsewhere in the Greater Glasgow NHS system, as part of a cohesive and coherent health improvement effort.

In response to a question from Mr McLaughlin, Ms Renfrew confirmed that Ms Crocket and Dr Cowan were leading on work on clinical governance and that this included CHP clinical governance.

**NOTED**

#### 134. ICT STRATEGY REFRESH 2004-2007

A report of the Director of Finance [Board Paper No 04/66] asked the Board to:

- endorse the ICT Strategy, 2004-2007;
- confirm the existing minimum fund of £2m per annum from capital funds;
- support the Project Management and wider resourcing issues set out in the Strategy;
- confirm the timetable set out in the Strategy.

Ms Hull restated NHS Greater Glasgow's ambitions to see technology as a major lever for change and modernisation in the way in which all patient services were delivered, in both hospitals and primary care.

The tasks set out in the initial ICT Strategy, 2002-2004, had been comprehensively achieved and as a consequence much of the technical and cultural infrastructure was now in place to realise the vision set out in the refreshed Strategy, 2004-2007. This vision clearly mirrored the National eHealth Strategy, which similarly saw the need to ensure that the culture was right to exploit to the full, the technology available. In commenting on NHS Greater Glasgow's approach, Peter Collings, Director of Performance Management and Finance, Scottish Executive Health Department, endorsed the progress made and confirmed that the two key components of the National Requirements had been well reflected in Glasgow's approach; those being:

- To ensure that the CHI number was universally used to uniquely identify all patients; and
- That national procurements should be undertaken and adopted locally for all major IT systems and applications.

Mrs Hull welcomed Alistair Bishop who was leading on the Electronic Clinical Communication Implementation (ECCI) Project and Joanne Frame who was leading on eMedicines Management.

Mr Bishop reiterated the importance in improving the way NHS Greater Glasgow held and shared information and the challenges associated with this. He discussed the electronic care record which would be available to all authorised staff (doctors, nurses, AHPs etc) via the Enterprise-wide Clinical Portal. This would provide a single log-on access to multiple sources of data about each patient and a user friendly means of navigating and organising patient information that could be tailored to specific clinical teams' requirements but retaining a common look and feel across all Glasgow sites. Of paramount importance was correctly identifying people and the use of the Community Health Index (CHI) number which was unique to each patient across Scotland.

Ms Frame re-iterated that the vision would only be achieved by getting both the technical environment and, more crucially, the clinical and cultural environment fit for purpose. Major investment in technology alone would not create the e-clinician; only the right attitude would as e-attitude embraced, with willingness and confidence, a need to be skilled in using technology, a desire to work in a more modern way and an approach that accepted working differently, more flexibly, to realise the benefits from investment in new technology.

Dr Groden re-enforced the value of the ICT Strategy and how the vision needed to incorporate the processes associated with getting the e-attitude and e-technology right as fundamental to delivering the effective e-clinician.

Ms Dhir asked if the Project Team had sought any comparisons with others of this scale and Mrs Hull confirmed that they had consulted with a similar project in Canada with whom they kept in touch. Furthermore, she clarified that the structure to support implementation of the overall Strategy although a new structure would be with existing staff who currently worked throughout the Divisions and at the NHS Board. Sir John thanked Mr Bishop and Ms Frame for attending and noted the many benefits from the ICT Strategy and the importance of it fitting in to the overall change programme within NHS Greater Glasgow at this very exciting time.

**DECIDED:**

- |       |                                                                                               |                            |
|-------|-----------------------------------------------------------------------------------------------|----------------------------|
| (i)   | That the ICT Strategy, 2004-2007 be endorsed.                                                 | <b>Director of Finance</b> |
| (ii)  | That the existing minimum fund of £2m per annum from Capital Funds be confirmed.              | <b>Director of Finance</b> |
| (iii) | That the project management and wider resourcing issues set out in the Strategy be supported. | <b>Director of Finance</b> |
| (iv)  | That the timetable set out in the Strategy be confirmed.                                      | <b>Director of Finance</b> |

**135. 2004/05 MID YEAR REVIEW**

A report of the Director of Finance [Board Paper No 04/65] was submitted setting out the mid year review of the financial position for 2004/05.

