

NHSGG&C(M)12/01
Minutes: 1 – 21

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, 21 February 2012 at 9.30 am**

P R E S E N T

Mr A O Robertson OBE (in the Chair)

Dr C Benton MBE	Councillor B Lawson
Ms M Brown	Mr I Lee
Mr R Calderwood	Councillor R McColl
Councillor J Coleman	Councillor J McIlwee
Ms R Crocket	Mrs J Murray
Mr P Daniels OBE	Dr R Reid
Dr L de Caestecker	Rev Dr N Shanks
Ms R Dhir MBE	Mr D Sime
Prof A Dominiczak	Mrs P Spencer
Mr I Fraser	Mr B Williamson
Mr P James	Mr K Winter
Dr M Kapasi MBE	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. 8)
Mr G Archibald	..	Director, Emergency Care & Medical Services (for Minute No. 12)
Dr J Dickson	..	Associate Medical Director (Acute Services Division) (for Minute Nos. 6 and 7)
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, 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

ACTION BY

1. APOLOGIES

Apologies for absence were intimated on behalf of Mr G Carson, Councillor J Handibode and Councillor A Stewart.

2. DECLARATION(S) OF INTEREST(S)

No declaration(s) of interest(s) were raised in relation to any of the Agenda Items to be discussed.

NOTED

3. CHAIR'S REPORT

- (i) Mr Robertson was a member of the interview panel held on 20 December 2011 to interview candidates for the post of Medical Director with the NHS Board. He confirmed that Dr Jennifer Armstrong had been appointed. Dr Armstrong had a Public Health background, having trained in Glasgow and the former Argyll and Clyde Board and beginning her career as a Consultant with Argyll and Clyde and then with the National Services Division. She was joining the NHS Board from the Scottish Government where she had been working on a number of national initiatives. She would take up post on 1 April 2012.
- (ii) On 10 January 2012, Mr Robertson attended the first meeting of the national Scottish Government Endowments Review Group. This Group was chaired by the Director of Finance, Mr P James, and would have three phases. Phase One would include reviewing transactions and fund types to ensure that they met the relevant charitable endowments test. During Phase Two, the Group would define and give guidance on best practice and governance by mid-year 2012/13. During Phase Three, the review would be completed. This national project affected NHS Greater Glasgow and Clyde significantly as it had the largest number of endowment funds in Scotland and because it may need to adopt different arrangements for some of the funds in the future. As well as ensuring that its endowment transactions were all appropriate, it should, also ensure that any plans for the future use of endowment funds were well constructed and appropriate. Mr Robertson had also attended a meeting of the NHS Greater Glasgow and Clyde Endowments Committee on 3 February 2012 where this had been discussed in detail.
- (iii) On 17 January 2012, Mr Robertson attended an awards ceremony at Glasgow City Chambers to celebrate the unique achievement of NHS Greater Glasgow and Clyde becoming the first Health Board in the UK to be awarded 100% accreditation from UNICEF for the support offered to breastfeeding mums across all of its acute and community services. The Cabinet Secretary for Health, Wellbeing and Cities Strategy, Nicola Sturgeon, honoured health staff at this event for their dedication, professionalism and valuable work with new mothers.
- (iv) On 24 and 25 January 2012, Mr Robertson had met with Mr A Morgan from the National Institute for Clinical Excellence (NICE) to discuss an asset based approach for Public Health. Many Public Health issues had a behavioural element and this approach played in with work ongoing with the Community Engagement Team and the Glasgow Centre for Population Health.
- (v) On 8, 9 and 10 February 2012, NHS Greater Glasgow and Clyde hosted a conference on supporting positive parenting. This brought together experts from across the world to share their experience and knowledge of positive parenting. The three day conference focussed on how effective positive parenting could be and what could be done to offer parents support in all aspects of parenting, particularly during the early years of a child's life. It also highlighted negative aspects that could affect a child's life. The conference offered the opportunity for experts from other country's to share with Glasgow experts their experiences of dealing with these issues.

NOTED

4. MINUTES

On the motion of Dr M Kapasi, seconded by Mr D Sime, the Minutes of the NHS Board meeting held on Tuesday 20 December 2011 [NHSGG&C(M)11/06] were approved as an accurate record and signed by the Chair.

NOTED

5. MATTERS ARISING FROM THE MINUTES

- (i) The rolling action list of matters arising was circulated and noted.
- (ii) In respect of progress on negotiations with St Margaret's Hospice (and the role it played in the future of continuing care in West Glasgow), Ms Renfrew confirmed that a proposal had been submitted to the Hospice as a single contract for continuing care and hospice beds and the NHS Board was awaiting to hear back.

