

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, 22 February 2005 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 (to start of Minute 20)
Mr J Best	Dr R Groden
Dr H Burns	Councillor J Handibode
Mr R Cleland	Mrs S Kuenssberg CBE (except Minute 23)
Councillor D Collins	Mr G McLaughlin
Dr B Cowan	Mrs J S Murray
Ms R Crocket (to Minute 24)	Mrs R K Nijjar
Mr T Davison	Mr A O Robertson OBE
Ms R Dhir MBE	Mrs E Smith
Mr T A Divers OBE	Mrs A Stewart MBE

Councillor A White

**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 Acute Division and Chair of the Car Parking Working Group (a Subgroup of the Transport and Access Group) (to Minute No 26)
Ms S Gordon	..	Secretariat Manager
Ms E Gregory	..	Communications Manager
Mr D Griffin	..	Acting Director of Finance
Mr J C Hamilton	..	Head of Board Administration
Ms S Laughlin	..	Women's Health Co-ordinator (for Minute 26)
Mr A McLaws	..	Director of Corporate Communications
Mr I Reid	..	Director of Human Resources
Ms C Renfrew	..	Director of Planning and Community Care

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

Mrs P Bryson	..	Convener, Greater Glasgow Health Council
Ms G Leslie	..	Chair, Area Optometric Committee
Dr B West	..	Chair, Area Medical Committee

**ACTION BY**

**14. APOLOGIES**

Apologies for absence were intimated on behalf of Professor D Barlow, Mr R Calderwood, Councillor J Coleman, Mr P Hamilton, Ms A Paul, Mr C Fergusson (Chair, Area Pharmaceutical Committee), Mr J Cassidy (Chair, Area Nursing and Midwifery Committee) and Mr H Smith (Chair, Area Allied Health Professionals Committee).

**15. CHAIRMAN'S REPORT**

The Chairman updated on the following:

- (i) He had met with Professor David Kerr on 15 February 2005 to discuss his ongoing work in relation to planning the future of the NHS in Scotland and, in particular, the work being progressed by the National Planning Team. This had been a useful exchange and it was envisaged Professor Kerr's report would be issued by the end of May 2005.
- (ii) He had chaired the Medical Additional Costs of Teaching (ACT) Workshop on 16 February 2005 at Stirling Management Centre which looked at the new evidence based formula for the allocation of funding to University Medical Schools and NHS Boards.

**NOTED**

**16. CHIEF EXECUTIVE'S UPDATE**

Mr Divers made reference to the following:

A meeting had been held on 17 February 2005 with colleagues at NHS Argyll and Clyde to discuss taking forward mutual areas of interest on a regional basis, in particular, acute services, mental health and Community Health Partnerships (CHPs). This meeting had formed one of a series of bi-monthly meetings that had been agreed would be held. It was considered that the Group had reached a point where it would be useful to broaden their coverage and remit and it was, therefore, agreed that colleagues from NHS Lanarkshire be invited to attend meetings in the future to take forward these areas on a tri-partite basis.

**NOTED**

**17. MINUTES**

On the motion of Dr B Cowan, seconded by Mr G McLaughlin, the Minutes of the meeting of the NHS Board held on Tuesday, 1 February 2005 [GGNHSB(M)05/1] were approved as an accurate record and signed by the Chairman.

**18. MATTERS ARISING FROM THE MINUTES**

The Matters Arising Rolling Action List was circulated and noted.

**NOTED**

**19. IMPLEMENTING PARTNERSHIP FOR CARE – THE NEXT STEPS :  
OUTCOME OF CONSULTATION**

A report of the Chief Executive [Board Paper No 05/06] asked the Board to:

- receive the comments submitted in response to the consultation paper "Implementing Partnership for Care – The Next Steps";
- confirm the Board level governance and committee arrangements set out in the paper;

- approve the creation of the structure proposed for acute services, comprising an Operating Division (including maternal and specialist children's hospital services), a Directorate for Rehabilitation and Older People's Services and an Acute Planning Team.

Mr Divers reminded the Board about the main focus of the consultation paper, which was moving away from the current Operating Divisions to a new structure for the planning and delivery of adult acute, maternity and specialist children's services as well as describing the proposals for the management of those services in terms of governance and corporate cohesion.

He restated the detailed core positions put to consultation and summarised the responses received to these proposals. The consultation process had included wide distribution of the paper and engagement with a number of key interests including Greater Glasgow Health Council, Local Authorities, Medical Staff Associations, the Local Medical Committee and senior managers. Eighty-one responses were received.

Mr Divers described the four main issues on which consultees' comments had been focussed including:

- Mental Health Partnership – a few responses had taken the opportunity to restate issues in relation to the mental health organisational arrangements which the Board had already approved. It was important to listen to those issues and ensure that they were addressed in concluding the detailed work setting out arrangements to develop the full organisational arrangements for mental health.
- Rehabilitation and Enablement – during the consultation, further discussions had taken place with the key clinical and managerial staff responsible for three component services namely, frail and mentally ill older people, physical disability and rehabilitation. Alongside the detailed design of the rest of the organisational arrangements, the Board would put forward revised proposals for rehabilitation and enablement services which addressed arising concerns while retaining the agreed principle that NHS Greater Glasgow should aim to manage these services in a way which brought them together into shared management arrangements.
- Adult Acute Services – the consultation proposed to link components for acute services, namely, a single Acute Division and a single Acute Planning Team. These proposals attracted relatively limited comment at a principle level. Where comments were made, they fell broadly into two groups:
  - ❖ the first comprised those who welcomed the move to a single, acute services operating structure as a logical progression from the current Divisional arrangements;
  - ❖ the second involved numerous detailed comments about aspects of the planning arrangements and structures within the Operating Division, which would be picked up as part of the detailed work underway to develop the management arrangements for this Division.

