NHSGG&C(M)10/05
Minutes: 87 – 110

NHS GREATER GLASGOW AND CLYDE

**Minutes of a Meeting of the
NHS Greater Glasgow and Clyde Board
held in the Board Room, Corporate Headquarters, J B Russell House,
Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH
on Tuesday, 26 October 2010 at 9.30 am**

P R E S E N T

Mr A O Robertson OBE (in the Chair)

Professor D Barlow
Dr C Benton MBE
Mr R Calderwood
Mr G Carson
Mr R Cleland
Councillor J Coleman (to Minute No. 99)
Dr B N Cowan
Ms R Crocket
Mr P Daniels OBE
Dr L de Caestecker
Ms R Dhir MBE
Mr I Fraser
Mr D Griffin
Mr P Hamilton (to Minute No. 98)
Councillor J Handibode
Dr M Kapasi MBE
Councillor D MacKay
Councillor R McColl
Councillor J McIlwee (to Minute No. 98)
Mrs J Murray
Mrs R K Nijjar
Mr D Sime
Mrs E Smith
Councillor A Stewart
Mr B Williamson
Mr K Winter

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

Ms S Gordon	..	Secretariat Manager
Mrs J Grant	..	Chief Operating Officer, Acute Services Division
Mrs A Hawkins	..	Director of Mental Health Partnership (for Minute No. 97)
Ms C Renfrew	..	Director of Corporate Planning and Policy/Lead NHS Director, Glasgow City CHCPs (for Minute No. 96)
Mr D Ross	..	Director, Currie and Brown UK Ltd (for Minute No. 94)
Mr A Seabourne	..	Project Director, New South Glasgow Hospitals (for Minute No. 94)

ACTION BY

87. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Mr C Bell, Mr I Lee, Rev Dr N Shanks and Councillor D Yates.

Mr Robertson welcomed the NHS Board members and attendees to the first Board meeting held in the new Corporate Headquarters, J B Russell House.

88. CHAIR'S REPORT

(i) On 19 August 2010, Mr Robertson had attended the opening, by the Cabinet Secretary for Health and Wellbeing, of the new Renfrew Health and Social Care Centre.

This was a very successful project which brought new life to Renfrew as the new Centre co-located the provision of GP services, social work and learning disability services. Feedback from staff and users of the Centre, to date, had been exceptionally positive.

(ii) On 6 September 2010, Mr Robertson had hosted a visit from the Chair and Chief Executive of South Staffordshire and Shropshire Health Care NHS Foundation Trust with whom, in Partnership, NHS Greater Glasgow and Clyde provided Mental Health Services to the Armed Forces. They had been most impressed to see the facilities and services provided by Gartnavel Royal Hospital.

(iii) On 15 September 2010, Mr Robertson and Mr Griffin had attended a meeting of Kirkintilloch's Initiative Partnership Board. He commended the work of the Kirkintilloch Health and Social Care Centre and confirmed that the NHS Board and Partnership Board's joint working had now delivered on two major projects; the new Leisure Centre and the Health and Social Care Centre with the third major project, the Kirkintilloch Link Road due to complete in early November.

(iv) Mr Robertson had attended a reception for reservists in NHS Greater Glasgow and Clyde's employment many of whom had just spent up to three months being responsible for medical and surgical services at Fort Bastion. He also alluded to the picture displayed at the reception area of J B Russell House which showed a recovery unit in Afghanistan and which had been presented to the NHS in appreciation of our support for our Reservists.

(v) On 8 October 2010, Mr Robertson had met with Mr K Hill, the newly appointed Director of Women and Children's Services. From this meeting, he had got a good sense of anticipation of the move of the Children's Hospital from its current site at Yorkihill to the South side.

(vi) On 12 October 2010, Mr Robertson had visited Mr David Allan at the Queen Elizabeth National Spinal Injuries Unit for Scotland. He commended this highly impressive specialist unit.

(vii) On 15 October 2010, Mr Robertson had visited Bodyworks at Parkhead Forge Shopping Centre. This was a peripatetic exhibition which included the simulation of many body parts. It had been provided by Glasgow City of Science and its huge throughput was in recognition of the excellent and informative display.

(viii) On 20 October 2010, Mr Robertson, along with other Non Executive members of the Board, had viewed a mock up of the en suite bedrooms proposed for the new south side hospitals.

(ix) On 22 October 2010, Mr Robertson had met with the Chair of St Margaret's Hospice. This meeting would be followed up with a letter from Mr Robertson re-emphasising the need to have a Service Level Agreement (SLA) with the Hospice as existed between the NHS Board and other Hospice providers and identifying future options for the continuing care beds currently located in St Margaret's.

NOTED

89. CHIEF EXECUTIVE'S UPDATE

(i) On 1 October 2010, Mr Calderwood had attended a Scottish Government Forum to discuss, with other agencies and Public Sector bodies, the current Public Sector climate and how each could work more collaboratively. From this meeting Statements of Intent would be drawn up and he would keep the NHS Board notified of further developments.

(ii) On 4 October 2010, Mr Calderwood and the Chairman had conducted interviews for the post of CHP Director for the new Glasgow City CHP. He reported that Anne Hawkins (Director, Mental Health Partnership) had been appointed. The transition date to the new structures for Health and Social Care Services was being finalised with the Glasgow City Council, at which time Mrs Hawkins and her new team would take up their responsibilities.