NOTED

6. SCOTTISH PATIENT SAFETY PROGRAMME UPDATE

A report of the NHS Board's Head of Clinical Governance [Board Paper No. 12/01] 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 Dickson reminded the NHS Board that the overall NHS Greater Glasgow and Clyde aim was to ensure the care provided to every patient was safe and reliable and local implementation of SPSP would contribute to this aim. The NHS Board's SPSP aim was to achieve full implementation of the core programme in NHS Greater Glasgow and Clyde's Acute Services Division by the end of 2012; achieve implementation of the national medium term goals for paediatrics by March 2012 and also fully describe SPSP-style improvement programmes in Primary Care, Mental Health Services and Obstetrics during 2012.

Dr Dickson led the NHS Board through the key progress points as follows:-

- Improved Data Management – the need to efficiently gather data on clinical process improvements within (and across) clinical teams had been a persistent challenge for the programme. Ongoing work had been developed to capture quality measures from the Leading Better Care Clinical Quality Indicators, Better Together Programme and Scottish Patient Safety Programme. This new portal would replace the current Excel spreadsheet process used by teams for the input and storage of SPSP measurement data. The rapid roll out was now well underway and had been implemented in six acute hospital sites, with the two remaining locations due to commence later in February 2012. This meant the NHS Board was on track to have all bed holding areas trained to use the system by 1 March 2012. In the short-term, it was predicted that the implementation of this system may cause some variation in the rates of data submission from the programmes clinical teams.

This should be a temporary shortfall, however, more than compensated by the data management benefits.

- Two New Programme Themes – at the end of January 2012, the SPSP National Team hosted an event to launch two new programme components – Venous Thromboembolism (VTE) and Sepsis improvement collaboratives. Given the very recent introduction, the Acute Services Division was still to fully resolve detail on leadership, scope, support and co-ordination. A number of local clinical leads, working with SPSP support, had already begun to test and develop ideas aiming to improve reliability of the linked clinical processes.

In response to a question from Dr Benton regarding the new Sepsis model, Dr Dickson explained that Sepsis could affect a person of any age and was a serious condition. It occurred when the body's normal reaction to inflammation or a bacterial infection went into overdrive. Given this, it was paramount to identify the right anti-biotic treatment for the right organism as early as possible. Given that no delay in commencing the anti-biotic treatment could be tolerated in a patient, work was going on to identify how the treatment could be fast tracked so that a treatment plan could be instigated as quickly as possible.

NOTED

7. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the Infection Control Manager [Board Paper No. 12/02] asked the NHS Board to note the latest in the regular bi-monthly reports on Healthcare Associated Infection (HAI) in NHS Greater Glasgow and Clyde.

Dr Dickson 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 revised as specified by the Scottish Government Health Directorates.

Dr Dickson highlighted key Healthcare Associated Infection headlines for February 2012 as follows:-

- In 2007, the Scottish Government Health Directorates issued HEAT targets in relation to the reduction in Staphylococcus Aureus Bacteraemias (SABs) against which NHS Greater Glasgow and Clyde successfully reduced SABs by 35% by April 2010. This target was extended to achieve an additional 15% reduction which was also successfully achieved by 31 March 2011. The revised national HEAT target required all Boards in Scotland to achieve a rate of 0.26 cases per 1000 Acute Occupied Bed Days (AOBDs), or lower, by 31 March 2013. For the last available reporting quarter (July - September 2011), NHS Greater Glasgow and Clyde reported 0.271 cases per 1000 AOBDs with NHS Scotland reporting an average of 0.304 per 1000 AOBDs. The revised target would be a challenging one as analysis of these infections had highlighted that a significant number originated in the community.
- The national report published in January 2012 (July – September 2011), showed the rate of C.difficile infection within NHS Greater Glasgow and Clyde as 0.24 per 1000 occupied bed days in over 65s. This clearly placed the NHS Board below the national mean of 0.32 per 1000 occupied bed days

in over 65s and also below the revised target, in patients aged 65 and over, to be attained by 31 March 2013 of 0.39 cases per 1000 occupied bed days.

- The Surgical Site Infection (SSI) rates for all procedure categories, apart from hip arthroplasty and reduction of long bone fracture, remained below the national average.
- 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 2573 members of staff who were now registered Cleanliness Champions.

NOTED

8. REPORT OF THE DIRECTOR OF PUBLIC HEALTH: BLOOD-BORNE VIRUSES IN NHS GREATER GLASGOW AND CLYDE

A report of the Director of Public Health [Board Paper No. 12/03] asked the NHS Board to receive and note the detail around Blood Borne Virus Infections in NHS Greater Glasgow and Clyde, prevention interventions to limit the transmission of these viruses and the treatment and care services available within the NHS Board’s area.