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- Children Services – in reflecting on the consultation responses in relation to the Women and Children’s Directorate, Mr Divers set out the strands of work being pursued in relation to community based children services. He commented that it was critical that, in the detail of the NHS organisational design, the Board followed through the logic of the integrated CHPs in relation to children’s services and, in parallel with ongoing work with Local Authorities, the Child Health Strategy Group had been promoting the development of further thinking within the NHS about how local children’s services could be organised and delivered. When that work was concluded, the migration of the present services into the new structures would be carefully managed as part of a detailed transition programme.

Mr Divers went on to describe a range of further issues arising from the consultation including:

- Transition Arrangements – a large number of responses raised concerns about implementation arrangements. Although more detailed migration arrangements remained to be made, it was the aim to conclude the final elements of work about the new organisational shape as quickly as possible, enabling the earliest possible appointments to the new structures. Thereafter, the Board would be in a position to put in place detailed migration plans which ensured that there were no changes to present organisational arrangements until the Board was clear that the new structure was able to take on a particular function. That rigour would be particularly important in relation to mental health services for adults and older people, specialist community children services, primary care services, health promotion, public health and planning responsibilities of the NHS Board. Equally, existing governance arrangements for finance, audit, risk management and clinical governance would not be changed until the replacements were fully developed and robust. Mr Divers reiterated this important message to NHS staff who would, naturally, be concerned about the significance of the change programme the reorganisation required.
- Disaggregation and Single System – the further development of headline propositions should give confidence that in meeting the Board’s key objectives of delegation and evolution, it would retain a coherent and co-ordinated NHS Greater Glasgow.
- Scale of Change – in offering reassurance, Mr Divers stated that, in designing the detailed implementation arrangements, the Board would ensure a considered and sensibly paced migration to the new arrangements.
- Service and Function Change – it was important to recognise that although the intention was that new organisations were directed at changing the way services and responsibilities were delivered, those changes would take place over the medium and long term.
- Primary Care – it was not believed that a pan Glasgow primary care structure was a viable arrangement when the construct of CHPs included full devolution of primary care services, planning and health improvement. It was clear that there would need to be a systematic approach to pull together the work of individual CHPs and it was important to challenge the construct that the Acute Division could not, as a matter of principle, manage services traditionally managed by the Primary Care Division.

Mr Divers concluded by highlighting the wide range of important and useful issues, most of which could only properly be addressed when the Board had concluded the high level principles of organisation which would enable the detail of structures and implementation to be finalised and the complex transition to begin. It was important that the Board did not lose momentum at the first stage of its change programme – consultation on the overall shape of NHS Greater Glasgow. Approval of that shape would ensure that the publication of detailed structures for final discussion could take place within the next four weeks.

Sir John referred to the vastly different ways of working that the consultation proposals presented and, in parallel with this, the huge opportunity for NHS Greater Glasgow in managing the interface between the Board and its partners.

Mrs Kuenssberg emphasised the importance of looking at the positives that the proposals envisaged particularly in bringing together children's and women's services in one Directorate. She referred to the paradox for many Yorkhill staff who regarded themselves as currently working in a single system whereas the proposals placed them within an Adult Acute Division whilst simultaneously providing community services at CHP level. She was reassured, however, by the proposed transition arrangements and, in particular, that services would not be moved until alternatives were in place.

Mr Davison referred to the work of various subgroups that had been established to pull together the structures and propositions to ensure that service structures were aligned. He referred to this as a matrix style structure that connected all of the work within NHS Greater Glasgow. He was reassured that the direction of travel of integration was logical and sensible in planning for NHS Greater Glasgow's services.

Mrs Smith expressed the view that the Board should be comforted from the few responses received from NHS staff and Dr Angell advised that many staff had fed their comments through the professional advisory structure. Mrs Smith was also reassured by the transition arrangements and recognised that the management of this change had to be undertaken in an evolutionary partnership way.

In response to a question from Sir John, Mr McLaws referred to the communication effort which had taken place to advise staff of the proposals. This had included use of the Intranet, the Board website, staff briefings as well as notification to all those on the patient focus public involvement (PFPI) database and a range of coverage in local media and press releases.

Mr Robertson referred to what appeared to be a daunting task in progressing this change but advised that there was commitment to pursue the overall strategy to maximise opportunities and closer community working. He referred to the clinical governance arrangements, in particular, where NHS Greater Glasgow had nine CHPs working with six Local Authorities. It would be important to ensure a level of consistency across these to deliver levels of support and the transitional arrangements should give a greater degree of clarity and local stability to take this forward in a coherent fashion. He felt that a fourth recommendation should be added which would see a report coming to the March NHS Board meeting on the progress being made in key areas of the implementation process. This was agreed.

