NHSGG&C(M)11/01
Minutes: 1 - 19

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, 15 February 2011 at 9.30 am**

P R E S E N T

Mr A O Robertson OBE (in the Chair)

Mr C Bell	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 R McColl
Councillor J Coleman	Councillor J McIlwee
Dr B N Cowan	Mrs J Murray
Ms R Crocket	Rev Dr N Shanks
Mr P Daniels OBE	Mr D Sime
Dr L de Caestecker	Mrs E Smith
Ms R Dhir MBE	Councillor A Stewart
Prof A Dominiczak	Mr B Williamson
Mr D Griffin	Councillor D Yates (to Minute No. 10)

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

Dr E Crighton	..	Consultant in Public Health Medicine (for Minute No. 9)
Ms S Gordon	..	Secretariat Manager
Mrs J Grant	..	Chief Operating Officer, Acute Services Division
Mr J C Hamilton	..	Head of Board Administration
Mrs A Hawkins	..	Director of Mental Health Partnership/Director, Glasgow City CHP
Mr A McLaws	..	Director of Corporate Communications
Mr I Reid	..	Director of Human Resources
Ms C Renfrew	..	Director of Corporate Planning and Policy (to Minute No. 9)

ACTION BY

1. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Mr I Fraser, Mr P Hamilton, Mrs R Nijjar and Mr K Winter.

Mr Robertson welcomed Professor Anna Dominiczak, Vice Principal and Head of College, Medical, Veterinary and Life Sciences, University of Glasgow who had recently taken up post and had, as such, been appointed a NHS Board member.

Mr Robertson sought, and received members approval, that the agenda be re-ordered in that agenda Item Number 9 (Development of Blawarthill Hospital) be considered before Agenda Item Number 8 (Public Health Screening Programmes Annual Report 1 April 2009 to 31 March 2010).

2. CHAIR'S REPORT

(i) On 11 January 2011, Mr Robertson met with Dr M Ross and Dr J White at Gorbals Psychology Service Unit at the Florence Street Resource Centre. They were developing a positive psychology model based on environmental circumstances with broader implications for communities. This was a holistic approach to minimise direct referrals to medical services.

(ii) Alongside Mr Cleland, Mr Lee and Mr Fraser, Mr Robertson attended a Board effectiveness day in Edinburgh on 13 January 2011. This event was not restricted to NHS Board members; some good generic points had been raised by the Permanent Secretary, Sir Peter Housden, who was very keen to emphasise the critical role of Non Executive members in public sector organisations.

(iii) On 17 January 2011 Mr Robertson, accompanied by Mrs A Hawkins, met with Councillor Matthew Kerr and David Crawford who had executive responsibilities for Health and Wellbeing at Glasgow City Council. This meeting had been cordial and friendly which would play out well in the developing work of the Joint Partnership Board.

(iv) On 18 January 2011, Mr Robertson attended the tenth anniversary of the Sandyford Initiative to celebrate its success in enhancing awareness, use and acceptance of sexual health services. Later that day, Mr Robertson had also attended the Victoria Infirmary where he had been presented with a cheque for £1.4M from the Women's Royal Volunteer Service (WRVS). He gratefully received this and paid tribute to the volunteers from the WRVS who tirelessly fundraised.

(v) On 20 January 2011, Mr Robertson participated in the short-listing panel for the two Non Executive Board Member vacancies. Interviews were held on 3 and 4 February 2011 and recommendations submitted to the Cabinet Secretary for consideration. He anticipated appointments being made to these two vacancies by the Cabinet Secretary prior to the April 2011 NHS Board meeting.

(vi) On 27 and 28 January 2011, Mr Robertson, along with twelve other clinical and management representatives of the NHS Board, attended the NHS Quality Improvement Scotland (QIS) "Boards on Board – the Role of the Board in Quality and Safety" event. This highlighted the importance of integration of the Quality Strategy and patient safety in mainstream service delivery. Again, there was very strong emphasis laid on the role of the Non Executives in achieving best results and NHS Greater Glasgow and Clyde had been well represented.

