

Lanarkshire NHS Board

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Meeting of Lanarkshire NHS Board, Wednesday  
26<sup>th</sup> July 2006, at 10.00 am in the Board Room,  
NHS Lanarkshire, 14 Beckford Street, Hamilton

**CHAIRMAN:** Mr P K Corsar, Non Executive Director

**PRESENT:** Mr D Clark, Non Executive Director  
Mr T Currie, Non Executive Director  
Mr T Davison, Chief Executive  
Mr M F Hill Modernisation Director  
Councillor J McCabe, Non Executive Director  
Dr D C Moir, CBE, Director of Public Health  
Mrs M Nelson, Non Executive Director  
Mr I A Ross, Director, Acute Services  
Mr W Sutherland, Non Executive Director  
Mr H Sweeney, Employee Director  
Mr G Walker, Director of Human Resources

**IN**

**ATTENDANCE**

Mr N J Agnew, Corporate Affairs Manager/ Board Secretary  
Mrs K Hamilton, Communications Manager  
Mr I Hair, Head of Planning and Performance, North Community Health Partnership  
Mr E J H Mallinson, Consultant in Pharmaceutical Public Health  
Mrs C Potter, Deputy Director of Finance  
Mr G Sage, Interim Director, South Community Health Partnership  
Mr K A Small, Director of Organisational Development  
Dr V J Sonthalia, Chairman, Area Medical Advisory Committee  
Miss M M Taylor, Consultant in Dental Public Health

**APOLOGIES:**

Mr J A Anning, Non Executive Director  
Dr J D Browning, Medical Director  
Mrs S Goldsmith, Director of Finance  
Councillor E McAvoy, Non Executive Director  
Mrs D McCormick, Non Executive Director  
Mrs N Mahal, Non Executive Director  
Mr C Sloey, Director, North Community Health Partnership  
Mr P Wilson, OBE, Director for Allied Health Professions, Nurses and Midwives  
Mr P McCrossan, Chairman, Area Allied Health Professions Advisory Committee

71.

**WELCOME**

The Chairman welcomed members to the meeting. He extended a particular welcome to Dr. Sonthalia, Mrs. Potter and Mr Hair. He also paid tribute to Mr. Sage for his contribution, as Interim Director, in taking the South Community Health Partnership

through its formative stages from April 2006.

72.

### **CHAIRMAN'S REPORT**

The Chairman confirmed that following the NHS Board meeting on 27<sup>th</sup> June 2006, a full submission had been made to the Deputy Minister for Health and Community Care, for consideration.

The Chairman confirmed that the Board's Annual Review meeting with the Deputy Minister for Health and Community Care and senior Departmental officials, would be held on Tuesday 1<sup>st</sup> August 2006, within the South Lanarkshire Council offices. This meeting would be open to the public. The formal Annual Review during the afternoon, would be preceded, in the morning, by meetings of the Deputy Minister with: the Area Clinical Forum; the Area Partnership Forum; A patients group; and a visit to the integrated Day Care Centre at Coathill Hospital.

The Chairman confirmed the appointment of Alan Lawrie as Director of the South Community Health Partnership, and advised that Alan would join NHS Lanarkshire in early August, bringing with him a substantial track record of experience and achievement at a senior level within the National Health Service, most recently in England.

The Chairman confirmed the Ministerial appointment of Sandra Smith as a Non Executive Director of Lanarkshire NHS Board. Mrs. Smith would also join the Board in August, from a background which included Community Regeneration, Housing and Mental Health.

73.

### **MINUTES**

The minute of the meeting of the Lanarkshire NHS Board held on 27<sup>th</sup> June 2006 was submitted for approval and signature.

### **THE BOARD:**

1. Approved the minute for signature, subject to noting the following:

69.142 – this paragraph to read

The Employee Director reported that the opportunity had been taken, when conducting the Annual Staff Survey, to include questions about the engagement process. More than 70% of respondents to the survey had confirmed that they were aware of 'A Picture of Health'; 26% of staff respondents had taken the opportunity to comment on 'A Picture of Health'; and 40% of staff respondents had indicated that they felt that they had had an opportunity to influence the consultation document. Also, the Staff Governance Conference had confirmed Quality of Care as the most important of the six Decision Criteria and had confirmed its contentment with level of staff engagement in the 'A Picture of Health' process.

74.

### **FINANCE**

The NHS Board considered a Finance report for the month ended 30<sup>th</sup> June 2006 (circulated).

