

NHSGG&C(M)09/5  
Minutes: 73 - 94

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, 18 August 2009 at 9.30 am**

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**P R E S E N T**

Mr A O Robertson OBE (in the Chair)

Dr C Benton MBE	Dr M Kapasi MBE
Mr R Calderwood	Mr I Lee
Mr G Carson	Councillor D MacKay
Mr R Cleland	Councillor J McIlwee
Councillor J Coleman (to Minute No.87)	Mr G McLaughlin
Dr B Cowan	Mrs J Murray
Ms R Crocket (to Minute No.83)	Mrs R K Nijjar
Mr P Daniels OBE	Councillor I Robertson (to Minute No.87)
Dr L de Caestecker	Mr D Sime
Ms R Dhir MBE	Mrs E Smith
Mr D Griffin	Mr B Williamson
Mr P Hamilton	Mr K Winter
Councillor J Handibode (to Minute No.87)	Councillor D Yates

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

Mr C Bell	..	Chair, Area Clinical Forum
Mr G Black	..	Chief Executive, Glasgow City Council (for Minute No.74)
Ms H Byrne	..	Director of Acute Services Strategy, Implementation and Planning
Ms S Gordon	..	Secretariat and Complaints Manager
Mrs J Grant	..	Chief Operating Officer, Acute Services Division
Mr J C Hamilton	..	Head of Board Administration
Mr I Reid	..	Director of Human Resources
Ms C Renfrew	..	Director of Corporate Planning and Policy/Lead NHS Director, Glasgow City CHCPs (to Minute No.83)

**ACTION BY**

**73. APOLOGIES AND WELCOME**

Apologies for absence were intimated on behalf of Mr J Bannon MBE, Professor D Barlow and Councillor A Stewart.

Mr Robertson welcomed Mr C Bell as the recently appointed Chair of the Area Clinical Forum (replacing Dr D Colville). He also announced that Mr P Hamilton would be Vice Chair of the East Glasgow CHCP (as a replacement for Mrs A Coultard) and Mr B Williamson was to join the Involving People Committee.

In welcoming Mr G Black, Chief Executive, Glasgow City Council, in attendance to discuss the agenda item entitled "Joint Working with Glasgow City Council – CHCPs", Mr Robertson sought and received the NHS Board's agreement that this agenda item would be discussed first.

#### **74. JOINT WORKING WITH GLASGOW CITY COUNCIL - CHCPs**

A report of the Chief Executive [Board Paper No. 09/42] was submitted advising the NHS Board on the progress reached in relation to discussions with Glasgow City Council in relation to the Community Health Care Partnerships in Glasgow.

Mr Robertson noted that NHS Board members had been kept up to speed with developments regarding joint working with Glasgow City Council by formal and informal briefings. He commended the developments to date and explained that it was now important to crystallise progress and move to the next stage as set out in the NHS Board Paper. This was a very important issue for both NHSGGC and Glasgow City Council and he welcomed Mr Black's attendance to discuss the progress to date and to confirm the extent of the Council's commitment to the integrated and devolved CHCP model.

Mr Calderwood acknowledged that the Leader of the Council was fully committed to CHCPs with fully devolved budgets for the services and care groups for which they were responsible but the necessary financial information to deliver this commitment had not yet been delivered. The NHS Board had previously agreed that until that information was confirmed the Joint Partnership Board (JPB) could not be confidently established. However, further confident exchanges with the Council Leader had led to the conclusion that the NHS Board should move from that position in order to make progress. The paper, therefore, recommended the establishment of the shadow Joint Partnership Board.

Ms Renfrew agreed that there was the commitment within both organisations to work together under a shadow Joint Partnership Board arrangement. However, it was vital that this new arrangement did, as agreed with the Council Leader, finally conclude the financial issues which had been under discussion for several months. She suggested that to ensure the NHS Board entered the JPB with confidence and clarity on its requirements, that the recommendations be amended to confirm the requirement that the JPB agree a final version of the Scheme of Establishment which the NHS Board had already considered in draft form. It was particularly important that this included delivery of the financial information to give effect to the commitment CHCPs would hold the social work budgets for the services and care groups for which they were responsible. These proposals were endorsed by members as was the proposed November 2009 timescale for the NHS Board to consider a final scheme.

Mr Black thanked the NHS Board for the opportunity to discuss this important issue. He restated the commitment to a devolved and integrated CHCP model, in line with the similar approach the Council had taken to service reform in establishing arms-length organisations with a high degree of autonomy. Mr Black noted the work undertaken over the years by both organisations to get to this point. He described the political commitment within Glasgow City Council and explained how the governance arrangements for full devolution to CHCPs, under the auspices of the JPB, had been put in place with the joint appointment of the five CHCP Directors.

Councillor Coleman echoed this commitment both in terms of political leadership and service reform. The full devolution of budgets to the CHCPs afforded the opportunity to improve service delivery in a way that had previously not been possible and the JPB would provide the means of confirming the detail of that devolution.

Mr Williamson was reassured by both organisations' commitment and agreed that it would be essential to confirm progress in November 2009. Mr McLaughlin agreed and noted that the shadow Joint Partnership Board must positively conclude its business, particularly in relation to the revised Scheme of Establishment, given the continued enthusiasm and challenges that had been addressed so far by both organisations.

