NHSGG&C(M)08/3
Minutes: 34 - 53

NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the NHS Greater Glasgow and Clyde Board held in the Board Room, Dalian House 350 St Vincent Street, Glasgow, G3 8YZ on Tuesday, 15 April 2008 at 9.30 am

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P R E S E N T

Mr A O Robertson OBE (in the Chair)

Mr J Bannon MBE
Dr C Benton MBE
Mr R Cleland
Councillor J Coleman (to Minute 42)
Dr D Colville (to Minute 43)
Dr B Cowan
Ms R Crocket (to Minute 42)
Ms R Dhir MBE
Mr T A Divers OBE
Mr D Griffin (to Minute 42)
Mr P Hamilton
Councillor J Handibode
Dr M Kapasi MBE
Councillor J McIlwee
Councillor D MacKay
Mr G McLaughlin
Mrs R K Nijjar (to Minute 41)
Councillor I Robertson
Mr D Sime
Councillor A Stewart
Mrs A Stewart MBE
Mr B Williamson (to Minute 45)
Councillor D Yates

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

Ms H Byrne	..	Director of Acute Services Strategy, Implementation and Planning (to Minute No 41)
Mr R Calderwood	..	Chief Operating Officer, Acute Services Division
Ms S Gordon	..	Secretariat Manager
Mr J C Hamilton	..	Head of Board Administration
Mr A McLaws	..	Director of Corporate Communications
Mr I Reid	..	Director of Human Resources

ACTION BY

34. APOLOGIES

Apologies for absence were intimated on behalf of Professor D Barlow, Mr G Carson, Dr L de Caestecker, Mrs A Coultard, Mr P Daniels OBE, Mrs J Murray and Mrs E Smith.

35. CHAIR'S REPORT

(i) Mr Robertson reported that Mrs E Smith had intimated an interest in the role of NHS Board Vice Chair.

Other members who had shown an interest had withdrawn. The proposal that Mrs Smith be appointed Vice-Chair would arise under Item No 11 later in the agenda and Mr Robertson encouraged the NHS Board to support her appointment.

(ii) On 22 February 2008, Mr Robertson had met with both Chairs of the North and South Monitoring Groups set up under the Acute Services Strategy to monitor named services at Stobhill Hospital and the Victoria

ACTION BY

Infirmary. It had been re-assuring to hear from them that they continued to receive all relevant information and that a good sense of engagement had been established in both areas.

In this regard, Mr Robertson paid tribute to the NHS Board's Community Engagement Team for ensuring consistent information was conveyed to local communities.

(iii) On 29 February 2008, Mr Robertson visited staff at Tara House where a large section of Human Resources (HR) teams had now been relocated. This paved the way for ongoing integration between NHS Greater Glasgow and Clyde staff.

(iv) On 10 March 2008, Mr Robertson and Mrs E Smith had met with leaders of Inverclyde Council – a meeting that had been set up by Councillor McIlwee. This had proved a good meeting and Mr Robertson had been encouraged by their willingness to maintain a regular dialogue with the NHS Board. He thanked Councillor McIlwee for his support in this iniative.

(v) The official opening of the new Gartnavel Royal Hospital by the Cabinet Secretary for Health and Wellbeing had taken place on 7 April 2008. This was an impressive new facility which would provide high quality care for patients.

(vi) Mr Robertson had attended the unveiling of Hamish McDonald Beatson Drawings 2007/08 at the Woolfson Medical School. Mr McDonald had been a patient at the Beatson Oncology Centre and, as a gifted artist, had illustrated his journey of care and treatment. Mr Robertson had taken this opportunity to also meet with Professor Anna Dominiczak who provided a tour of the clinics and laboratories within the new Translational Centre which had been very interesting. In a similar vein, Mr Robertson had toured the Beatson Institute for Cancer Research facility the previous week when Professor Karen Vousden had shown him the work at that Centre. From both tours he had gained tremendous encouragement of the world class research being undertaken.

(vii) In recognition of the Territorial Army (TA) celebrating its centenary, Mr Robertson encouraged the NHS Board to identify any employees within the NHS who were TA volunteers in order to celebrate their contribution.