Dr Ahmed explained that Blood Borne Viruses (BBVs) were those viruses that were transmitted from the blood of one person to the blood of another person. Some of these viruses could also be transmitted through other means including sexual intercourse and from mother to child during birth. Of particular concern in Scotland (and NHS Greater Glasgow and Clyde) were Human Immunodeficiency Virus (HIV) Hepatitis C (HCV) and Hepatitis B (HBV).

In recognition of the serious public health challenges posed by these BBVs in Scotland, in August 2011, the Scottish Government published the Sexual Health and Blood Borne Viruses Framework 2011/2015. This set out the Government’s agenda in relation to sexual health and BBVs for the next four years bringing together the four policy areas of HIV, HCV, HBV and sexual health for the first time in an overarching policy document. It recognised the links and commonalities between the work strands and aimed to focus delivery on realising five outcomes that were embedded in the Quality Strategy and the inequalities agenda. In outlining these Dr Ahmed explained that, in progressing these outcomes, there was also an opportunity to link with other relevant policy areas including drugs and alcohol, Early Years, Curriculum for Excellence, Long Term Conditions and Equally Well. Dr Ahmed explained that, in NHS Greater Glasgow and Clyde, the planning structure for sexual health and blood borne viruses was revised in 2011 to reflect and align with the national framework so that effective communication was in place and constructive relationships were developed and maintained.

Dr Ahmed led the NHS Board through further information in relation to HIV, HCV and HBV as follows:-

- HIV- although treatment advances had transformed the HIV infection from a fatal disease into a long term chronic condition, it remained one of the most important and serious communicable diseases in the UK because of its potential for serious long term morbidity, premature loss of life, high treatment and care costs and psychosocial impact. Cumulatively to 30 September 2011, a total of 1974 NHS Greater Glasgow and Clyde residents

had been diagnosed with the HIV infection. Of those, 854 were men who had sex with men (MSM), 819 heterosexual and 209 Injecting Drug Users (IDUs).

The remaining 92 acquired the HIV infection from other/undetermined exposures. All adults diagnosed with HIV and living in NHS Greater Glasgow and Clyde attended for treatment and care at the Brownlee Centre for Infectious Diseases located on the main Gartnavel campus. Children infected with HIV attended the paediatric infectious diseases service at Yorkhill Hospital.

Prevention strategies adopted in NHS Greater Glasgow and Clyde were aimed at preventing HIV acquisition by using a range of biomedical and behavioural approaches, early detection of those already infected by encouraging more testing among clinicians and managing established HIV infections to prevent serious complications and minimise the risk of onward transmission.

- HCV – Hepatitis C infection was caused by the Hepatitis C virus that was transmitted through blood to blood contacts and primarily infected and affected the liver. Following infection, around 20% of cases were naturally resolved within the first six months and the remainder developed chronic life long infection. At the end of 2011, almost 13000 people were known to be living and infected with HCV in NHS Greater Glasgow and Clyde. Health Protection Scotland recently estimated that more than half of all HCV cases in Scotland remained undiagnosed, suggesting that the local number of infected individuals in NHS Greater Glasgow and Clyde exceeded 26,000.

Within NHS Greater Glasgow and Clyde, clinical management of HCV cases was provided from the department of gastroenterology and the department of infectious diseases at Gartnavel General Hospital and the departments of gastroenterology at Glasgow Royal Infirmary, Southern General Hospital, Victoria Infirmary, Royal Alexandra Hospital and Inverclyde Royal Hospital. Various service developments enabled Acute Services to significantly increase the number of patients initiated onto anti-viral treatment and by 2010, the number of patients starting each HCV treatment had increased annually by 178% compared to the 2006 baseline exceeding the targets set in the HCV Action Plan by the Scottish Government.

Dr Ahmed highlighted another key priority of the HCV Action Plan was to reduce the incidence of new infections through increased provision of sterile injecting equipment to IDUs. In 2006, 32 community pharmacies and 6 drug services provided sterile injecting equipment to local injectors. Glasgow Addiction Services recruited 30 additional community pharmacies to this Scheme, predominantly in areas with a high number of injectors but historically low levels of provision.

- HBV – Hepatitis B was an infection of the liver caused by the Hepatitis B virus. If infection was acquired peri-natally, over 90% became chronic. HBV was uncommon in NHS Greater Glasgow and Clyde and approximately 80 new diagnosis of HBV were made annually in NHS Greater Glasgow and Clyde during 2009 and 2010. A vaccine against Hepatitis B had been available since 1982. Groups targeted for the vaccination in NHS Greater Glasgow and Clyde included babies born to infected mothers, current and former injecting drug users, close family contacts of those with chronic infection and NHS staff and others who were at occupational risk. Anti-viral drugs were available for the treatment of

HBV infection but the therapy simply suppressed the viral load rather than cured the infection.