Ms Dhir referred to the wealth of experience and knowledge that existed within both organisations. This paved the way for the success of CHCPs and she hoped that staff would remain positive to see this through to fruition. Mr Black agreed and hoped there would be an element of trust regarding progress within both organisations. He outlined the outcomes the shadow Joint Partnership Board would address in confirming the budget devolution, namely, to improve service outcomes; to ensure effective management of resources and enhance greater scope for service redesign.

Ms Renfrew explained that currently all NHS resources for community health services were devolved to CHCPs. She recognised that there would be financial challenges ahead and that service redesign would be critical to improve outcomes.

In summing up, Mrs Smith recognised the huge undertaking that lay ahead. She understood that future monitoring reports would be considered by the Performance Review Group whilst the revised Scheme of Establishment (as considered by the shadow Joint Partnership Board) would be considered in November 2009 by the NHS Board.

### **DECIDED**

- That the establishment of the shadow Joint Partnership Board and its NHS membership including the five Vice Chairs of the CHCPs, together with the Vice Chair of the NHS Board, who would act as Vice Chair of the shadow Joint Partnership Board be agreed.
- That the shadow Joint Partnership Board be required to agree a final version of the Scheme of Establishment which the NHS Board had already considered in draft form. This was to include delivery of the financial information to give effect to the commitment CHCPs would hold the social work budgets for the services and care groups for which they were responsible.
- That this revised Scheme of Establishment be prepared and submitted to NHS Board members for approval by November 2009.

**Director of  
Corporate  
Planning and  
Policy/Lead  
Director,  
Glasgow  
CHCPs**

## **75. CHAIR'S REPORT**

- (i) Mr Robertson reported that he had attended four meetings in connection with the armed forces as follows:-
  - On 24 June, he had attended a reception for reservists employed by NHS Greater Glasgow and Clyde to afford recognition to this staff group. He explained that a proposal was with the Cabinet Secretary for consideration to agree revised Terms and Conditions across Scotland for such staff members.

- On 13 July, Mr Robertson met with Brigadier David Allfrey (51<sup>st</sup> Scottish Brigade) and Lieutenant Colonel Gadd. At this meeting, a number of issues were discussed within the broad NHS Scotland context, but in particular, within NHS Greater Glasgow and Clyde.
  - On 17 July, he had visited Combat Stress, Hollybush House, Ayr.
  - On 17 August, he had visited the Erskine Army Recovery Centre in Edinburgh and had met with military personnel there.
- (ii) On 30 June, Mr Robertson attended a meeting of West Dunbartonshire Council. This had been the first meeting of a regular programme to take forward matters of common interest. Similarly, he had attended a meeting of Inverclyde Council on 31 July and on 14 August the hand-over ceremony to East Dunbartonshire Council of the Kirkintilloch Integrated Care Centre had taken place.
- (iii) On 21 July, Mr Robertson attended the Soil Cutting Ceremony to commence work on the new Barrhead Health and Social Care Centre. In attendance had also been Councillor D Yates and Dr H Burns (Chief Medical Officer).
- (iv) On 30 July, Mr Robertson had met with Sir Muir Russell, Principal, University of Glasgow, and Mr David Newall, Secretary of Court, University of Glasgow, to take forward matters relative to the Western Infirmary Hospital site and a University presence on the new South Side Hospital Campus. On a similar theme, Mr Calderwood and Mr Robertson had met with Professor Anton Muscatelli, Principal Designate, University of Glasgow, on 17 August to take forward developments on the strategic alliance with the University of Glasgow.

**NOTED****76. CHIEF EXECUTIVE'S UPDATE**

- (i) Mr Calderwood had visited St Margaret's Hospice and had met with Sister Rita. This meeting had been constructive and gave Mr Calderwood an opportunity to reinforce the NHS Board's position to work with the Hospice in going forward.
- (ii) Mr Calderwood and senior colleagues had provided a briefing on 29 June to MSPs on the H1N1 virus. A broad range of issues had been discussed in relation not only to the handling of the Pandemic across NHS Scotland but, in particular, the response by NHS Greater Glasgow and Clyde.
- (iii) On 22 July, Mr Calderwood had visited the Quarriers Epilepsy Centre at Bridge of Weir.
- (iv) On 3 August, Mr Calderwood had met with Councillor McIlwee and fellow Inverclyde Councillors including the Council Leader, Stephen McCabe, accompanied by Mr D Walker (Director, Inverclyde, CHP) to discuss the NHS Board's commitment to the Inverclyde area and to address local concerns in relation to water ingress at Inverclyde Royal Hospital.

**NOTED**

**77. MINUTES**

On the motion of Mr R Cleland seconded by Councillor D MacKay, the minutes of the NHS Board meeting held on Tuesday 23 June 2009 [NHSGG&C(M)09/4] were approved as an accurate record and signed by the Chair.

**NOTED****78. MATTERS ARISING FROM THE MINUTES**

The rolling action list of matters arising was circulated and noted.

