

NHSGG&C(M)15/01

Minutes: 01 - 04

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, 20 January 2015 at 9:00a.m.**

PRESENT

Mr A O Robertson OBE (in the Chair)

Dr J Armstrong	Mr I Fraser
Dr C Benton MBE	Councillor A Lafferty
Ms M Brown	Mr I Lee
Mr R Calderwood	Dr D Lyons
Dr H Cameron	Mrs T McAuley OBE
Ms R Crocket MBE	Councillor J McIlwee
Councillor M Cunning	Ms R Micklem
Mr P Daniels	Dr R Reid
Councillor M Devlin	Rev Dr N Shanks
Mr R Finnie	Mr D Sime
	Mr K Winter

IN ATTENDANCE

Mr R Garscadden	Director of Corporate Affairs
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Ms A Harkness	Director, Emergency Care & Medical Services
Mr J Hobson	Interim Director of Finance
Mr B Moore	Chief Officer Designate, Inverclyde Integrated Joint Board
Ms J Murray	Chief Officer Designate, East Renfrewshire Integrated Joint Board
Mr K Redpath	Chief Officer Designate, West Dunbartonshire Integrated Joint Board
Ms C Renfrew	Director of Corporate Planning and Policy
Mr D Williams	Chief Officer Designate, Glasgow Integrated Joint Board

ACTION BY

01. WELCOME, APOLOGIES AND INTRODUCTORY REMARKS

Mr Robertson wished all Members and those in attendance a Happy New Year and thanked everyone for attending this specially scheduled NHS Board meeting. He also took the opportunity to congratulate Mrs T McAuley on her OBE and welcomed the four Chief Officer Designates of the Integrated Joint Boards.

Apologies for absence were intimated on behalf of Mr J Brown CBE, Dr L de Caestecker, Professor A Dominiczak, Councillor M Macmillan, Councillor M O'Donnell and Councillor M Rooney.

Mr Calderwood referred to the winter pressures facing NHSGGC and NHS services across the UK over the last few weeks. He set out the current position in NHSGGC and the actions being taken to date. He reported that initial analysis suggested

pressures currently being experienced within NHSGGC were not solely as a result of a significant rise in the number of patients presenting to A&E departments, but instead due to a sharp rise in the proportion of those patients who required admission to a bed. Patients also appeared to require a longer stay in hospital and staff were working to ensure that all patients were seen and either admitted or discharged as soon as possible. It was regrettable that many patients had waited longer than four hours at A&E but he stressed that the vast majority of those were assessed, treated and either admitted or discharged within eight hours – some, unfortunately, had waited over 12 hours. This presented a huge operational challenge for NHSGGC in terms of A&E attendances, acute medical admissions and a reduction in the elective programme to create capacity for the impact of these issues. Clearly, these factors had resulted in a deterioration of local performance but he reassured the NHS Board that staff and senior management teams remained entirely focused on managing the situation and ensuring that patients were admitted or discharged as quickly as possible.

Ms Harkness referred to the extraordinarily difficult recent 2-3 weeks and explained that acute directors and colleagues were meeting up to three times daily to keep abreast of the situation. Mr Calderwood had also met with all A&E teams. Additional acute beds had been opened on 5 January 2015 as planned and a medical assessment area was opened at the Victoria Infirmary and a surgical assessment area at Glasgow Royal Infirmary.

NOTED

02. 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

03. APPROVAL OF SCHEMES OF INTEGRATION – INTRODUCTORY PAPER

A report of the Director of Corporate Planning and Policy [Board Paper No 15/01] asked the NHS Board to approve the Integration Schemes for East Renfrewshire, West Dunbartonshire, Inverclyde and Glasgow City so as to provide a clear basis to move the four draft Integration Schemes into the next phase of process which was submission to the four respective Councils and then to Scottish Ministers for their approval. Once that approval was granted, Integrated Joint Boards (IJBs) could be established by order of Scottish Ministers.