(iii) On 6 October 2010, Mr Calderwood took part in a leadership debate at the Institute of Health Service Management Conference which explored how leaders dealt with competing service objectives alongside fiscal demands in delivering service provision.

NOTED

90. MINUTES

On the motion of Mr I Fraser, seconded by Dr M Kapasi, the Minutes of the NHS Board meeting held on Tuesday 17 August 2010 [NHSGG&C(M)10/04] were approved as an accurate record and signed by the Chair.

NOTED

91. MATTERS ARISING FROM THE MINUTES

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

Mr Robertson reported that some later agenda items would be re-ordered to facilitate other pressing priorities of presenters.

NOTED

92. SCOTTISH PATIENT SAFETY PROGRAMME UPDATE

A report of the Board's Medical Director and Head of Clinical Governance [Board Paper No. 10/42] 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 of the overall NHS Greater Glasgow and Clyde aim to ensure the care provided to every patient was safe and reliable. The Scottish Patient Safety Programme's (SPSP) aim was to achieve full implementation of the core programme in the Acute Services Division by the end of 2012.

Dr Cowan described the core programme as including improved staff capability in all wards and the creation of reliable processes for every relevant element in every ward. He confirmed that the NHS Board was also developing SPSP-style improvement programmes in Paediatrics and Mental Health Services in 2010 then in Primary Care and Obstetrics in 2011.

Dr Cowan led the NHS Board through the update report and noted, in particular, four success areas:-

- Ward 43 (Glasgow Royal Infirmary) had become the first Acute receiving ward in NHS Greater Glasgow and Clyde to achieve six consecutive data points demonstrating high reliability in medicine reconciliation at admission. This had been expected given the major redesign work the team had completed and was significant given that it was over the period of the new junior doctor intake in August 2010. Another major factor to be recognised was that the Ward created a prescriber-led reconciliation model rather than a pharmacy-led model.
- Areas not previously showing the required level of high reliability had now all been successful and the NHS Board would now progress to the next point on the national SPSP assessment trajectory.
- The start-up programme had been accelerated and it was now expected that all adult ward and theatre teams would be working within the programme by Easter 2011. This was six months earlier than originally planned.
- The NHS Board had been asked by the national team to support improved engagement of medical staff leadership. The national target was to identify 100 doctors over a 100 day period across Scotland. As a result of NHS Greater Glasgow and Clyde's local efforts, 75 doctors had been identified who had taken on key roles in the programme over recent months.

Professor Barlow confirmed that the NHS Board's Clinical Governance Committee also studied SPSP data at each of its meetings and had been most impressed with local activities.

In response to a question from Mrs Murray concerning the "100 doctors in 100 days" programme, Dr Cowan reported that this development in the programme was introduced in response to reports of a lack of medical engagement. The national team, therefore, introduced an aim to recruit 100 new doctors to the programme work within 100 days. All Boards were asked to address this issue by introducing medical staff to the programme and ensuring that they became involved in pushing forward the work.

Dr Kapasi commended the report and, in thanking Dr Cowan for his leadership in taking it forward, hoped the excellent momentum continued.

NOTED

93. HEALTHCARE ASSOCIATED INFECTION – REPORTING TEMPLATE (HAIRT)

A report of the Medical Director [Board Paper No. 10/43] 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. Dr Cowan confirmed that this was the first report in the revised template style as specified by the Scottish Government. As requested by the NHS Board, however, the previously reported Statistical Process Charts were attached as an appendix.

Dr Cowan highlighted four key Healthcare Associated Infection headlines for October 2010 as follows:-

- In 2007, the Scottish Government Health Directorate (SGHD) issued HEAT Targets in relation to S.aureus bacteraemias (SABs) which required NHS Greater Glasgow and Clyde to reduce SABs by at least 35% by April 2010. Dr Cowan was pleased to report that this target had been achieved.

  In 2010, this target was extended by an additional 15% and NHS Greater Glasgow and Clyde's progress would be included in future Board reports.

- The national report published in July 2010 showed a further reduction in the rate of C.difficile infection within NHS Greater Glasgow and Clyde and clearly placed the NHS Board below the national mean (0.47 per 1000 Occupied Bed Days (OBDs) over 65s) and also below the 0.6 per 1000 OBD HEAT Target for 2011. The rate for the most recent quarter reported (January-March 2010) was 0.34 per 1000 OBDs. This was a reduction from the previous quarter from 0.36 to 0.34 per 1000 OBDs.

- The Surgical Site Infections (SSI) rates in NHS Greater Glasgow and Clyde, (for the first quarter of 2010), remained below the national average for all categories apart from reduction of long bone fracture and repair of neck femur procedures.

- Cleanliness Champions Programme – the Cleanliness Champions Programme was part of the Scottish Government's Action Plan to combat HAI within NHS Scotland. To date, NHS Greater Glasgow and Clyde had supported over 2000 members of staff who were now registered Cleanliness Champions.

