

NHSGG&C(M)09/6
Minutes: 95 - 116

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, 20 October 2009 at 9.30 am**

P R E S E N T

Mr A O Robertson OBE (in the Chair)

Professor D Barlow	Councillor J Handibode
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	Mr G McLaughlin
Dr B Cowan	Mrs J Murray
Ms R Crocket	Mrs R K Nijjar
Mr P Daniels OBE	Councillor I Robertson
Dr L de Caestecker	Mr D Sime
Ms R Dhir MBE	Councillor A Stewart
Mr D Griffin	Mr B Williamson
Mr P Hamilton	Mr K Winter
	Councillor D Yates

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

Dr S Ahmed	..	Consultant in Public Health Medicine (for Minute No. 100)
Ms H Byrne	..	Director of Acute Services Strategy, Implementation and Planning (to Minute No. 115)
Ms S Gordon	..	Secretariat and Complaints Manager
Mrs J Grant	..	Chief Operating Officer, Acute Services Division (to Minute No. 115)
Mr J C Hamilton	..	Head of Board Administration
Mr A McLaws	..	Director of Corporate Communications (to Minute No. 115)
Mr I Reid	..	Director of Human Resources (to Minute No. 115)
Ms C Renfrew	..	Director of Corporate Planning and Policy/Lead NHS Director, Glasgow City CHCPs (to Minute No. 115)
Ms P Spencer	..	Vice Chair, Area Clinical Forum (to Minute No. 115)
Mr N Zappia	..	Head of Primary Care Support (for Minute No. 116)

ACTION BY

95. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Mr J Bannon MBE, Mr C Bell and Mrs E Smith.

In welcoming Dr S Ahmed, Consultant in Public Health Medicine, in attendance to discuss the agenda item entitled "Update on Pandemic Flu Planning", Mr Robertson sought and received the NHS Board's agreement that this agenda item would be taken after Matters Arising from the Minutes.

96. CHAIR'S REPORT

- (i) The NHS Board had held three very useful development sessions on 25 August, 8 September and 29 September 2009. Key topics discussed included addressing financial pressures, risk management and corporate planning systems. The discussions had been most worthwhile and informative and Mr Robertson encouraged all Non Executive Board members to attend future development sessions.
- (ii) On 27 August 2009, the Cabinet Secretary launched the "Personalised Journey Plans", an innovative new scheme launched jointly by Strathclyde Partnership for Transport (SPT), NHS Greater Glasgow and Clyde and Traveline Scotland. Patients attending appointments at a number of Glasgow hospitals would now be issued with a printed personalised journey plan alongside their usual appointment letter. The journey plan gave detailed instructions on how to get from the patient's home to the hospital, by using public transport and/or walking.

Later that day, the Cabinet Secretary officially opened Skye House (on the Stobhill Hospital site) which provided a range of dedicated services for young people aged 12 – 18 years from across the West of Scotland who had serious mental health problems. This had replaced the existing West of Scotland Adolescent Inpatient Unit at Gartnavel.

A new state-of-the-art dental department at Greenock Health Centre was officially opened on 14 September 2009 by the Minister for Public Health and Sport, Shona Robison MSP.

- (iii) He had attended meetings (and visited staff) at four of the NHS Board's CH(C)Ps including; West Dunbartonshire on 22 September, East Glasgow on 29 September, South-East Glasgow on 2 October and Inverclyde on 7 October. All sessions had proved to be most worthwhile and he commended the staff and services he had visited.
- (iv) The NHS Board's Annual Review had been held on 19 October 2009 and was very well attended. Following the formal meeting between the NHS Board's senior management, the Cabinet Secretary for Health and Well-Being and representatives from the Scottish Government Health Directorates (SGHD), the format was an open floor question and answer session. The Non Executive Board members who had attended the Annual Review meeting agreed that it had been useful although there were concerns at the length of time the public had to wait until the open question session commenced and the use of acronyms and technical language. Mr Robertson agreed that some lessons could be learned but that the format for the day was a strategic event measuring, in public, the NHS Board's performance over the past year. It was a difficult balance to address both the public audience and the SGHD's performance measuring mechanisms.

NOTED

97. CHIEF EXECUTIVE'S UPDATE

- (i) Mr Calderwood, accompanied by Dr Cowan, conducted a tour of the new Stobhill Hospital with the Director General of NHS Scotland, Dr Kevin Woods.