- The number of patients currently on treatment were relatively small (approximately 20 patients) but this number was expected to increase significantly over the next few years in keeping with the aspirations of the National Framework.

In response to a series of questions from Dr Kapasi, Dr Ahmed firstly thanked him for his commendation of such valuable and effective information. Dr Ahmed agreed that this was an excellent example of joint work between community services and the Acute Services Division and acknowledged the contribution of all involved. In terms of screening, all pregnant women were screened for HIV and HBV. Screening for HCV was not routinely undertaken but rather a recommendation to clinical colleagues to screen for this based on associated patient risk factors. Regarding the cost of treatment and how this differed between developed and non-developed countries, it was Dr Ahmed's understanding that pharmaceutical companies tried to recoup their investment from developed countries and constructed their costs accordingly.

Rev Dr Shanks referred to the high cost of HIV treatment and wondered what work was being undertaken on education. Dr Ahmed alluded to ongoing research on how best to inform client groups about infection control and risk reduction. Current work included peer education, social marketing and community development and Dr Ahmed agreed that pursuit of value for money was a key priority for all health systems and the HIV prevention programme in NHS Greater Glasgow and Clyde was no exception. Although assessing values of investment in prevention was intrinsically challenging because success was defined by an absence of events, high quality evidence was beginning to accumulate in several areas.

Mr Williamson thought it would be useful to have comparative data regarding the NHS Board's performance against other areas in the UK and Europe to measure performance. Dr Ahmed confirmed that this could be done and that, in Scotland, Lothian NHS Board was probably the most comparable as bigger cities tended to have the largest problems in these areas. He agreed to consider this for future reports.

**Director of
Public Health**

In response to a question from Dr Benton regarding the provision of a needle exchange service through community pharmacies, Dr Ahmed confirmed that the Glasgow Addictions Service assessed demand for this service and looked at ease of access to ensure demand was met. There was no cap on how many pharmacies could provide this service or on how many clients each could see.

Mr Robertson thanked Dr Ahmed for the insightful presentation and suggested that a further update be considered by the NHS Board in one year.

**Director of
Public Health**

NOTED

9. PUBLIC HEALTH SCREENING PROGRAMMES ANNUAL REPORT 1 APRIL 2010 TO 31 MARCH 2011

A report of the Director of Public Health [Board Paper No. 12/04] asked the NHS Board to note the Public Health Screening Programmes Annual Report from 1 April 2010 to 31 March 2011.

Dr de Caestecker presented information about the following Screening Programmes offered to residents across NHS Greater Glasgow and Clyde in the period 2010/11:-

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

Dr de Caestecker 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.

Dr de Caestecker explained that, as part of NHS Greater Glasgow and Clyde's commitment to tackle inequalities to health, the Public Health Screening Unit engaged with voluntary and statutory services to identify innovative ways to encourage uptake of screening programmes. Screening Programmes stretched across the whole organisation and the successful delivery relied on a large number of individuals working in a co-ordinated manner towards common goals in a quality assured environment. 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 to NHS Greater Glasgow and Clyde residents. All the screening programmes (with the exception of pre-school vision screening) had clinical standards set by Health Improvement Scotland which the NHS Board strived to meet. Equality Impact Assessments (EQIAs) for 8 of the screening programmes had been completed with the outstanding assessments for Pregnancy and Newborn Screening programmes to be completed in 2012. The outcome of the completed assessments identified areas of good examples but also areas for improvement.

Dr de Caestecker commended the efficiency of the screening programmes and reiterated that they could prevent disease. She responded to a range of members questions by confirming the following:-

- Councillor Yates noted that the proportion of children screened for pre-school vision screening that were referred for further investigation was lowest at 18.5%, in Renfrewshire. He wondered why this would be the case and Dr de Caestecker agreed to explain this outwith the meeting.
- 10.8% of smears were reported as abnormal in 2010/11. Dr de Caestecker explained that this was in line with the NHS Board's expectation.
- In clinical governance terms, Mrs Brown suggested that it would be useful to see more information around interval times of cancer detection. Such information would be helpful in looking at overall detection. Mr Williamson agreed that, as the purpose of screening was not just to detect but to detect at

**Director of
Public Health**

an *earlier* stage, it would be useful to measure and report on the interval/stage of the cancer detection. Dr de Caestecker acknowledged that many of the cancer networks did obtain this information at the moment and it could be included in future reports.

