NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the Performance Review Group held at 9.30 am on Tuesday, 18 May 2010 in the Board Room, Dalian House, 350 St Vincent Street, Glasgow, G3 8YZ

P R E S E N T

Mr A O Robertson OBE (in the Chair)

Mr R Cleland
Mr P Daniels OBE
Ms R Dhir MBE
Mr P Hamilton
Mr I Lee (to Minute 39)
Mr D Sime
Mrs E Smith
Mr K Winter
Cllr. D Yates

OTHER BOARD MEMBERS IN ATTENDANCE

Mr C Bell
Mr R Calderwood
Mr D Griffin
Cllr. J McIlwee

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

Ms I Colvin	..	Director, South West Glasgow CHCP (for Minute 37)
Mr R Copland	..	Director of Health Information and Technology
Mr M Feinmann	..	Director, East Glasgow CHCP (for Minute 37)
Mrs J Grant	..	Chief Operating Officer - Acute Services Division
Mr J C Hamilton	..	Head of Board Administration
Mrs A Hawkins	..	Director, Mental Health Partnership (to Minute 40)
Mr A MacKenzie	..	Director, North Glasgow CHCP (for Minute 37)
Mr A McLaws	..	Director of Corporate Communications
Mr P Moir	..	Head of Major Projects
Mr I Nicol	..	Interim Head of Performance & Corporate Reporting
Mr K Redpath	..	Director, West Dunbartonshire CHP (for Minute 36)
Mr I Reid	..	Director of Human Resources
Ms C Renfrew	..	Director of Corporate Planning and Policy/Lead Director, Glasgow CHCPs
Mr D Ross	..	Director, Currie & Brown UK Limited
Mr J Rundell	..	Audit Scotland
Mr D Walker	..	Director, South East Glasgow CHCP (for Minute 37)

ACTION BY

31 APOLOGY

An apology for absence was intimated on behalf of Cllr. D Mackay.

32. MINUTES

On the motion of Mr P Hamilton and seconded by Mrs E Smith, the Minutes of the Performance Review Group meeting held on 16 March 2010 [PRG(M)10/02] were approved as an accurate record subject to the following amendment:-

Minute 20: Financial Plan and Priorities: 2010/11

- 7th line – amend "2.1%" to "2.15%".

33. MATTERS ARISING

a) Financial Plan and Priorities – 2010/11

In relation to Minute 20 – Financial Plan and Priorities – 2010/11 – it was reported that two NHS Board Seminars had now been held to discuss the Financial Plan and it was on today's agenda for discussion and approval prior to submission to the June NHS Board meeting. **Director of Finance**

b) New South Glasgow Hospitals Laboratory Project

In relation to Minute 21 – New South Glasgow Hospitals Laboratory Project – it was reported that the submission of the Full Business Case to the November meeting of the Performance Review Group (PRG) was still on target; progress on the project would now be a standing agenda item at future Performance Review Group meetings and the newly approved governance arrangements for the Acute Services Review had been implemented.

NOTED

c) Overview of Mental Health Services

In relation to Minute 23 – Audit Scotland: Overview of Mental Health Services – it was reported that comparative data from England in relation to psychological therapy had been provided to Members and a visit to the new Adolescent Unit at Stobhill had been added to the list of proposed Member visits for the year.

NOTED

d) Planning and Performance Arrangements – 2010/13

In relation to Minute 25 – Update on 2010/13 Planning and Performance Arrangements – it was reported that the outcome of the discussions at the March NHS Board Seminar had fed into the discussions on the Financial Plan and Priorities at the April NHS Board Seminar and that the outcomes from the Policy and Planning Framework had been implemented.

NOTED

34. NEW SOUTH-SIDE ADULT AND CHILDREN'S HOSPITAL AND LABORATORY PROJECT - UPDATE

There was submitted a paper [Paper No. 10/24] by the Project Director setting out the progress of the construction of the new Laboratory facility and the design development of the new hospitals; the appointment of Project Supervisors and a request from the Contractors to carry out the planning and management of the residual demolition and site clearance work.

The Chairman welcomed Mr Peter Moir, Head of Major Projects, and Mr Douglas Ross, Director, Currie & Brown UK Limited (Technical Advisers) who were attending to update Members on this project.