Ms Renfrew led the NHS Board through the introductory paper which set the context for the draft Integration Schemes which were the formal step required by legislation to establish the new IJBs. These had been developed in a process led by each Chief Officer and an important point of that context was that, for the NHS Board, the planning and service responsibilities which would be discharged by IJBs remained part of a whole NHS system for NHSGGC.

Ms Renfrew described NHSGGC's approach to operational delivery, the essence of which was that the Chief Officer would carry that responsibility with oversight and direction provided by the IJB. The Scheme of Delegation (Appendix 1 of the Board Paper) had been drafted to ensure a clear basis for delegation and assurance about the lines of sight back to the NHS Board's statutory responsibilities for governance across clinical quality and safety, staff and employment, equalities and finance. That Scheme

of Delegation would be finalised following further discussion with Directors and Chief Officers. NHSGGC also needed to ensure, with the Scottish Government, that the Scheme was a legally secure basis to establish that operational delegation. That was a point of debate between lawyers on which the NHS Board needed the Scottish Government to take a definitive position. There also had to be clarity that lines of governance for specialist services, not prescribed in the regulations, were differentiated in line with the last paragraph of section 3 (page 2 of the NHS Board papers “Operational Arrangements”) and the final Schemes securely reflected that.

Ms Renfrew set out how the approach to staff governance had been developed and points of clarification would be raised on each of the draft Schemes of Integration when being discussed.

In terms of the current position on the chairing of the IJBs, Ms Renfrew reported that the Schemes, as drafted, reflected Council positions and would see five of the six Partnerships chaired by Council members. The NHS Board’s Quality and Performance Committee had previously taken the view, on behalf of the NHS Board, that this would not be a desirable outcome. NHSGGC continued to seek a compromise with Councils on this issue before Schemes were submitted. Inverclyde and Glasgow City had not agreed the NHS Board’s approach which would deliver a 50/50 split.

Referring to the responsibilities with regard to performance which needed to be addressed in the Integration Schemes, Ms Renfrew explained that these were drawn directly from the legislation and associated regulations but were not consistently reflected in the draft Schemes. The importance of this, from the NHS Board’s perspective, lay in her earlier comments that the planning and services covered in these proposals were part of an overall system of healthcare planning and delivery. There had to be clear responsibility on IJBs for targets and measures which were critical to that whole system and the requirements to the Scottish Government placed directly on NHS Boards through the Local Delivery Planning (LDP) process.

Ms Renfrew confirmed that the NHS Board needed to have confidence in establishing IJBs and that the funding allocated to them was appropriate to the responsibilities which the IJB would discharge. She explained that the NHS Board would not finalise 2015/16 allocations at this stage, but it was important that approval of these Schemes was underpinned by an appraisal of financial viability, particularly in relation to the outcomes described earlier. She outlined an approach to establishing headline allocations which would deliver viable NHS budgets for the Partnerships in 2015/16 albeit significant financial challenges beyond that, and she made the important link to performance delivery essential within those budget allocations.

Ms Renfrew outlined the acute service planning role of IJBs defined in the legislation and regulations and national guidance which underpinned those roles.

Ms Renfrew noted her proposed approach had a degree of flexibility to work with Interim Chief Officers to finalise Schemes for submission to the Scottish Government (SG). She highlighted that, should that joint work or the approval process with the SG raise issues which could be resolved, she would report back to the NHS Board for further direction.

Mr Finnie referred to the NHS Board policies which IJBs were required to comply with and related governance arrangements. He questioned whether the Scheme of Establishment provided a sound basis for the delivery of these functions on behalf of the NHS Board. He understood that an IJB would need a means to scrutinise such compliance but was the NHS Board indemnified in terms of an IJB’s decisions and performance? Ms Renfrew reported that the legal position in that regard was not yet clear. This matter needed to be resolved with further discussion between the CLO, Councils and the Scottish Government lawyers. However, she was advised that if the

SG approved the Scheme that would protect the NHS Board's position. Mr Calderwood added that, as well as the NHS Board's role as the legal entity, performance and compliance with NHS Board policies would be measured through managerial accountability and line management responsibilities.