**NOTED****79. SCOTTISH PATIENT SAFETY PROGRAMME (SPSP) UPDATE**

A report of the Board's Medical Director and Head of Clinical Governance [Board Paper No. 09/38] asked the NHS Board to review and comment on the progress achieved by NHS Greater Glasgow and Clyde in implementing the Scottish Patient Safety Programme.

Dr Cowan reminded members that the Programme focused on improving safety by increasing the reliability of health care processes within Acute care. This was achieved by frontline teams testing and establishing more consistent application of clinical and/or communication processes. Success was monitored through a measurement framework and supported by a visible commitment to safety by the organisation and the achievement of an overarching set of improvement aims which currently were:-

- Mortality – 15% reduction
- Adverse events – 30% reduction
- Ventilator associated pneumonia - reduction
- Central line bloodstream infection - reduction
- Blood sugars within range (ITU/HDU) – 80% or > within range
- MRSA bloodstream infection – 50% reduction
- Crash calls – 30% reduction
- Harm from anti-coagulation – 50% reduction in ADEs
- Surgical site infections – 50% reduction (clean)

Phase 1 was launched in January 2008 and involved nine wards and by June 2008 a further 22 wards had become involved in Phase 2. Phase 3 was currently being established and a further 60 wards being prepared.

Dr Cowan provided a summary of programme implementation across NHS Greater Glasgow and Clyde. The Phase 1 frontline teams working on critical care and general ward packages were maintaining tempo that kept NHS Greater Glasgow and Clyde in line with the published Scottish Patient Safety Programme (SPSP) timeline for each workstream. He illustrated some of the reliability levels currently being observed in Phase 1 and highlighted the following:-

- There was a high level of compliance with implementing a set of preventative measures reducing Ventilators Associated Pneumonias (VAPs) in Intensive Care Units (ITUs). In the Royal Alexandra Hospital, ITU staff had been able to significantly improve compliance levels.

- There was a reduction in the rate of central line bloodstream infections that produced a period of over 200 days without such an infection in the ITU at Glasgow Royal Infirmary.
- It was known that reliable completion of Early Warning Scoring Charts was a problematic area but a team from the Royal Alexandra Hospital showed that they could generate much improved levels of reliable completion. Dr Cowan described a new communication practice to ensure all staff on duty were aware of the key safety issues. This had also generated high levels of reliability.

The full deployment of the measurement strategy around Phase 2 teams continued to be a challenge. Dr Cowan described a full breakdown of the measures available as at 13 July 2009 and explained that initial plans had not progressed as anticipated, therefore, further focus on Phase 2 teams was required to reconfirm a timeline to completion. A gap analysis was being developed to provide the necessary prediction of requirements to complete within the next 3 months.

Sustainability of measurement support had been highlighted as a programme risk so a new approach to measurement support was being developed with Phase 3 to minimise the expected challenges. This was just being rolled out so it would be a few months before Phase 3 was included in the routine update reports on progress. A number of Phase 3 teams had begun working after completing the preparatory work of identifying members and attending training. It was expected that the target of 60 new teams started before the end of 2009 would be achieved.

In terms of the Leadership Action Plan, Dr Cowan noted that it was being well maintained, however, further communication would be issued to Directors following observations of limitations in the data flow regarding walk-round actions. Walk-rounds continued to be well received by clinical staff and considered useful by Directors.

A fifth national event for the SPSF had been announced and would take place on Monday 16 and Tuesday 17 November 2009 in the SECC. Following up on feedback from staff attending the last national event, the two conferences would be targeted toward new teams as they appeared to get most from the experience.

In response to a question from Mr P Hamilton, Dr Cowan explained how valuable the walk-rounds were proving to be. This process was more direct and formal than before and an action plan was compiled that required to be completed. The whole process was monitored by the Head of Clinical Governance.

Mrs Murray asked if the improvements could be sustained. Dr Cowan responded by confirming that evidence showed (most notably from the USA) that it could. He cautioned, however, that this evidence was based on individual units and not across an area the size of NHS Greater Glasgow and Clyde. He had, however, been impressed so far with the results and seeing how challenges were being met and was hopeful that lessons learned from other countries such as Denmark and Holland would result in the sustainability of the programme. He was hopeful that the practice could be embedded within local wards.

Dr Benton asked if lessons learned and best practice were shared across all NHS Scotland Boards. Dr Cowan confirmed that this was the case and that intelligence was shared internationally via a website, regular visits and conference calls. Although this was positive and a step in the right direction, more work would be done to further share experiences but this would be addressed nationally.

**NOTED**

**80. HEALTHCARE ASSOCIATED INFECTION – MONITORING REPORT**

A report of the Medical Director [Board Paper No. 09/39] asked the NHS Board to note the latest of the regular bi-monthly reports on Healthcare Associated Infection (HAI) in NHSGG&C. The report presented data on the performance of NHSGG&C on a range of key HAI indicators at national and individual hospital level.