(vii) On 8 February 2011, Mr Robertson attended the topping out ceremony for the new laboratory building on the South Glasgow Hospitals campus. Mr Robertson referred to the interface between NHS Greater Glasgow and Clyde and the University of Glasgow (in particular, the Medical, Veterinary and Life Sciences College) in relation to the joint work being undertaken at the South Glasgow Hospitals.

(viii) On 9 February 2011, Mr Robertson attended the opening of the refurbished pre-clinical skills facility at Glasgow Dental Hospital and School. Later that day he also visited the Vale of Leven Hospital for an infection control update.

NOTED

3. CHIEF EXECUTIVE'S UPDATE

(i) Mr Calderwood and colleagues met with Senior Executives from the Scottish Government Health Directorates to conduct the NHS Board's mid year review. Subsequently, a letter dated 2 February 2011 had been received confirming the points discussed and the NHS Board's progress in terms of workforce, finance and efficiency and service pressures and redesign activities. Overall, the NHS Board was progressing well and addressing ongoing challenges.

(ii) On 26 January 2011, Mr Calderwood, accompanied by Ms Crocket, met with Professor Pamela Gillies (Principal and Vice Chancellor of Glasgow Caledonian University) to discuss education and training matters as they related to Nursing and Allied Health Professionals.

(iii) On 4 February 2011, Mr Calderwood visited the new pharmacy distribution centre in Ibrox. This was one of the most modern such centres in the UK in that it used robotic technology to dispense drugs and dressings. It was an excellent example of the integration of a service within a single storage facility.

(iv) On 14 February 2011, Mr Calderwood participated in a panel regarding progress of the e-Health agenda particularly identifying how it dovetailed with the Quality Strategy. The event had been well attended by health representatives throughout NHS Scotland.

NOTED

4. MINUTES

On the motion of Mr I Lee, seconded by Dr M Kapasi, the Minutes of the NHS Board meeting held on Tuesday 21 December 2010 [NHSGG&C(M)10/06] were approved as an accurate record and signed by the Chair.

NOTED

5. MATTERS ARISING FROM THE MINUTES

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

NOTED

6. SCOTTISH PATIENT SAFETY PROGRAMME UPDATE

A report of the Board's Medical Director and Head of Clinical Governance [Board Paper No. 11/01] 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 SPSP's 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 had also developed SPSP style improvement programmes in Paediatrics and Mental Health Services in 2010 and was working towards Primary Care and Obstetrics in 2011.

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

- The previous report in December 2010, confirmed that NHS Greater Glasgow and Clyde had achieved Level 3 on the national assessment scale. Dr Cowan reported that the conditions had now been met for the next point on the assessment scale, Level 3.5. As such, the national SPSP team and advisers were being asked to review and confirm the local assessment.

- There were now 246 active frontline clinical teams within the Scottish Patient Safety Programme in NHS Greater Glasgow and Clyde which demonstrated spread of the core programme work into 85% of the total target areas and would secure 100% involvement by Spring. Furthermore, a number of teams were being activated into multiple workstreams, for instance, the programmes General Ward Care worksteam was now being implemented to all surgical ward areas who previously commenced the Peri-Operative workstream.

- The NHS Board provided a range of internal opportunities and participated in those more formal arrangements supported from the national team. For example, two NHS Greater Glasgow and Clyde staff were on the Scottish Improvement Advisor Course which aimed to produce expert level knowledge. Furthermore, three graduates and two staff were in the current cohort of the SPSP Fellowship aimed at creating clinical leadership for quality improvement.

- As had been referred to earlier, Dr Cowan confirmed that thirteen staff from NHS Greater Glasgow and Clyde (including the Chairman and Chief Executive) had attended the "Boards on Board" two day event for senior leadership and Board members to review national and international experience of governance and quality improvement knowledge.

- The NHS Board's plan for improving the Hospital Standardised Mortality Ratio (HSMR) indicator levels at the Royal Alexandra Hospital/Vale of Leven Hospital had now been shared for external critical review with colleagues in NHS QIS.