Dr Cowan led the NHS Board through the various "report cards" that provided information for each Acute Hospital and key community Hospitals. In addition, there was a single report card which covered all community hospitals (which did not have individual cards) and a report which covered infections identified as having been contracted from outwith hospital. He explained that the information in the report cards was provisional local data and may differ from the national surveillance reports carried out by Health Protection Scotland and Health Facilities Scotland. The national reports were official statistics which underwent rigorous validation which meant that final national figures may differ from those reported to the NHS Board.

Professor Barlow welcomed clarification on the differing local/national figures. This was particularly important as it had to be hoped that, as levels got lower, there was not an over-reaction to any sudden peak. Such peaks may arise when the figures were so low and simply one instance then occurred. Given this, it was also important to look at global trends.

With regard to "out of hospital infections", Dr Cowan clarified that these accounted for people who presented to hospital with infections. All patients were now routinely screened for MRSA and those patients who presented with symptoms of diarrhoea where also screened for C.diff. In response to a question from Mrs Nijjar, Dr Cowan highlighted some measures taking place to improve out of hospital infection rates including work ongoing with GPs and prescribing advisors to ensure the correct prescribing of the correct antibiotics. This should go some way to reduce this infection rate.

NOTED

94. FULL BUSINESS CASE - NEW SOUTH GLASGOW ADULT AND CHILDREN'S HOSPITALS

A report of the Project Director, New South Glasgow Hospitals [Board Paper No. 10/44] asked the NHS Board to approve the Full Business Case (FBC) for the new South Glasgow Hospitals. Thereafter, it was planned to submit the FBC to the Capital Investment Group (CIG) for consideration at their meeting of 9 November 2010.
Mr Seabourne delivered a detailed presentation describing the strategic context of the project and the actions undertaken since Outline Business Case approval. He outlined the scope of the new hospitals, the Stage 2 design work undertaken, expected benefits of the project, governance and contractual arrangements, risk management, financial appraisal, status of planning permission, economic benefits to the local community and the outcome of the recent Gateway Review. He concluded by displaying various illustrations and photographs of how the new South Glasgow Hospitals would look following completion.

In terms of a timetable for the project, Mr Seabourne explained that, if the FBC was approved and everything else went to plan then it was hoped that construction of the Adult and Children's Hospitals should be completed in January 2015. This would see the new South Glasgow hospitals achieving the gold standard triple co-location of adult, children's and maternity services.

Mr Seabourne summarised the scope of the Adult and Children's Hospitals as follows:-

- New Adult Hospital – would be a 1,109 bedded adult new build acute hospital providing A&E services and acute specialist in-patient care, a small volume of medical day cases and out-patient clinics serving the local (South West Glasgow) population. No day surgery would be undertaken as this would be provided at the new Victoria Hospital.

- New Children's Hospital – this proposed a new 256 bedded children's hospital and would provide A&E services and a comprehensive range of in-patient and day case specialist medical and surgical paediatric services on a local, regional and national basis. The new development would also have out-patient facilities. The NHS Board's strategy was that all Glasgow's children's services (up to the age of 16 and up to 18 year where appropriate) would be provided at the new children's hospital.

The Laboratory Project remained on programme to be completed by mid March 2012 and the procurement programme was making good progress, with the work packages tendered prices coming in within allocated budgets.

Mr Ross of Currie and Brown UK Ltd reported that the project had demonstrated and followed good management processes and had robust risk management governance structures in place. Risk management had been, and remained, a primary focus in the management of the project. In developing all aspects of planning the new facilities, Mr Ross confirmed that the project team and advisors had proactively managed potential risks by early identification and action to ensure maximum reduction and mitigation of risk. This approach had been enacted at all key stages of the project including pre-procurement, during procurement and post procurement and had included actions such as market sounding, consultation with key organisations, community engagement, robust control of any limited specification changes and ensuring the site to be handed over to the contractor was clear with known ground conditions.

Mr Ross summarised the contract between NHS Greater Glasgow and Clyde and Brookfield Construction Limited (BCL) and confirmed that there was collaborative working between both parties in taking the project forward.

Mr Griffin outlined the financial appraisal of the project explaining that, as part of finalising the FBC, an exercise was undertaken to recalculate both the capital and revenue consequences of the new South Glasgow Adult and Children's Hospitals to ensure that the preferred solution continued to be affordable in both capital and revenue terms. He explained that the original contract value, agreed with the preferred bidder in December 2009 for the construction of the hospitals, was confirmed as being within the overall affordability envelope. Since contract award, strict change control procedures had ensured minimal change to this contract value. The aggregate of the contract value at October 2010, and all other associated costs including equipment, fees, other non works costs, VAT (at the 20% rate applicable from January 2011) and a reasonable provision for quantified risk (agreed in conjunction with professional advisors), remained within the overall capital budget and the affordability envelope for the project. Furthermore, the impact the project would have on the NHS Board's revenue position had also been revisited during the preparation of the FBC. Mr Griffin noted that the updated cost estimates confirmed that by proceeding with the project, the NHS Board was forecasting the achievement of a net revenue saving of £18M. This saving arose partly due to a reduction in capital charges to be incurred on the new hospitals and significantly through service redesign.