**Director of
Public Health**

- Dr Kapasi referred to the 23.8% of women who were excluded from the cervical screening target population under the General Medical Services (GMS) exception reporting. Dr de Caestecker explained that this included those women who had been called 3 times but had not taken up the opportunity to have cervical screening. In an attempt to reduce this rate, she agreed that it may be useful to discuss further what locally enhanced services within CH(C)P's could be provided to make a difference.
- NHS Greater Glasgow and Clyde had one of the highest uptake in the UK of the Human Papilloma Virus (HPV) vaccination which prevented infection associated with the development of cervical cancer. This was a national programme to invite girls aged 12-13 to have the vaccination. Mrs Spencer was concerned that there were conflicting messages at schools and it remained the case that even those girls who had had the HPV vaccination did require regular cervical screening. Dr de Caestecker acknowledged that as girls who were vaccinated with HPV were coming to an age when screening was offered, perhaps some further education work was needed in this regard.
- As these were national screening programmes, the nature of their evaluation was national as well. In terms of looking at aspects of value for money, Dr de Caestecker agreed to consider how this could be best presented in future reports.
- Rev Dr Shanks referred to a recent visit to the diabetic renal screening service which had been worthwhile in understanding further the services provided there. Mr Robertson echoed this view and took the opportunity to encourage all NHS Board members to undertake pre-arranged site visits to a broad range of the NHS Board's facilities.

**Director of
Public Health**

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

NOTED

10. REVIEW OF PAEDIATRIC INPATIENT SERVICES, WARD 15, ROYAL ALEXANDRA HOSPITAL

A report of the Chief Operating Officer (Acute Services Division) [Board Paper No. 12/05] asked the NHS Board to receive an update on the review of the Paediatric In-Patient Service at the Royal Alexandra Hospital (RAH) and approve the recommendation that a full review of the overall service provision be incorporated into the wider strategic review of clinical services across NHS Greater Glasgow and Clyde to ensure that all of the implications in relation to other services were considered within the wider strategic framework.

Mrs Grant reminded the NHS Board that, as part of discussions at the NHS Board meeting held in June 2011 in relation to the financial plan, the NHS Board agreed to explore, as part of the process of clinical and financial reviews, the potential to consider the relocation of the in-patient paediatric service from ward 15, RAH to the Royal Hospital for Sick Children (RHSC). Any such proposals would only be taken forward with full engagement with stakeholders prior to any launch of formal public consultation and a report back to the NHS Board for approval. At the September 2011 NHS Board meeting, it was reported that discussions were being held

(including a meeting with Renfrewshire Council) regarding paediatric services provided from Ward 15 at the RAH.

Mrs Grant explained that, in reviewing the work carried out to date, it was acknowledged that a number of issues required further consideration. It was initially thought that this proposal involved a discreet ward transfer, however, in undertaking the detailed analysis, a more complex picture of clinical interdependencies had emerged. Some of these were linked to regional and/or national/clinical service reviews such as neonatology. To take cognisance of the emerging picture, it was, therefore, proposed that the work undertaken to date be taken forward as part of the wider strategic review of Acute Services in NHS Greater Glasgow and Clyde during 2012/13 to ensure that all implications in relation to other services were fully considered within that wider strategic framework.

Mrs Grant outlined service provision currently from Ward 15 at the RAH and summarised some of the other services that the paediatric in-patient service there interfaced with. She led the NHS Board through the drivers for change and explained that a review of the current services provided for children at the RAH had been carried out. This had involved a detailed analysis of the activity flows and range of services offered to consider the impact of potential changes to the current service model. Work had been undertaken to consider the impact of this activity change in relation to the other services with whom the paediatric service interfaced. This had included discussions with key stakeholders such as the emergency department, maternity and neonatal services and the Scottish Ambulance Service. A number of these interfaces were complex and were difficult to consider in isolation from the wider strategic context.

In response to concerns from some NHS Board members that these wider issues had not been considered when this issue was first discussed in June 2011 when considering the NHS Board's Financial Plan at that time, Mr Calderwood referred to the interdependencies that had subsequently emerged during the review of current services and, as a consequence, it was now being suggested that the review of current services provided for children at the RAH be considered alongside the wider strategic clinical services review. This would allow the NHS Board to consider all the implications in relation to other services and to fully explore a fully integrated solution covering the whole range of services rather than undertaking this review as a single exercise.

In response to a question from Ms Dhir regarding how the NHS Board approached long term planning particularly to avoid creating uncertainty, Mr Calderwood reaffirmed that lessons learned from other NHS Board strategic decision making processes were often not always transferable to others. He hoped that in discussing the next agenda item "Clinical Services Fit for the Future", this would give NHS Board members some reassurance around the process and information provided when undertaking fundamental reviews to reach decisions.