Dr Cowan reminded members that the bi-monthly report outlined the position on performance in relation to:-

- S.aureus bacteraemias (HEAT Target)
- C.difficile
- Surgical Site Infections
- Hand hygiene compliance
- Monitoring of cleaning services

In summarising the report for Members, Dr Cowan reported the following:-

- If current trends were maintained, NHS Greater Glasgow and Clyde would achieve the target of a 35% reduction in S.aureus bacteraemias by 2010.
- The national report published on 8 July 2009 (January – March 2009) indicated that the annual rate of C.difficile infection in NHS Greater Glasgow and Clyde (April 08 – March 09) was 0.79 per 1000 occupied bed days. The rate for NHS Scotland was reported as 1.09 per 1000 occupied bed days for the same period.
- The Surgical Site Infections (SSI) rates in NHS Greater Glasgow and Clyde were below the national average for all procedures.
- NHS Greater Glasgow and Clyde had demonstrated a steady rise in hand hygiene compliance during the national audit periods from a 62% base line in February 2007 to achieve the 90% target in September 2008 and a current figure of 93%.
- All areas within NHSGGC scored green (>90%) in the most recent report on the national cleaning specification.

Dr Cowan led the NHS Board through the illustrations showing the number of new cases of Hospital Acquired Infection (HAI) per hospital site 2007 – 2009. In terms of Glasgow Royal Infirmary, Lightburn Hospital, Stobhill Hospital, Royal Alexandra Hospital, Inverclyde Hospital, Victoria infirmary Hospital, Southern General Hospital, Western Infirmary, Gartnavel General Hospital, Drumchapel Hospital, Blawarthill Hospital and the Vale of Leven Hospital all were within control limits in June 2009. There was one ward-based exception report within Stobhill Hospital for June 2009. Dr Cowan described work led by the antimicrobial management team in the implementation of a new antibiotic policy and supporting guidelines. These had resulted in a notable drop in C.Diff instances which was commendable.

Mr McLaughlin asked about any further targets that may be set given that the NHS Board was now meeting existing targets. Dr Cowan responded by confirming that if more challenging targets were to be set, this would be done at Scottish Government Health Directorate (SGHD) level via HEAT targets. Given that the NHS Board had met its targets in such a short space of time, however, he would be reluctant to set further challenges at the moment but would prefer that the focus be on sustaining challenges already met. He explained that there were varying degrees of success in meeting the targets across NHS Scotland Boards and, as such, the SGHD was likely to await some consistency Scotland-wide. Otherwise, it would need to enforce different targets for individual NHS Boards.

Mr Williamson congratulated the NHS Board and its leadership on the visible significant progress in infection control. Mr Cleland agreed and noted the role of the Clinical Governance Committee in monitoring the NHS Board's compliance with the targets.

**NOTED**

**81. WINTER PLAN 2009/10 – PROGRESS REPORT**

A report of the Director of Acute Services Strategy, Implementation and Planning [Board Paper No.09/40] asked the NHS Board to receive an update on winter planning for 2009/10 which included reference to lessons learned from 2008/09.

Ms Byrne provided a summary of the lessons learned in 2008/09. She updated on issues raised nationally and regionally and set out work underway in developing the Winter Plan for 2009/10 and the key timelines.

The 2008/09 Winter Plan for NHS Greater Glasgow and Clyde was developed on a single system basis with all partners in the delivery of key services involved. The system wide Winter Planning Group and Executive Group (with representation at senior level from across the key organisations) ensured a co-ordinated approach to the planning and delivery of services and this was being further developed in progressing the 2009/10 Winter Plan. Overall, the 2008/09 Winter Plan worked effectively and Ms Byrne led the NHS Board through some of the lessons learned that would guide winter planning for 2009/10 including communication, information sharing, the escalation plan/senior decision making rota, occupational health and public holidays. In attempting to address problems encountered in previous years, a number of new initiatives were introduced in 2008/09 which worked well and were positively welcomed by patients.

Ms Byrne confirmed that the Winter Planning Group and Executive Group had continued to meet to progress the winter planning process for 2009/10 and a national winter planning event had been held on 16 June 2009 which was very well attended by representatives from all partners across NHS Greater Glasgow and Clyde and other NHS Boards across Scotland. The point was clearly made that in planning for winter 2009/10, all NHS Boards should ensure that flu plans were aligned to the winter planning process. This would be discussed in a meeting on 7 September 2009. Concerns were raised about the four day holiday period and this had been raised separately again with the Scottish Government Health Directorate for them to review and provide guidance on service delivery during this period. It was stressed at the national event, the need to ensure there was full engagement with local authority partners, in particular Social Work, in the winter planning process. Through the CH(C)Ps, meetings were being arranged with individual local authorities as appropriate to discuss how they could become more involved in this process.

A regional event was scheduled for 24 September 2009 where NHS Boards were expected to share their draft Winter Plans with finalised Winter Plans being submitted for formal approval in October 2009. In preparation locally, a winter planning meeting would be held on 7 September 2009 to ensure all partners had in place their winter planning processes for 2009/10. It was intended that NHS Greater Glasgow and Clyde would have a prominent role at this event in sharing good practice. Following that, amendments would be made as appropriate and the Winter Plan would be considered by both the Winter Planning Group and Executive Group before submission to the NHS Board in October 2009 for formal approval.