Dr Cowan congratulated Mr Seabourne and his team for the comprehensive nature of the FBC. He fully supported the project and recognised the huge benefits to Glasgow, patients and clinicians. Better accommodation would be provided for patients and clinicians were looking forward to this new resource which also achieved significant efficiencies.

Ms Crocket echoed Dr Cowan's comments and paid tribute to the huge engagement undertaken by the project team especially with clinical staff and members of the public. Such engagement had been worthwhile and hugely significant in reaching this stage. Mrs Grant agreed and, despite many challenges along the way, reaffirmed the enthusiasm from staff to meet the aspirations of the project.

Mr Williamson recorded the support from clinicians and professionals not only within the NHS Greater Glasgow and Clyde area but outwith. This project would see a new Centre of Excellence in Glasgow which was a very exciting development for medicine and surgery.

Mr Winter had visited the site and met with the project team and the contractor. In his view, the project had been excellently managed to date with the new buildings being designed to address environmental issues in energy consumption and carbon footprint. This provided a good working environment which would enhance staff morale, recruitment and retention. The new builds would also allow innovative solutions for materials management and logistics.

As Chair of the Audit Committee, Mrs Smith paid tribute to this project and the fact that it was forecast to be delivered on budget and on time. She congratulated all staff involved in reaching the FBC stage and had no hesitation in providing the project with her support.

In response to a question from Dr Kapasi, Mr Seabourne described the new automated dispensing facility that would be available on the new site.

Councillor MacKay welcomed this public sector procurement model and the form of contract agreed. He asked where Fast-link featured in terms of ease of public access. Mr Seabourne responded by confirming that this formed part of the section 75 agreement with Glasgow City Council and negotiations were ongoing to establish the necessary transport routes and infrastructures.

Professor Barlow referred to the full size mock-ups of an adult en suite bedroom, children's bedroom and en suite, the staff touch down and a working space mock up of a critical care space that had been built to assist users in developing the individual room layouts. This had proved to be extremely helpful in progressing the design and aided understanding of what the final layout would look like. He asked about any likelihood of the Scottish Government changing its policy on capital charging before anticipated completion of the FBC. Mr Griffin confirmed that this change had been made by the Scottish Government due to the bank's base rate being continually reduced. It could happen again if policy changed, however, Mr Calderwood reported that it was 18 years ago that the Treasury last made a change to capital charging so a future regular change was unlikely.

In response to a question from Mrs Dhir, Mr Griffin confirmed that a number of key contractual risks had already been mitigated through work undertaken over the past months and this included the rise in VAT to 20% from January 2011. This had been accounted for within the current budget.

In response to various questions from Mr Carson, it was confirmed that total bed provision at the new hospitals (1365 beds) was a reduction in respect of the existing model but that, due to further efficiencies and reduction in patient's length of stay, a smaller bed base would still allow the NHS Board to meet the Government's HEAT targets. Mr Seabourne confirmed that the community engagement team had actively worked with Groups with disabilities to ensure their input to the layout and design of the hospitals. Similarly, there would be disabled parking bays (some within 50 metres of the new buildings) within the new campus.

In response to a question from Mr P Daniels regarding the Gateway 3 report, Mr Seabourne confirmed that this was very positive and two actions had been highlighted for completion before the next Gateway Review. These were to add some indirect risks (such as political risks) to the risk register and continue to develop the benefits management plan to define targets and gather baseline data.

Dr Benton asked what the likelihood was of the capital receipts not materialising. Mr Griffin responded by confirming that there was a risk associated with this particularly given that the property market had been very difficult to predict. Some of the NHS Board's surplus sites, however, were likely to be very attractive for disposal and would hopefully be marketable when the time came. In terms of the Scottish Government election scheduled for May 2011, Mr Calderwood confirmed that this project would form part of the current Government's decision making and, therefore, any change of Government would not have an impact.

In summarising, Mr Calderwood emphasised that NHS Greater Glasgow (and latterly NHS Greater Glasgow and Clyde) had spent many years developing an acute services strategy for the City. Despite many challenges, the programme saw investment of £1.5 billion when completed. The FBC had been a significant piece of work and he commended Mr Seabourne and his team for taking this forward.

DECIDED

That the Full Business Case for the new South Glasgow Hospitals be unanimously supported and approved. **Project Director**

95. HEALTH IMPACT ASSESSMENT (HIA) OF THE CITY OF GLASGOW LICENSING BOARD, LICENSING POLICY STATEMENT

A report of the Director of Public Health [Board Paper 10/45] asked the NHS Board to note the Health Impact Assessment (HIA) of Glasgow City Council's Licensing Policy and support its recommendations.

Dr de Caestecker described the unenviable record in relation to alcohol misuse in NHS Greater Glasgow and Clyde. Local data showed that the prevalence of alcohol misuse in the Board's area was worse than the rest of Scotland. Glasgow Health Commission 2009 recommended that the City make use of its powers, under the licensing legislation, to tackle some of the issues around alcohol misuse in the City. Alcohol licensing policies were reviewed on a three yearly basis and the Glasgow City Licensing Board must review its Licensing Policy by November 2010. The opportunity was presented, therefore, in the last year to influence the development of its new policy.