Ms Micklem highlighted the importance of the framework of Key Performance Indicators and wondered if there would be consistency across all the IJBs especially in those relating to inequalities. Ms Renfrew reported that that should be addressed by the Integration Schemes having clear targets and reporting as recommended in her covering paper and required in the Regulations. Performance against all of the strategic commissioning plan outcome indicators was still in draft with targets to be agreed.

Mrs McAuley commended the work done so far to reach this stage. She wondered where Public Health fitted in and Ms Renfrew reported that the Act did not change the professional regulatory framework or established professional accountabilities currently in place, of which the role of Director of Public Health was one. As such, the Director of Public Health would be one of the NHS Board's professional advisors. Dr de Caestecker had already begun to look at local arrangements.

Dr Armstrong referred to the proposed professional leadership within each IJB which would identify professional leads as an integral part of the management team and who would have professional accountability to the NHS Board's professional advisers through formal arrangements set out in more detail in the NHS Board's management processes. This was essential in clinical governance terms and also in taking forward a coherent clinical strategy.

Mr Sime referred to governance for the operational services which were carried out by the IJB and was reassured that, in carrying out that role, there were a number of obligations placed on the NHS Board by statute and Scottish Government direction to which the IJB needed to have regard.

Councillor Cunning hoped that the agreement still to be reached on IJB chairing would get resolved soon and would not cause delay. Mr Sime noted that agreement to deliver a balanced approach to chairing needed to be reached. He expressed concern about the message to NHS staff if Chairs were not distributed as the NHS Board had proposed.

In response to a question from Dr Benton, Ms Renfrew clarified that if a Councillor member was not re-elected (or was no longer a Councillor for whatever reason), they would be ineligible to remain on an IJB.

In response to a question from Mr Finnie, Ms Renfrew agreed to make consistent throughout the Schemes of Integration the wording in relation to creating IJBs. The Order established IJBs and not Health and Social Care Partnerships. She would also make consistent the use of the NHS Board's legal name which was "Greater Glasgow Health Board" and not "Greater Glasgow and Clyde NHS Board".

**Director of
Corporate
Planning &
Policy**

Mr Robertson invited each Chief Officer designate to lead the NHS Board through their draft Scheme of Integration as follows:-

- (a) East Renfrewshire
- (b) West Dunbartonshire
- (c) Inverclyde
- (d) Glasgow

(a) East Renfrewshire Scheme of Integration

Ms J Murray, Chief Officer Designate, East Renfrewshire Integrated Joint Board, led the NHS Board through the draft East Renfrewshire Health and Social Care Partnership Integration Scheme. She summarised that the consultation on the Integration Scheme had been taken forward through the Shadow Integration Board which included stakeholder members. She reported that the draft Scheme was due to be considered by a special meeting of East Renfrewshire Council on 21 January 2015.

Councillor Lafferty referred to the long and successful experience of developing and running an integrated health and social care partnership for all community adults, children and families and criminal justice services. The development of the IJB was a natural progression of the positive work of partners in East Renfrewshire and he recorded his thanks and appreciation of the work undertaken to date. He also commended the work of the current NHS Chair of the Community Healthcare Partnership (CH(C)P).

Ms Brown referred to the proposal that a Joint Staff Forum would act as a formal consultative body for the workforce. She welcomed this approach and suggested that this Forum also link to the NHSGGC Staff Governance Committee as well as the NHSGGC Area Partnership Forum. Ms Murray agreed to reflect this addition at paragraph 7.11 of the draft Scheme.

Chief Officer

Mr Sime welcomed the overall content of the draft Scheme and suggested that the Partnership report on staff governance issues (as well as human resource issues) in relation to the Equality Act. Ms Murray agreed to make this inclusion at paragraph 7.5 of the draft Scheme.

Chief Officer

Dr Reid referred to Annex 1 (Part 2) which detailed services currently provided by the NHS Board which were to be integrated and regarded this as a useful breakdown.