- (ii) On 26 August 2009, Mr Calderwood attended an away day, accompanied by Dr de Caestecker and Ms Renfrew with Glasgow City Council. The focus was on developing community planning and associated structures and identifying how best these could be taken forward. The event had proved most constructive with a follow-up being arranged.
- (iii) On 11 September 2009, a joint meeting was held with the North and South Monitoring Groups to conclude their work. Mr Robertson had extended his thanks to all members who had contributed to the Groups over the seven years in monitoring named services and the resultant opening of the two new Ambulatory Care Hospitals at Stobhill and the Victoria.
- (iv) On 15 and 16 September 2009, NHS Quality Improvement Scotland (QIS) had conducted their peer review of clinical governance and risk management systems. Early feedback was positive and the final report was due in early November 2009.
- (v) Mr Calderwood had met with Chief Executives of the Clyde Valley local authorities to discuss work being undertaken by Sir John Arbuthnott regarding the future of shared services and efficiencies within the public sector, particularly at NHS and Council level. The Chief Executive of NHS Lanarkshire was also in attendance and a further meeting would be scheduled to take forward this important agenda.
- (vi) Mr Calderwood had visited the Accord Hospice, situated within the former grounds of Hawkhead Hospital, Paisley. He had been most impressed with the facilities there and the outreach model of care adopted by the hospice.

NOTED

98. MINUTES

On the motion of Councillor D Yates, seconded by Mr P Hamilton, the minutes of the NHS Board meeting held on Tuesday 18 August 2009 [NHSGG&C(M)09/5] were approved as an accurate record and signed by the Chair.

NOTED

99. MATTERS ARISING FROM THE MINUTES

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

NOTED

100. UPDATE ON PANDEMIC FLU PLANNING

A report of the Director of Public Health [Board Paper No. 09/55] asked the NHS Board to note the update on Pandemic Flu Planning in NHS Greater Glasgow and Clyde.

Dr de Caestecker reported that pandemic flu response planning had been progressing in NHS Greater Glasgow and Clyde for a number of years. Plans were based on the Scottish Government's framework for responding to a pandemic and modified following a series of local and national exercises. In recent months, in view of the current H1N1 influenza situation, pandemic flu planning had increased in priority for NHS Greater Glasgow and Clyde and partners with an aim to ensure appropriate control and management of the pandemic while simultaneously maintaining business continuity across the NHS and partners' services.

Dr de Caestecker outlined the planning structures set up to address the pandemic flu response; both regionally and locally within NHS Greater Glasgow and Clyde. She explained that the complexities of planning for a flu pandemic in a Health Board serving such a large population had necessitated the development of a suite of plans covering all aspects of flu planning. As such, there were 17 pandemic flu planning workstreams ranging from plans for health information and technology during the pandemic to those for care homes and other enclosed settings. Efforts had been focused around three key areas; activities relating to the care of flu patients, activities relating to business continuity of normal services during the pandemic and the roll out of the vaccination programme. All planning assumptions were being estimated on a reasonable worst case scenario.

Dr de Caestecker reported that daily and weekly reports relating to flu were based on locally collected data and Health Protection Scotland (HPS) generated reports. In the last few weeks, while planning work had continued on a number of fronts, NHS Greater Glasgow and Clyde had moved from the largely planning phase of recent months to that of response. Chief Executive-led Executive meetings and daily Acute and Partnership conference calls had been established to allow these command and control structures to become embedded prior to the system experiencing significant pressure.

Dr Ahmed delivered a presentation to the NHS Board on the vaccination programme. He reported that it was the UK Government's aspiration to vaccinate 100% of the population starting in late October 2009. It had been agreed to purchase 130 million doses with a two dose schedule and this vaccine supply would come in stages over a number of months. A priority order had been established to receive and administer the vaccines. Dr Ahmed briefly summarised the two specific vaccines that would be available in the UK, both of which were licensed by EU Countries. It was expected that both would be used on a relatively equal basis however this would be dependant on their availabilities and he outlined the recommendations that had been made by the expert Committee to determine which vaccine to be offered to what groups of patients; the key differences being that one of the vaccines required only one dose for adults and would offer earlier protection than the other one.