**DECIDED:**

- That the comments submitted in response to the consultation paper “Implementing Partnership for Care – The Next Steps” be received.
- That the Board level governance and committee arrangements set out in the paper be confirmed. **Chief Executive**
- That the creation of the structure proposed for Acute Services, comprising an Operating Division, including maternal and specialist children hospital services, a Directorate for rehabilitation and older people services and an acute planning team be approved. **Chief Executive**
- That the Chief Executive be charged with progressing the following key strands of work and reporting to the March NHS Board meeting on the implementation plan for: **Chief Executive**
  - ❖ Primary Care
  - ❖ Future arrangements for Public Health, Health Promotion and Planning
  - ❖ Acute Operating Division
  - ❖ CHPs
  - ❖ Clinical governance, risk management and other governance
  - ❖ Child Health Strategy Group

**20. COMMUNITY HEALTH PARTNERSHIPS :**

- **SCHEME OF ESTABLISHMENT IN WEST DUNBARTONSHIRE COUNCIL**
- **UPDATE ON THE PROGRESS**

A report of the Director of Planning and Community Care [Board Paper No 05/07] asked the Board to:

- approve the proposed Scheme of Establishment for a Community Health Partnership in West Dunbartonshire Council;
- note progress on establishing Community Health Partnerships with:
  - ❖ South Lanarkshire Council
  - ❖ East Renfrewshire Council
  - ❖ Glasgow City Council.

Mr Goudie expressed his concern that the trade unions and staff side officials were in official dispute with the NHS Board over the Schemes of Establishment for Community Health Partnerships and the Board had been asked not to introduce any further Schemes of Establishment until this had been resolved. As such, he asked that the Board did not consider this paper until a mutual resolution had been reached.

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Mr Divers advised that ongoing work and dialogue would take place with the trade unions and the Area Partnership Forum to move this forward to a resolution but that, in the meantime, it was reasonable for the Board to consider this paper. Mr Reid advised that the current dispute had been discussed recently at the Staff Governance Committee and he was expecting to see ongoing and intensive discussions taking place in the near future to resolve the dispute. Ms Renfrew confirmed that the NHS Board would seek further discussions with the Area Partnership Forum to reach a form of words in relation to staff partnership and governance prior to submission to the Scottish Executive Health Department. Mr Goudie reiterated that this was an official dispute and he could take no part in any further discussions if the Board decided to consider this paper. Mr Goudie left the meeting.

Ms Renfrew led the Board through the draft Scheme of Establishment for a Community Health Partnership (CHP) covering the West Dunbartonshire area. The proposed CHP brought into a single authority wide structure the responsibilities for local health services and health improvement of the appropriate area of Argyll and Clyde and Greater Glasgow NHS Boards.

West Dunbartonshire Council did not wish to pursue the Board's preferred model of an integrated CHP and, therefore, the Scheme of Establishment covered only NHS responsibility. The Scheme of Establishment, subject to approval by Argyll and Clyde NHS Board in early March, was a significant step forward in bringing together services to a single population and, in achieving co-terminosity with the Council area, provided a platform to strengthen and extend joint working.

In response to a question from Dr Groden in relation to the membership of the CHP Board, Ms Renfrew confirmed that it would be chaired by a Board Non Executive Member.

Mr Davison was of the view that the Board should take advantage of the two defined models of CHPs and, at a later date, evaluate these two models to compare and contrast their impact within local communities.

Councillor White expressed the view that much time had been taken in forming the boundaries of CHPs in NHS Greater Glasgow but little time on the actual formation of the Schemes of Establishment. Over and above this point, he was confident that the paper reflected fairly the discussions with West Dunbartonshire Council.

Mr McLaughlin referred back to the point made by Mr Goudie and was reassured by Mr Reid that the issues around staff governance and the composition and remit of partnership forums within CHPs would be fully discussed with the Area Partnership Forum in an attempt to find a satisfactory resolution to the outstanding areas of concern. On this point, Mr Divers confirmed that further dialogue would take place with Mr Goudie to try and agree a form of words to be added to the report to resolve this matter prior to it being submitted to the Scottish Executive Health Department.

**Chief Executive**

In terms of progress with other Local Authorities, Ms Renfrew updated on the following:

- East Dunbartonshire Council – the Council and the Board had already approved a Scheme of Establishment for a health and social care partnership.

- Glasgow City Council – the Council had endorsed a joint approach to the development of CHPs and instructed the Chief Executive and the Director of Social Work Services to lead negotiations with NHS Greater Glasgow to establish those joint CHPs. Discussions were underway to develop a Scheme of Establishment for consideration by the Council and the NHS Board during March.
- South Lanarkshire Council – the previous update to the Board noted that South Lanarkshire Council did not wish to pursue an integrated model CHP and that Lanarkshire NHS Board did not wish to establish a cross-boundary CHP including the population of Rutherglen and Cambuslang. This raised the issue about the viability of a health only CHP for a relatively small population which the Board undertook to discuss further with the Council. The outcome of those further discussions was an agreement to engage with Lanarkshire NHS Board to discuss their boundary proposals. That further engagement had led to a detailed review between the three parties of potential boundary options. The Board would be kept informed of progress.
- East Renfrewshire Council – the Council was considering its position on the integrated model of CHPs over the next three weeks. The Council's conclusions would then inform the development of a Scheme of Establishment for the Board's consideration.

**DECIDED:**

- That the proposed Scheme of Establishment for a Community Health Partnership in West Dunbartonshire Council be approved subject to further discussions with the Area Partnership Forum on the outstanding issues highlighted above and prior to its submission to the Scottish Executive Health Department.
- That progress on establishing Community Health Partnerships with South Lanarkshire Council, East Renfrewshire Council and Glasgow City Council be noted.

**Director of  
Planning and  
Community Care**

**Director of  
Planning and  
Community Care**

**21. NHS GREATER GLASGOW NO-SMOKING POLICY**

A report of the Acting Director of Health Promotion [Board Paper No 05/08] asked the Board to approve the draft No-smoking Policy for consultation with staff and public.