DECIDED

- That the update on the review of the paediatric in-patient service at the Royal Alexandra Hospital be noted.
- That a full review of the overall service provision be incorporated into the wider strategic review of clinical services across NHS Greater Glasgow and Clyde to ensure that all of the implications in relation to other services were considered within the wider strategic framework be approved.

**Chief
Operating
Officer**

11. CLINICAL SERVICES FIT FOR THE FUTURE

A report of the Chief Executive [Board paper No. 12/06] asked the NHS Board to endorse the aims, principles and policy direction outlined to deliver the National 2020 vision and plan clinical services fit for the future.

Mr Calderwood set out the Scottish Government's vision for NHS Scotland which provided the context for taking forward implementation of the Healthcare Quality Strategy and the required actions to improve efficiency and achieve financial sustainability as well as for the development of the NHS Board's approach to planning clinical services fit for the future. He led the NHS Board through the actions outlined for NHS Scotland which drove the requirement to reshape Acute Services and explained that NHS Greater Glasgow and Clyde needed to undertake a comprehensive review of services to respond to the National 2020 vision. This would ensure that, in the face of increasing demands and changing circumstances, the NHS Board could continue to provide high quality sustainable health services to the population it served.

With this in mind, Mr Calderwood reminded the NHS Board that NHS Greater Glasgow and Clyde had two separate approved acute strategies – one for Greater Glasgow and the other for Clyde. The Clyde strategy had already been fully implemented and the Greater Glasgow strategy would be delivered during 2015. He set out the approach to deliver a Board wide services review with the objective of developing an acute strategy that would integrate services across the NHS Board area between 2015 and 2020 and redefine the 2015 pattern of services. In doing so, he set out the key aims and core principles that would underpin the new strategy and described the process to review services and the key areas of work to be progressed to determine the strategy. He explained that the review process would commence in February 2012 and run through to late 2012 with patient and public engagement throughout. Formal strategy pre-consultation should commence in late 2012 with the aim of the draft strategy being presented to the NHS Board prior to proceeding to full consultation in spring 2013. It was planned that the final strategy would be submitted to the NHS Board by September 2013.

In recognising that healthcare was delivered in an ever evolving landscape and that new challenges were presented with Scotland's aging population and the expected continuing shift in the pattern of disease towards the management of long term conditions, Mr Calderwood described some of the key challenges and opportunities presented with medical advances, better technology and improved drugs and treatments. This all affected how services required to be provided and needed to be considered when setting the strategic direction for NHS Greater Glasgow and Clyde.

Mr Calderwood described the NHS Board's approach to reviewing the organisation of clinical services to achieve the best health outcomes for patients. To determine the service strategy for 2015 to 2020 and identify the future clinical service provision, a number of workstreams had been identified. Underpinning each would be a core set of activities to consider current pathways, delivery models, workforce requirements and the relationship between primary and secondary care to ensure efficient and effective patient pathways. At the core of these workstreams, led in partnership between hospital, primary care and academic clinicians, was the engagement of patient and public interests. Mr Calderwood described how the clinical workstreams would be progressed over the period February to October 2012 and would be the key to determine the future service models. A range of activities would be undertaken and there would be engagement with patients to obtain their views in relation to the current pathways and to understand what was important to them in terms of the care provided. The clinical review work would be organised through the following workstreams:-

- Child and Maternal Health
- Emergency and Trauma Care
- Planned Care
- Cancer Services
- Chronic Disease Management
- Older People's Services
- Specialist Tertiary Services

The work programme would be overseen by a Clinical Strategy Review Steering Group (CSRSG) leading the development and delivery of the strategic review, including relevant risk analysis and supported by a team drawn from Public Health, Corporate Planning and Policy and Health Information and Technology led by the current Head of Acute Planning seconded in to act as lead for this clinical services review. The CSRSG would report to the NHS Board and would be chaired by Mr Calderwood. It would govern and direct the programme of work to ensure that the key aims and core principles underpinning the strategy were adhered to, target deadlines met and that the strategy was within the organisation's financial framework. This Group would also be responsible for performance monitoring the programme of work including reviewing and monitoring risks and would ensure that risk action plans were established in order to manage and mitigate risks. Regular briefings would be submitted to the Scottish Government Health Directorate.