Dr Cowan reported that although good progress towards the implementation aim had been achieved, some issues had been identified as hindering the spread of the programme work and consequently delaying full realisation of all acute in-patient areas active in the programme by March 2011. In particular, the continuing Acute Services Division's process of managing service change from Stobhill Hospital to the Glasgow Royal Infirmary indicated that a number of previously identified areas would be disrupted with frontline teams being reorganised.

Mr Robertson asked about the 246 frontline clinical teams within the Scottish Patient Safety Programme and Dr Cowan confirmed that these were Acute Teams spread over the whole of NHS Greater Glasgow and Clyde. Furthermore, the Scottish Patient Safety Programme improvement programmes were operational in mental health services and paediatrics. A pilot within primary care was currently being undertaken in NHS Lothian and outcomes were awaited before further local implementation.

NOTED

7. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the Medical Director [Board Paper No. 11/02] 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 explained that the report presented data on the performance of NHS Greater Glasgow and Clyde on a range of key HAI indicators at national and individual hospital site level and the template used was that specified by the Scottish Government Health Directorates.

Dr Cowan highlighted four key Healthcare Associated Infection headlines for February 2011 as follows:-

- In 2007, the Scottish Government Health Directorates (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% to be achieved by the end of March 2011. The NHS Board was maintaining steady progress towards this target. Further, and more challenging, targets would be implemented from April 2011.

- The national report published in September 2010 (April – June 2010), showed the rate of C.difficile infection within NHS Greater Glasgow and Clyde as 0.38 per 1000 occupied bed days and clearly placed the NHS Board below the national mean of 0.47 per 1000 occupied bed days in over 65s and also below the 0.6 per 1000 occupied bed days updated HEAT Target for 2011.

- The Surgical Site Infection (SSI) rates in monitored procedures in NHS Greater Glasgow and Clyde, (for the last available quarter of 2010), remained below the national average for all categories.

- 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 2136 members of staff who were now registered Cleanliness Champions.

Dr Cowan summarised the requirements and recommendations made by the Healthcare Environment Inspectorate (HEI) following their announced inspection of the Victoria Infirmary. They also conducted an unannounced inspection at Inverclyde Royal Hospital on 18 January 2011 and the report and action plan of that visit was awaited.

In response to a question concerning infection outbreaks, Dr Cowan reported that, from September 2010 to mid January 2011, there had been 18 wards closed across 10 different NHS Greater Glasgow and Clyde hospital sites for suspected norovirus.

In response to a question from Councillor McColl, Dr Cowan confirmed that the report and action plan from the HEI unannounced inspection of Inverclyde Royal Hospital would be summarised in the NHS Board paper due to be considered at the 19 April 2011 Board meeting. **Medical Director**

Councillor Yates asked that future HAIRT Reports have attached a glossary of terms for ease of reading. **Medical Director**

NOTED

8. DEVELOPMENT OF BLAWARTHILL HOSPITAL

A report of the Director of Corporate Planning and Policy [Board Paper No. 11/04] asked the NHS Board to approve action now considered necessary to deliver on proposals for the development on the Blawarthill site.

Ms Renfrew summarised the issues which had arisen with the land transaction to redevelop the Blawarthill site since the NHS Board's Performance Review Group approved the proposal in November 2009. She explained that a critical part of the legal transaction agreement with the developer was that they were required to have a partner to run the care home services approved through the City Council's procurement process. Southern Cross Healthcare was approved through that process, however, in late 2010, Council and NHS Board Officers were informed that the developer and Southern Cross were no longer working in partnership.

Ms Renfrew reported that in formal legal terms the situation meant that the binding requirements and the timescale of the concluded missive had not been met by the developer and as such, she outlined the NHS Board's proposals for an alternative way forward which would still achieve the development of the site for care services.