Dr Ahmed went on to describe the immunisation responsibility areas within NHS Greater Glasgow and Clyde including GPs/Primary Care, Occupational Health, CH(C)Ps and Acute Health. He outlined within each of these responsibility areas how patients would be identified and contacted to attend for their vaccination. For staff, much of this work would include notices on Staffnet, posters, email and other publicity materials and the seasonal flu vaccination would be offered to staff at the same time. In terms of recording and reporting the uptake, immunisation forms would be completed and centrally collated by Health Protection Scotland. The launch for health and social care staff for the vaccination was Wednesday 21 October and, thereafter, for clinical priority groups from Monday 26 October (depending on vaccine availability).

Mr Robertson thanked both Dr Ahmed and Dr de Caestecker for providing such an informative and insightful update on the H1N1 pandemic.

In response to questions from NHS Board members regarding the safety/risks of the vaccination, Dr Ahmed confirmed that all ingredients had been well tried, tested and used before. Data and scientific evidence supported use of the vaccination which had no additional side effects to that of the well used seasonal flu vaccination. He accepted that it was a patient's choice to have the vaccination but hoped that the availability of information and the education and training of staff would allay any worries. He emphasised, however, that a national publicity campaign would also be held and that patients did, in fact, put themselves at risk if they did not present for the vaccination.

In response to a series of questions from Dr Kapasi, Dr Ahmed confirmed that there was no interaction between the H1N1 vaccination and the seasonal flu vaccination and both could be given at the same time. Individual GP practices would be advised by public health staff regarding the supply of their vaccination. He suggested that local GP practices did not wait for their supply prior to carrying out the seasonal flu vaccination. In terms of the "buddying up" system, Dr de Caestecker outlined how this was anticipated to operate locally by neighbouring GP practices. She also confirmed that, in accordance with the worse case scenario planning, a schedule had been compiled of services that could be postponed (and in what order) whilst working through the pandemic. All pandemic flu planning had been linked with the NHS Board's overall winter plan for 2009/10.

NOTED

101. SCOTTISH PATIENT SAFETY PROGRAMME (SPSP) UPDATE

A report of the Board's Medical Director and Head of Clinical Governance [Board Paper No. 09/49] 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 (SPSP).

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 as follows:-

- 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).

Dr Cowan provided a summary of the Programme implementation across NHS Greater Glasgow and Clyde explaining that the NHS Board was currently assessed as level 2.5 by the national SPSP Team. He outlined the Board's progress against SPSP target dates and the predicted trajectories for future milestones.

A full assessment was being developed against the conditions to achieve a level 3 rating, however, initial discussions suggested that a strict interpretation may mean that this may not be secured for some time due to challenges around medicines reconciliation and limited data quality associated with outcome measures. It was predicted, therefore, that NHS Greater Glasgow and Clyde would remain behind the trajectory until the final year. So far, the feedback from the SPSP national team and the SGHD confirmed that they remained satisfied with the NHS Board's ongoing progress and performance.

Dr Cowan summarised progress in the Phase 1 frontline pilot teams in respect of general wards, critical care, peri-operative and medicine management. An increased number of Phase 3 teams had begun working after completing the preparatory work of identifying members and attending training. The NHS Board had now confirmed that 40 teams had formally commenced and would continue to work through the process of finalising start dates with the others. It was expected that the target of 60 teams commencing in 2009 would be confirmed by the end of October. It was intended to begin planning with the Acute Services Division on identifying and training for teams commencing in 2010, for which the target was an additional 90 teams working in with the programme. Although the spread plan focused on the core programme, Dr Cowan noted that work was well advanced in developing SPSP workstreams within paediatric settings with staff attending a national workshop on 9 November 2009.

The fifth national event for the SPSP would take place on 16 and 17 November 2009 in the SECC. The national team would be conducting an inspection visit on 4 November where they would meet with programme staff, leaders and also visit teams at the Southern General Hospital and the Victoria Infirmary.

In response to a question concerning better performance within Intensive Care Units, Dr Cowan confirmed that this was significant because the programme adopted was an American programme and, therefore, focused on critical care. The Board's intention was, however, to tackle four areas; critical care, theatres, ward areas and medicines management. Pilots were currently being undertaken within primary care and, although challenging, the results were awaited to determine how the overall methodology could be transferred and rolled out throughout all primary care settings.