Ms Borland described the primary focus of the policy which was to protect staff, visitors and patients from the harmful effects of environmental tobacco smoke. It also included support for staff and patients to stop smoking and recognised the contribution the policy could make to smoking prevention and the reduction of smoking rates in the wider community.

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Currently each part of NHS Greater Glasgow had its own no-smoking policy and, in the main, these policies were similar and promoted a situation where smoking was allowed only in designated smoking areas and smoking rooms (available in some hospitals). In practice, however, the policies were less well defined resulting in ambiguity regarding where and when staff and public could smoke. Over time, the reliance on the discretion of local management regarding what was appropriate had resulted in a lack of consistency that undermined the enforcement of the policies. There was a need, therefore, for a single, unified policy for the whole of NHS Greater Glasgow which would have the support of staff and public (smokers and non smokers) and which could be implemented effectively.

The Scottish Executive proposed ban on smoking in enclosed public places would provide a strong legislative framework to support the policy. It would be mid 2006, however, at the earliest before this ban was in place and the introduction of NHS Greater Glasgow's own policy in the meantime would ensure that NHS Greater Glasgow was prepared to meet the new legislative requirements.

Ms Borland led the Board through the key provisions in the policy and explained that while the detail of the Scottish ban on smoking in public places had yet to be worked through, it was likely that it would be similar to that operating in the Republic of Ireland.

She explained that the successful implementation of the policy would depend upon unambiguous and visible commitments from the Board, management and staff throughout the whole organisation noting that successful implementation would also require to be adequately resourced.

Ms Borland acknowledged that it was difficult to achieve the right balance between giving a clear message that NHS Greater Glasgow was anti-smoking and gaining support of all (staff and public, smokers and non-smokers) on whose compliance it ultimately relied. The consultation would provide the opportunity to determine whether the draft policy had achieved this. It was the intention to consult widely with staff and public using a range of communication channels including Staff News, Health News, intranet, NHSGG website, staff partnership structures and the Involving People network. The consultation would be carried out during the period March to June 2005.

Dr Burns emphasised that smoking was socially unacceptable and that the draft no-smoking policy struck a good balance and provided a clear sense of travel in reiterating that NHS Greater Glasgow did not support smoking on NHS premises. In progressing this, he accepted that staff and patients would be supported to give up smoking.

In response to a question from Dr Groden, Ms Borland explained that one of the exemption categories which referred to psychiatric departments referred to long-stay patients only.

Mrs Murray sought clarity that staff would be supported when dealing with visitors to health care premises who smoked and were trained in how to manage implementation of the policy in this respect.

Councillor Handibode asked how implementation of this policy could be policed. Dr Burns was hopeful that staff and patients would respect the policy and all groups (staff, patients and visitors) would be offered cessation services. He reiterated that smoking killed 3,000 people in Glasgow every year and was the single biggest avoidable problem that existed. He did not underestimate the challenge that lay ahead but thought the policy provided a platform to progress this in a measured way.

In issuing the policy for consultation, Ms Dhir suggested the Board define what it regarded as being a building, an area and grounds particularly as sites across NHS Greater Glasgow varied greatly. Ms Borland agreed to clarify this point prior to the consultation being issued.

**Acting Director of  
Health Promotion**

Councillor Collins referred to the well supported no-smoking policy that had operated in East Renfrewshire Council. He asked that in issuing the consultation response questionnaire, a box be added asking if the respondee was a smoker or non-smoker as this may assist in the analysis of responses.

**Acting Director of  
Health Promotion**

**DECIDED:**

The NHS Greater Glasgow no-smoking policy be amended to reflect Members' comments and thereafter be approved and issued for consultation with staff and public with a report back to the NHS Board in August 2005.

**Acting Director of  
Health Promotion**

**22. WEST SECTOR REPROVISION OF MENTAL HEALTH SERVICES –  
FULL BUSINESS CASE**

A report of the Acting Chief Executive, Primary Care Division [Board Paper No 05/9] asked the Board to consider the Full Business Case for Mental Health West Sector Inpatient Reprovision and approve the submission of the Full Business Case to the Scottish Executive.

Ms Crocket advised that the purpose of the paper was to submit a Full Business Case for the reprovision of the main inpatient services currently located on the Gartnavel Royal Hospital site to a new build facility to be constructed on an agreed foot-print designated within the Gartnavel master plan. This would allow for replacement of old and unsuitable accommodation currently located on that site.

Ms Crocket summarised the Full Business Case submission and referred, in particular, to the key milestones and timetable to the financial close and delivery of services which was:

- |  |                  |
|--|------------------|
| • Primary Care Division FBC approval         | 3 February 2005  |
| • NHS Greater Glasgow Board approval for FBC | 22 February 2005 |
| • Scottish Executive approval of FBC         | 14 March 2005    |
| • Financial close                            | 31 March 2005    |
| • Commence construction                      | July 2005        |
| • Complete construction                      | June 2007        |
| • Service commencement                       | August 2007      |

Mr Robertson encouraged approval of this Full Business Case to get the wheels in motion for construction to commence. Councillor Duncan echoed this view.

**DECIDED:**

- That the Full Business Case for Mental Health West Sector Inpatient Reprovision be approved.
- That submission of the Full Business Case to the Scottish Executive be approved.