(viii) Mr Robertson referred to two new initiatives for staff, namely, "Ideas in Action Award", designed to recognise and encourage good ideas across the organisation and the "NHS Diamond Awards", which were part of plans to celebrate the 60th anniversary of the NHS. Nominations were welcomed for both awards and he encouraged NHS Board Members to support the new initiatives and encourage staff to apply.

(ix) Mr Robertson referred to a series of master classes that the NHS Board was conducting for senior management. The first of these was on leadership and Mr Robertson invited NHS Board Members to attend.

NOTED

36. CHIEF EXECUTIVE'S UPDATE

(i) On 28 February 2008, Mr Divers had been delighted to participate in a summit meeting, led by Councillor D MacKay, with Renfrewshire Council on alcohol.

(ii) On 6 March 2008, Mr Divers was asked to give a key note address at the **Chief Executive**

ACTION BY

Keep Well Conference on anticipatory care. The first phase of this initiative was being rolled out in North and East Glasgow with the second phase scheduled for South Glasgow, West Dunbartonshire and Inverclyde. So far, early lessons had been learned from phase one and these would be presented to the NHS Board at a future seminar.

(iii) On 26 March, Mr Divers had attended the Annual Child Protection Conference in Renfrewshire Council. There had been very compelling key note addresses made at this conference and work was ongoing with each Local Authority to progress this work including an emphasis on identifying risk.

(iv) On 27 March 2008, Mr Divers had joined Councillor Yates to acknowledge and receive the Her Majesty's Inspectorate of Education (HMIE) Report on child protection for East Renfrewshire Council. This had been a positive report with many areas of good work being recognised. He thanked all staff involved in the inspection and noted that an action plan had already been developed to address the cases identified for further input.

NOTED

37. MINUTES

On the motion of Dr C Benton, seconded by Dr M Kapasi, the Minutes of the meeting of the NHS Board held on Tuesday, 19 February 2008 [NHSGG&C(M)08/2] were approved as an accurate record and signed by the Chair.

NOTED

38. MATTERS ARISING FROM THE MINUTES

(i) The rolling action list of Matters Arising was circulated and noted.

(ii) In respect of Item 23 "New South-side Hospital, New Children's Hospital and New Laboratory Build – Approval of the Outline Business Case", Ms Byrne was hopeful that, by the end of April 2008, an announcement would be made by the Scottish Government on the Outline Business Case submitted for their consideration. In the meantime, Ms Byrne described work that was ongoing to progress the development as follows:

- Procurement options for the new hospitals were being explored.
- Governance arrangements had been approved at the March ASR Programme Board meeting and would be submitted to PRG in May 2008.
- Visits had taken place to two English hospitals to establish lessons learned and areas of best practice.
- Bed modelling work was ongoing.

Mr Robertson was reassured that ongoing work in these key four areas prepared the NHS Board for the next stage in the process.

(iii) In respect of Item 27 "Clyde Services Update", Mr Divers reported the following:

ACTION BY

- The consultations on services provided at Johnstone Hospital, Clyde inpatient disability services, Clyde maternity services review and modernising Clyde mental health services had all been launched. The consultation on changes to unscheduled medical care at the Vale of Leven Hospital was still being drafted with Scottish Government Health Directorate colleagues' participation.

  Part of this work involved exploring further one of the options from the Independent Scrutiny Panel Report on retaining the status quo for a specified period with the continuation of anaesthetic support to permit evaluation of the prediction model. The Cabinet Secretary had made it clear that she wanted, if it was possible, to include within the consultation pack any piece of audit work that could inform that option further.

NOTED

39. NHS GREATER GLASGOW AND CLYDE UPDATE ON CHILD PROTECTION UNIT

A report of the Board Nurse Director [Board Paper No 08/16] asked the NHS Board to note progress made by NHSGGC's Child Protection Forum from June 2007 and agree to receive a further update in October 2008.

Ms Crocket described the context of the Child Protection Unit and how the work of the Child Protection Forum continued to be rooted in the key objectives of national policies and the Government's vision for children to be safe, nurtured, healthy, achieving, active, respected and responsible and included.

Ms Crocket explained that because the Child Protection Unit was not a front-line operational service but set up to strengthen organisational arrangements in respect of child protection, it was not easy to evidence directly outcomes for children. It was, however, agreed that the area that could most likely be evidenced was in the recently introduced early sharing and collation of information systems where there could be some tracking of decision making where information was shared early with other agencies. As such, an evaluation of this service would be done once it had been up and running for one year.