In outlining the recommendation on the current development contract, Ms Renfrew indicated that the NHS Board remained committed to the development of the site in a way which provided a range of care services to the local community. She led the NHS Board through the proposed approach as it related to each of the three elements, namely, care home beds, social housing and continuing care. Concluding, she explained that it was extremely disappointing that, at this late stage, the contract to deliver nursing home, continuing care and social housing on this site could not now be delivered as originally planned. The local community had been fully supportive of the plans and if the NHS Board was able to deliver on its proposals, there would still be development of significant new care services on the Blawarthill site.

Ms Dhir expressed her disappointment at the outcome and asked if the site would be of interest to the Council for its development if it was to proceed. Ms Renfrew advised that until the decision was taken by the NHS Board not to proceed with the current proposal, it had not been possible to have these discussions with the Council. If approved, the NHS Board would offer the Council the possibility of considering the site for their development.

Councillor McColl asked how these proposals impacted on any previous decisions taken by the NHS Board. Ms Renfrew replied by outlining why a short review process to consider the future level, location and configuration of continuing care beds for West Glasgow was needed. It was proposed that this be concluded by the summer of 2011.

DECIDED

- That formal notification to the developer that the required legal terms had not been met and that the planned commercial development of the site could not now proceed be approved. **Director of Corporate Planning and Policy**

- That, in principle, the proposals to deliver the agreed social housing and to seek agreement with the City Council to site their planned 120 bed care home at the hospital, subject to the necessary planning and land transactions coming forward for approval, be approved. **“ “**

- That a review of continuing care provision for the West area to be completed during the summer of 2011 be approved. **“ “**

9. PUBLIC HEALTH SCREENING PROGRAMMES ANNUAL REPORT 1 APRIL 2009 TO 31 MARCH 2010

A report of the Director of Public Health [Board Paper No. 11/03] asked the NHS Board to note the Public Health Screening Programmes Annual Report from 1 April 2009 to 31 March 2010. Dr de Caestecker introduced Dr Emilia Crighton, Consultant in Public Health Medicine, to present information about the following screening programmes offered to residents across NHS Greater Glasgow and Clyde for the period 2009/10:-

- Cervical Screening
- Bowel Screening
- Breast Screening
- Communicable Diseases in Pregnancy
- Down’s syndrome and other congenital anomalies
- Pregnancy and Newborn Bloodspot
- Universal Newborn Hearing
- Diabetic Retinopathy Screening
- Pre-School Vision Screening

Dr Crighton explained that screening was a public health service offered to specific population groups to detect potential health conditions before symptoms appeared. Screening had the potential to save lives and improve quality of life through early diagnosis of serious conditions. In NHS Greater Glasgow and Clyde, the co-ordination of all screening programmes was the responsibility of the Public Health Screening Unit. Multi-disciplinary Steering Groups for the programmes were in place and their remit was to monitor performance, uptake and quality assurance.

In 2009/2010, Dr Crighton reported that approximately 238,212 NHS Greater Glasgow and Clyde residents were eligible for screening and that 35.7% of NHS Greater Glasgow and Clyde's population lived in the most deprived areas of Scotland as determined by the Scottish Index of Multiple Deprivation. She led the NHS Board through a summary of each of the above named screening programmes confirming that they stretched across the whole organisation and their successful delivery relied on a large number of individuals working in a co-ordinated manner.

As such, it was essential that good information management systems were in place to monitor and evaluate each component and the overall performance of every screening programme offered.

Dr de Caestecker commended the efficiency of the screening programmes and reiterated that they could prevent disease. She briefly described the accountability arrangements for the screening programmes across NHS Greater Glasgow and Clyde in terms of quality, governance and risk management.

Dr Crighton responded to a range of members questions by confirming the following:-

- In terms of evidenced reduced rates of cervical cancer following the introduction of the cervical cancer vaccination, this was subject to a large research programme currently being undertaken. The introduction of the vaccine would change the prevalence of cervical cancer and the research outcomes were awaited with interest.

- The breast screening programme met the minimum performance attendance standard of 70% in NHS Greater Glasgow and Clyde. This was consistent across NHS Scotland. Evidence suggested a downturn in death rates for women who had taken part in a screening programme. It was recognised that promotion of the programme may need refreshed to increase the uptake.