**Acting Chief  
Executive, PCD**

**Acting Chief  
Executive, PCD**

**23. LOCAL FORENSIC PSYCHIATRIC UNIT CONTRACT FOR PROVISION OF UNIT**

Mrs Kuenssberg declared an interest in this item and, therefore, left the meeting during consideration of this item.

A report of the Acting Chief Executive, Primary Care Division [Board Paper No 05/10] was submitted on the provision of the Local Forensic Psychiatric Unit.

Ms Crocket invited Mr Griffin to update on the current status of the project. Mr Griffin explained that the project was being taken forward through Public/Private Partnership (PPP) and that its purpose was to create a local forensic psychiatric facility which would provide services as discussed and outlined in the NHS Board Minute of the meeting of 20 April 2004. Copies of the principal documents to be entered into by the Board pursuant to the project ("Project Documents" listed below) were available to Members for their consideration. Mr Griffin explained that the project documents were not yet in their final form and would be subject to amendments as advised necessary by the Board's external advisers. Any such amendments would be consistent with the general agreed principles of the project documents exhibited at the meeting. He explained that the project was moving towards financial close.

The "Project Documents" referred to were as follows:

- (i) Project agreement between the Board and Stobhill Healthcare Facilities Limited.
- (ii) Funders direct agreement between the Board, Dexia Public Finance Bank and Stobhill Healthcare Facilities Limited.
- (iii) Construction direct agreement between the Board and Balfour Beattie Construction Limited.
- (iv) Services direct agreement between the Board and Parsons Brinckerhoff Limited
- (v) Independent tester contract amongst the Board, Stobhill Healthcare Facilities Limited, Capita Simons, Dexia Public Finance Bank and Balfour Beattie Construction Limited.

**DECIDED:**

- That approval for the Board to enter into a contract, based on the project documents and additional documentation required in connection with the project as advised by the Board's external advisers be given.
- That any two from the Chief Executive, the Acting Director of Finance/Director of Finance, Primary Care Division, the Director of Planning and Community Care and the Acting Chief Executive, Primary Care Division, be authorised to consider and agree any such amendments after the date of the meeting, including agreement of the final pricing amendments to the project documents as advised by the Board's external advisers provided any such amendment was consistent with the general agreed principles of the project documents exhibited at the meeting.

**Acting Chief  
Executive, PCD**

**Acting Chief  
Executive, PCD**

- That any two/three from the Chief Executive, the Director of Finance/Director of Finance, Primary Care Division, the Director of Planning and Community Care and the Acting Chief Executive, Primary Care Division, be authorised to sign and deliver, on behalf of the Board, the project documents with such amendments to the project documents as advised by the Board's external advisers and any additional documentation required in connection with the project as advised by the Board's external advisers (provided any such amendments were consistent with the general agreed principles of the project documents exhibited at the meeting).
- That the Acting Director of Finance/Director of Finance, Primary Care Division be authorised as the named individual on behalf of Greater Glasgow NHS Board for the purpose of the insurance proceeds account to be opened in terms of the project agreement.
- That the Chairman produce a certified copy of the Minute of the proceedings of the meeting as verification that approval had been granted.

**Acting Chief  
Executive, PCD**

**Director of  
Finance, PCD**

**Chairman**

Mrs Kuenssberg returned to the meeting

**24. REVIEW OF ASSUMPTIONS UNDERPINNING JUNE 2002 DECISIONS ON ACCIDENT AND EMERGENCY SERVICES**

A report of the Director of Planning and Community Care [Board Paper No 05/11] asked the Board to consider the outcome of the review of assumptions underpinning June 2002 decisions on Accident and Emergency (A & E) Services and confirm that those assumptions which underpinned the two site A & E model approved in the Acute Services Review remained valid. The review had been carried out to meet a requirement set down in September 2002 by the Minister for Health and Community Care that the Board would review these assumptions in two years' time.

Ms Renfrew outlined the three stage process undertaken to meet the commitment to retest the assumptions which underpinned the two site A & E model included in the Acute Services Review as follows:

- Stage 1 – a detailed paper restating the original analysis which underpinned the decisions and the programme of work which had taken place since June 2002 was circulated to a wide range of key interests inviting their feedback.
- Stage 2 – a major workshop was held in October 2004 designed to enable direct debate with key interests.
- Stage 3 – a report back to the Board – the purpose of this paper to report the outcome of the above processes.

Ms Renfrew outlined and addressed the issues the review process had raised. She described the three different types of response that the engagement had led to as follows:

- Some interests simply restating positions taken in the earlier consultation.
- A number of stakeholders clearly had limited knowledge of the proposals and the significant debate and consultation around them over a two year period. They, therefore, had a legitimate desire to see a rerun of the full consultation process which this relatively bounded process could not meet.

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- Issues and discussion which did focus on the key assumptions.

She summarised the points emerging from this last group of responses against the original key assumptions which were:

- Patients would be streamed into the appropriate services, not all routed through a single A & E entry point.
- Localised minor injuries services would treat substantial numbers of patients and timely access for seriously ill patients would not be compromised.
- The Board set out the volume of patients who would be treated in each service.
- Significant changes needed to be made to arrangements for dealing with acute admissions and the Board needed to plan the right number of beds.

She led the Board through an updated position of each of these assumptions. Over and above this, the review had highlighted three further noteworthy areas as follows:

- Argyll and Clyde NHS Board's clinical strategy
- Waiting times for treatment and admission
- Major incident responses

In concluding, Ms Renfrew confirmed that the detailed emergency review process had not highlighted any new issues or challenges to the key assumptions which underpinned the two site A & E proposal. It did re-emphasise, however, the importance of substantial and effective communication on a number of issues which continued to cause concerns among key interest groups. These particularly related to the durability of the final arrangements for beds, ambulances and other infrastructure when NHS Greater Glasgow moved to two sites.