**Director of  
Acute Services  
Strategy,  
Implementation  
and Planning**

In response to a question, Ms Byrne explained that, in the past, planning for winter pressures had involved preparation for and delivery of the Influenza Vaccination Scheme. Although the number of reported cases of H1N1 had dipped lately, medical experts, who had studied previous pandemics, believed the Autumn was a crucial period when an upsurge was likely.

It was, therefore, vital that the work of the NHS Greater Glasgow and Clyde Pandemic Flu Planning Group was integrally linked with the preparations being made by the Winter Planning Group.

### **NOTED**

## **82. NHS GREATER GLASGOW AND CLYDE – OUTCOME OF HER MAJESTY’S INSPECTORATE OF EDUCATION (HMIe) REVIEWS - CHILD PROTECTION**

A report of the Nurse Director [Board Paper No. 09/41] asked the NHS Board to note the key messages arising from Her Majesty’s Inspectorate of Education Joint Child Protection Inspections for Inverclyde and Glasgow City and note the overall progress being made as a result of these.

Ms Crocket summarised the HMIe Inspection Reports for Inverclyde (which took place in February 2009) and Glasgow City (which took place in March 2009). She described the overall strengths recorded and highlighted areas for future development. In this regard, she led the NHS Board through some of the activity either underway or completed which the HMIe Inspection Reports had identified as areas of future development as follows:-

- Early involvement of health staff in child protection processes - all Child Protection Committees had an agreed tripartite discussion/initial referral discussion protocol in place or had ensured that it was being developed.
- Medical examinations of children and adolescents – paediatric medical services had been redesigned and plans were underway to roll out the Archway Service (acute sexual assault on adolescents and adults) across a wider area. Furthermore, a review of overall medical services for adolescents was in progress and a 24 hour service for all child sexual abuse cases requiring paediatric input was now in place across NHS Greater Glasgow and Clyde.
- Supervision of key staff – a model of supervision for Health Visitors and School Nurses had been agreed and training for this was currently being rolled out by Glasgow Caledonian University. A tool to assist team leaders in the supervision of child protection cases was in draft form.

Ms Crocket confirmed that the three year programme of Joint Inspections to protect children which commenced in 2005 was now complete and the NHS Board was working with all its local authorities, through their Child Protection Committees, to continue to improve child protection services.

A new model of inspection was being introduced later this year with East Dunbartonshire Council being the first local authority in the NHS Board’s area to be inspected. Work was underway to understand the new inspection process and prepare for the inspection which would take place between 16 and 30 November 2009.

Both Councillors McIlwee and Coleman welcomed the reports and, in particular, the areas identified both in Inverclyde and Glasgow City for future development. In respect of the consistent message that relevant staff must always communicate at an early stage, Ms Crocket explained that a protocol had been prepared for all staff between local authorities and the NHS in terms of the sharing of information. Processes and guidelines had been drawn up to back up practice and all local authorities had given their commitment to these. Ms Renfrew explained that the protocol would be formally launched in September 2009 and she hoped that this would enhance confidence that measures were taking place to ensure staff across relevant agencies communicated early.

Councillor MacKay found the report heartening and congratulated all staff within the NHS who had ensured that systems and joint working existed. He reflected that there was a rise in the number of children on child protection registers and this work was, therefore, paramount. Councillor Handibode endorsed these comments and suggested that the communication systems be rolled out to ensure communication existed for vulnerable adults too.

In response to a question from Mrs Nijjar, Ms Crocket confirmed that local Child Protection Committees were responsible for putting in place an action plan to address the suggested areas of development. These Committees also monitored delivery of the Plan.

Dr Kapasi asked what measures were being put in place to heighten awareness with GPs and in local accident and emergency departments. Ms Crocket responded by confirming that information about child protection had been issued twice to NHS Board staff via messages in staff pay slips. Furthermore, Child Protection Committees had been charged with looking at how to inform local communities about their role. Within A&E departments, protocols and guidelines existed and awareness had been raised significantly with the role of a Child Protection Nurse Advisor who linked in with all NHS Greater Glasgow and Clyde A&E Departments. In relation to GPs, they could access training online and each CH(C)P had training plans in place to ensure GPs were trained. This was revisited on a six monthly basis and was a key priority for CH(C)P Directors.

Mr Williamson wondered how effectiveness could be measured in relation to child protection. Ms Crocket agreed that it was difficult to have tangible outcomes in which to identify in terms of improvement in child health but she was confident that within the governance structures described earlier appropriate actions were being addressed. Referring to a comment made earlier regarding the increase of children on child protection registers, she commented that this could be, in part, due to better processes and systems working more effectively.

### **NOTED**

#### **83. DESIGN ACTION PLAN: UPDATE**

A report of the Director of Acute Services Strategy, Implementation and Planning [Board Paper 09/43] asked the NHS Board to note progress on the implementation of the Design Action Plan.

Ms Byrne led the NHS Board through the second annual progress report and explained that it outlined seven objectives against which a number of actions were identified. The NHS Greater Glasgow and Clyde Design Champion Network had continued to complete this work and supported implementation of the Design Action Plan. She summarised progress as follows:-

- Mechanisms to support effective project management, ensuring projects delivered the NHS Board's vision for design quality – 2 projects (Barrhead Health & Social Care Centre and the new maternity development on the Southern General Hospital site) were initially identified against which key concepts and processes outlined in the action plan were tested. The “test” was led by Capital Planning Managers and considered the scope, the process outline and the objectives identified in the Design Action Plan within each project.