At the end of 2009, with the approval of Glasgow City Licensing Forum, a multi agency group was established to carry out a Health Impact Assessment of Glasgow City's Alcohol Licensing Policy. Dr de Caestecker described how this Health Impact Assessment was undertaken and explained that it contained 64 recommendations. Most of these related to the Licensing Board, though there were some directed at the local council, Strathclyde Police and Scottish Government. In general, the recommendations related to four main areas as follows:-

- Improving accessibility of the licensed trade, local communities and individual members of the Public to the licensing policy process as originally intended by national legislation.

- Developing a tool for use by the Licensing Board in assessing over provision of licensed premises.

- Providing guidance to the Licensing Board on the relationship between Public Health and the Licensing Policy.

- Encouraging enforcement of existing laws to protect our communities.

Dr de Caestecker explained that, while adoption of these recommendations would not transform the poor alcohol related health within Glasgow City, they would help to ensure that communities and agencies could use the Licensing Policy to limit, to a degree, the harm due to alcohol misuse. Adoption of these recommendations would also help to ensure that alcohol consumption may be enjoyed by those who use it sensibly and was likely to result in a more positive relationship with alcohol by our local population.

In response to a question from Councillor McColl, Dr de Caestecker confirmed that data generated from Strathclyde Police and NHS Greater Glasgow and Clyde would be provided to Glasgow City Licensing Board to inform their decision making process. Mr Williamson welcomed this particularly as the data provided would include alcohol associated hospital admission rates, alcohol associated crime rates and alcohol associated death rates. Dr de Caestecker agreed that the data would be useful to the Licensing Board and it was important to present it in an easy to understand way to maximise its use.

Councillor MacKay referred to cross party support for the minimum pricing of alcohol as well as the social responsibility of its misuse. He was anxious that the application of the Licensing Policy did not affect those responsible license holders. Dr de Caestecker responded by confirming that the NHS Board did lobby the Scottish Government in terms of overall social responsibility and agreed that Glasgow City could explore the potential of enforcing a minimum policy locally. Such a localised policy had been proposed in Manchester.

In response to questions raised by several members regarding the provision of cheap alcohol by supermarkets, Dr de Caestecker re-emphasised the importance of working with local supermarkets and multi-national companies at national level in an effort to find a balance. Councillor MacKay confirmed that local authorities could not stipulate what adverts appeared on local advertising boards. Councillor Coleman agreed that discussions with supermarkets were key but this was difficult to control as they were often huge national companies.

Dr de Caestecker agreed to include reference within the NHS Board's response to the social responsibility levy and this was welcomed.

DECIDED

That the NHS Board note the Health Impact Assessment (HIA) of Glasgow City Council Licensing Policy and support its recommendations. **Director of Public Health**

96. PROPOSED INTEGRATED SERVICE DELIVERY FOR ADDICTIONS: NHSGGC AND GLASGOW CITY COUNCIL

A report of the Director of Corporate Planning and Policy/Lead NHS Director, Glasgow City CHCPs [Board Paper No. 10/47] asked the NHS Board to note the proposed approach and arrangements for a joint approach to consider options to continue to have integration of the operational delivery of addiction services.

Ms Renfrew described the basis for change to current addiction services structures and outlined the components that would be included within the partnership agreement. The proposals focused on delivering integrated services with the key features of NHS and Social Care staff working in single teams, integrated assessment and care planning, a single access point for service users and aligned NHS and Social Care resources under the direction of a single management team. In summarising the single management structure, Ms Renfrew explained that this would deliver management cost reductions because of the move from five areas to three and the full integration of addiction service delivery into local NHS and Social Work structures.

In terms of next steps, she anticipated that a joint process would be established to appoint to key management roles from the existing pool of CHCP and Partnership addictions staff.

Thereafter, development of an interim partnership agreement detailing resources, joint roles, structure and accountabilities and the process to review and establish second tier structures including a joint finance role would take place. These processes would be conducted without delay to enable the transition from the current CHCPs to the new structures.

Mr Daniels sought clarity around the lines of accountability particularly in relation to the Head of Addiction/Addiction Services Lead post. Ms Renfrew confirmed that this post-holder would report to the Social Work Manager and NHS Sector Director and hoped that these two posts would be co-located. Such dual accountability would be carefully managed in accordance with the partnership agreement.

In response to a question from Mrs Smith, Ms Renfrew confirmed that NHS and Council colleagues were working collaboratively to progress this joint piece of work to ensure strategic partnership working in service delivery for addictions.

NOTED

97. MODERNISING AND IMPROVING MENTAL HEALTH SERVICES IN WEST DUNBARTONSHIRE IMPLICATIONS OF CHRISTIE WARD FIRE – 11 JULY 2010

A report of the Director of the Mental Health Partnership [Board Paper No. 10/49] asked the NHS Board to receive a further report in eight to ten months time identifying the impact on community services on adult acute metal health bed usage for the West Dunbartonshire, Helensburgh and Loch Side area and agree that, for the time being, beds for this area should be provided from Gartnavel Royal Hospital.