The Deputy Director of Finance explained that, as highlighted in the previous report, there had been significant challenges for the Finance Department during the first few months of the new financial year, as a result of changes in organisational structures across NHS Lanarkshire. She advised that trend analysis had proved difficult due to lack of available comparators for previous years, however, progress was being made, and the Finance team were working closely with Managers in their new roles to

ensure financial management reports reflected the revised structures, and that sound financial control was maintained.

The Deputy Director of Finance reminded members that the Five Year Financial Plan 2006/2011 approved by the NHS Board in February 2006, included a forecast year end surplus of £0.121m. She advised that the actual financial position to the end of June showed an overspend of £0.433m, compared with an overspend of £0.255m at the end of May. She stressed that work was in progress to provide a robust assessment of the likely year-end outturn in comparison to the planned surplus. She acknowledged that the in-year position was not as favourable as would have been expected, with the key contributory issue being a £2.162m recurring shortfall against the Corporate Recovery Programme. She highlighted a number of risks to the Financial Plan which had already been identified and presented significant challenges for the year ahead, including: Law Hospital; the Corporate Recovery Programme, where there was a need to identify other measures to offset the shortfall; and Out of Hours funding.

The Deputy Director of Finance explained that the Acute Division was reporting an overspend of £0.455m for the year to date, the most significant single contributory factor being approximately £0.225m relating to the costs of Original Pack Dispensing – there was currently an assessment underway of the impact of this service across NHS Lanarkshire, and any offsetting benefits would be taken into account through the mid-year review process. Within Primary Care, the North Community Health Partnership showed an underspend of £0.178m for the period, with the South Community Health Partnership recording a slight overspend of £0.010m. She advised that savings withdrawn from Primary Care budgets, as part of the Corporate Recovery Programme, had been allocated to specific areas within each of the Community Health Partnerships.

The Deputy Director of Finance explained that at the end of June, Headquarters Departments showed an underspend of £0.153m, mainly reflected across non pay expenditure. As the Corporate Recovery Plan had an expected level of savings in order to deliver the approved Financial Plan, this underspend could not be extrapolated to the year end. Work was, however, ongoing with budget holders to manage expenditure levels, to agree withdrawal of savings and to provide a robust assessment of any potential financial risks or benefits.

The Deputy Director of Finance explained that a proposal setting out a National Standard uplift to be applied to the NHS Scotland Service Agreements, had been issued to the National Directors of Finance Group in late June – work was underway to quantify the impact of this proposal, and to assess this against the level of funding provided for both pay and prices uplifts within the Financial Plan.

The Deputy Director of Finance stressed that the Corporate Recovery Programme remained a key component of the Financial Plan, in order to meet the financial target for the year, to move towards a recurring balanced position, and to achieve the Efficient Government Targets set out by the Scottish Executive. Against the CRP target of £8m, there was a forecast recurring shortfall of £2.162m, offset by £0.610m additional non-recurring savings, leaving an in-year shortfall of £1.552m to be addressed. A series of meetings with key Directors and other Senior Managers had been set up in early August, to consider options to address the shortfall, both in-year and on a recurring basis, given the impact that this would have on the overall achievement of a balanced financial position.

In discussion, Members sought clarification on the extent to which, in relation to the Law Hospital sale, there was a requirement to reassess the risk profile, particularly with regard to the consequences for the Board's financial position if the sale was not concluded in the current financial year. They also sought clarification on the potential impact of the extrapolation of the current overspend position through to the

financial year end, and the contribution of the actual staffing levels, including vacancy management, to the position.

The Deputy Director of Finance explained that whilst there was no material movement in the risk profile associated with the sale of the Law site, this remained a significant issue in terms of the Board's overall financial recovery. The Director, Acute Services, explained that the processes were moving forward to Outline Planning Permission which, when achieved, would require to be followed, within a period of 30 days, by the production of a detailed site plan by the Consortium. He reported a level of confidence on the part of the Board's Property Advisers that the sale could be concluded within the current financial year.

The Chief Executive reassured members that the comprehensive mid-year financial review would include a systematic reassessment of overall risk to the Board's financial stability, including an assessment of the additional challenges which the system could face during the remainder of the financial year, and the consideration of contingencies that might be employed to mitigate the loss of the £5m non-recurring revenue benefit, in year, that would accrue to the system from the conclusion to the sale of the Law site. He explained that the Law site had a current book value of £5m – therefore, the realisation of the anticipated £20m receipt would enable a contribution of £10m to address the Accumulated Deficit, leaving £5m as the non-recurring revenue benefit. He advised that the book value of the site, in the event that the sale was not concluded in the current financial year, would require further dialogue with the Board's external auditors. He reassured members that everything possible was being done to achieve the necessary Title Transfer in the current financial year.