This approach had now been adopted within all major developments and was currently being applied to Possilpark Health Centre and planned mental health developments in Clyde.

Since then, the guidance had been further developed as criteria for consideration when assessing tender documentation for capital projects. Ms Byrne also referred to the “Better Access to Healthcare Buildings Project” where service users with a range of individual needs and disabilities advised the NHS Board's project teams on physical design issues in relation to the new Stobhill and Victoria Hospitals.

- Stakeholder engagement – progress had been made in terms of both service user engagement and external partner engagement. An “accessibility network” had been established to support the estates and capital planning functions. This network would support ongoing systematic and proactive engagement with people with a wide range of disabilities. Furthermore, working with the Glasgow Centre for Population Health, Scottish Health Impact Assessment Network and Glasgow City Council, the new South Glasgow capital project had formally initiated a health impact assessment and equality impact assessment process to support formal engagement with external partners.
- Skills and resources to deliver the NHS Board's vision for design quality – a training needs assessment was undertaken with capital project teams, clinicians and wider NHS staff by the learning and education department in 2008 and a learning and education plan was developed to support the implementation of the NHS Greater Glasgow and Clyde Design Action Plan.
- Measured process and outcomes – the Design Action Plan outlined the need for formal review of capital projects on completion and timescales now accommodated the development of a post occupancy evaluation approach and evaluation tools which were currently being piloted within the Beatson West of Scotland Cancer Centre.

Ms Byrne concluded by confirming that the Design Action Plan continued to be developed and integrated into the range of capital projects underway across NHS Greater Glasgow and Clyde. Notably, the new South Glasgow Hospitals and Laboratory Project procurement demonstrated clear commitment to the principles and values outlined within the Design Action Plan.

Ms Dhir welcomed the progress that had been made particularly in relation to access to and around the NHS Board's premises. She was concerned, however, that information about public transport to the Board's premises was either not accessible or not available. Mr Calderwood referred to public transport leaflets that had been compiled in conjunction with Strathclyde Passenger Transport and tailored for the two new Ambulatory Care Hospitals in Stobhill and the Victoria. Investment was made for this very reason and Mr Calderwood agreed to check this with the Head of Community Engagement/Transport.

**Chief Executive**

In response to a question from Mr Cleland, Ms Byrne confirmed that as part of the ongoing evaluation, the service user engagement process would be revisited to identify what lessons could be learned in terms of embedding into future processes. Mrs Grant agreed and confirmed that learning points would be identified to ensure efficiency and action for future plans.

Mr Carson commended the “Better Access to Healthcare Buildings Report” but suggested that disability groups, especially wheelchair users, be involved at the planning stages. Ms Byrne took this comment on board.

### **NOTED**

#### **84. NHS GREATER GLASGOW AND CLYDE – AWARD OF CONTRACT**

Board Paper No. 09/44 asked the NHS Board to approve the award of the contract for taxi services for Greater Glasgow to Network Private Hire Limited.

Mr Griffin explained the background to NHS Greater Glasgow and Clyde’s requirement for taxi services to transport staff, patients, records, samples and equipment between sites. He briefed the NHS Board on the competitive tendering process followed to secure the provision of taxi services within the NHS Board’s area and explained that this process was overseen by a project team. The process began on 15 February 2008 with the publication of a notice in the official Journal of the EU seeking expressions of interest. Spring Radio Cars Limited trading as Network Private Hire Limited (NPH) submitted a well structured and well thought out tender response and scored highly in all criteria areas. Furthermore, the information supplied to demonstrate how NPH would deliver the service was of a high standard with all drivers servicing the NHS Board’s contract having received enhanced disclosure checks.

In their response to the invitation to tender, NPH stated they had a fleet of 750 vehicles and stated a commitment to purchase a further 56 vehicles to function as facility cabs. NPH was part of the Network Group who stated on their website they were the largest private hire company in Scotland and had a number of public bodies as customers including the BBC and Glasgow City Council. As part of the competitive tendering process, references were required and in the case of NPH one of these was provided by Glasgow City Council.

Mr Griffin explained that EU Regulations required that there be a standstill period (minimum 10 calendar days) between notifying tenderers of the contract award decision and entering into a contractually binding agreement with the successful tenderer. This standstill period was intended to allow unsuccessful bidders to query or, if appropriate, challenge the award decision.

In this case, a standstill letter was issued to all tenderers on 16 January 2009. Since then a number of challenges had been made to the proposed award of a contract to NPH. Consideration of these matters had taken considerable time and, to date, prevented the award of a contract to NPH. Thorough and extensive investigations had been carried out in respect of those matters which had included obtaining legal advice and seeking the opinion of Junior and Senior Counsel. The stage had been reached where it was reasonable to conclude that the matters raised in the challenges had been resolved.

In response to a question, Mr Calderwood reported that the contract was for a 2 year period unless performance was sub-optimum in which case the contract could be terminated.