Mr P Hamilton asked why it remained problematic to show a reduction in adverse events. Dr Cowan described how this measure was assessed using the technique described as the "global trigger tool". In spite of developing a number of tests of the approach and working with SPSP on training, the NHS Board continued to have detection rates that were below the expected range. A similar result had been reported amongst a number of NHS Boards in Scotland. The tool was applied by a series of trained clinical observers to a randomly chosen selection of case notes every month to detect incidents which had led to patient harm. Work was ongoing between the Institute for Healthcare Improvement (IHI) and some Scottish Boards to identify the reasons for the low reporting rate in Scotland. Dr Cowan noted that worldwide, when compared with case sheet reviews, it was found that critical incident reporting using conventional methods was low and could be as low as between 8% - 18% of actual incidents noted on case note reviews.

NOTED

102. HEALTHCARE ASSOCIATED INFECTION – MONITORING REPORT

A report of the Medical Director [Board Paper No.09/50] asked the NHS Board to note the latest of the regular bi-monthly reports on Healthcare Associated Infection (HAI) in NHS Greater Glasgow and Clyde. The report presented data on the performance of NHS Greater Glasgow and Clyde on a range of 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 Royal Hospital, Victoria Infirmary, Southern General Hospital, Western Infirmary, Gartnavel General Hospital, Drumchapel Hospital, Blawarthill Hospital and the Vale of Leven Hospital, all were within control limits in August 2009. There was one ward based exception report within Inverclyde Royal Hospital for August 2009.

In response to a question from Dr Benton, Dr Cowan confirmed that if a patient was profiled as positive for any Healthcare Associated Infection, their elective surgery would be postponed. In emergency patients, if this was the case, they would be treated in isolation.

NOTED

103. MIND THE GAPS: IMPROVING SERVICES FOR VULNERABLE CHILDREN

A report of the Director of Corporate Planning and Policy/Lead NHS Director Glasgow City CHCPs and the Director of Public Health [Board Paper No. 09/51] asked the NHS Board to consider the issues raised in relation to children and vulnerable families.

Ms Renfrew set out the challenges faced in protecting children, the evidence base for effective intervention and proposed a series of developments which would improve the protection of children in partnership with Glasgow City. She reported that the paper had already been endorsed by the Glasgow City Child Protection Committee, Chief Officers Group and the Glasgow Community Planning Executive Group. Within the community planning process, the NHS Board was continuing to promote the programmes outlined as a priority for use of resources available for community planning.

The proposals were in line with recent agreement to refocus community planning on addressing the causes of social problems rather than their consequences with a particular focus on early intervention.

Ms Renfrew summarised the key messages as follows:-

- The high level of need and vulnerability among children in the Board's area.
- The strong evidence base for the earliest possible intervention to give vulnerable children the highest chance of successful life outcomes.
- The current gaps in the services provided.
- The medium to long term cost effectiveness of the proposed developments.

Ms Renfrew explained that the issues and responses recorded in the paper had been developed as part of the response to the inspection of child protection in Glasgow City, however, the conclusions and recommendations were significant for the whole of NHS Greater Glasgow and Clyde. There were particular challenges for the NHS and local authorities in addressing these issues at a time of significant financial pressure but the paper set out an agenda for change which the NHS Board must be able to positively progress to ensure vulnerable children had access to effective and appropriate services at the earliest possible stage.

Dr de Caestecker emphasised that to break the current cycle, where the needs of vulnerable children were not met, there needed to be a sustained, comprehensive, coherent programme of development and investment with strong political leadership and full commitment, most particularly from the Council and the NHS, but with the essential support of the Police, the Scottish Children's Reporters Administration and the voluntary sector. She outlined the proposed actions which, taken together, would represent a step change in the outcomes that could be achieved for such children as follows:-

- Parenting
- Family Support
- Early Intervention
- Assessing progress.

She concluded by stating that significant numbers of Glasgow's children were vulnerable, largely as a result of poverty and substance abuse. Early intervention would enable them to reach their full potential and would break the intergenerational cycle of poverty. In order to address the issues, there needed to be an early commitment to start a major programme of investment with funding building up over a number of years. It was proposed that £5M of funding should be earmarked to underwrite the proposed first phase of developments and that allocation should rise to £10M and then to £15M in subsequent years.

In the longer term, it was clear that the focus on early years would require a fundamental reprioritisation across the city to see all organisations refocusing their budgets on these services.