Mrs Hull advised that, relative to the financial challenge and agreed in year financial plan, the Board was making good progress at the mid year point in 2004/05. Divisions were able to forecast breakeven at the year end against both operational budgets and Recovery Plan targets and she led the Board through a detailed position of each Division.

In terms of the waiting times non-recurrent funding requirements, these could be met from a combination of the 2004/05 capital and land sales. Nonetheless, the remaining deficit gap was £9m which would still leave a year end position of £4.6m deficit for 2004/05 to be carried non recurrently into 2005/06. As a result, it remained crucial that a combination of further in-year recovery plan savings were identified and strict continuation of monitoring of vacancy and other cost pressures was maintained. Mrs Hull stated that the NHS Board remained too reliant on non-recurrent funding and needed to move in 2005/06 to identify recurrent savings to lead to a break even position.

In response to a question from Mr Goudie in respect of the new pay arrangements under Agenda for Change (due to be implemented from October 2004), Mrs Hull recognised the challenges that lay ahead but commented that service change was at the heart of meeting this challenge.

**DECIDED:**

- |   |                                                                                                               |                            |
|---|---------------------------------------------------------------------------------------------------------------|----------------------------|
| • | That the 2004/05 Mid Year Review position as continuing to forecast a year end deficit of £4.6m be confirmed. | <b>Director of Finance</b> |
|---|---------------------------------------------------------------------------------------------------------------|----------------------------|

- That the Corporate Management Team be asked to further review opportunities in year for added savings to reduce the remaining deficit gap. **Director of Finance**
- That the Corporate Management Team be asked to continue to maintain strict vacancy management and other cost control measures in year. **Director of Finance**
- That further financial monitoring reports for the remaining months of 2004/05 be received. **Director of Finance**
- That the immediate implications for the 5 Year Financial Plan, 2005/06 to 2009/10, ahead of its detailed consideration be noted. **Director of Finance**

### **136. IMPROVING CORPORATE POLICY TO ADDRESS INEQUALITY ISSUES**

A report from Ms Rani Dhir, Non Executive Board Member, Sue Laughlin, Women's Health Co-ordinator and the Director of Planning and Community Care [Board Paper No 04/67] asked the Board to:

- Endorse the conclusions of the Short Life Working Group.
- Charge the Chief Executive to establish a process to implement the recommendations.
- Receive an update within six months on the extent to which recommendations have been integrated into new organisational arrangements.

Ms Dhir and Ms Laughlin delivered a presentation to the Board outlining the report of the Short Life Working Group which was set up to examine critically current issues relating to corporate policy development and implementation. The Group had been chaired by Rani Dhir, non Executive Board Member with Councillor Danny Collins as Vice Chair. The key aim of the Group was to make a series of recommendations as to how NHS Greater Glasgow could become more efficient and effective in defining policy aimed at addressing different aspects of inequality and health and also in the implementation of such policy. Three phases of work were undertaken by the Group:

- Evidence was collected on current perceptions, attitudes and activity aimed at addressing inequalities within NHS Greater Glasgow, current national policy developments and good practice within other related organisations.
- This evidence was then used as the basis of a problem solving phase in order to bring forward recommendations.
- The Group considered how the new emerging organisational structure might impact on the Board's ability to address inequalities.

Ms Dhir explained that the Working Group had identified that inequalities and health had a number of dimensions that needed to be described and addressed. She described these and the nine key areas for health service intervention. Ms Laughlin presented the key findings and conclusions from the Group's work where the view had been endorsed that there was both a desire and a need to address the issues of inequalities in its complexity in a more systematic and accountable fashion in order to build a modern, contemporary service in Greater Glasgow.