It was reported, however, that further new information had been received by NHS Board Officers immediately prior to the Board meeting and it was suggested that the recommendation receive only conditional approval from the NHS Board. Such approval being conditional upon satisfactory resolution of the matters raised in the new information.

### **DECIDED**

That the award of the contract for taxi services for Greater Glasgow to Network Private Hire Ltd could only be granted conditional approval at this stage and would be subject to the satisfactory resolution of the matters raised in the new information provided. If the officers of the Board considered the information to be materially significant then the matter should be referred to a Performance Review Group to consider how to proceed.

**Chief Executive**

## **85. VISION FOR THE VALE OF LEVEN HOSPITAL: UPDATE AND NEXT STEPS**

A report of the Director of Acute Services Strategy, Implementation and Planning, [Board Paper No. 09/45] was submitted on the updated position on the vision for the Vale of Leven Hospital and next steps.

Ms Byrne reminded the NHS Board of the recommendations approved at the NHS Board meeting held on 24 February 2009 in respect of the Vale of Leven Hospital. These recommendations were subsequently forwarded to the Cabinet Secretary for Health and Wellbeing for her formal consideration in March 2009. She had since publically announced the outcome of her deliberations on 16 July 2009 and Ms Byrne referred to the letter addressed to the NHS Board's Chairman dated 15 July 2009 outlining her key decisions which were as follows:-

- Approve the Board's main proposals.
- Reserve final decision on the future of the Christie Ward pending a further report from NHSGGC confirming levels of admission in 12/18 months time.
- Appoint a Monitoring Group to oversee development and delivery of the service change plans.
- Require NHSGGC to carry out promotion of current and future services provided from the Vale.

The Cabinet Secretary's office had now confirmed the Monitoring Group's remit and had agreed that the most straightforward way of assembling this Group would be to reconstitute and expand the existing Helensburgh and Lomond Planning Group. This Monitoring Group would meet bimonthly and the current Planning Group Chair, Mr Bill Brackenbridge, would chair it. Ms Byrne confirmed that it would take approximately 9 months from the date of the Cabinet Secretary's approval to implement the specified service changes. An early requirement was for letters to be sent to all individuals and groups who responded to the consultation confirming the Cabinet Secretary's decision and the forthcoming actions.

**Director of  
Acute Services  
Strategy,  
Implementation  
and Planning**

Councillor Robertson welcomed this and confirmed that it had been well received in the local press and with local campaigners who were pleased with the outcome. It also afforded some certainty not only to local residents but to members of staff. In respect of the Monitoring Group membership, he wondered if there was scope for Social Work representation. Ms Byrne confirmed that discussions were still ongoing to finalise Monitoring Group membership and she would make this suggestion.

**Director of  
Acute Services  
Strategy,  
Implementation  
and Planning**

**DECIDED**

- That the Cabinet Secretary's decision on NHS Greater Glasgow and Clyde proposals for the future of the Vale of Leven Hospital be noted.
- That the progress being made to establish a Monitoring Group in line with the Cabinet Secretary's requirement be noted.
- That an outline of work and timescales required to initiate implementation of the proposals be noted.

**86. WAITING TIMES AND ACCESS TARGETS**

A report of the Chief Operating Officer (Acute Services Division) asked the NHS Board to note progress against the national targets as at the end of June 2009.

Mrs Grant led the NHS Board through the report referring, in particular, to the following:-

- At the end of June 2009, throughout the Acute Division, no patients waited more than 12 weeks from GP referral to an outpatient appointment. Proposals were being prepared which would further reduce the stage of treatment target in advance of the 18 week referral to treatment guarantee. The next milestone would be to achieve 11 weeks, although no definite date had yet been agreed for this achievement.
- The Acute Division continued to work towards the milestone of no patient waiting over 11 weeks from the decision to undertake treatment to the start of that treatment, with the eventual aim of achieving a 9 week wait for inpatient and daycase treatment by December 2011. From April 2009, all specialities had maintained the 12 week inpatient and daycase target, with progress being made towards reducing to an 11 week position.
- The 6 week target from referral to MRI scan, CT scan, non obstetric ultrasound, barium studies, gastroscopy, sigmoidoscopy, colonoscopy and cystoscopy continued to be maintained. The Acute Division was currently reviewing the model required to meet the next milestone for diagnostics which was yet to be finalised.
- The target from referral to completion of treatment for cataract surgery of 18 weeks continued to be maintained.
- The target to operate on 98% of all hip fracture patients within 24 hours of admission to an orthopaedic unit, subject to medical fitness and during safe operating hours has continued to be met.
- Despite a difficult start to the year, the NHS Board had achieved 98% compliance of accident and emergency patients being treated and discharged, admitted or transferred within 4 hours of arrival at the department in 2 of the 3 months from April to June 2009. Despite increasing demand, the Directorate of Emergency Care and Medical Services remained strongly committed to maintaining a position of sustained achievement of this target.
- An internal clinical review process in respect of cancer waiting times, undertaken in conjunction with the Clinical Audit Departments, indicated that the Acute Division achieved 96.4% of all urgent referrals with suspected cancer waiting a maximum of 62 days from urgent referral to first treatment (31 days for breast cancer).
- The 2 week target for Rapid Access Chest Pain Services (as part of the overall 16 week patient journey) continued to be met.