Councillor White encouraged the Board not to commit itself to two A & E sites but to keep the matter under review as a lot of changes had taken place since the original June 2002 decisions particularly in relation to regional planning. He advised that he had met Professor David Kerr who was leading work in looking at national planning across NHS Scotland and who was due to produce a report late in May. Councillor White was of the view that a decision should not be reached until Professor Kerr's report was published to ensure that the Board could take account of any issues raised in his report.

Ms Renfrew agreed that when this report was published the Board would wish to consider its recommendations but was not of the view that this should delay a decision being made today. She referred, in particular, to the evidence base produced in the paper which was on patient flows and not NHS Board boundaries. She referred to the A & E closure at the Vale of Leven (within Argyll and Clyde NHS Board area) which had not affected patient flows to NHS Greater Glasgow.

Mr Best referred to the successful shift in pattern of children previously presenting to an adult acute hospitals – now almost 98% of ambulance journeys for children attended Yorkhill A & E.

Mr Divers reminded Members that the three stage process had been approved by the Board of the review. He confirmed that the Board had undertaken the work required by the Minister for Health and Community Care. As such, it was appropriate thus, to report to the Minister the outcome of the three stage review. Any recommendations contained within Professor Kerr's report which had implications for the Board's strategies would be looked at with the appropriate planning partners at that time. He reiterated that as and when fresh issues arose, the Board would certainly look at these.

**DECIDED:**

- That the outcome of the review of assumptions underpinning June 2002 decisions on A & E services be considered.
- That those assumptions which underpinned the two A & E sites model (approved in the Acute Services Review) be confirmed and remain valid.

**Director of  
Planning and  
Community Care  
Director of  
Planning and  
Community Care**

**25. NHS GG DRAFT CAR PARKING POLICY**

A report of the Chief Executive, Yorkhill Division [Board Paper No 05/12] asked the Board to consider the outcome of the consultation on the draft Car Parking Policy.

Mr Best welcomed Mr Cameron to the meeting as Chair of the Car Parking Working Group (a subgroup of the Transport and Access Group). Mr Cameron advised that the proposed policy was a framework document which set out principles which should underpin the introduction of car park charging arrangements on a fair and consistent basis pan-Glasgow, and it sought to deal with the tension between the need to ensure staff could get to their workplace while enabling patients and their visitors, many of whom were elderly and disabled, to have reasonable access to NHS Greater Glasgow's hospitals.

He described the consultation process which concluded in November 2004. An independent panel evaluated over 200 responses and submissions received.

The feedback particularly highlighted some anxiety as to the practicalities of implementation particularly as it applied to staff working cross-sites, disabled access and early and late shift workers. The aim would be, if the policy was approved, to establish a "Glasgow permit office" to ensure the consistent and effective management of car parking pan-Glasgow.

The need for better public transport links was also raised as a significant issue and the feedback from the consultation process would be directed to the Board's Transport and Access Group who were currently working with Strathclyde Passenger Transport, Glasgow City Council and public transport providers to enhance the provision of services to Glasgow hospital sites.

In response to a question, Mr Cameron confirmed that the implementation group set up to establish an action plan to implement the Car Parking Policy would include patients/visitors representation and from the staff side of the Area Partnership Forum.

Ms Dhir encouraged the policy to be clear in terms of its definition of staff, visitors, patients and carers to ensure clarity and fairness across the principles.

Mr Davison reported that the North Division had already utilised these draft principles when reviewing car parking provision at Glasgow Royal Infirmary (GRI). In reviewing the timetable for implementation, he reminded the NHS Board that the new car park complex at GRI was due to be completed this summer and encouraged the implementation group to resolve the permit issue by late Spring/early Summer 2005 to facilitate implementation on the GRI site earlier.

In response to a question from Mrs Nijjar, Mr Cameron advised that the implementation group would be flexible in its considerations to cover various circumstances such as a visitor who attends the hospital several times a day.

**DECIDED:**

- That the outcome of formal discussion and engagement with NHS Greater Glasgow patients, public and staff be noted.
- That the Car Parking Policy document be approved.
- That the Chief Executive be delegated to set up a partnership based implementation group which will be required to establish an action plan to implement the Car Parking Policy across the designated sites over the period to 1 April 2006 on a cost neutral basis.

**Chief Executive,  
Yorkhill Division**

**Chief Executive,  
Yorkhill Division**

**Chief Executive**

**26. BEING OUTSIDE : CONSTRUCTING A RESPONSE TO STREET PROSTITUTION – REPORT OF THE EXPERT GROUP ON PROSTITUTION IN SCOTLAND - RESPONSE TO CONSULTATION**

A report of the Director of Planning and Community Care, Women's Health Co-ordinator and Senior Health Promotion Officer Sexual Health [Board Paper No 05/13] asked the Board to welcome the Being Outside report as a response to addressing the important issue of street prostitution and agree that the concerns detailed in the paper were submitted as a response to the consultation.

Ms Renfrew introduced Ms Laughlin who was in attendance to present the report.

Ms Laughlin referred to prostitution being a major issue for NHS Greater Glasgow as the health consequences of involvement in prostitution were significant. The magnitude and complexity of health problems exhibited by women involved in prostitution meant that they were likely to use a range of health services in both primary and secondary care as well as to seek support from voluntary sector organisations. There was a need, therefore, for health care providers to be sensitive to the health problems that women presented with and to assess their health problems sensitively.