Over and above this, there had been two main areas of activity that had central focus in the Child Protection Unit in recent months:

- HMIE child protection multi agency inspections – Ms Crocket described the three year programme of inspections introduced in 2005. In terms of the NHS Board's area, Renfrewshire was scheduled for May 2008, Inverclyde for June/August 2008 and Glasgow City in November 2008. Key messages for NHSGGC could be extracted from the four relevant published inspection reports to date from East Dunbartonshire (pilot and follow through), West Dunbartonshire and East Renfrewshire.

- Paediatric/forensic medical redesign – work was in its early stages to redesign all roles, responsibilities and accountabilities in paediatric and forensic medical services. Work was also currently underway to improve tripartite discussion/initial referral discussion arrangements across agencies as well as developing more appropriate child protection services for adolescents.

ACTION BY

Mr Williamson referred to the HMIE reports already published and, in particular, areas highlighted as requiring improvement. Within this list, although some could be achieved in the short/medium term, many were longer term aspirations. Mr Williamson wondered about the action plan and timescales for these. Ms Crocket explained that following an HMIE inspection, local action plans were developed to meet any shortfalls. Thereafter, monitoring was via local Child Protection Committees and the NHS Board's Child Protection Forum. She accepted that some would take time to implement but commended the high awareness of child protection issues within the NHS Board's responsibilities – both at CH(C)P level and within the Acute Division.

Councillor MacKay commended this as an excellent example of partnership working and the positive outcomes of professionals working together to build expertise and good practice.

In response to a question from Mrs Stewart, Ms Crocket confirmed that partners included Social Work Services, Education Services, housing providers, Police Service and voluntary organisations. Mr Divers referred also to the Chief Officers Group and its role to ensure action plans were driven forward and the platform it provided to look at cross-cutting issues across each agency. He suggested that, with the next update report, Ms Crocket include some progress of developments with some examples from Local Authorities working with NHSGGC. **Nurse Director**

Councillor Handibode recognised the achievements made by the Child Protection Unit in three years. He was concerned to note, however, that GPs rarely attended child protection meetings or submitted reports in some areas. Ms Crocket responded by confirming that an audit had been undertaken to establish who from practices attended case conferences and, as a result of this, a policy had been developed to prepare staff to attend case conferences. The case conference policy and guidelines did suggest that a practice could be represented by the most appropriate person be that the GP or the health visitor. Dr Colville re-iterated that often the health visitor was best placed to attend case conferences on behalf of GPs as they were the frontline provider for this work and it would be important to preserve that contact. Dr Kapasi recognised that often GPs found it difficult to attend case conferences in terms of getting locum cover and the nature of child protection case conferences meant they were often at short notice. In respect of the changing role of health visitors, Ms Crocket explained that the NHS Board had been in dialogue with educational establishments to ensure that undergraduate programmes accommodated this aspect of their role.

Mrs Nijjar asked about staff training and Ms Crocket explained that there was a comprehensive programme at CH(C)P level as well as inter-agency training ranging from basic awareness to targeted specific areas such as A & E Departments and Maternity Units. GPs could also access online training and CD-roms could be used locally in ward environments. Dr Kapasi explained that GPs and primary care staff had protected learning time and this could be used for child protection training to share experiences together as a primary care team. Dr Colville agreed with this suggestion and described how training could also be undertaken in the wider CH(C)P environment. Ms Crocket confirmed that all CH(C)P Directors had a training plan for this purpose.

DECIDED:

- That the progress made by NHS Greater Glasgow and Clyde Child Protection Forum from June 2007 be noted.

- That a further update report be considered by the NHS Board in October 2008. **Nurse Director**

ACTION BY

40. NATIONAL DELIVERY PLAN FOR CHILDREN AND YOUNG PEOPLE'S SPECIALIST SERVICES IN SCOTLAND – CONSULTATION DOCUMENT : NHS GREATER GLASGOW AND CLYDE CONSULTATION PROCESS

A report of the Director of Acute Services Strategy, Implementation and Planning [Board Paper No 08/17] asked the NHS Board to note the publication of the National Delivery Plan (NDP) for specialist children's services in Scotland which was the subject of consultation until 28 May 2008 and provide comments for incorporation into the consultation feedback.