- The report highlighted continuing health inequalities and it would be important to cascade this information down into local CH(C)Ps to ensure increased efforts to target harder to reach groups. Some examples were cited and there was a general agreement that personal stories/experiences resonated more with local people. Furthermore, much work had been undertaken with the corporate communications department to assist in engaging the wider media. The NHS Board discussed various examples whereby local involvement (local leaders/champions) had had a huge influence in addressing local populations. The "Have a Heart Paisley" project was discussed and its successes recognised. Dr de Caestecker confirmed that lessons learned from that project, and others, had been rolled into other programmes to maximise their potential.

- The NHS Board would welcome data on outcomes, from the bowel screening programme, particularly where there was evidence that early detection enhanced survival rates. Dr Crighton confirmed that although this data was not available at the time of publishing the 2009/10 Annual Report, it would indeed be included in the 2010/11 version.

- In terms of the bowel cancer screening programme, Dr Crighton described the preparation and planning assumptions that had taken place to address resource and capacity issues prior to its introduction. To date, demand had been met and a bespoke information management and technology system to support the bowel screening programme was developed in-house. The data collected allowed staff to monitor service performance and track patients through the process from point of referral to diagnosis and treatment for

colorectal cancer.

The Acute Services Division and the Public Health Screening Unit had worked well together in tandem to anticipate demand and make modifications as were required.

- The Information Services Division (ISD) collated Scotland-wide data on all the screening programmes. It was paramount to identify within NHS Greater Glasgow and Clyde data and statistics so that local factors impacting on morbidity and mortality could be identified and influence future planning of local service delivery.

- There was a perception that the new General Medical Services (GMS) contract may have caused a decline in practices pursuing patients to attend cervical screening programmes. Locally, the NHS Board had written to the Scottish Government Health Directorates to pursue this matter. The declining rate was mirrored across all practices not only in NHS Greater Glasgow and Clyde. Disappointingly defaulter rates had also increased.

- NHS Greater Glasgow and Clyde had commissioned a TV and radio advertising and poster campaign to help raise public awareness and maximise the uptake of the bowel screening programme. The campaign ran from April to August 2009 and won the 2010 gold star social marketing award. It had been a huge success particularly given its low cost. In terms of future campaigns, national and regional work was ongoing to broaden the messages and enhance joined up working across NHS Boards. There could also be an opportunity to enhance work in marketing campaigns with NHS Board and Local Authorities in the future building on the successes of the recent child protection and the bowel screening campaigns.

Mr Robertson, on behalf of the NHS Board, thanked Dr Crighton for her comprehensive summary of the Annual Report.

NOTED

10. CONTINUOUS QUALITY IMPROVEMENT – LEADING BETTER CARE

A report of the Board Nurse Director [Board Paper No. 11/05] asked the NHS Board to note the measures being taken to implement "Leading Better Care" in all in-patient settings across NHS Greater Glasgow and Clyde.

Ms Crocket provided the NHS Board with an update on the implementation of Leading Better Care which was made up of three parts as follows:-

- The Senior Charge Nurse Review (SCNR)
- Releasing Time to Care (RTTC)
- Clinical Quality Indicators (CQIs)

Ms Crocket explained that Leading Better Care formed part of a continuous quality improvement programme with the objectives of improving the quality of patient care and experience.

Ms Crocket led the NHS Board through progress so far in NHS Greater Glasgow and Clyde as follows:-

- Senior Charge Nurse Review – at the launch of Leading Better Care 2008, the Cabinet Secretary for Health and Wellbeing set the target for all Senior Charge Nurses in in-patient areas in NHS Scotland to complete the Senior Charge Nurse Development Programme and move to their revised role by 2010. This target was achieved in NHS Greater Glasgow and Clyde with 495 Senior Charge Nurses completing the programme and moving to their revised role.

- Releasing Time To Care – Currently, 88 wards in the Acute Division and 16 wards in Mental Health Services were at the early stages of implementing the RTTC tools. All wards would utilise LEAN methodology as part of the continuous improvement cycle. The overall target set by NHS Greater Glasgow and Clyde was all wards to have implemented the tools and methodologies of RTTC by 2012.