Mrs Hawkins outlined the background to the Clyde Mental Health Strategy and summarised developments since August 2008 when the NHS Board, as a consequence of a full consultation exercise on Clyde Mental Health Services, endorsed a series of significant service change proposals. In relation to North Clyde and, in particular, the Christie Ward, the Cabinet Secretary wished to reconsider the NHS Board's proposals in 12/18 months or sooner, should the demand for beds fall more rapidly, informed by a further report on the actual levels and trends in demand that were experienced. She also established a Monitoring Group to oversee the development and delivery of the service change plans affecting the Vale of Leven Hospital.

Mrs Hawkins summarised the work of the Vale Monitoring Group since it first met on 23 November 2009.

On 11 July 2010, a patient set fire to their room in the Christie Ward causing extensive damage. This necessitated the rapid movement of all patients and, on Monday 12 July 2010, 12 patients were moved to Gartnavel Royal Hospital. The Vale Monitoring Group met on 26 July 2010 and received a Monitoring Report and an initial report on the consequences of the fire. Since that time, the Monitoring Group had met on three occasions at which the discussions were wide ranging and detailed. The Chair of the Vale Monitoring Group had also communicated with the Cabinet Secretary.

In terms of options identified since the fire in the Christie Ward, Mrs Hawkins summarised six options identified with indicative associated costs. All options had a capital implication.

The very strong views expressed by the Monitoring Group were that capital should be made available in this financial year to allow the reopening of the Christie Ward. The Cabinet Secretary had expressed the view that a further period of monitoring take place and that repatriation of patients back to the Vale of Leven would not be in their, or their carers, best interest.

Councillor McColl as a member of the Monitoring Group, raised a motion "recommending the reinstatement of the Christie Ward or its equivalent, at the Vale of Leven with funding allocated and work commencing in the current financial year". He reaffirmed that there was a strong feeling from the community and the Monitoring Group that the Christie Ward should be reinstated. Mr Robertson sought a seconder for this motion. No seconder was received and the motion fell.

Councillor McColl referred to the area which was one of high deprivation and needs for Mental Health Services. He understood that West Dunbartonshire CHCP would be working to identify what further Mental Health Services could be provided from within the community if the Mental Health beds at the Christie Ward were not retained.

In response to a question from Mr Daniels regarding the preferred option (out of the six options listed), of the Monitoring Group, Councillor McColl reported that the Monitoring Group did not have a preferred option. They left this decision to the NHS Board but were clear that they wished the beds retained in West Dunbartonshire.

In response to a question from Councillor MacKay regarding the critical mass to declare a ward unsustainable, Mrs Hawkins confirmed that bed usage in the Christie Ward was running at around 12, on average, and this level was considered to be clinically unsustainable. This level of activity accounted for around 140 admissions per annum with an average length of stay between 21 and 40 days. Mrs Hawkins re-emphasised that most of this client group were cared for in the community.

Mr Williamson focused on the clinical side of this debate. He reiterated that Gartnavel Royal Hospital provided a far better level of care than the Vale of Leven. He recognised that whilst relatives were happy with the facilities provided, some found the journey to Gartnavel Royal Hospital more difficult than to the Vale of Leven. Mrs Hawkins agreed that, inevitably, the journey did take longer but that a further patient and carer survey would take place in the next one/two months with the outcome being reported to the Monitoring Group. She also explained that existing medical staff continued to manage patient care whilst they were in Gartnavel Royal Hospital. All clinical staff had adjusted to a new way of working which had maintained continuity of care for patients and their carers.

Mrs Dhir echoed Mr Williamson's comments and concluded that the quality of service to patients was paramount rather than the location. In integrating NHS Greater Glasgow and Clyde, much had been achieved in terms of quality of Mental Health Services within the Clyde community. She commended this work and the resultant reduction for the hospital beds within the Christie Ward.

DECIDED

- That the NHS Board receive a further report in eight/ten months time identifying the impact on community services on adult acute mental health bed usage for the West Dunbartonshire, Helensburgh and Loch Side area. **Director of the Mental Health Partnership**
- That, for the time being, beds for this area should be provided from Gartnavel Royal Hospital. **" "**

Councillor McColl asked that his dissent be recorded in respect of this decision.

98. OUTCOME OF HER MAJESTY'S INSPECTORATE OF EDUCATION (HMIe) REVIEWS

A report of the Nurse Director [Board Paper No. 10/46] asked the NHS Board to note the summary of two HMIe Joint Inspection of Services to Protect Children and Young People Reports, recognising that inspections were multi-agency.

Ms Crocket summarised the two HMIe inspection reports relating to East Dunbartonshire and East Renfrewshire. She explained that lessons learned from the inspections were progressed through a comprehensive range of governance structures. The inspections covered the range of services and staff working in each area who had a role to protect children. These included services provided by health, the police, the local authority and the Scottish Children's Reporter Administration, as well as those provided by voluntary and independent organisations. As part of the inspection process, inspectors reviewed practice through reading a sample of files held by services who worked to protect children living in the area.

Ms Crocket summarised the lessons learned from the inspections and highlighted particular strengths noted by the inspectors. She was pleased to report that both reports indicated that overall services were improving. Each Child Protection Committee had developed an action plan specific to their own report which would address the main recommendations and allow for monitoring and measuring progress.

In response to a question from Mrs Murray, Ms Crocket confirmed that relevant health staff were now involved more fully at an earlier stage particularly in relation to a medical opinion or a medical examination.