Mr Moir reported that construction work on the new Laboratory had commenced on site on 4 March 2010 and the favourable weather had assisted in ensuring that the project remained on programme. The site accommodation for Phase 1 was to be completed by the end of May 2010 and this would house the Contractor, main Sub-Contractors and the Board's Project Team to ensure a close working relationship and good communications between the key parties.

In relation to the design development of the new hospitals, Mr Moir advised that the 1:200 drawings showing the departmental layouts would be completed by the end of May 2010. The next level of detail, providing circa 500 detailed 1:50 scale room layout drawings would be prepared by September 2010 and they would feed into the Full Business Case process.

In response to Members' questions in connection with the Control Process and Compensation Events for the Laboratory Facility, Mr Ross advised that the major cost change to date had been in relation to the Laboratories stage D to E reconciliation. The Contractor's Contract Bid had not contained a separate contingency allowance for Laboratories and the NHS Board's Risk Register included an item for Laboratory Design Development beyond Stage D to a value of circa £2m. The out-turn cost for the design development between stages D and E was expected to be £750,000 of profit and overheads. Mr Moir confirmed that the excavated materials from previous schemes that had been removed from site at a cost of £54,000 was the subject of ongoing discussion, and efforts were under way to recover costs against the organisations concerned.

Mrs Smith had been pleased to hear about the Community Benefit Programme and that Brookfield Construction Ltd (BCL) had entered into a partnership agreement with the NHS Board, Glasgow South West Regeneration Agency (GSWRA), the City Council and Community Enterprise, Scotland. To date 25% of posts notified to GSWRD have been filled through the recruitment protocol and 10% of employees on site were new entrants (a tender requirement). It was agreed that future updates to the PRG would include a section on the ongoing work undertaken by the Community Engagement Team in involving and informing the local community of the project.

Mr Moir reported that the Board was utilising the NEC3 form of Contract for the project and this required the appointment of a Supervisor to inspect and confirm that the works were constructed in compliance with the Board's requirements. The appointed Supervisor would report directly to the Project Director. The Scottish Government Framework procurement process was utilised to select the preferred company and the Project Team was recommending that Capita Symonds be appointed as Supervisor.

In addition, Mr Moir advised that a number of demolitions of existing buildings were required once vacated by the end of June 2010 before the next stage of the project could proceed. The two options of procuring the demolitions and site clearance were set out for Members and it was recommended that this work be procured by Brookfield through market testing with a number of demolition companies and the costs be funded by the transfer of costs from the Board's Capital Plan – 2010/11 to the Contract as a Compensation Event within the NEC3 Contract.

DECIDED:

1. That the progress of Stage 1 (Laboratory Facility Construction) and Stage 2 (Design Development of the new Hospitals) be noted and that future reports incorporate the work of the Community Engagement Team. **Project Director**

2. That Capita Symonds be appointed Project Supervisor for Stage 1 Laboratory Contract and Stage 2 design development of the new Hospitals, and that subject to approval of the Full Business Case in November 2010, the commission for Stages 3 and 3A, construction of the new hospitals. **Project Director**

3. That Brookfield Construction Ltd be appointed to carry out the planning and management of the required demolition and site clearance works as described in Option 2 of Table 4 of the Paper. **Project Director**

35. OVERVIEW FOR CONTRACTING FOR NHS PARTNERSHIP BEDS AND LOCAL AUTHORITY RESIDENTIAL CARE BEDS IN INVERCLYDE

There was submitted a paper [Paper No. 10/26] by the Director of the Mental Health Partnership which provided a strategic overview of the joint arrangements between Inverclyde CHP (NHSGG&C) and Inverclyde Council to contract with a developer for the provision of specialist residential and partnership beds to meet the needs of adults and older people with mental illness and to provide these services on the Kempock House site in Gourock.