- Clinical Quality Indicators – the Clinical Quality Indicators specific to falls, food, fluid and nutrition, pressure area prevention and monitoring and observation were at the early stage of implementation across all in-patient wards in the Acute Division.

The Acute Services Division and Mental Health Partnership had embedded Leading Better Care into their performance management systems. To date, measuring the impact of Leading Better Care had been very process focused which was reflective of the stage reached so far with its implementation. The challenge over the next six months was to define specific patient outcomes as a result of Leading Better Care.

In response to a question from Mr Williamson concerning the involvement of patients and/carers in this process, Ms Crocket confirmed that the work resonated from public comments and that patients and carers had been at the centre of the whole process in an effort to enhance their confidence and provide holistic care and services. By way of feedback to patients, information on individual ward performance was displayed in wards across NHS Greater Glasgow and Clyde.

Mrs Smith was encouraged by the report in terms of its quality improvement measures but highlighted that to manage outcomes they had to firstly be measured. Ms Crocket agreed and explained that the clinical quality indicators provided a process for identifying trajectories. Once these were set, outcomes could better be measured.

Mr Cleland highlighted the difference between "care" and "attention" and sought further clarity, in future update reports, on how Leading Better Care directly impacted on patient care. Ms Crocket agreed and re-emphasised that the role of the Senior Charge Nurse was key to taking this forward as well as establishing a positive culture within ward environments. She recognised that it was paramount to equip staff and teams to deliver the NHS Board's expectations of care, dignity and respect.

NOTED

11. INTEGRATION OF ACUTE IN-PATIENT SERVICES FOR NORTH EAST GLASGOW

A report of the Chief Operating Officer, Acute Services Division [Board Paper No. 11/06] asked the NHS Board to note an update on the modernisation programme of Acute Services as it related to the Integration of Acute In-Patient Services for North East Glasgow.

Mrs Grant described the significant progress made in implementing the modernisation programme of Acute Services since the NHS Board approved the Acute Services Review in June 2002. Following some initial service moves (and in light of ongoing service pressures linked to the changes both in the numbers of junior doctors and in their patterns of work), it was agreed to accelerate the implementation of the Acute Services Review for North and East Glasgow, with the aim of rationalising the remaining in-patient beds from Stobhill Hospital on to the Glasgow Royal Infirmary site in March 2011. Mrs Grant highlighted that in order to create sufficient capacity for services to support the Integrated Clinical Service model at Glasgow Royal Infirmary, a number of other speciality moves had taken place in the intervening period within Urology, Vascular and Renal Services. She described developments at Glasgow Royal Infirmary and outlined how engagement had been undertaken with staff and the local community as well as other stakeholders. In terms of the impact on Stobhill Hospital, in order to minimise service disruption during the move, services would transfer over the period of one week with the final moves being Casualty closing on the evening of 18 March 2011 and the remaining services transferring that weekend.

Mrs Smith commended this conclusion to a long process but asked if it was feasible to conduct all the moves in one week. Mrs Grant detailed the day-to-day plan that had been organised for the move and confirmed that whilst it was a challenge it was considered achievable. Contingency plans had been drafted to minimise risk.

DECIDED

That the Board note:-

- Acute Medical and Surgical Receiving, critical care and in-patient elective surgery for North and East Glasgow would be provided from Glasgow Royal Infirmary by 20 March 2011. — **Chief Operating Officer Acute Services Division**
- That Stobhill Casualty would close on 18 March 2011 although the Minor Injuries Unit would remain open between 9:00 am to 9:00 pm each day. — **" "**
- The extension to the new Stobhill Hospital would be open and fully operational by 26 March 2011.

12. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer (Acute Services Division) [Board Paper No. 11/07] asked the NHS Board to note progress against the national targets as at the end of December 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.

She explained that the Acute Services Division had achieved, for the first time, the interim target of no out-patients waiting over ten weeks by the end of December 2010, although the winter weather had brought some challenges in maintaining this position.