- The standard of no patients waiting over 6 weeks for discharge had proved very challenging in recent months. There were significant staffing issues in hospital social work provided by Glasgow City that had only recently been resolved. This had delayed both allocation and assessment and, although now much improved, would have an impact for a further period. Despite additional care home places being funded in Renfrewshire, there remained patients awaiting funding being allocated for their required form of community care.
- Quality Improvement Scotland (QIS) had recently issued updated standards for the care of stroke patients in the Acute setting and the Managed Clinical Network (MCN) was currently preparing to review services against these revised standards.

Dr Benton asked if accident and emergency departments would be adversely affected with the new Junior Doctor Hours. Mrs Grant reported that this should not be the case as robust processes were in place to support revised rotas. Any breaches of the target that occurred would be scrutinised to identify if any redesign work was required.

Mr Carson commended the many positives in respect of this report and congratulated all staff involved. He suggested more textual context around the delayed discharges and would welcome further information particularly if breaches related to lack of support packages. Mrs Grant was confident that the existing issues could be resolved but agreed to provide further detail in future reports.

**Chief Operating  
Officer (Acute  
Services  
Division)**

In response to a question from Mr Williamson regarding the 18 week referral to treatment target, Mr Calderwood confirmed that this would include all component parts of the patient journey. On a similar theme, Ms Dhir questioned the quantity and times allocated for appointments within different clinics. Mrs Grant confirmed that monitoring took place across the whole of the Acute Division to determine adherence to clinic protocols with particular regard to start and finish times for clinics.

### **NOTED**

#### **87. FINANCIAL MONITORING REPORT FOR THE THREE MONTH PERIOD TO 30 JUNE 2009**

A report of the Director of Finance [Board Paper No.09/47] asked the NHS Board to note the financial performance for the first 3 months of the financial year.

Mr Griffin highlighted that the NHS Board was currently reporting an expenditure out-turn of £0.9M in excess of its budget for the first 3 months of the year. At this stage, the NHS Board considered that a year end break even position remained achievable.

Mr Griffin led the NHS Board through details of expenditure to date against the NHS Board's 2009/10 capital allocation and a progress report on achievement of the Board's 2009/10 cost savings target. He reminded the NHS Board that it had approved a balanced financial plan for 2009/10 which deployed £14.9M of non recurring resources in order to achieve a balanced out-turn for the year. The financial plan also assumed that £45.4M of cost savings targets would be achieved. The timing of achieving these cost savings targets would be a key factor in achieving the NHS Board's overall financial target for 2009/10.

In response to a question from Mr Lee, Mr Griffin confirmed that, as at 30 June 2009, the NHS Board had achieved savings of £10M against a year to date target of £11M. At this stage, therefore, the NHS Board was currently forecasting full achievement of its 2009/10 savings targets. He confirmed that this would be closely monitored during the remainder of the year as delivery of this savings target was crucial to achievement of the Board's revenue plan for the year.

In response to a question regarding costs associated with the H1N1 virus, Mr Griffin explained that it was difficult to be precise about exact costings as most would be associated with staff overtime. The Scottish Government Health Directorate was funding the vaccinations so there were no associated costs to local NHS Boards with this. Mr Calderwood outlined that work would be undertaken to explore financial risks going into the winter period. He anticipated that the NHS Board would continue to be responsible for the vaccination programme but not the vaccinations themselves and discussions were ongoing with the Scottish Government Health Directorate to look at the implications for local NHS Boards.

In response to a question from Mr Williamson, Mr Griffin confirmed that in relation to the Clyde deficit this would be the final financial year in respect of which this supplementary report was provided and in future a consolidated report for NHSGG&C would incorporate the Clyde activities/expenditure.

**NOTED**

**88. 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. 09/48] 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 one Medical Practitioner listed in 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**

**89. INVOLVING PEOPLE COMMITTEE MINUTES: 1 JUNE 2009**

The Minutes of the Involving People Committee meeting held on 1 June 2009 [IPC(M)09/3] were noted.

**NOTED**

**90. CLINICAL GOVERNANCE COMMITTEE MINUTES: 2 JUNE 2009**

The Minutes of the Clinical Governance Committee meeting held on 2 June 2009 [GGC(M)09/3] were noted.

**NOTED**

**91. AREA CLINICAL FORUM MINUTES: 11 JUNE 2009**

The Minutes of the Area Clinical Forum meeting held on 11 June 2009 [ACF(M)09/2] were noted.

**NOTED**

**92. AUDIT COMMITTEE MINUTES: 23 JUNE 2009**

The Minutes of the Audit Committee meeting held on 23 June 2009 [A(M)09/4] were noted.

**NOTED**

**93. STAFF GOVERNANCE COMMITTEE MINUTES: 30 JUNE 2009**

The Minutes of the Staff Governance Committee meeting held on 30 June 2009 [SGC(M)09/2] were noted.

**NOTED**

**94. PHARMACY PRACTICES COMMITTEE MINUTES: 27 JULY 2009**

The Minutes of the Pharmacy Practices Committee meeting held on 27 July 2009 [PPC(M) 09/05] were noted.

**NOTED**

The meeting ended at 11:50am