Mrs Hawkins advised that this was a joint scheme made possible as a result of the Ravenscraig Hospital closure and was an opportunity to provide alternative services to meet current and future needs of Inverclyde residents with significant mental illness and who previously had been placed in NHS continuing care wards on the Ravenscraig Hospital site. It was intended to go to the market to seek two bed contracts: one for the NHS and the other for Inverclyde Council. These would be jointly commissioned but separately contracted for by each party and the length of the contract would include options on 20, 25, and 30 years which would then be assessed for financial viability and value for money. The joint contract would seek bed contracts for 77 beds – 45 NHS and 32 Local Authority – and would comprise 33 Elderly Mentally Ill Continuing Care beds; 24 Elderly Mentally Ill Care Home beds; 10 Continuing Care beds; and 10 Care Home beds. For the NHS beds (33 Elderly Mentally Ill Continuing Care beds and 10 Continuing Care beds for Adults with Mental Health Needs), the NHS would employ the clinical staff required to support the patients and the Local Authority would envisage the care staff being provided by the successful contractor.

Mrs Hawkins described the contract arrangements and the restricted procedure approach which had been agreed by the Council and the NHS Board and the intention to issue the Invitation to Tender in June 2010. Mrs Hawkins advised that it was essential that the project remained within the affordability envelope and if this proved not to be possible, the Continuing Care beds would require to remain on the Ravenscraig Hospital site.

Cllr. McIlwee welcomed this project and indicated that this was part of a wider range of improvements being brought about for the care of residents within the Inverclyde area. Mrs Smith endorsed this and saw this as the final stage in moving away from facilities which were no longer fit for purpose and brought many benefits to residents and the community.

Mrs Hawkins advised that the remaining facilities on the Ravenscraig Hospital site (the Alcohol-related beds and temporary accommodation for Acute Services Division) would move off the site at the appropriate time to allow the disposal of the hospital site.

DECIDED:

1. That the Business Case for the Ravenscraig Hospital Re-provision – Adult and Older People's Continuing Care – Partnership Beds to enable progress to the next stage of the procurement/commissioning process and Invitation to Tender being issued at the end of June 2010 be approved. **Director, Mental Health Partnership**

2. That the scheme commits revenue as one element of delivering the approved NHSGG&C Modernising Mental Health Services Strategy for South Clyde for a 20-30 year period be noted. **Director, Mental Health Partnership**

3. That the procurement/commissioning process would require further authorisation/approval by the Performance Review Group at further key stages be noted. **Director, Mental Health Partnership**

36. GPASS REPLACEMENT – APPROVAL OF BUSINESS CASE

There was submitted a paper [Paper No. 10/27] by the Director of Health Information and Technology, which sought approval to proceed with the replacement of GPASS within NHS Greater Glasgow and Clyde.

Mr Copland advised that NHS Scotland eHealth Strategy Board, Chaired by the Chief Executive of the NHS in Scotland, recommended that GPASS (the national in-house GP clinical IT application) no longer had a long term future and that a process of retiring the application should be undertaken and it would be replaced with a national framework agreement giving choice to NHS Boards and the GPs to choose a replacement system. NHSGG&C was commissioned to lead the procurement exercise in partnership with all other NHS Boards and the Scottish Government for accredited GP systems following an established European Union tender process.

The objective of the GP replacement system procurement process was to put in place a framework agreement with accredited Scottish enhanced frameworks suppliers (i.e. suppliers of GP systems). Two accredited suppliers – e.g. Egton Medical Information Systems Ltd and Practice Systems Ltd were identified and both suppliers were by far the largest in the UK and both had sizeable numbers of practices in Scotland, including within NHSGG&C.

Discussions had been undertaken with the Local Medical Committee (LMC) around GP practices' choice of system from the framework throughout the procurement process. The support of the LMC in recommending a single supplier had been vital in maximising the savings achieved. NHSGG&C set up a local GPASS Replacement Board chaired by Keith Redpath, Director, West Dunbartonshire CHP, and following mini-tender exercises and completion of a scoring matrix, EMIS was the successful bidder by scoring higher overall and offering an exceptional discount to NHSGG&C for an enterprise license model. The anticipated gross level of savings from the GPASS license costs would be in the range of £850,000 per annum subject to an allowance to cover the capital charges that would be incurred.