Mr Lee wondered where audit and any associated Audit Committee of the IJB would interact with the NHS Board's Audit Committee. Mr Hobson clarified that each IJB would have an Audit Committee and a mechanism would be established to link that with the NHS Board's internal and external audit processes. Each IJB would also be required to approve its annual accounts.

In response to a question from Dr Lyons concerning "honorary contracts", as mentioned at paragraph 7.2, Mr Reid confirmed that, following legal advice, that approach had been confirmed as acceptable.

(b) West Dunbartonshire Scheme of Integration

Mr Redpath, Chief Officer Designate, West Dunbartonshire Integrated Joint Board, led the NHS Board through the draft West Dunbartonshire Integration Scheme and reported that a Council meeting of West Dunbartonshire was arranged for 4 February 2015 to similarly consider the draft Scheme. He summarised the formal public consultation undertaken in relation to the Scheme and outlined the IJB's strategic priorities.

Mr Sime welcomed the reporting arrangements and linkages in relation to the IJB and the Staff Partnership Forum (as referred to at paragraph 10.3). He highlighted the reference made to the NHS Board's Acute Services as referenced at paragraph 10.2 of the draft Scheme and Mr Redpath agreed to reword this paragraph.

Chief Officer

Ms Micklem asked about the relationship between the IJB and the Community

Planning Partnership. Ms Renfrew confirmed that the IJB would be a member of the Community Planning Partnership and there would be a local lead for this.

Mrs McAuley commended Mr Redpath in relation to the participation and engagement that had been undertaken in taking this work forward.

In response to a question from Dr Lyons, Mr Redpath and Mr Hobson confirmed that the section on “finance”, although providing additional robust detail, did still comply with the national guidance.

(c) **Inverclyde Scheme of Integration**

Mr Moore, Chief Officer Designate, Inverclyde Integrated Joint Board, led the NHS Board through the detail on the draft Scheme of Integration for Inverclyde. He confirmed that this was due to be considered by Inverclyde Council the following week. Ms Renfrew noted the Chair arrangement was not agreed.

Councillor McIlwee thanked Mr Moore and Ms Renfrew for their proactive contribution in taking this work forward.

Mr Sime referred to Section 10 of the draft and reported that the Area Partnership Forum’s comments had been incorporated into that and thanked Mr Moore for highlighting the linkages to be established with the Forum.

Ms Renfrew noted the Chair issue remained outstanding with Inverclyde Council.

(d) **Glasgow City Scheme of Integration**

Mr Williams, Chief Officer Designate, Glasgow Integrated Joint Board, led the NHS Board through the detail of Glasgow City’s draft Integration Scheme and reported that this was due to be considered by Glasgow City Council on 20 February 2015. He referred to some of the differences already discussed between the draft Schemes and considered this appropriate as the priority was to ensure that they reflected local discussions and decisions and it was to be expected that each Scheme would be unique.

Mr Daniels agreed with Mr Williams’ comments and was pleased to note the genuine partnership working that had taken place between respective Councils and the NHS Board to reach this stage.

Mr Sime welcomed paragraphs 9.2 to 9.4 referencing workforce governance and the linkages to the NHS Board’s Area Partnership Forum.

Dr Benton asked about the future of “hosted services” that were currently provided by one Community Health Partnership within the NHS Board on behalf of the others (in accordance with a Service Level Agreement). Ms Renfrew reported that it was the intention that the IJB be invited to accept delegation of such hosted services but the governance arrangements for those services needed to be clear.

DECIDED

- That, the Integration Schemes for East Renfrewshire, West Dunbartonshire, Inverclyde and Glasgow City be approved:-
 - Subject to resolution of the final points of discussion indicated including chairing and arrangements for the NHS Board to ensure targets and measures were established as described, directly drawn from the regulations;

**Director of
Corporate
Planning &
Policy**

- With authorisation to the Interim Chief Officers and Director of Corporate Planning and Policy to work together with Council colleagues to revise Schemes based on the NHS Board discussion and to engage with the Scottish Government to progress the Schemes' approval; " "
- Should that approval process raise issues which could not be resolved, to report back to the NHS Board for further direction; " "
- Confirmation in the approval process that the NHS Board's Scheme of Delegation could frame the operational responsibilities so that the NHS Board could be assured its governance and accountability requirements and responsibilities could be met. " "

04. CLINICAL SERVICES FIT FOR THE FUTURE: APPROVING THE CLINICAL STRATEGY

A report of the Medical Director [Board Paper No 15/02] asked the NHS Board to approve the Clinical Strategy developed from the Clinical Services Review process.