The Deputy Director of Finance cautioned against extrapolating the current overspend in the Corporate Recovery Plan and in Acute Services, through to the financial year end, particularly in the case of Acute Services, where a substantial proportion of the overspend related to Original Pack Dispensing, which was currently the subject of in-depth review. In this regard, the Director, Acute Services, emphasised the extent of management action being taken, both to deliver in-year savings and achieve balance within the Division. He also explained the approach to managing staffing levels, and advised that this required to be viewed within a context where, in the current year, there had been material increases in emergency pressures within the Division, particularly at Wishaw General and Hairmyres Hospital, and on neonatal costs. He advised that whilst there were significant Consultant vacancies, the associated funding was utilised in the employment of locum and agency staff in order to maintain service provision. In an endorsement of this position, the Director of Human Resources explained for members the approach to funded establishments and actual workforce costs.

#### **THE BOARD:**

1. Noted the Finance Report for the month ended 30<sup>th</sup> June 2006.
2. Noted the actual revenue overspend of £0.433m.
3. Noted that further cost saving measures would be required to achieve in-year financial balance.
4. Asked to receive a further report.

Director  
of Finance

75.

#### **WAITING TIMES**

The NHS Board considered a report on waiting times (circulated).

The Director, Acute Services, explained that to evidence progress towards delivery of waiting time guarantees, a trajectory had been prepared for each guarantee – this indicated and anticipated improvements in waiting times, or number of patients

waiting on a monthly basis, through to the end of March 2007, with delivery of those improvements being informed by ongoing work around capacity planning and the impact of Service Redesign currently being taken forward through Collaboratives in Diagnostics and Cataracts, the Managed Clinical Network for Cardiology and the Lanarkshire Cancer Group. He advised that whilst the trajectory indicated improvements month on month, it was possible that fluctuations would arise due to unplanned pressures – an explanation for variations and actions to address them would routinely be provided to the NHS Board.

He advised that the maximum waiting time of 26 weeks for inpatients, daycases and outpatients, achieved at December 2005 was being maintained, as were the maximum waiting times of 8 weeks and 18 weeks, respectively, for angiography and angioplasty. He explained that there had been an increase during June in the total number of inpatients and daycases waiting over 18 weeks although, within that, the number of orthopaedic patients continued to fall, in line with the trajectory – the continued pressure around orthopaedics was being addressed through work with clinical staff to further refine the capacity plan, in addition to which, further capacity was being generated through internal waiting list initiatives, increased access to The Golden Jubilee National Hospital, and a contract through to the end of the calendar year 2006 with the Independent Sector. Through the Cataract Collaborative, work was in progress to identify capacity and demand – the number of patients waiting over 3 months had increased during May and June due, in part, to the underutilisation of available capacity, but this situation was currently being addressed. Considerable progress had been made to reduce the number of outpatients waiting over 18 weeks, and whilst this had increased during June, it remained in line with the trajectory.

The Director, Acute Services, explained that whilst there continued to be a month on month reduction in the number of patients with an Availability Status Code, the number for June exceeded the trajectory – this reflected the backlog of patients that had been on the ASC list for some time. He stressed that work was in progress to review waiting lists where patients had been allocated an Availability Status Code, and this was reflected in the increased reduction during June – this phase would shortly be completed, following which, it was proposed to introduce the recommendations of the New Ways Guidance, designed to improve the management of waiting lists.

He advised that there were particular pressures around compliance with the Waiting Time Guarantee for lung and colorectal cancer – a mechanism to capture real-time patient information was however now established, with protocols in place to ensure urgent referrals from GPs were processed appropriately, and within the 62 day maximum Waiting Time Guarantee. He emphasised the action being taken to address the backlog of patients currently on the waiting list, through the provision of additional capacity during July, August and September, to ensure that those patients were diagnosed and, if necessary, received their first treatment over that period. He assured the Board that the National Delivery Unit had been advised of the actions being taken, with reassurance that the objective was to deliver the Waiting Time Guarantee by 30<sup>th</sup> September 2006 and, thereafter, to sustain that position. The National Delivery Unit had also been advised that a consequence of the actions being taken, with an increased number of backlog patients being seen and, as appropriately, receiving their first treatment, was that the percentage compliance with the Waiting Time Guarantee in colorectal and lung cancers would fall during July, August and September. The Delivery Unit had advised the NHS Board of their intention to introduce weekly performance reporting against each of the main tumour types from September 2006 – this, for Lanarkshire, would involve reporting on 9 or 10 cancer sites, as opposed to the current four priority cancer sites, and this would also be reflected in waiting times reports to the NHS Board from October 2006.