In relation to a point raised by Mrs Nijjar concerning the sharing of good practice, Ms Crocket reported that all HMIe reports were discussed at Child Protection Committees and the Chairs of these Committees met regularly to share best practice and lessons learned from inspections.

NOTED

99. WINTER PLAN 2010/11

A report of the Director of Emergency Care and Medical Services [Board Paper No. 10/48] asked members to note an update on the approach to winter planning 2010/11.

Mrs Grant explained that this was now the fifth year that NHS Greater Glasgow and Clyde had progressed winter planning as a single system approach. The membership of the Winter Planning Group included senior representation from all partner agencies and the Group met, during Winter, on a monthly basis and bi-monthly during the rest of the year. The Winter Planning Group had overseen the formulation of the Winter Plan for 2010/11 taking into account the lessons learned from 2009/10 and central advice. The escalation plan had also been revised and the NHS Board and other agencies continuity plans had all recently been updated.

Mrs Grant led the NHS Board through the key components of winter planning highlighting a number of key challenges and a focus on how these would be addressed. The National Emergency Access Delivery Team had identified the current financial challenges faced by Boards and the interface with local authorities (in particular, the impact of any changes to social care and home support services that may be effected as a result of the financial targets set) as key issues for Boards to address in preparing for Winter. In previous years, specific funding to support winter plan initiatives was available. In preparing for the 2010/11 Winter, the current financial climate had been recognised.

NOTED

100. ANNUAL UPDATE - FOOD FLUID AND NUTRITION

A report of the Nurse Director [Board Paper No. 10/50] asked the NHS Board to note the annual update on food, fluid and nutrition. Ms Crocket reported that the Food and Nutrition Planning and Implementation Group had prioritised the "achievement of a well nourished patient" objective within the implementation of the Board's Food, Fluid, and Nutrition Policy. Ms Crocket set out progress on the implementation of Food in Hospitals (national catering specification) and QIS Food, Fluid and Nutritional Care Standards.

In terms of future developments, Ms Crocket explained that a Hydration Policy had been drafted to support a standardised and multi-disciplinary approach to fluid provision and monitoring. In addition to the Patient Experience (Better Together) and annual catering satisfaction surveys as methods of seeking patient feedback, a specific patient engagement session was being held on 12 November 2010 to develop an objective bench mark for the patients "food journey". This session would validate an aspirational food journey, prioritise aspects of nutritional care and food provision and describe success. This would be used along with other feedback to focus improvement and to define patient centred outcomes and measures.

NOTED

101. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer (Acute Services Division) [Board Paper No. 10/51] asked the NHS Board to note progress against the national targets as at the end of August 2010.

Mrs Grant led the NHS Board through the report highlighting the actions being taken to deliver the waiting times and access targets including out-patient waiting times, in-patient/daycase waiting times, diagnostic waiting times, accident and emergency four hour wait, cancer waiting times, chest pain, delayed discharge and stroke.

In response to a question, Mrs Grant reported that attendance at Accident and Emergency Departments was likely to continue to rise as greater pressure was placed on A&E Departments in the Winter months. Winter planning arrangements were currently being finalised and a number of initiatives involving direct admission of GP referrals were being put in place and refined.

In terms of delayed discharges, the NHS Board was required to maintain a performance standard of no patients waiting over six weeks for discharge. Mrs Grant reported that there continued to be individual circumstances where, due to case complexity, arrangements were not completed in accordance with the standard. Local Authority funding restrictions were now also starting to impact on the timely discharge of patients and this was under discussion between the respective Chief Executives.

NOTED

102. FINANCIAL MONITORING REPORT FOR THE 5 MONTH PERIOD TO 31 AUGUST 2010

A report of the Director of Finance [Board Paper No. 10/52] asked the NHS Board to note the Board's financial performance for the first five months of the financial year.

Mr Griffin explained that the NHS Board was currently reporting an expenditure outturn of £4M in excess of its budget for the first five months of the year. At this stage, however, the NHS Board considered a year end break even position remained achievable.

Mr Griffin outlined some of the reasons for the NHS Board reporting expenditure ahead of budget and explained that looking forward, there were some additional cost pressures which would have a bearing on the 2010/11 outturn, namely, the increased costs as a result of the recent national rates re-evaluation exercise, the increase in VAT (from 17.5% to 20%) which would occur in January 2011 and, a more recently recorded cost pressure, in expenditure relating to the dispensing of appliances. This was pushing Primary Care prescribing expenditure above budget for the first quarter of 2010/11 and could, if it continued, lead to an overspend on budget for the full year. Mr Griffin confirmed that this was currently being investigated to confirm the underlying cause and assess the potential full year impact.

In response to a question, Mr Griffin confirmed that, at this stage of the financial year, it was still premature to be making firm predictions of the likely outturn. There were some clear indications, however, based on trends to date, that expenditure levels were running at higher levels than the NHS Board would want to be confident that it could return to a break-even position by the year end.

Assuming that full achievement of the cost saving plans could be secured month on month from October 2010 onwards (and taking cognisance of the cost pressures noted) it was not unreasonable to anticipate that the NHS Board would require to identify around £10M of supplementary cost savings/cost reduction measures during 2010/11 if it was to succeed in managing expenditure within its revenue resource limit for the year.