Ms Byrne described the background to the formation of the NDP which saw a National Steering Group for specialist children's services in Scotland being established in 2006. Both Ms Byrne and Dr Iain Wallace, Associate Medical Director for Women and Children's Services, were members of this group representing NHSGGC.

Detailed work was undertaken on a range of areas which included specific service reviews, planning and commissioning, networks, age appropriate care, models of care and review of workforce requirements. The major areas of focus for the National Steering Group were on priority areas for action including:

- Children's cancer services
- Inherited metabolic diseases and cystic fibrosis
- Paediatric rheumatology
- General surgery of childhood

The Group sought to avoid duplicating work already completed or underway while also seeking to ensure that, wherever relevant, the National Delivery Plan complemented other national work streams. It was recognised that the NDP, even taken in conjunction with the other work streams, did not address the full spectrum of specialist children's services.

The Scottish Government issued the draft NDP in February 2008 for formal consultation until 28 May 2008 and at the same time announced an extra £32m investment over the next three years to support implementation of the NDP. Ms Byrne explained that this represented £2m in year one, £10m in year two and £20m in year three although it had not yet been determined how this funding would be allocated nor whether it would be made recurrent. The Cabinet Secretary for Health made a commitment in the document to the development of two new children's hospitals, one in Glasgow and one in Edinburgh complementing what had already been achieved in Aberdeen and Dundee.

Ms Byrne highlighted some of the reasons why change was proposed and why, within Scotland, there had been difficulties in sustaining the current pattern of delivery of specialist children's services.

Ms Byrne acknowledged that whilst progress had been made in developing specialist children's services nationally and the funding allocation was very much welcomed, throughout the development of the NDP, there had been considerable clinical concern about the sustainability of specialist children's services, in particular, cancer services and paediatric neurosciences in a country with the population size of Scotland.

ACTION BY

In terms of supporting participation in the formal consultation process, Ms Byrne outlined the structured process for responses within the Acute Division and the co-ordination of those responses with those that were submitted from CH(C)P organisations. Furthermore, a copy of the consultation response, prior to submission to the Scottish Government Health Department, would be shared with Local Authority partners.

Mr Williamson was concerned to note that NICE guidelines had been ignored and questioned the sustainability of four sites across Scotland for children's cancer. He referred, in particular, to staff development and training within these centres if outcomes were diluted to a degree by such a small number of children's cancers being treated.

Mr Cleland highlighted the sensitive area in moving from children's services to adult services and the often difficult transition this involved for children. As such, he welcomed the inclusion of age appropriate care.

Mr Divers explained that a lot of work had been undertaken regarding specialist cancer services in children recently and this consultation provided an opportunity to get a wide range of views on how this could be best developed. He was hopeful that the funding would be recurring and that, in terms of prioritisation of this, it would be paramount to get the best return from the investment.

Mr McLaughlin enquired about the timing and sequencing of the NDP given the progress already made for the new children's hospital on the NHS Board's south-side campus. Ms Byrne confirmed that there were unlikely to be any major changes arising from the NDP that would have an impact on the plans for the new Children's Hospital but confirmed that there was flexibility drawn into their plans if changes were required.

DECIDED:

- That the publication of the National Delivery Plan (NDP) for specialist children's services in Scotland which was subject to consultation until 28 May 2008 be noted.

- That comments from the NHS Board be incorporated into the consultation feedback. **Director of Acute Services Strategy, Implementation and Planning**

41. REVIEW OF NHS CONTINUING CARE FOR FRAIL ELDERLY

A report of the Chief Executive and Director of Rehabilitation and Assessment [Board Paper No 08/18] asked the NHS Board to note the outcome of the review of planning for NHS Continuing Care for frail older people resident in NHS Glasgow and agree that the implementation of the shift in balance of care be continued.

Mr Divers described the background to the review of NHS Continuing Care in the NHS Board's former area, NHSGG. He presented the review of previous planning assumptions and updated on the implementation of further service change explaining that this was concluding a change programme in NHS continuing care of eleven years.