The Director, Acute Services, explained that the approach to managing the cancer backlog and moving, increasingly, towards the delivery of the Ministerial guarantee

involved a whole – system review of the patient pathway, around: protocolised GP referrals; Consultant review; access to diagnostics; and treatment, including the role of the trackers in arranging direct access from GP referral to diagnostic services – the management of sustainability of this revised patient pathway for diagnostics and treatment, was currently under review. He outlined the definitional issues in relation to treatment within 62 days for GP urgent cancer referrals, and explained that the system’s performance in this area should be clarified during September, and reflected in the waiting times report to the Board in October – this report would confirm system performance in relation to the achievement of 95% delivery and a clear explanation of the additional numbers of patients being treated. He also explained that following SEHD clarification on definitions around waiting times, there was then a requirement to work-up a robust data capture system to underpin measurement of the system’s performance against the waiting time guarantees.

He explained that work was in progress through the Unscheduled Care Collaborative, to reduce waits in Accident and Emergency Departments to less than four hours – in this regard, the overall NHS Lanarkshire performance had increased in June from 86% to 87%, slightly below the target performance set out in the Delivery Plan. He emphasised that a whole system approach was being adopted, reflected in a detailed Action Plan that had been shared with the National Centre for Change and Innovation.

The Director, Acute Services, highlighted the explanation within the waiting times report that increases in some areas in the numbers of patients waiting during May and June was due, in part, to the underutilisation of available capacity, and emphasised the extent to which improving the system’s efficiency in this area was being addressed within the Division.

He stressed that in future reporting, the opportunity would be taken to further refine and improve the information made available to the Board, to increase awareness of the waiting time position, the pressures on the service that may result in variation from the anticipated trajectory, and the action being taken to address those issues.

**THE BOARD:**

1. Noted the report on Waiting Times.
2. Asked to receive a further report.

Director  
Acute  
Services

76.

**DELAYED DISCHARGES**

The Board considered a report on the Delayed Discharges position at 15<sup>th</sup> July 2006 (circulated).

The Director, Acute Services, explained that there were 51 delayed discharges at 15<sup>th</sup> July 2006 – this represented an increase from the previous month, but remained below the delayed discharge target of 66, achieved at 15<sup>th</sup> April 2006. He stressed that further discussions had taken place with the Scottish Executive on the format and content of future reporting of delayed discharges, in line with the revised targets to be achieved by 15<sup>th</sup> April 2007 to reduce all delays over 6 weeks by 50%, and to free up 50% of all beds occupied by delayed discharge patients in short term beds. He explained that recent agreement on the detail in these areas would enable the new reporting of delayed discharges to commence in August 2006, including information on Adults with Incapacity.

**THE BOARD:**

1. Noted the report on the Delayed Discharges position at 15<sup>th</sup> July 2006.
2. Asked to receive a further report.

Director  
Acute

77.

**PRIMARY CARE OUT OF HOURS SERVICES**

The Board considered a report on the Primary Care Out of Hours Service (circulated).

The Interim Director, South Community Health Partnership, highlighted the principal elements of the report, in relation to: Performance, including overall activity in May and in June and overall response times; Staffing; IT; and the NHS 24/Lanarkshire Satellite Centre, including the Emergency Dental Service, Primary Care Nurse Triage, and Calls Answered. He also highlighted referrals to the Community Nursing Service, and the pilot for direct referral from the Scottish Ambulance Service for catheter and PEG feeding tube patients, which commenced on 1<sup>st</sup> July 2006, and would be evaluated over 6 months – the purpose of this pilot was to investigate whether direct referral to District Nursing would prevent unnecessary admission to hospital for these patients.

In discussion, he acknowledged the need to contextualise response times, in terms of the prioritisation of calls, and confirmed that this would be a feature of the presentation in future reports.