The Scottish Government provided recurring funding of £1.97m per annum to cover the license/support costs of GPASS and its successor and the total up front cost for the NHS Board migration programme was £5.65m. Resources to enable the migration of the 244 practices within NHSGG&C had been identified and £4m had been included in the NHS Board's Capital Plan over 2010/11 and 2011/12 with the balance of funding provided by the Scottish Government eHealth.

Ms Dhir asked about accessing future software upgrades and whether this had been included as part of the contract. Mr Copland advised that it was a seven-year contract which could be extended by a further three years and it included access to all future upgrades and technical and support costs. It was recognised, however, that there would require to be additional support and training for GP practices as part of the transition of moving from GPASS to the new system. However, this support was always going to be required when a change of a national system was to be implemented. Mr Copland acknowledged that the GPs, through the LMC, had participated in the process as knowledgeable and informed customers and he was also pleased to confirm that the Scottish Prison Service had been involved nationally with this contract.

It was also acknowledged that the position of the LMC in supporting the recommendation to award the contract to replace GPASS to a single provider had been most welcome.

DECIDED:

1. That the proposal to award the contract for the replacement of the 244 GP IT systems to a single supplier – Egton Medical Information Systems Ltd (EMIS) – based on the mini-tender process be approved. **Director of Health Information and Technology**

2. That the use of £4m of capital, monies for financial years 2010/11 and 2011/12 to enable the migration programme be approved. **Director of Health Information and Technology**

3. That the Board Chair write formally to the LMC Chair to acknowledge the importance of their support in maximising savings. **Chairman**

37. COMMUNITY HEALTH AND CARE PARTNERSHIPS WITHIN GLASGOW CITY COUNCIL

There was submitted a paper [Paper No. 10/25] by the Chief Executive and Vice Chair/Joint Partnership Vice Chair setting out the stage reached with Glasgow City Council on the Community Health and Care Partnerships.

Mr Calderwood advised that having worked up the concept for CHCPs from first proposing the model to the City Council in 2005, there had been recognition that both organisations would be required to adopt new ways of working and be prepared to reduce central control and decision making while retaining clear lines of accountability and governance in return for delivering service improvements, engagement with communities, gains in community planning, improving health and focusing on tackling inequalities.

There had, however, been continuing delays in delivering the organisational changes within the Council to enable the CHCPs to fully function and fully deliver their potential. Discussions had been held over the last two years to deliver agreement with the Council to move to the similar approach of that of the NHS with changes to Council budgets, centre decision making, staffing and control arrangements in order to enable CHCPs to fully function.

Mr Calderwood emphasised that commitments to the shared vision and necessary decentralisation and devolution of decision making had been consistently made by senior Councillors within the City Council and, in September 2009, at the request of the Council, the Board agreed to establish a Shadow Joint Partnership Board (JPB) to bring together the Councillors and Board Members to ensure that desired change was delivered. Within three months of establishing the JPB, agreement had been reached to deliver the changes within the Council from April 2010. However, the Council had since decided to set aside that agreement and develop its own revised proposals for CHCPs. The NHS Board needed to consider whether the Council's decision to reverse the agreement to fully implement the revised Scheme of Establishment and instead make limited changes to the present position, offered a viable way forward. The position set out in the paper being considered by Members had been informed by careful consideration with CHCP Directors of the Council's proposal. This process had identified a series of issues and a number of critical matters which the full implementation of the agreed revised Scheme of Establishment would have addressed but which the Council proposal did not address. It was the case, therefore, that the Council was not able to make the substantive changes required to deliver the agreed approach and, as a consequence, the NHS Board could not expect to have effective and fully functioning CHCPs within any known and reasonable timescale. The NHS Board continued to believe

that integrated NHS and Social Care services were in the best interests of the public and patients served by both organisations.

Mrs Smith described the work of the JPB and the involvement of the five Non-Executive Directors who sat as Vice Chairs of the five CHCPs within Glasgow. She had been pleased that the November meeting of the JPB had endorsed the revised Scheme of Establishment with the full support of the six Councillors present and at subsequent JPB meetings, there had been assurances that the Scheme of Establishment had been agreed by the Council administration and would be fully approved before the end of March 2010. However, very soon thereafter, it became clear that the Council was separately developing its own proposals which were different from the approach agreed by the JPB. Given the JPB was established at the Council's request and was chaired by the Executive Member for Social Work, this was surprising and disappointing. A series of exchanges between the NHS Board Chair and Chief Executive, the Acting Council Leader, Councillors chairing CHCPs and Council officers made very clear the extent of NHS Board's concern at this departure from the fundamental agreements reached and the risk that the Council's change in position would create for the future of the CHCPs. At its April meeting, the Council's Executive Committee rejected the option to fully implement the agreed Scheme of Establishment and approved instead a series of changes described as incremental progress towards the Scheme of Establishment.