In terms of in-patient/daycase waiting times, work was ongoing to meet the next target of no patients waiting over eight weeks by the end of March 2011. As at December 2010, the number of patients waiting over eight weeks was 156.

Given this, the delivery of the eight week position would require considerable further effort in a number of specialities, most notably orthopaedics, but every effort was being made to ensure robust plans were in place to deliver this.

In relation to the Accident and Emergency four hour wait target, December 2010 was an exceptionally busy month Scotland-wide with prolonged severe weather conditions from the end of November 2010 impacting on services considerably. This was followed in late December 2010 by a sustained period of service demand significantly greater than seasonal norms and predicted levels. Performance against the four hour waiting standard fell from 96% compliance in October 2010 to 94% in November and December 2010. In response to this pressure, winter plan actions were escalated and the Scottish Government introduced daily severe weather winter reporting to brief the Cabinet Secretary. These operated throughout December 2010 and January 2011.

Dr Benton enquired about the 89% compliance at the Western Infirmary in respect of the four hour wait at Accident and Emergency. Mrs Grant agreed this was disappointing and explained that the Acute Services Division was looking at pathways by which patients were moved through the assessment unit to in-patient beds. Some transfer issues had been identified and measures were being taken to remedy this across the Western Infirmary/Gartnavel General Hospital. Some redesign changes would also be made and these efforts would continue via a Senior Officer Group that met regularly to discuss such matters.

In response to a question from Mr Williamson, Mrs Grant illustrated overall performance for breast, colorectal and cervical cancer types particularly where these related to screening and non screening cases. Although, so far, the Quarter four statistics had not yet been validated by ISD, a meeting between the Director of Regional Services and General Managers responsible for cancer investigative and treatment services had been scheduled to review breach analysis and assess if there were further pathway measures which could be implemented to improve overall performance.

Mr Daniels asked about associated costs from meeting one target to then working to achieve another, for example, the in-patient/daycase waiting times changing from nine weeks to eight weeks. Mr Calderwood confirmed that a level of funding was available for waiting times which would be revised in 2011/12 to ensure maximum benefit for the funds available and that it was Government policy to deliver these targets. In addition, cost savings were identified from improving the patient pathway and/or in redesign proposals.

NOTED

13 FINANCIAL MONITORING REPORT FOR THE 9 MONTH PERIOD TO 31 DECEMBER 2010

A report of the Director of Finance [Board Paper No. 11/08] asked the NHS Board to note the Board's financial performance for the first nine months of the financial year and its details of expenditure to date against the Board's 2010/11 capital allocation.

Mr Griffin explained that the NHS Board was currently reporting an expenditure outturn of £4.3M in excess of its budget for the first nine months of the year. At this stage, however, the NHS Board considered that a year end breakeven position remained achievable.

Mr Griffin described a number of further cost pressures which would impact on the outturn in the final quarter of the year and referred, in particular, to the costs associated with the December 2010/January 2011 winter period.

In relation to cost savings, Mr Griffin reported that, as at 31 December 2010, the NHS Board had reported achievement of cost savings of £36.5M against a year to date target of £36.5M. At this stage, the NHS Board was forecasting full achievement of its 2010/11 cost savings plan. This would continue to be monitored closely as delivery of its savings target was crucial to achievement of the NHS Board's revenue plan for the year.

With regard to capital expenditure, this was in line with plan and reflected the timing of expenditure across a wide range of programmes. The level of slippage required to be generated in year increased to £16.5M at 30 November 2010 following a review by the Scottish Government Health Directorates of forecast expenditure, against funding allocation across NHS Scotland. This had led to the NHS Board's capital resource limit being adjusted to reflect forecast spend on a range of specific capital funding allocations in 2010/11.

Expenditure plans for all remaining schemes had been reviewed and by 31 January 2011, almost all of the slippage target had been identified. It was, therefore, still considered reasonable to assume that the NHS Board would meet its capital resource limit for the year. Mr Griffin cautioned, however, that the movement of capital expenditure in 2011/12 would present the NHS Board with a significant challenge into preparing a capital plan which was affordable within the context of its 2011/12 capital resource limit, in light of further reductions in likely 2011/12 capital funding levels.