There was overwhelming support from the NHS Board for the principles in this paper. A detailed discussion ensued and the following points were raised:-

- Although a powerful and focussed paper, the costs and affordability within the current climate could not be overlooked. It was recognised there was a challenge around resources but that, longer term, evidence existed that it was economic to see monies spent in this key area.
- The proposals were ambitious but members were unanimous of the need to break the current cycle. There may be a reluctance of parents to engage with supportive agencies in the fear that their children may be taken into care. This “fear factor” and the stigma associated with approaching supportive agencies had to be tackled and this barrier removed to ensure that all parents had the necessary confidence. To this end, it was important to not just engage with the most needy but to encourage self help and peer learning. Research showed that people preferred to learn parenting skills from self help internet/DVD use and this would be explored further.
- The role of health visitors was crucial in working with the more needy families. The Health Visitor Review recognised that this staff group had unique skills and would free up their time to tackle this at an earlier stage.
- It would be important to see all sectors working better together to address this challenge, not simply within geographical areas, but across the whole of NHS Greater Glasgow and Clyde; being proactive rather than reactive.
- There was an imperative to see this work through particularly as it concerned around one third of the population of children within the NHS Board’s area.
- Although much work was ongoing within local communities to address these issues, it would be important, as a starting block, to get a sense from them regarding what was currently being encapsulated to identify how to build on that momentum and firm up next steps. It would also be useful to draw attention to the situation at a national level to raise its profile.
- The NHS Board was conscious that although a very important issue, in order to make the proposals happen using existing resources (given that no new monies would be made available), some other service would have to cease to release the necessary funding.

**Director of
Public Health**

**Director of
Public Health**

DECIDED

- That the issues raised in relation to children and vulnerable families be considered.
- That the paper be re-drafted for further consideration, both locally and nationally.

**Director of
Corporate
Planning and
Policy/Lead
NHS Director
Glasgow City
CHCPs/
Director of
Public Health**

104. WINTER PLAN 2009/10

A report of the Director of Acute Services Strategy, Implementation and Planning [Board Paper No. 09/52] asked the NHS Board to receive an update on the approach to Winter Planning 2009/10 and to approve the Winter Plan for 2009/10.

Ms Byrne explained that NHS Boards were expected to have an agreed winter plan (which was clearly aligned with flu planning) signed off by their Chief Executive. At a national level, the Emergency Access Delivery Team (EADT) was responsible for co-ordinating winter planning for 2009/10. There was a national event in June 2009 and this was followed by a regional event in September 2009 where NHS Boards highlighted initiatives they were taking forward to support winter planning and address areas of risk. There was a particular focus on flu planning at both of these events and the need to ensure that both winter and flu planning were aligned.

Ms Byrne led the NHS Board through the recommendations from the Beckett Review of Winter Planning in 2008/09. Each of these recommendations had been addressed in the NHS Board's Winter Plan 2009/10.

Ms Byrne summarised how winter planning was taken forward across NHS Greater Glasgow and Clyde under the leadership of a Winter Planning Group that met all year round (through winter on a monthly basis and bi-monthly during the rest of the year). This Group had overseen the formulation of the Winter Plan for 2009/10 taking into account the lessons learned from 2008/09 and the need to ensure this was aligned with pandemic flu planning. As in winter 2008/09, the Winter Plan had been developed on a partnership basis with all partners working together to ensure a joined up approach to the overall plan. She described the key challenges for all agencies (particularly NHS 24, the Scottish Ambulance Service, GP Out-of-Hours Services and Acute Services) due to high rises in activity over the winter period. As in previous years, an information booklet (service directory) would be developed outlining service availability and advice to patients. There would also be wide publicity to encourage uptake of the flu vaccination for staff as a preventative measure.

In response to a question from Councillor Stewart concerning publicity opportunities with local authorities, it was suggested that the information booklet be also available on their websites. Mr McLaws agreed this would be useful and he would pursue with relevant communications colleagues.

**Director Of
Corporate
Communications**

Mr McLaws also confirmed that the NHS Board would adopt the national posters for use throughout NHS Greater Glasgow and Clyde and reassured the NHS Board that these tended to have a simple message with enhanced use of pictures and/or photography.

In response to a question concerning any likely increased emergency demand, Mrs Grant confirmed that elective activity was being reviewed to endeavour to create additional capacity in January 2010 to manage any increased emergency demand. This was also to ensure "referral to treatment" targets would continue to be met.