The PRG paper set out the careful consideration of the Council's proposals and provided comment on the policy influences which were suggested to provide the basis for the Council's revised position. The paper also commented on the key elements of the Council's Option 1B and provides consideration of the implications of the Council's Option 1B.

Members noted that the primary focus for the NHS has been an attempt to reach agreement with the City Council and make positive progress on the alternative organisational arrangements. The recommendation for PRG was that if it was concluded that the Council's alternative option was not a viable way forward, it was proposed that work be undertaken to establish alternative organisational arrangements to create a Community Health Partnership model for Glasgow and submit proposals to the NHS Board meeting in June. As the CHCP boundaries were principally driven by the City Council's electoral boundaries, this would provide an opportunity to create boundaries which are of greater significance to NHS services. In developing transition arrangements to move from a CHCP to a CHP model it would be important to ensure that services to patients were not disrupted and that there was no break in the continuity of care.

A number of Members commented on the helpful, thorough and detailed analysis presented and expressed their disappointment at the outcome reached with the City Council. It was clear that different organisations had different cultures and, while this had been recognised at the beginning, it had been difficult for the Council to move away from a centralised approach to the NHS Board's devolved approach to managing budgets, staff and decision making. Members continued to believe that CHCPs were the correct model for both parties going forward. However, having fully considered the Council's Option 1B, Members concluded it was not a viable alternative to the full implementation of the agreed Scheme of Establishment. Staff within CHCPs were working well together and integrated services had proved beneficial not just within the CHCPs but also within the Partnerships for Homelessness and Addictions. However, the absence of fully devolved budgetary, staffing and decision making after two years of discussions, had led Members to unanimously conclude that Option 1B was not a viable alternative and it was necessary for the NHS Board officers to put to the June NHS Board meeting alternative arrangements to manage NHS community and primary care services.

The Chairman recognised the shared disappointment of NHS Board Members at the position reached and was keen that all efforts be maded to work with the Council now and in the future as major and key partners in the provision of public services to the populations served by both. He recognised the comment that the Council's Option 1B while described as incremental, was more a partial approach to integrated CHCPs and did not meet Board Members' aspirations for a fully integrated model consistent with the previously approved revised Scheme of Establishment. The work with the remaining Councils within the NHS Board's area would continue on establishing integrated CHCP models, reflecting the Board's continuing commitment to deliver that model where it could find willing partners.

DECIDED:

1. That the City Council's revised position on CHCPs and its Option 1B were not an acceptable alternative way forward to deliver viable and effective integrated CHCPs.

2. That NHS Board officers develop proposals for alternative arrangements to manage NHS community and primary care services to the NHS Board meeting in June 2010. **Chief Executive**

38. LOCAL DELIVERY PLAN – 2010/11

There was submitted a paper [Paper No. 10/28] by the Director of Corporate Planning and Policy/Lead Director, Glasgow City CHCPs, advising that the Scottish Government Health Directorates had approved the NHS Board's Local Delivery Plan subject to agreement of the NHS Board's final Financial Plan and finalisation of Annex 6 – Single Outcome Agreements.

Ms Renfrew advised that in submitting the Local Delivery Plan for 2010/11 on 19 March 2010, it was again emphasised to the Scottish Government the real challenges in delivering the Local Delivery Plan targets whilst, at the same time, managing service pressures and achieving substantial cash savings. The NHS Board's Financial Plan would be submitted for approval to the NHS Board meeting on 22 June 2010.

NOTED

39. FINANCIAL PLAN – 2010/11

There was submitted a paper [Paper No. 10/29] from the Director of Finance setting out the Financial Plan – 2010/11.