The view in Glasgow was that mainstream and specialist NHS services needed to be available to all women involved in prostitution. There was also the view that services had a responsibility to make themselves as accessible as possible. NHS Greater Glasgow had developed and funded specialist services such as Base 75, the Supporting Women Abused Through Prostitute Project (SWAPP), the Centre for Women's Health and Local Addiction Project. All of these services were known to be used by women who were involved in prostitution.

Ms Laughlin summarised the report from the Expert Group which had been set up in August 2003 to carry out a comprehensive report, on behalf of the Scottish Executive, of the wide ranging issues surrounding prostitution in Scotland. "Being Outside : Constructing a Response to Street Prostitution (2004)" was the first product for consultation from this Expert Group and it made recommendations in four key areas as follows:

- Preventing involvement
- Early intervention
- Reducing harm
- Exiting

These elicited a number of common challenges regarded as defining the strategic objectives which any strategy to respond to the problem must fulfil. Such objectives contained dilemmas to which policy and practice must also respond and those had dominated the considerations of the Group.

Ms Laughlin identified the proposed way forward for the Group and summarised the NHS Board's proposed response highlighting that whilst the Expert Group report was welcome in that it provided a greater focus on this important issue, a number of the detailed recommendations were not adequate to seriously tackle such a significant public policy challenge.

Mrs Smith echoed the view of Ms Laughlin in that the report had not addressed some important issues. She referred, in particular, to the ongoing work and lessons learned in studies undertaken in Sweden. Similarly she highlighted the Social Inclusion Partnership (SIP) and 218 Project, both of which worked in the field of prostitution and commended their work.

In response to a question from Mrs Stewart, Ms Renfrew confirmed that, at CHP level, an interest would be taken in tackling inequalities and prostitution was one example of this. Projects such as 218 and Base 75 would continue to exist as they were and would not, however, be fragmented over the nine CHPs. Dr Burns added that CHPs may further play a role in preventative measures of prostitution.

Mr McLaughlin suggested that as well as the academic points to be included in the NHS Board's response, emphasis should be added to the Board's own experiences in dealing with prostitution and the successes of projects such as 218 and Base 75.

**DECIDED:**

- That the Being Outside report as a response to address the important issue of street prostitution be welcomed.
- That the concerns detailed in the paper be submitted as a response to the consultation.

**Director of  
Planning and  
Community Care  
Director of  
Planning and  
Community Care**

**27. PATIENTS' PRIVATE FUNDS STATEMENT OF ACCOUNTS FOR 2003/04**

A report of the Acting Director of Finance [Board Paper 05/14] was submitted on the Patients' Private Funds Accounts for 2003/2004.

Mr Griffin explained that following the dissolution of Trusts on 31 March 2004, the Board was responsible for signing off the Patients' Private Funds Accounts for the year 31 March 2004.

The Divisions held the private funds of residents and patients who had no ready alternative to safe keeping and management of the funds. Each of the hospitals maintained individual patient records of funds. Any funds not available for immediate use were invested in interest bearing deposit accounts. The interest generated by those accounts was distributed across patients' accounts based on balances held.

**DECIDED:**

- That the 2003/04 Patients' Private Funds Statement of Accounts for the former Trusts, namely, North Glasgow University Hospitals NHS Trust, South Glasgow University Hospitals NHS Trust and Greater Glasgow Primary Care NHS Trust be adopted and approved.
- That the Acting Director of Finance and the Chief Executive be authorised to sign the consolidated Trusts Patients' Private Funds Annual Accounts Statement and the Chairman and the Acting Director of Finance be authorised to sign the Statement NHS Trusts Management Team Responsibilities

**Acting Director of  
Finance**

**Acting Director of  
Finance**

**28. WAITING TIMES**

A report of the Director of Planning and Community Care [Board Paper No 05/15] asked the Board to note progress made in meeting national waiting times targets.

NHS Greater Glasgow had agreed to two main waiting time milestones (numbers waiting beyond 26 weeks for outpatients, inpatients/day cases) in 2004/05 – for December 2004 and for March 2005. These milestones were agreed as part of the 2004 Accountability Review process. Ms Renfrew reported that NHS Greater Glasgow had achieved the December 2004 milestone and, at this point, plans were in place and on track to ensure delivery of the March 2005 milestone of a maximum of 12,000 outpatients and 700 inpatients/day cases waiting longer than 26 weeks.

No milestones had been agreed for the period from April to December 2005 inclusive. It was important, however, that the Board continued to phase the reduction in waiting times so that both the December 2005 target was met and was delivered and sustained thereafter. By December 2005, NHS Greater Glasgow would have no patient waiting beyond 6 months for an outpatient appointment or for the subsequent inpatient/day case treatment that may be required.

Sir John commended all staff involved in meeting these milestones and had asked Mr McLaws to convey this in the next edition of the Staff News.

**Director of  
Corporate  
Communications**

In response to a question from Dr Angell, Mr Divers advised that targets for referrals from General Dental Practitioners and Optometric referrals were currently being reviewed.

In response to a question from Dr West regarding referral for plastic surgery, Mr Divers confirmed that work was being taken forward at two levels (regionally and nationally) to ensure consistency in patterns of referral for plastic surgery and their appropriateness.