Mr Sime welcomed this paper and its overall direction of travel. He considered the overall vision for NHS Scotland as set by the Cabinet Secretary for Health, Wellbeing and Cities Strategy to be aspirational but thought that the proposals laid out a good path to deliver and achieve this. Engagement with staff and stakeholders would be paramount and he acknowledged the fundamental importance of the first key workstream which would be to consider the health needs of the population which would underpin the whole programme in assessing and understanding population health. Councillor McColl agreed and was impressed by the measured way to proceed. He expressed concern at information received during the NHS Board meeting regarding a discussion document setting out issues to be agreed as part of the service and financial plan for 2012/13. In particular, the mention of a review of the Inverclyde Community Midwifery Unit (CMU). Ms Renfrew reported that the paper referred to had been circulated as a discussion paper on the financial year 2012/13 and had followed the discussion at the NHS Board Away Session in early December 2011. The Board had agreed in 2008 that the CMU would be reviewed after 3 years following the efforts to promote the benefits of the CMU to expectant mothers. This review was now due and formed part of the options for the Financial Plan 2012/13 and not the clinical services review which was looking at a strategic review of services from 2015 to 2020. Further discussion of this issue was scheduled to take place at the April 2012 Board Seminar to enable the Board to take a decision on next steps.

Rev Dr Shanks commended the proposals in the paper but cautioned on the timetable – was it realistic? Mr Calderwood agreed that the timetable was challenging but was hopeful that, as the work being undertaken by the various workstreams evolved, pace would be gathered.

Professor Dominiczak welcomed the ambitious nature of this paper and, in response to her question, Mr Calderwood confirmed that the proposed membership of the CSRSG included membership from the University of Glasgow.

Mr Williamson suggested that, as the work of the workstreams progressed and development of the strategic plan started to take shape, it would be important to include evidence based information for ease of understanding of the various arguments that may be made. Mr Calderwood thanked Mr Williamson for this suggestion and confirmed that this would be included in future draftings.

Chief Executive

Mrs Brown suggested that the areas of integration needed to be more robust and wondered where mental health sat in the reviews. Mr Calderwood reported that future redrafted versions would include both issues.

Chief Executive

DECIDED

That the aims, principles and policy direction outlined to deliver the National 2020 vision and plan clinical services for the future be endorsed.

12. WINTER PLAN – 2011/12 PROGRESS REPORT

A report of the Director of Emergency Care and Medical Services [Board Paper No. 12/07] asked the NHS Board to note the performance of NHS Greater Glasgow and Clyde's Winter Plan in 2011/12 and early plans for 2012/13.

Mr Archibald reported that December 2011 and January 2012 had proved to be exceptionally busy and challenging months across Scotland and, in particular, for Acute Services within NHS Greater Glasgow and Clyde. A sustained period of service demand significantly greater than seasonal norms and predicted levels had impacted considerably on services. He described work that had been progressed with main partners, including, primary care, NHS 24, Out-of-Hours GP Service, Scottish Ambulance Service, Strathclyde Police and Glasgow City Council. He described some of the key issues identified within the Acute Services Division where two major actions for managing emergency care during the winter period had been implemented. Daily reporting had been provided and the provision of this information had been beneficial with further work being undertaken to consider how better use could be made of information to predicatively plan services. In line with the Scottish Government's requirements, a weekly winter pressure report was sent to the Scottish Government Health Directorate. In addition, the NHS Board's communications department contacted the Scottish Government Health Directorate as necessary, to inform them of any exceptional circumstances.

Mr Archibald emphasised that the winter period was not yet over and further work was ongoing to ensure that all services were well placed to cope with any further peaks in demand. Working together, across the system, in the pre-winter period, proved beneficial in ensuring good communication between partners and co-ordination of services to respond. Similar pressure had been acknowledged by other NHS Board areas. 2012/13 would be the first year in four years where there was not a four day holiday period and winter planning would need to ensure that all services were fully operational up to and including Monday 24 December 2012 and Monday 31 December 2012.

NOTED

13. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer (Acute Services Division) [Board Paper No. 12/08] asked the NHS Board to note progress against the national targets as at the end of December 2011.

Mrs Grant led the NHS Board through the report highlighting the actions being taken to deliver the waiting times and access targets. The Scottish Government target for waiting times for out-patient appointments, in-patients/day cases treatment and diagnostic tests was that, by December 2011, the total maximum journey time would be 18 weeks from referral to treatment (RTT), referred to as the 18 weeks RTT target.

The national target required the NHS Board to deliver 90% performance for combined admitted/non admitted performance by 31 December 2011. The clock started for a RTT period on the date of receipt of a referral to a consultant led service.

Mrs Grant explained that there were two main components which were routinely assessed in relation to the 18 week RTT standard as follows:-

- Combined admitted/non admitted performance – this measure outlined the NHS Board’s performance against the agreed trajectory for both the admitted and non admitted pathways. The NHS Board was currently achieving 90.2% performance against an agreed trajectory of 90%.
- Linked pathways – this was a measure of the percentage of patients where the total pathway was being linked at present. The NHS Board achieved 85.1% against an agreed trajectory of 80%.