ACTION BY

Mr Divers led the NHS Board through the 2005 agreed plan between NHS Greater Glasgow and Glasgow City Council (GCC) on "Review of Provision and Plans for Institutional Care for Older People in the City of Glasgow". Within this, was a section on NHS Continuing Care which had been approved by the Joint Community Care Committee with the recommendation that a further review be undertaken in 2008. In that plan, it was recommended that there be a reduction in NHS Continuing Care beds from December 2004 (656 beds) to a planned figure of 312 beds, with the objective of achieving that shift in the balance of care by 2007. Mr Divers outlined that this reduction was based on a number of factors, including:

- A declining number of admissions to continuing care as a wider range of community services became available.

- A declining length of stay in the beds as patients were generally admitted in the last months of their lives.

- A reduction in the number of patients awaiting discharge who were inappropriately in continuing care beds.

Mr Divers explained that the number of beds had been reducing since the late 1990s and illustrated a reduction of 240 beds since the plan was agreed on 2002. The final phase of reduction had not yet been implemented but included the closure of 60 beds in the south of the city and 26 beds at St Margaret's in the west of the city. This would lead to the provision of NHS Continuing Care on three sites in the north of the city and three in the south of the city. The majority of beds would be provided in units of 60 to provide critical mass for clinical staff and, in particular, to facilitate cover by medical staff.

In terms of reviewing planning assumptions, the updated "balance of care" study had included a review of each of the key elements of the planning assumptions which were relevant to that exercise. In turn they comprised:

- A review of admissions – in order to identify the number of true continuing care admissions, the number of discharges was subtracted from the number of total admissions. The discharges would have been of patients temporarily occupying the beds whilst awaiting a place in another type of care as part of their planned discharge.

- The pattern in average length of stay – the overall length of stay had continued to fall with the average length of stay of patients who had died falling in a similar way. The mean length of stay was higher than the median due to the continuing presence of patients who were admitted before the current criteria for use of continuing care were agreed. Notwithstanding this, the average length of stay had fallen substantially over the past six years. In December 2007, all continuing care providers were asked to complete a snapshot audit of current patients and their date of admission. At the point of that snapshot, only 270 of the available 416 beds were being used for continuing care patients. A similar snapshot was undertaken on 25 September and showed 282 beds in use. This equated to an average occupancy of 65 to 68% by patients meeting the criteria for NHS Continuing Care. The NHS Board would expect an average occupancy of 95%.

- The impact on future service requirements of the changing demographics among the elderly population over the next ten years – the average age of admission to NHS Continuing Care continued to be 82. From 2008 to 2018, a 25% increase in the number of people over the age of 80 could be expected. The increase in admissions which would flow from this change in demography could be met within the complement of 312 continuing care beds (which allowed for a 15% increase in admissions over the next decade).

ACTION BY

Mr Divers confirmed that further discussions would take place with St Margaret's to agree a detailed implementation plan to cease the continuing care service and to continue to encourage them to shift the type of care provided there to a social care model in partnership with Local Authority colleagues or another model consistent with shared NHS/GCC requirements. It was not intended that current continuing care patients at St Margaret's would be moved to another ward and this would form part of the implementation discussions. There was a clear demand for that type of service in that area.

Mr Robertson reported that Des McNulty MSP had written to him in connection with the NHS Board's proposals. This was circulated to NHS Board Members and Mr Robertson hoped to meet with Mr McNulty to discuss the issues he had raised, ahead of the meeting with St Margaret's on 2 May 2008.

Councillor Coleman advised that Glasgow City Council was supportive of the continued implementation of the shift in the balance of care.

Councillor Robertson sought clarification around the resources required for the transfer from a continuing care service to a social care model. Mr Divers described the migration process between the NHS Board and Local Authorities and other providers during the implementation of this plan. To date, for the other providers, the resource implications of the new model of care and transitional funding had been agreed with the final contracts being signed off. Mr Divers had confidence in this model and, in particular, in its longevity.

Councillor Stewart considered the implications of the recommendations and, at this stage, was not comfortable with them being agreed on that day. She referred to the public concern about the removal of the continuing care beds from St Margaret's and to a 90,000 signature petition presented to the Scottish Government. She suggested that before any decision was made in relation to the shift of care to a social care model, this model be further explored and a full report presented to the NHS Board on its findings which should include the input from the Local Authority to ensure that their views concurred with that of the NHS Board's. She asked that the NHS Board defer its decision until it received a fuller report following discussions with St Margaret's Hospice due to take place on 2 May 2008.