Councillor Handibode asked about the additional costs in relation to the incidents of clinical and medical negligence. Mr Griffin explained that, in general terms, there had been an increase in claims across NHS Scotland and, therefore, associated costs had incurred. Mr Griffin briefly summarised the risk sharing scheme (CNORIS) across NHS Scotland that existed for clinical and medical negligence claims but as overall payments increased, the NHS Board's contribution to the scheme also increased.

Mr Williamson referred to the year end forecast cost savings target of £56.9M. He took the opportunity to comment positively on the NHS Board's efforts to deliver on this huge challenge which had been made from a combination of local initiatives applied to all service areas and a number of area wide strategic reviews.

NOTED

14. 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. 11/09] 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 two 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**

15. AREA CLINICAL FORUM MINUTES: 2 DECEMBER 2010

The Minutes of the Area Clinical Forum meeting held on 2 December 2010 [ACF(M)10/06] were noted.

NOTED

16. STAFF GOVERNANCE COMMITTEE MINUTES: 21 DECEMBER 2010

The Minutes of the Staff Governance Committee meeting held on 21 December 2010 [SGC(M)10/04] were noted.

NOTED

17. PHARMACY PRACTICES COMMITTEE MINUTES: 6 JANUARY 2011 AND 20 JANUARY 2011

The Minutes of the Pharmacy Practices Committee meetings held on 6 January 2011 [PPC(M)11/01] and 20 January 2011 [PPC(M)11/02] were noted.

NOTED

18. PERFORMANCE REVIEW GROUP MINUTES: 18 JANUARY 2011

The Minutes of the Performance Review Group meeting held on 18 January 2011 [PRG(M)11/01] were noted.

NOTED

19. ANY OTHER BUSINESS

Mr Robertson advised that this would be the last NHS Board meeting for four members, namely, Mr R Cleland, Mr P Hamilton, Mrs R K Nijjar and Councillor D MacKay.

He firstly recorded his appreciation for their contribution to the work of the NHS Board throughout their terms of office.

He paid tribute to the work of Mr Cleland and his significant role in the Staff Governance Committee and Clinical Governance Committee. He had also had a Non Executive Lead role in the reorganisation of cardiovascular services and had made a significant contribution to the work of the Organ Donation Committee and Performance Review Group.

His input to general NHS Board discussions and decisions had been hugely helpful and welcomed. Mr Cleland, in turn, thanked the NHS Board for the wealth of experience it had given him since 1992. He had the highest regard for all staff in terms of their expertise and commitment. He looked forward to his new role as Chair of Audit Scotland.

Mr P Hamilton's role went back beyond the work of the NHS Board as he had originally been a member and the Chair of Greater Glasgow Health Council. Since joining the NHS Board he had been Chair of the Involving People Committee and played an active role in "Our Health" events, the review of maternity services and the public consultation on the Vision for the Vale of Leven Hospital. His deliberations at the NHS Board and Performance Review Group meetings had been invaluable as had his contribution as Vice Chair of East Renfrewshire CHCP and East Glasgow CHCP.

Mrs Nijjar had been active in progressing the Spiritual Care agenda and had taken on the role of Chair of the Spiritual Care Committee. She had brought a wealth of knowledge on the faith perspective to NHS Board discussions.

Councillor MacKay was shortly to stand down as an NHS Board Member as he was planning to submit papers to the Scottish Government to be a candidate in the forthcoming Scottish Parliamentary election. During his four year membership of the NHS Board he had actively participated in discussions and debates both at the NHS Board and Performance Review Group meetings. His active role as Chair of Renfrewshire CHP had been appreciated both by staff and the local community.

Councillor MacKay recorded his appreciation to NHS Board and CHP colleagues. He had thoroughly enjoyed the work and broad knowledge and experience it had afforded him. He hoped that this would stand him in good stead to take forward the health agenda in a new role.

NOTED

The meeting ended at 12:00 p.m.