This should have the effect of improving services for patients and health as well as maximising clinical effectiveness and partnership working. Achieving such a change required, as a first step, a more explicit statement on the role of NHS Greater Glasgow and its workforce, an agreement that there were implications for all services, settings and the entire workforce and meaningful action. Taking a mainstreaming approach required the integration of the different aspects of the inequalities agenda into policy, programmes and practice. Such an approach recognised the need to provide targeted services for specific population groups but more fundamentally established the principle and the means to ensure that a sensitivity to inequalities and the needs of a diverse population became the responsibility, in different ways, of everyone.

On the basis of the findings of the research phase and the problem solving process, the Short Life Working Group made eleven strategic recommendations. The new organisational arrangements designed to ensure delivery on Partnership for Care and Community Planning needed to take these strategic recommendations into account. As such, the Group also recommended that a detailed programme of action was agreed as soon as possible to deliver change.

In response to a question from a Member, Mr Divers commended the work done by the Group in such a short period of time and the pragmatic ways of taking action that had been suggested – these would be picked up with the Corporate Management Team.

Councillor Collins recorded his appreciation of the excellent work undertaken by the Group and encouraged the CMT to take on the challenges presented in the recommendations as a high priority.

**DECIDED:**

- That the conclusions of the Short Life Working Group be endorsed.
- That the Chief Executive be charged with establishing a process to implement the recommendations.
- That an update, within six months, on the extent to which recommendations had been integrated into the new organisational arrangements be received.

**Chief Executive**

**Director of  
Planning and  
Community Care**

**137. WAITING TIMES**

A report of the Director of Planning and Community Care [Board Paper No 04/68] asked the Board to note the progress on meeting waiting time targets.

Ms Renfrew referred to the number of patients waiting over six months at 30 November 2004 with availability status codes and without availability status codes.

Over six months waits reduced by 391 patients (23%) between October and November 2004. The number of patients waiting over six months with ASC codes reduced by 448 patients (5%) between October and November 2004.

**NOTED**

**138. AIDS (CONTROL) ACT REPORT 2003/2004**

A report of the Director of Public Health [Board Paper No 04/69] asked the Board to approve that the AIDS (Control) Act Report 2003/2004 be submitted to the Scottish Executive, published by the Board and widely distributed in accordance with the 1987 Act.

Dr Ahmed advised that during the year, there were 103 newly diagnosed cases of HIV infection among Greater Glasgow residents. Of these, 27 probably resulted from sexual intercourse between men, 57 from sexual intercourse between men and women, 2 from mother to child transmission, 14 from other or uncertain routes and 3 from drug injecting. Similar to last year, heterosexuals had the highest number of cases of any group – 55% of the total new cases reported.

Diagnosing HIV in the mother before birth enabled interventions that could prevent infection in the baby. NHS Greater Glasgow introduced routine antenatal HIV screening for pregnant women and this had been offered to all women receiving antenatal care in Glasgow since July 2003. Since screening began, 8 women had been identified as HIV positive.

There were 22 new cases of AIDS reported during the year. Clinicians reported a 35% increase in AIDS related events compared with 2002-2003 and this was almost exclusively due to patients presenting with an AIDS defining illness. There were 5 deaths during 2003-2004, 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 purpose built infectious diseases unit at Gartnavel Hospital. During 2003-2004, 523 patients were followed up, of whom around 80% were from Greater Glasgow. Compared with the previous year, the number of patients requiring admission had increased from 79 to 90, the number of bed nights had increased as had the average length of stay. This could be attributed to the overall rise in the cohort numbers, the greater numbers with AIDS defining symptoms and the increase in late presentations.

The cost of HIV related treatment was over £2m in 2003-2004. 69% of the patients currently attending for care were receiving anti-retroviral therapy. As the number of patients being treated was expected to continue to increase, the cost of drug treatment was likely to go on rising for the foreseeable future. The targeted preventive measures continued to focus on reducing transmission between men who had sex with men and drug injectors. Prevention of transmission due to heterosexual sex was addressed through the ongoing improvement in sexual health and family planning services in Glasgow.