Mrs Stewart sought a breakdown of residents in a north/south split. Mr Calderwood confirmed that this projection would be possible. Furthermore, she wondered about provision in the new hospital at the Victoria and the likelihood of NHS provision to elderly patients there. Mr Calderwood reported that it would have available 48 elderly slow stream patient beds.

Chief Operating Officer

Mr Williamson was content to accept the recommendations as they stood and welcomed the flexibility of returning to the projections if they required modification. He considered that a good projection measure would be to evaluate re-admission rates as this would give an indication to where community services were not being provided and patients were required to be re-admitted to continuing care beds. Mr Divers reported that there were no re-admissions within NHS Continuing Care. Mr Williamson reported that with this care group, it was important to periodically look at whether the strategy remained fit for purpose and/or whether increased dependency required increased capacity. Mr Divers assured the NHS Board that this would take place especially as any planning assumptions had an element of risk associated with them.

Mr Bannon was under the impression that Glasgow City Council was about to conduct a review of its residential care beds – he wondered what implications this may have. Mr Divers was unaware of such a review.

ACTION BY

Councillor Yates referred to the continuing care beds in Mearnskirk House and appealed to the NHS Board to review transport links to this site as they were currently poor. Mr Divers confirmed that he would be happy to pick this up with the Community Engagement Team. **Chief Executive**

In response to a question from Ms Dhir, Mr Divers explained that the review was being conducted for the old boundary of NHS Greater Glasgow only at the moment as this was what fell under the 2005 agreement between the previous NHS Board and Glasgow City Council.

He confirmed that the numbers from the previous NHSGG population remained as a basis for a reasonable planning process. In relation to the majority of beds being provided in units of 60, this provided critical mass for clinical staff and, in particular, facilitated cover by medical staff. He accepted that Mearnskirk House had a quota of 72 beds but this had formed part of their original contract and it did not make sense to change that at this stage. The total of 312 continuing care beds for Glasgow was considered a reasonable planning assumption. Ms Dhir thought that Clyde should be included in the NHS Board's review so that the totality of the NHS Board's area could be looked at.

Mr McLaughlin intimated that the historical perspective and analysis, together with the sequencing of events, had been very helpful and he was re-assured by that detail provided by Mr Divers. He understood that other providers had been involved in NHS Continuing Care, however, he did reflect that St Margaret's was, in essence, a slightly different type of provider which had its basis as a charity. He was sure that the meeting set for 2 May 2008, between the NHS Board Chair and the Chief Executive and the representatives of St Margaret's Hospice, would deal with the adjacencies and interdependency issues. He wondered what other options could be put to St Margaret's Hospice to ensure their sustainability.

Mr Divers replied that there had never been a proposition simply to remove the 30 NHS Continuing Care beds from St Margaret's. There were two propositions; one was that the beds be redesignated as elderly continuing care with mental illness and the second that the beds be re-designated as Enhanced Social Care Beds. He (and the former NHS Board Chair) had had three meetings with representatives from St Margaret's over the last three years and clear options had been put to St Margaret's in an attempt to ensure the sustainability of the Hospice. St Margaret's preference was to stay in partnership with the NHS Board and, therefore, had a preference for continuing care beds remaining at St Margaret's rather than enhanced social care beds. Real efforts had been made to try and find a way forward that would not involve any financial risk for St Margaret's; on reflection, Mr Divers did wonder whether this dialogue should have been pushed more at an earlier date. He was keen that he and the Chair should meet with St Margaret's on 2 May 2008 and would do so with a commitment to try and find an acceptable way forward which dealt with the adjacencies and interdependencies.

Dr Benton asked why there was not a proportionate increase in admissions if there was a projected 25% increase in the population over 80 years of age. Mr Divers advised that the continued development of community services would result in a likely 15% increase in admissions and this had been built into the planned number of beds (312).

ACTION BY

With this in mind and given that it was difficult to pre-empt the outcome of the discussion on 2 May, Councillor Stewart suggested that the NHS Board consider a further report from the Chair and Chief Executive following their meeting with St Margaret's. Councillor MacKay, Mrs Stewart and Mr Bannon agreed with this particularly as there was no need to rush this decision. Councillor Robertson was of the view that given the huge public concern, the NHS Board had an obligation to listen regardless of the support from other agencies to the proposals. Councillors Coleman and Handibode, Mr Sime and Mr Hamilton advised that they remained happy to support the NHS Board's recommendation to continue with the implementation of the shift of the balance of care.