Mr Griffin advised that the Board had submitted a draft Financial Plan to SGHD in March, although at that stage it had not included a finalised Cost Savings Plan for 2010/11. The Financial Plan 2010/11 included proposals to address the cost savings challenge in order to achieve a balanced out-turn in 2010/11; set out the key assumptions and risks and provided an indication of the scale of financial challenge to be faced in 2010/11 and beyond.

Mr Griffin highlighted the following.

- The NHS Board had succeeded in addressing all but £7m of the £26m recurring deficit which was transferred in 2006/07 from the former Argyll and Clyde Health Board into the management responsibility of NHSGG&C. This sum would be incorporated within the context of the Financial Plan.

- Presenting a balanced Financial Plan for 2010/11 was largely dependent upon implementing a comprehensive Cost Savings Plan which was capable of releasing up to £57m of recurring cost savings; the detail of the Cost Savings Plan was set out within the paper.

- The projection of expenditure growth at the sum of £80.6m was the aggregate of a range of additional expenditure commitments which the NHS Board was required to meet in 2010/11. A full list of these was set out in an Appendix to the paper which highlighted that they were all unavoidable rather than discretionary commitments. Despite strenuous efforts to generate recurring cost savings in previous years the 2010/11 plan would inherit an £18.1m recurring deficit from the previous year.

Mr Griffin highlighted the key assumptions and risks on which the Financial Plan – 2010/11 had been based and these related to the following:-

1. Access Targets

   It had been assumed that the NHS Board would require to make an additional £5m of recurring funding per annum available to secure the achievement of national access targets on an ongoing basis, consistent with being able to meet the 18-week referral to treatment guarantee by December 2011.

2. Prescribing Cost Growth

   The financial projections assumed that a cost saving plan of £9.5m would be successfully implemented containing overall net prescribing expenditure growth within an overall envelope of £10m and this represented a higher level of risk of non-achievement than in previous years.

3. Gas/Electricity Prices

   The forecast was that this expenditure would remain fairly static in 2010/11 based on the current forecast energy prices.

4. Pay Growth

   It had been assumed that the closing stages of the Agenda for Change appeals process would not produce any further significant additional cost pressures.

5. Cost Savings Plan

   The achievement of the Financial Plan – 2010/11 would depend largely on the NHS Board's ability to deliver a recurring cost savings plan of up to £57m in 2010/11.

Following consideration and approval of the Financial Plan by the Performance Review Group, it would be submitted to the NHS Board in June 2010 for final approval.

DECIDED:

That the Financial Plan for 2010/11 be approved and submitted to the June NHS Board meeting. **Director of Finance**

40. CAPITAL PLAN - 2010/11 – 2012/13

Thee was submitted a paper [Paper No. 10/30] by the Director of Finance setting out the proposed Capital Plan – 2010/11 – 2012/13.

Mr Griffin advised that NHS Board officers had worked with SGHD colleagues to confirm the level of capital funding which was likely to be available in 2010/11 and beyond and this had enabled agreement on a capital funding allocation for 2010/11 and indicative allocations which would be reasonable to anticipate for the two following financial years. While general capital funding allocations were being reduced, SGHD had confirmed its commitment to fund the £841.7m new South-side Glasgow Hospitals and Laboratory development and the purpose of the paper submitted to Members was to set out how the NHS Board planned to deploy its allocation of capital funds on individual schemes in 2010/11 and highlighted the indicative plans for future years.

Mr Griffin reported that whilst subject to final audit review, the net capital expenditure in 2009/10 had amounted to £329.044m against a capital resource limit of £329.047 and the Board had, therefore, met its requirement to operate within its capital resource limit.

As in previous years, expenditure on all capital projects would be monitored throughout the year and reported to the Capital Planning Group to allow the required decisions to be made in year to ensure that a balanced capital position was achieved in 2010/11.

DECIDED:

1. That the Capital Plan for 2010/11 be approved. **Director of Finance**

2. That the current indicative allocations for 2011/12 and 2012/13 be noted. **Director of Finance**

3. That the Capital Planning Group be delegated the authority to allocate any additional funds against the 2010/11 Capital Plan throughout the year. **Director of Finance**

41. HEAT PERFORMANCE REPORT – 2009/10

There was submitted a paper [Paper No. 10/31] from the Interim Head of Performance and Corporate Reporting, which outlined performance in relation to the HEAT targets as set out in the NHS Local Delivery Plan for 2009/10, focusing on areas in need of improvement as well as highlighting those where significant progress had been made.