DECIDED

- That an update on the approach to Winter Planning 2009/10 be received.
- That the Winter Plan 2009/10 be approved

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

105. INVERCLYDE COMMUNITY HEALTH PARTNERSHIP COMMITTEE - CHAIR

A report of the Head of Board Administration [Board Paper No. 09/53] considered the position of Chair of Inverclyde Community Health Partnership.

Mr Calderwood suggested that consideration of this paper be deferred until his further discussion with the Chief Executive of Inverclyde Council was concluded as it was likely that there would be moves towards an integrated partnership model which would have implications for the membership of the Committee.

Chief Executive**DECIDED:**

That any further discussion on this issue be deferred until there was clarity on the future partnership model.

106. JOINT PARTNERSHIP BOARD UPDATE

A report of the Director of Corporate Planning and Policy / Lead NHS Director, Glasgow City CHCPs [Board Paper No. 09/54] asked the NHS Board to note the positive progress made through the Joint Partnership Board.

Ms Renfrew provided an update on progress with the Joint Partnership Board arrangements with Glasgow City Council and the outcome of its first meeting on 29 September 2009. This Board brought together the CHCP Chairs who were elected members of Glasgow City Council and Vice Chairs (who were Non Executive members of the NHS Board). The Convenor was the executive member for Social Care Services and the Vice Convenor was the NHS Board's Vice Chair, Mrs E Smith.

Ms Renfrew explained that the Joint Partnership Board would oversee the next stage of development of CHCPs and had responsibility for a number of decisions and processes which she summarised. She outlined the issues considered at the Board's first meeting and the decisions reached therein including the following:-

- A revised Scheme of Establishment was proposed reflecting the new arrangements agreed between the Council and the NHS particularly the devolved approach. The Joint Partnership Board agreed to consider a final version of the Scheme of Establishment shortly enabling an agreed final version to be submitted to the NHS Board for approval thereafter.
- Financial issues for 2009/10 – the NHS and Council financial pressures and challenges in 2009/10 were noted and the Joint Partnership Board approved the CHCP Directors' proposals to develop a change programme.
- Financial issues for 2010/11 – work to date on NHS and Council financial plans were noted and a more detailed discussion would take place at their next meeting.
- Moving to devolved budgets – it was confirmed that CHCPs would hold, on a devolved basis, by April 2010, the totality of the budgets for the services and care groups for which they were responsible.

- CHCP Directors were asked to take forward the work programme to finalise the devolution of commissioning budgets and functions.
- On the future of partnerships, the Joint Partnership Board noted work in progress with the Homelessness and Mental Health Partnerships and agreed to take final proposals for the future arrangements for the Addictions and Learning Disability Partnerships at its October 2009 meeting.

Both Mr Daniels and Mr P Hamilton who had attended the Joint Partnership Board meeting agreed that it had been successful in terms of progress made and getting a clear commitment from elected members on the direction of travel.

NOTED

107. FINANCIAL MONITORING REPORT FOR THE 5 MONTH PERIOD TO 31 AUGUST 2009

A report of the Director of Finance [Board Paper No. 09/56] asked the NHS Board to note the financial performance for the first 5 months of the financial year. Mr Griffin highlighted that the NHS Board was currently reporting an expenditure outturn of £1.5M in excess of its budget for the first 5 months of the year. At this stage, however, the NHS Board considered that a year end break even position remained achievable.

Mr Griffin led the Board through details of expenditure to date against the NHS Board's 2009/10 allocation and provided a progress report on achievement of the NHS Board's 2009/10 cost savings targets. He reported that an early insight into the outturn for the six months to 30 September 2009 showed no change to the picture reported at the end of August 2009.

Mr Griffin highlighted a number of factors which could have a significant negative impact on the NHS Board's financial position during 2009/10 including pandemic flu, the outcome of agenda for change appeals and prescribing expenditure trends.

The Board had approved a balanced financial plan for 2009/10 which deployed £14.9M of non recurring resources in order to achieve a balanced outcome for the year. The financial plan also assumed that £45.4M of cost savings would be achieved. The timing of achieving these cost savings targets would be a key factor in achieving the overall financial target for 2009/10.

In response to a question, Mr Griffin confirmed that the NHS Board expected to finalise its forecast of capital slippage with the Scottish Government Health Directorates (SGHD) within the next few weeks. It was likely that the level of brokerage which was agreed with the SGHD, to be carried forward to 2010/11, would be in excess of £30M and the NHS Board was currently reviewing expenditure forecasts to see if this level of slippage could be accommodated.