Mr Robertson recognised the difficult decision that was required particularly around such a sensitive issue. Nonetheless, given the full debate and views of NHS Board Members, he agreed to recommend the decision be deferred until following the 2 May 2008 meeting. That, in turn, would mean that the matter would be further considered by the NHS Board at its June 2008 meeting.

Mr Divers recognised the sensitivity of the issue and was pleased that Members were comfortable with the analysis provided in the NHS Board paper. In continuing the discussion to the next NHS Board meeting in June 2008 in order to reflect the discussions with St Margaret's, he expressed the hope that St Margaret's would come to the 2 May 2008 meeting prepared to discuss constructively how these issues could be moved forward.

DECIDED:

- That the outcome of the review of planning for NHS Continuing Care for frail older people resident in NHS Greater Glasgow be noted.

- That the decision to be made on the continued implementation of the shift in the balance of care be deferred until the June 2008 NHS Board meeting in order to reflect the discussions with St Margaret's at the meeting to be held on 2 May 2008. **Chairman/Chief Executive**

42. MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003 – LIST OF SECTION 22 APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No 08/19] asked that the NHS Board approve the list of Medical Practitioners employed by the NHS Board to be authorised for the purpose of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

DECIDED:

That the four Medical Practitioners listed on the NHS Board paper for the purposes of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003 be approved. **Director of Public Health**

43. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer (Acute Services Division) [Board Paper No 08/20] asked the NHS Board to note progress against the national targets as at the end of February 2008.

ACTION BY

Mr Calderwood led the NHS Board through progress across the single system towards achieving waiting time and other access targets set by the Scottish Government Health Directorate – commonly known at HEAT Targets. He explained that this would be the final report to be presented focusing on these targets. A new format would be developed for the June 2008 NHS Board focusing on the revised HEAT targets which had been agreed with the Scottish Government towards the 2011 target of 18 weeks from referral to treatment.

In response to a question from Mr Sime, Mr Calderwood confirmed that the building vacated by the Beatson Oncology Centre (on the Western Infirmary site) was being utilised for medical receiving to deal with pressure from the Accident and Emergency Department.

Councillor MacKay welcomed the NHS Board's performance in relation to delayed discharges and Mr Calderwood confirmed that the census information regarding delayed discharges was scheduled to be published at the end of April.

NOTED

44. NHS GREATER GLASGOW AND CLYDE – ANNUAL REVIEW OF GOVERNANCE ARRANGEMENTS

A report of the Head of Board Administration [Board Paper No 08/21] asked the NHS Board to approve, note and agree the new governance arrangements being put into place.

Mr Hamilton reminded the NHS Board that, in February 2005, it approved the new organisational arrangements to implement the White Paper "Partnership for Care". Subsequently, two significant reviews of the governance arrangements took place as the moves to single system working were carried out and, as a result, the NHS Board approved in December 2006 a detailed set of new governance arrangements to support the new organisation.

Mr Hamilton led the NHS Board through the changes which provided a solid governance framework for the NHS Board properly to discharge is responsibilities and statutory functions. The Audit Committee had considered the annual review of the corporate governance documentation at its meeting on 25 March 2008 and had endorsed the submission to the NHS Board and recommended its approval.

DECIDED:

(i) That the revised Standing Orders for the proceedings and business of the NHS Board and the decisions reserved for the NHS Board (Board Paper Appendix 1) be approved. **Head of Board Administration**

(ii) That the changes to the Standing Financial Instructions be approved. **Director of Finance**

(iii) That the remits of the Standing Committees – Audit (Board Paper Appendix 2), Clinical Governance (Board Paper Appendix 3), Staff Governance (Board Paper Appendix 4), Performance Review Group (Board Paper Appendix 5), Involving People (Board Paper Appendix 6), Research Ethics Governance (Board Paper Appendix 7), Pharmacy Practices (Board Paper Appendix 8) and Area Clinical Forum (Board Paper Appendix 9) be approved. **Head of Board Administration**

(iv) That delegation to the CH(C)P Committees and Mental Health Partnership Committee of the authority to approve future amendments to their own Standing Orders be agreed. **Head of Board Administration**