As had been discussed at the previous meeting, the report drew out areas where improvement was required and provided a description of the actions being taken to bring about an improvement in performance. In addition, those targets where there was a significant risk that they would not be met would be the subject of a separate report to the Performance Review Group in order to cover the issues and mitigation plans in greater detail.

DECIDED:

That the HEAT Performance Report – 2009/10 in respect of the HEAT targets set out in the 2009/10 Local Delivery Plan be noted.

42. ACCIDENT AND EMERGENCY ATTENDANCE – HEAT T10: ACTION PLAN

There was submitted a paper [Paper No. 10/32] from the Director of Corporate Planning and Policy/Lead Director, Glasgow CHCPs, asking Members to note the action being taken to achieve the HEAT target for Accident and Emergency attendances.

Ms Renfrew advised that the HEAT Target T10 required NHS Boards to achieve agreed reductions in the rates of attendances at Accident and Emergency over the period 2007/08 to 2010/11. This represented a very significant challenge for NHSGG&C as Accident and Emergency attendances had been rising in recent years. Discussions with the Scottish Government Health Directorates had led to an agreement that the trajectory for the NHS Board was to cap rather than reduce A&E attendances. The paper highlighted the 12-monthly average attendances and demonstrated the rising trend over this period which had led to the NHS Board breaching the trajectory of 3,242 attendances per month per 100,000 population in October 2009 and had remained above it since.

Nationally, the Scottish Government had set up an Emergency Access Delivery Team to work with NHS Boards to develop, evaluate and learn from improvement strategies to deliver the Accident and Emergency targets. It had also developed a series of milestones. An NHSGG&C Steering Group was established in 2009 to direct and develop work to try to meet this target and an action plan had been developed which detailed a range of local work streams and links into the milestones. This comprehensive approach would continue with a realistic focus on action which would bring improvements to patient care.

NOTED

43. PROPERTY COMMITTEE MINUTES – 18 JANUARY 2010

The Minutes of the Property Committee meeting held on 18 January 2010 were noted.

44. COMMUNICATION ISSUES: 17 MARCH TO 18 MAY 2010

There was submitted a paper [Paper No. 10/34] from the Director of Corporate Communications covering communication actions and issues from 17 March to 18 May 2010.

Mr McLaws highlighted the following:-

- A new dedicated Triple P website offering tips for patients and local information on how parents can get involved in the universal parenting programme was being rolled out by the NHS Board and Glasgow City Council. The launch was timed to tie in with the Baby Show at the SECC and over 9,000 visitors attended the Triple P stand over the weekend, 23 – 25 April 2010. In addition, thousands of leaflets and posters had been delivered to schools, primary care premises, police stations, libraries, nurseries and a four-page newspaper and DVD had been produced with personal testimonies of Glasgow parents who had already participated in the programme.

- Work had been undertaken with BBC Scotland to film an exclusive news package on an innovative technique developed by Gartnavel Anaesthetist, Dr Nick Pace. The technique aimed at reducing the number of patients having a general anaesthetic by giving them the option of watching a DVD whilst having surgery under local anaesthetic. The story ran across the BBC UK network on Election Day and was picked up by the national broadcast and print media, as well as having an international interest from some countries.

- Work was well under way in preparing for the major publicity campaign specified by the Cabinet Secretary for Health and Wellbeing when she approved the Vision for the Vale of Leven Hospital. The campaign will be launched in the autumn 2010 to coincide with the implementation of key planned service changes. A newsletter would be delivered to every household within the hospital's catchment area, with a copy of the supporting advertising and media releases being prepared for review by the Vale of Leven Monitoring Group.

NOTED

45. DATE OF NEXT MEETING

The next meeting of the Performance Review Group will be held at 9.30 am on Tuesday, 6 July 2010 in Board Room 1, Dalian House, 350 St Vincent Street, Glasgow, G3 8YZ.

The meeting ended at 12.35 p.m.