Mr Griffin confirmed that a full review of the first half of the year outturn and any resultant action required would be discussed by the NHS Board's Performance Review Group meeting in November 2010.

NOTED

103. QUARTERLY REPORT ON COMPLAINTS – 1 APRIL TO 30 JUNE 2010

A report of the Head of Board Administration, Chief Operating Officer (Acute Services Division) and Director, Mental Health Partnership [Board Paper No. 10/53] asked the NHS Board to note the quarterly report on complaints in NHS Greater Glasgow and Clyde for the period 1 April to 30 June 2010 and note that a revised NHS Greater Glasgow and Clyde Complaints Policy had been developed and approved by the Corporate Management Team.

Mrs Grant summarised the statistical information on complaints handling for this period and highlighted areas of service improvements and ongoing developments. She recorded an overall complaints handling performance of 75% of all complaints being responded to within 20 working days (the national target was 70%).

In terms of the revised Complaints Policy, this had been approved by the Corporate Management Team at its meeting held on 14 September 2010. Although there were no significant changes of principle to the Complaints Policy, it had been rewritten to separate it from the Guidance and updated to reflect organisational changes, national documents and initiatives. Supporting documentation would now be prepared to underpin the re-launch of this policy such as revised leaflets, website review, posters and training.

Mr Williamson commended some of the service improvements and lessons learned made as a result of patient complaints. Not only were they interesting and informative to read, but demonstrated proactive action taken as a result of feedback from patients.

NOTED

104. UPDATE ON PROGRESS WITH ACTION FROM DIRECTOR OF PUBLIC HEALTH (DPH) REPORT, OCTOBER 2010

A report of the Director of Public Health [Board Paper No. 10/54] asked the NHS Board to note an update on progress with key actions from "An Unequal Struggle for Health, Report of the Director of Public Health 2009/2011". Dr de Caestecker led the NHS Board through the update reporting on progress taken forward in the priority areas for action. She reviewed how issues were being addressed and focussed on some key areas as follows:-

- Early Years – including focussing resources, supporting parents, addressing the social circumstances of families and children and changing attitudes towards children.

- Implications of the financial crisis for health and understanding the impact of the recession.

- Alcohol – the Public Health and Health Improvement Directorate continued to advocate for minimum pricing of alcohol and to provide briefings and information for local and national politicians.

- The population of NHS Greater Glasgow and Clyde needed to get more active.

- Health at Work – recognising the workplace as a community and providing information and training for workplaces on improving their environment and providing physical activity and healthy eating initiatives.

Furthermore, Dr de Caestecker summarised three key areas in preventative health approaches including anticipatory care, the falls and fracture liaison service and smoking cessation services. In summarising, Dr de Caestecker recorded that there had been substantial progress in taking forward the actions from "An Unhealthy Struggle for Health" but also areas where progress was more challenging particularly around the use of alcohol.

Renfrewshire CHP and Renfrewshire Council would jointly host an event to review action from the report on 10 November 2010 and Dr de Caestecker extended an invitation to all members to attend this event.

In response to a question from Mr Robertson, Dr de Caestecker confirmed that Health at Work had 228 organisations across Greater Glasgow and Clyde registered – this covered 189,723 employees. She explained that awards were presented in gold, silver and bronze.

Mrs Nijjar raised a concern that Cordia, the company contracted with Glasgow City Council to provide school meals, now sold cakes and biscuits which was of concern. Dr de Caestecker continued to advocate healthy eating in schools with both Cordia and Glasgow City Council and had written regarding the decision to provide such snacks. Cordia had reported that the snacks met national nutritional standards. Nonetheless, Dr de Caestecker confirmed that she would continue to advocate and monitor the effect of that decision but that data would need to be collected to support and evaluate the sale or otherwise of these snacks.

NOTED

105. 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. 10/55] asked 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 six 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**

106. CLINICAL GOVERNANCE COMMITTEE MINUTES: 3 AUGUST 2010 AND 5 OCTOBER 2010

The Minutes of the Clinical Governance Committee meetings held on 3 August 2010 and 5 October 2010 [CGC(M)10/04] and [CGC(M)10/05] were noted.

NOTED

107. AREA CLINICAL FORUM MINUTES: 5 AUGUST 2010

The Minutes of the Area Clinical Forum meeting held on 5 August 2010 [ACF(M)10/04] were noted.

NOTED

108. PHARMACY PRACTICES COMMITTEE MINUTES: 23 AUGUST 2010

The Minutes of the Pharmacy Practices Committee meeting held on 23 August 2010 [PPC(M)10/06] were noted.

NOTED

109. STAFF GOVERNANCE COMMITTEE MINUTES: 7 SEPTEMBER 2010

The Minutes of the Staff Governance Committee meeting held on 7 September 2010 [SGC(M)10/03] were noted.

NOTED

110. PERFORMANCE REVIEW GROUP MINUTES: 21 SEPTEMBER 2010

The Minutes of the Performance Review Group meeting held on 21 September 2010 [PRG(M)10/05] were noted.

NOTED

The meeting ended at 13:05 p.m.