ACTION BY

(v) That the memberships of the Standing and CH(C)P Committees (Board Paper Appendix 10) and delegation to the CH(C)P and Mental Health Partnership Committee of the authority to approve future changes to their membership and submit annually for NHS Board approval be agreed and approved. **Head of Board Administration**

(vi) That the membership of the Adults with Incapacity Supervisory Body (Board Paper Appendix 11) be approved. **Head of Board Administration**

(vii) That the list of authorised officers to sign Healthcare Agreements and related contracts (Board Paper Appendix 12) be approved. **Head of Board Administration**

(viii) That the appointment of Ms Elinor Smith as Vice Chair of the NHS Board for a period of four years, or to the end of her term of office, whichever was earlier be endorsed. **Head of Board Administration**

45. QUARTERLY REPORT ON COMPLAINTS : 1 OCTOBER 2007 – 31 DECEMBER 2007

A report of the Head of Board Administration, Chief Operating Officer (Acute) and Lead Director, CHCP (Glasgow) [Board Paper No 08/22] asked the NHS Board to note the quarterly report on NHS complaints in Greater Glasgow and Clyde for the period 1 October to 31 December 2007.

Mr Hamilton led the NHS Board through the commentary and statistics on complaints handling referring, in particular, to areas of service improvements and ongoing developments. Throughout the period, 361 complaints have been received with 183 (51%) being received and completed within the national target of 20 working days.

Mr Hamilton referred to this disappointing performance and reported that the Acute Services Division had recently undertaken a full review of how it handled complaints and identified a number of operational issues in which they believed would be able to improve future performance.

NOTED

46. FINANCIAL MONITORING REPORT TO 31 JANUARY 2008

A report of the Director of Finance [Board Paper No 08/23] asked the NHS Board to note the financial monitoring report for the ten month period to 31 January 2008.

Mr Divers highlighted that, as at 31 January 2008, NHSGGC was reporting expenditure levels running £4.1m below the year to date budget of £2096.5m. This confirmed that the NHS Board continued to manage its expenditure levels in line with budget. As such, the NHS Board continued to forecast a revenue break-even position for 2007/08. The ability to achieve this, however, would depend on the timing of expenditure against further ring-fenced funding allocations received in the final two months of the year, the impact of which could potentially produce a year-end surplus of up to £5m.

NOTED

ACTION BY

47. PHARMACY PRACTICES COMMITTEE MEETING MINUTES : 8 FEBRUARY 2008, 22 FEBRUARY 2008, 26 FEBRUARY 2008, 6 MARCH 2008, 10 MARCH 2008 AND 14 MARCH 2008

The Minutes of the Pharmacy Practices Committee meetings held on 8 February 2008, 22 February 2008, 26 February 2008, 6 March 2008, 10 March 2008 and 14 March 2008 [PPC(M)08/02 to PPC(M)08/07]were noted.

NOTED

48. CLINICAL GOVERNANCE COMMITTEE MEETING MINUTES : 5 FEBRUARY 2008

The Minutes of the Clinical Governance Committee meeting held on 5 February 2008 [CGC(M)08/1] were noted.

NOTED

49. AREA CLINICAL FORUM MEETING MINUTES : 7 FEBRUARY 2008

The Minutes of the Area Clinical Forum meeting held on 7 February 2008 [ACF(M)08/1] were noted

NOTED

50. AUDIT COMMITTEE MEETING MINUTES : 30 JANUARY 2008 AND 25 MARCH 2008

The Minutes of the Audit Committee meetings held on 30 January 2008 [A(M)08/01] and 25 March 2008 [A(M)08/02] were noted.

NOTED

51. STAFF GOVERNANCE COMMITTEE MEETING MINUTES : 19 FEBRUARY 2008

The Minutes of the Staff Governance Committee meeting held on 19 February 2008 [SGC(M)08/1] were noted.

NOTED

52. PERFORMANCE REVIEW GROUP MEETING MINUTES : 18 MARCH 2008

The Minutes of the Performance Review Group meeting held on 18 March 2008 [PRG(M)08/02] were noted.

53. MENTAL HEALTH PARTNERSHIP COMMITTEE MEETING MINUTES : 28 FEBRUARY 2008

The Minutes of the Mental Health Partnership Committee meeting held on 28 February 2008 [2007/02] were noted

The meeting ended at 12.45 pm