In response to a question from a Member, Ms Renfrew who was Chair of the Sexual Health Group, advised that, although waiting for the issue of the national strategy, the Group was pursuing as vigorously as it could sexual health messages across NHS Greater Glasgow.

**NOTED**

**139. QUARTERLY REPORTS ON COMPLAINTS : JULY – SEPTEMBER 2004**

A report of the Head of Board Administration and Divisional Chief Executives [Board Paper No 04/70] asked the Board to note the quarterly reports on NHS complaints in Greater Glasgow for the period 1 July to 30 September 2004 and note an extract from the Information Service Division's (ISD) Annual Report entitled "NHSScotland Complaints Statistics – Year Ending 31 March 2004".

Mr Hamilton referred to the improved performance at each Division from the last quarter against the national target. Mr Hamilton advised that the NHS Board awaited formal notification of the timescale of the introduction of the new NHS Complaints Procedure but that it appeared likely this would be 1 April 2005.

**NOTED**

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

A report of the Director of Public Health [Board Paper No 04/71] asked the Board to approve the following medical practitioners employed by the Primary Care Division of NHS Greater Glasgow to be authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984;

Dr Elspeth McCue

Dr Rona Gow

Dr Alison Gordon

Dr Rekha Hegde

Dr Alex Wootton

Dr Duncan Stewart

Dr Katherine McElroy

Dr Jennifer Murphy

Dr Luqman Khan

Dr Carol Bindon

Dr Olwyn Gallagher (previously approved in June when employed as a locum – now substantive)

Dr Blair Leslie (retrospective approval sought – Dr Leslie employed through an agency for one month)

**DECIDED:**

That the above-named medical practitioners be approved and authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984.

**Director of Public  
Health**

**141. AUDIT COMMITTEE MINUTES**

The Minutes of the Audit Committee held on Tuesday 26 October 2004 [A(M)04/5] were noted.

**NOTED**

**142. AREA CLINICAL FORUM NOTES**

The Notes of a meeting of the Area Clinical Forum held on Tuesday 16 November 2004 [ACF(N)04/04] were noted.

**NOTED**

**143. PHARMACY PRACTICES COMMITTEE MINUTES**

The Minutes of the Pharmacy Practices Committee [Paper No 04/72] held on Tuesday 5 October 2004 were noted.

**NOTED**

**144. INVOLVING PEOPLE COMMITTEE MINUTES**

The Minutes of the Involving People Committee held on Wednesday 10 November 2004 [Board Paper No 04/73] were noted.

**NOTED**

**145. NORTH GLASGOW UNIVERSITY HOSPITALS DIVISION MINUTES**

The Minutes of the Divisional Management Team of North Glasgow University Hospitals Division held on Wednesday 24 November 2004 [Board Paper No 04/74] were noted.

**NOTED**

**146. SOUTH GLASGOW UNIVERSITY HOSPITALS DIVISION MINUTES**

The Minutes of the Divisional Management Team of South Glasgow University Hospitals Division held on Monday 11 October 2004 [Board Paper No 04/75] were noted.

**NOTED**

**147. PRIMARY CARE DIVISION MINUTES**

The Minutes of a meeting of the Divisional Management Team of the Primary Care Division held on Thursday 4 November 2004 [PCDMIN2004/03] were noted.

**NOTED**

**148. YORKHILL DIVISION MINUTES**

The Minutes of the Divisional Management Team of Yorkhill Division held on Friday 15 October 2004 [Board Paper No 04/76] were noted.

**NOTED**

**149. MINUTES OF STANDING COMMITTEES**

It was agreed that Minutes submitted to the NHS Board for noting which had not been formally approved by that Committee, should be appropriately labelled as “draft”.

**Head of Board  
Administration**

The meeting ended at 12.30 pm