NOTED

108. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer, Acute Services Division [Board Paper No. 09/57] asked the NHS Board to note progress against the national targets as at the end of August 2009.

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

- Outpatient waiting times – at the end of March 2009, the NHS Board achieved the milestone of no patient waiting more than 12 weeks from GP referral to an outpatient appointment. From April 2009, the Acute Division had worked to maintain this target and 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 internal milestone would be to achieve 11 weeks by the end of November 2009 for all patients on an admitted pathway. The milestone for patients following a non admitted pathway would remain at 12 weeks. Work was underway to determine which pathways fell into which category; this work was being progressed using clinic outcome forms to inform the pathway types.
- Inpatient/day case waiting times – from April 2009, all specialties had maintained the 12 week inpatient and day case target, with progress being made towards reducing to an 11 week position. The interim internal target of 11 weeks by the end of June 2009 was set for all specialties with the exception of orthopaedics, where the target remained 12 weeks. The Acute Division met this target on 30 June 2009.
- Diagnostic waiting times – The maximum wait from referral to MRI scan, CT scan, non obstetric ultrasound, barium studies, gastroscopy, sigmoidoscopy, colonoscopy and cystoscopy was 6 weeks by the end of March 2009. The 6 week target was achieved at the end of December 2008 for all 4 imaging modalities and continues to be maintained, for all 8 tests. The next local interim target was 5 weeks by the end of September 2009 for endoscopy.
- Cataract targets - the maximum time from referral to completion of treatment for cataract surgery would be 18 weeks. This target was achieved in December 2007 and has been maintained since that date.
- Hip fracture – the target was 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. This target continued to be met.
- Accident and Emergency 4 hour wait – 98% of accident and emergency patients should be treated and discharged, admitted or transferred within 4 hours of arrival at the department. The Board achieved this target for the first time in December 2007 and had posted 98% compliance in 16 of the 20 months since then, and has achieved it for the last 3 months of the reporting period. Despite increasing demand, the Directorate of Emergency Care and Medical Services remained strongly committed to maintaining a position of sustained achievement of this target.

- Cancer waiting times – a minimum of 95% of all urgent referrals with suspected cancer should achieve a maximum wait of 62 days from urgent referral to first treatment (31 days for breast cancer). All patients referred as urgent were tracked to ensure monitoring of the progress along the patient journey. The Board had achieved this target in the last two quarters, October/December 2008 and January/March 2009 and data submitted indicated the target had been achieved for a third quarter, April/June 2009.
- Chest pain – the Board was now only responsible for rapid access chest pain services, with a target waiting time of 2 weeks as part of the overall 16 week patient journey. The NHS Board had met the 2 week target throughout 2008 and continued to do so in 2009.
- Delayed discharge – the NHS Board was required to maintain a performance standard of no patients waiting over 6 weeks for discharge. That standard was met in April 2009 but performance since then had deteriorated..
- Stroke – Quality Improvement Scotland (QIS) had recently issued updated standards for the care of stroke patients in the Acute setting and the stroke Managed Clinical Network (MCN) was currently preparing to review services against these revised standards.

In response to a question from Mr Daniels regarding delayed discharges, Mrs Grant confirmed that there were two principal reasons for these patients remaining in hospital; firstly, delays in identifying care homes including delays in chosen placement availability or failure to accept interim placements. Secondly, local authorities were to allocate funds for community care packages. The Associate Medical Director of the Rehabilitation and Assessment Directorate continued to work with colleagues from local authorities to review the process by which consultant medical staff provided information to social work and to patients and their families. The output included a standard letter advising families of the need for the early identification of a preferred home and of the need for interim placement. The introduction of this new paperwork was being used as an opportunity to further raise the profile of this issue with all staff involved in planning and implementing patient discharge. In addition, funding was identified as an issue in a number of cases. Mr Calderwood acknowledged that a whole range of factors affected delayed discharges month on month but reassured the NHS Board that these were being addressed jointly between the NHS and local authorities.

NOTED

109. QUARTERLY REPORT ON COMPLAINTS : 1 APRIL – 30 JUNE 2009

A report of the Head of Board Administration, Chief Operating Officer (Acute Division) and Lead Director, CHCPs (Glasgow) [Board Paper No. 09/58] asked the NHS Board to note the quarterly report on NHS complaints in Greater Glasgow and Clyde for the period of 1 April to 30 June 2009.