In relation to the stage of treatment position, all specialties continued to meet the NHS Greater Glasgow and Clyde target of 10 weeks for available new out-patients and eight weeks for available in-patients and day cases, with the exception of Orthopaedics. Orthopaedics remained within the waiting time of 12 weeks for both available out-patients and in-patient/day cases. Mrs Grant led the NHS Board through the remaining waiting times including accident and emergency, cancer, chest pain, stroke and delayed discharges.

In response to a question from Dr Benton concerning Accident and Emergency performance at the Western Infirmary and Royal Alexandra Hospitals, Mrs Grant explained that over the three month period to December 2011, both hospitals had been under the greatest pressure in performance terms. The Acute Services Division had, however, prioritised two major actions for managing emergency care particularly during the winter period and she was hopeful that this would meet the demands of the winter months as well as deliver focussed actions to ensure real and sustained performance improvement.

NOTED

14. FINANCIAL MONITORING REPORT FOR THE 9 MONTH PERIOD TO 31 DECEMBER 2011

A report of the Director of Finance [Board Paper No. 12/09] asked the NHS Board to note the financial performance for the first nine months of the financial year.

Mr James explained that the NHS Board was currently reporting an expenditure outturn of £1.1m in excess of its budget for the first nine months of the year. At this stage, the NHS Board considered that a year end breakeven position remained achievable.

By way of a further update, Mr James confirmed that the period 10 (to 31 January 2012) results had just been signed off and submitted to the Scottish Government Health Directorates showing a £0.6m overspend; this represented a good improvement between periods 9 and 10.

Mr Winter congratulated Mr James and his team for their efforts in reducing the overall overspend. He sought clarification around the overspend at Inverclyde CHCP and Mr James confirmed that the CHCP’s prescribing expenditure was higher than expected. Work was ongoing with GP practices in the area to address this. Furthermore, Mr James alluded to national developments on prescribing expenditure which were being evaluated to establish the impact on the year end outturn.

This may have a positive impact on the NHS Board's reporting but final confirmation was awaited.

NOTED

15. DISSOLUTION OF THE VALE OF LEVEN MONITORING GROUP

A report of the Chief Executive [Board Paper No. 12/10] asked the NHS Board to note that the Cabinet Secretary for Health, Wellbeing and Cities Strategy had approved the Vale of Leven Monitoring Group's request for formal dissolution of the Group having fulfilled its remit as established in 2009.

Mr Calderwood reminded the NHS Board that the Cabinet Secretary had requested the establishment of the Vale of Leven Monitoring Group as part of the arrangements to support the vision for the Vale of Leven Hospital. The Vale of Leven Monitoring Group met for the first time on 23 November 2009 and met regularly up to its last meeting on 30 January 2012. At that time, the Group agreed that it was time to seek the Cabinet Secretary's approval for the formal dissolution of the Group as it was believed that members had fulfilled the remit established by the Cabinet Secretary in 2009.

NOTED

16. 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. 12/11] 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 one Medical Practitioner listed in the NHS Board paper for the purposes of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003 be approved.

**Director of
Public Health**

17. AUDIT COMMITTEE MINUTES: 25 OCTOBER 2011

The Minutes of the Audit Committee meeting held on 25 October 2011 [A(M) 11/06] were noted.

NOTED

18. AREA CLINICAL FORUM MINUTES: : 1 DECEMBER 2011

The Minutes of the Area Clinical Forum meeting held on 1 December 2011 [ACF(M)11/06] were noted.

NOTED

19. PHARMACY PRACTICES COMMITTEE MINUTES: 24 JANUARY 2012

The Minutes of the Pharmacy Practices Committee meeting held on 24 January 2012 [PPC(M)12/01] were noted.

NOTED

20. QUALITY AND PERFORMANCE COMMITTEE MINUTES: 15 NOVEMBER 2011 AND 17 JANUARY 2012

The Minutes of the Quality and Performance Committee meetings held on 15 November 2011 [QPC(M) 11/03] and 17 January 2012 [QPC(M) 12/01] were noted.

NOTED

21. ANY OTHER BUSINESS

Mr Robertson noted that this would be the last NHS Board meeting for Mrs J Murray and Ms R Dhir. Both had served a period of eight years on the NHS Board and had been involved in many of the decisions taken to improve both community and acute services throughout NHS Greater Glasgow and Clyde. He thanked them for their commitment and input to the work of the NHS Board and wished them well in the future.

Mrs Murray and Ms Dhir expressed their appreciation and gratitude for Mr Robertson's kind words.

NOTED

The meeting ended at 12:20 p.m.