Dr Armstrong outlined the key aims of the Clinical Strategy which provided a framework to ensure that best clinical outcomes were achieved for patients and that services were:-

- Safe and sustainable;
- Patient centred;
- Integrated between Primary and Secondary care;
- Efficient, making best use of resources;
- Affordable, provided within the funding available;
- Accessible, provided as locally as possible;
- Adaptable, achieving change over time.

She led the NHS Board through the local context in which the Clinical Services Strategy had been developed, noting the demographics of the population as well as summarising key trends, projections and forecasts. In recent years across NHS GGC, there had been some significant improvements in health. Overall, life expectancy had risen; rates of premature mortality had fallen, with particular improvements for coronary heart disease. Cancer survival had improved significantly across a range of cancers, however, there remained many significant health challenges and marked inequality across NHS GGC. Overall, average life expectancy was well below the Scottish average and, again, there was considerable variation between different parts of NHS GGC.

Dr Armstrong described the approach taken to review the organisation of clinical services and to consider what would be required to achieve the best health outcomes for patients. The critical characteristics of the review work were clinical leadership, whole-system clinical engagement and intensive patient and public engagement. The Clinical Services Review had enabled the development of the Clinical Strategy to provide a basis for the development of detailed service change proposals working with Integrated Joint Boards and with the emerging national approach to Clinical Strategy and delivering the 2020 Vision.

Dr Benton commended the paper and noted the multiple co-morbidities. She wondered if the same applied to multiple trauma and, if so, if a few words could be added about that. Dr Armstrong confirmed that she chaired a West of Scotland Clinical Group.

This group was developing a high quality clinical plan to improve trauma care across the West of Scotland.

**Medical
Director**

Ms Micklem similarly found the paper exceptionally enlightening and helpful and recognised that a key element was the strategic leadership role. She looked forward to receiving an update on the Paisley Programme. Dr Armstrong suggested some early indication of success with the Programme and confirmed that a further update paper would be considered in the future.

**Medical
Director**

Mr Finnie recognised the challenges ahead but welcomed the overall service model which was to provide a balanced system of care where people got care in the right place from people with the right skills, working across the artificial boundary of “hospital” and “community” services. He particularly welcomed the approach relying on a strong emphasis on prevention which linked with the ongoing work led by Dr de Caestecker.

Dr Reid suggested that the admission criteria at Section 5.11 be embellished. Similarly, Dr Lyons suggested that reference be made to savings and rationalisation at Section 6.7.2 as well as mentioning delirium and mental health input into A&E services. Dr Armstrong agreed that these were important areas to consider as the Clinical Strategy was developed.

**Medical
Director**

In response to a question from Mrs McAuley, Dr Armstrong agreed that the service models also required GPs to work in different ways and hoped that, in so doing, barriers to change would be worked through. Ms Harkness added that the development of the Strategy had incorporated a huge amount of engagement work and she provided reassurance that this work was ongoing with a broad range of clinical staff.

Ms Brown welcomed the focus of patients being at the centre of the Strategy and recognised the work that lay ahead in supporting areas such as dementia, anticipatory care, hospital at home and how junior doctors could be used in a more effective way.

In response to a question from Rev Dr Shanks, Mr Calderwood confirmed that all service provision going forward would be tested, particularly with regard to its interaction with the six IJBs as this Strategy would apply to them – to date, it was too early to say where there would be areas of consensus and/or friction but these would be debated at IJB and NHS Board level.

DECIDED

- That, the Clinical Strategy developed from the Clinical Services Review process be approved and it would be used to develop, as well as assess, clinical change proposals.

**Medical
Director**

The meeting ended at 10.50am