Mr J Hamilton reported that the overall NHS Board complaints performance was 78% for this quarter and that was above the national target of responding to 70% of complaints within 20 working days. He also set in context the number of complaints received by the NHS Board against the number of patient contacts/episodes which was a ratio of 1 complaint to 1960 patient attendances.

The Board's framework for Patient Focus Public Involvement (PFPI) 2009/10, had an objective which related to complaints, namely, "to increase awareness of NHS Greater Glasgow and Clyde's complaints system and improve communications therein". An action plan had been formulated and approved by the Scottish Health Council to set out how this goal would be achieved.

Councillor McIlwee raised concern about continued smoking outside hospital front entrances. Mrs Grant reported that smoking control officers had been told to specifically approach any individual found smoking in hospital grounds. This was a challenge but efforts were being renewed to address this matter which, she agreed, was not acceptable. In terms of legislation, Dr de Caestecker confirmed that the NHS was lobbying the Scottish Government as although smoking was banned from hospital buildings, it was not banned from hospital grounds.

NOTED

110. PATIENTS PRIVATE FUNDS – ANNUAL ACCOUNTS 2008/2009

A report of the Director of Finance [Board Paper No. 09/59] asked the NHS Board to adopt and approve for submission to the Scottish Government Health Directorates the 2008/9 patients private funds annual accounts for NHS Greater Glasgow and Clyde.

Mr Griffin advised that the NHS Board held the private funds of many of its patients, especially those who were in long term residence and who would have no ready alternative to the safe-keeping and management of their funds. Each of the Board's hospitals had arrangements in place to receive and hold and, where appropriate, manage the funds of any patients requiring this service and any funds that were not required for immediate use were invested to generate interest which was then distributed to the patients' accounts based on each individual's balance of funds held.

NHS Boards were required to submit audited annual accounts for these funds in the form of an Abstract of Receipts and Payments to the Scottish Government Health Directorates. The funds had been audited and now required NHS Board approval prior to the auditors then signing their report, which had no qualifications.

DECIDED

- | | |
|--|---|
| 1. That the Patients' Private Funds Annual Accounts for 2008/09 be adopted and approved for submission to the Scottish Government Health Directorates. | Director of Finance |
| 2. That the Director of Finance and Chief Executive be authorised to sign the Abstracts of Receipts and Payments for 2008/09. | Director of Finance/ Chief Executive |
| 3. That the Chair and Director of Finance be authorised to sign the Statements of Board Members' Responsibilities for 2008/09. | Chair/Director of Finance |
| 4. That the Chief Executive be authorised to sign the Letter of Representation to KPMG LLP on behalf of the NHS Board. | Chief Executive |

111. 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. 09/60] asked that the NHS Board to 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 6 Medical Practitioners 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**

112. PERFORMANCE REVIEW GROUP MINUTES : 7 JULY 2009 AND 15 SEPTEMBER 2009

The Minutes of the Performance Review Group meetings held on 7 July 2009 and 15 September 2009 [PRG(M)09/04 and PRG(M)09/05] were noted.

NOTED**113. CLINICAL GOVERNANCE COMMITTEE MINUTES : 4 AUGUST 2009**

The Minutes of the Clinical Governance Committee meeting held on 4 August 2009 [GGC(M)09/4] were noted.

NOTED**114. PHARMACY PRACTICES COMMITTEE MINUTES : 31 AUGUST 2009**

The Minutes of the Pharmacy Practices Committee meeting held on 31 August 2009 [PPC(M) 2009/6] were noted.

NOTED**115. EXCLUSION OF PUBLIC AND PRESS**

On the motion of Mr Robertson and seconded by Mr Cleland, the NHS Board agreed to exclude the public and press during consideration of the item listed in Part II of the agenda in view of the confidential nature of the business to be transacted.

NOTED

**116. MINUTES OF PRIMARY MEDICAL SERVICES PERFORMERS LIST –
OUTCOME OF ORAL HEARING**

A report of the Head of Primary Care Support [Board Paper No. 09/61] asked the NHS Board to note the minutes of an Oral Hearing in relation to the performers list for the non provision of services.

In response to a question, Mr Zappia agreed to consider the future presentation of these minutes to the NHS Board.

**Head of Primary
Care Support**

NOTED

The meeting ended at 12:45pm