**NOTED**

**29. CONTINUATION OF THE LHCC PROFESSIONAL ADVISORY COMMITTEE**

A report of the Chief Executive [Board Paper No 05/16] asked the Board to approve the continuation of the Local Health Care Co-operative (LHCC) Professional Advisory Committee pending the full establishment of Community Health Partnerships and their related advisory arrangements.

Mr Divers stated that the LHCC Professional Advisory Committee brought together representatives from all of the professional groups within primary care. It had an important role in developing policy for the LHCCs and, through its Chair, in contributing to thinking at the NHS Board. As such, it was proposed that, until revised organisational arrangements were in place, the LHCC Professional Advisory Committee should continue as at present. This gave a clear message to primary care contractors and staff that the NHS Board continued to value their views and advice as NHS Greater Glasgow moved to the detailed discussion beyond the outline Schemes of Establishment for Community Health Partnerships.

**DECIDED:**

That the continuation of the LHCC Professional Advisory Committee (pending the full establishment of Community Health Partnerships and their related advisory arrangements) be approved.

**Chief Executive**

**30. FUTURE ARRANGEMENTS FOR SERVICE REDESIGN AND IMPROVEMENT**

A report of the Chair, Service Redesign Committee and Director of Planning and Community Care [Board Paper No 05/17] asked the Board to approve the paper as a basis for wider discussion about future arrangements for service redesign and improvement.

Mr McLaughlin reported that the Board's Service Redesign Committee had been in place for one year and that it had decided that its first anniversary, coupled with impending changes to wider NHS organisational arrangements, meant it should review its progress. He led the Board through the conclusions of that review in the context that, while the improvement of NHS services must remain a key priority for the Board, a separate subcommittee with that focus may not be the best vehicle to deliver added value. The move to a different NHS organisation could create other opportunities to embed improvement throughout the organisation and within much more systematic performance arrangements.

Ms Renfrew advised that Service Redesign Committees were required to be created by the Partnership for Care White Paper and NHS Greater Glasgow's was established at the end of 2003 with the Board carefully considering a role and remit for the Committee within the wider context of NHS Greater Glasgow. She explained that the Service Redesign Committee had had the benefit of reviewing the remit and constitution of other NHS Board Service Redesign Committees within NHS Scotland and explained the wide array of differences that existed.

Dr Cowan commented on the huge amount of service design work ongoing in NHS Greater Glasgow and the links that existed from these to the Acute Services Review and Managed Clinical Networks.

Mr McLaughlin had discussed with Mr Robertson (Chair, Performance Review Group) whether there were any linkages in the areas of Service Redesign and Performance Review. They had agreed that this may be something that could be explored further and Sir John echoed these views in terms of the impact of service redesign being audited and accountable.

Mrs Kuenssberg encouraged the Board to recognise and celebrate successful service redesign initiatives by offering scholarships and prizes.

**DECIDED:**

That the attached paper form a basis for wider discussion about future arrangements for service redesign and improvement be approved.

**Director of  
Planning and  
Community Care**

**31. REMIT OF PERFORMANCE REVIEW GROUP AND CHANGES TO DECISIONS RESERVED FOR THE BOARD**

A report of the Head of Board Administration [Board Paper No 05/18] asked the Board to endorse the revised remit of the Performance Review Group and subsequent changes to decisions reserved for the NHS Board.

Mr Hamilton explained that it had been agreed at the August 2004 NHS Board that all Committees review their remit and composition and, thereafter, make any recommendations to the NHS Board should any change be proposed. The Performance Review Group was established as a Standing Committee of the NHS Board in August 2003. He referred to the original remit of this group and the amendments made to strengthen its remit allowing it to take greater delegated authority from the NHS Board.

Ms Dhir sought clarification around the timing of this request when the totality of the NHS Greater Glasgow (and, therefore, its supporting Committee structure) had yet to be finalised. Mr Divers replied by confirming that, in the interim, the Audit Committee had agreed to the revisions, whilst acknowledging that the Group's composition would need to be reviewed shortly in light of the forthcoming changes to the organisational arrangements for NHS Greater Glasgow and there was a need for the Group to continue its work as proposed in the redrafted report.

**DECIDED:**

That the revised remit of the Performance Review Group and subsequent changes to decisions reserved for the NHS Board be endorsed.

**Head of Board  
Administration**

**32. PERFORMANCE REVIEW GROUP MINUTES**

The Minutes of the Performance Review Group meetings held on 30 November 2004 [PRG(M)04/7] and 18 January 2005 [PRG(M)05/1] were noted.

**NOTED**

**33. AUDIT COMMITTEE MINUTES**

The Minutes of the Audit Committee meeting held on 25 January 2005 [A(M)05/1] were noted.

**NOTED**

**34. PRIMARY CARE DIVISION MANAGEMENT TEAM MINUTES**

The Minutes of the Primary Care Division Management Team meetings held on 13 January 2005 [PCDMIN 2005/01] and 2 February 2005 [PCDMIN 2005/02] were noted.

**NOTED**

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

The Minutes of the South Glasgow University Hospitals Division meeting held on 8 December 2004 [Board Paper No 05/19] were noted.

**NOTED**

**36. INVOLVING PEOPLE COMMITTEE MINUTES**

The Minutes of the Involving People Committee meeting held on 11 January 2005 [Board Paper No 05/20] were noted.

**NOTED**

**37. PHARMACY PRACTICE COMMITTEE MINUTES**

The Minutes of the Pharmacy Practice Committee meeting held on 1 February 2005 [Board Paper No 05/21] were noted.

**NOTED**

The meeting ended at 12.40 pm