Director,  
North CHP

The Chief Executive explained that the Lanarkshire Out of Hours Primary Care Service was now well established and developed. He suggested that it would be appropriate for the Directors of the North and South Community Health Partnerships and the General Manager at Hairmyres Hospital, who had a specific responsibility for unscheduled care, to give a presentation to the Board at a future meeting on unscheduled care, focussing on the linkages across the Primary Care Out of Hours Service and Accident and Emergency Services.

Director,  
Acute  
Services and  
Directors,  
CHPs

The Consultant in Dental Public Health outlined the progress in the Emergency Dental Service, including the level of voluntary participation on the rota by General Dental Practitioners and the follow up arrangements for patients, registered or unregistered, who accessed the service.

Members, whilst welcome the reporting on Primary Care Out of Hours Service activity, asked that the future development of the reports to the Board should focus, increasingly, on measuring the performance of the Lanarkshire Service. In this regard, it was noted that the report of an NHS Quality Improvement Scotland Review of the Provision of Safe and Effective Primary Medical Services Out of Hours within NHS Lanarkshire would be considered by the Board's Health and Clinical Governance Committee on Monday 31<sup>st</sup> July 2006.

**THE BOARD:**

1. Noted the report on Primary Care Out of Hours Services.
2. Asked to receive a further report.

Director,  
North  
CHP

78.

**COMMUNITY HEALTH PARTNERSHIPS**

The NHS Board received a presentation on Community Health Partnerships – Improving Health, Reducing Inequalities, from the Interim Director of the South Community Health Partnership and the Head of Planning and Performance of the North Community Health Partnership.

The presentation covered the Community Health Partnership main priorities, in relation to: improving health; reducing inequalities in health; improving services; empowering staff and localities; working in partnership; and patient focus and public

involvement. Members received an explanation on: the background to the development of Community Health Partnerships and their structures; CHPs focus on health improvement and reducing inequalities; partnership working and development; examples of practical action and partnerships, and developing public involvement and community engagement. Emphasis was placed on CHP development in relation to: integration of mental health, learning disabilities, health promotion and children's services into localities; and delegated responsibility to CHPs for Community Planning, Joint Future, and Joint Health Improvement. Patient Focus Public Involvement was highlighted, with an explanation of the mechanisms through which this statutory requirement was being given effect, including through the creation of Public Partnership Forums – these were joint structures, focussed on empowered localities, and were linked to Joint Future/user and carer structures and Managed Clinical Networks. The extent to which Community Health Partnerships were focussing on improved health and reducing inequalities, was emphasised, through: capitalising on their delegated roles; recognising the wider determinants of health and the need for partnership; reorganised and focussed staff teams; empowered localities, and adopting engagement methods and the new Public Partnership Forums, to reach excluded individuals.

Members welcomed the explanation of progress in the development of Community Health Partnerships and in relation to developments current and planned within Community Health Partnerships. The need was highlighted to focus, in particular, on the performance management of the interface agenda between the Community Health Partnerships and the Acute Division. The Director, Acute Services, explained that there already were substantial linkages in place between Acute Services and Primary Care, including through the Collaboratives, the arrangements for the management of Cancer Services and agreement on joint objectives. Work on further developing the integration agenda would, however, continue. It was noted, also, that the Senior Management Teams for each of the Community Health Partnerships and the Acute Division were now co-located, and this should further enhance the scope for joint working.

The Interim Director of the South CHP and the Head of Planning and Performance of the North CHP outlined for members specific examples of initiatives which already were delivering results, including: quit rates within the smoking cessation service; the beneficial impact of breastfeeding, reflected in increased birth weights; the further development of Clinical Support Workers; employment opportunities for the long term unemployed; fruit sales via the Shotts Food Co-operative; and engaging young people in diversionary activities, with consequent reductions in crime rates and levels of attendance at Accident and Emergency Departments.

Members particularly welcomed the development of Patient Focus Public Involvement. Whilst the range of mechanisms for public involvement was noted, there was recognition of the need, increasingly, to further development of the patient focus element, and this would be taken forward systematically within both Community Health Partnerships.

Emphasis was placed on the need to identify the means by which the success of Community Health Partnerships would be measured, and further consideration would be given to this issue, both within the Community Health Partnership Operating Management Committees, and at NHS Board level. There was recognition, also, of the importance of making information about CHP achievements and successes publicly available.

#### **THE BOARD:**

1. Noted presentation on Community Health Partnerships – Improving Health, Reducing Inequalities.

79.

**MINUTES FOR INFORMATION**

The Board received and noted the minutes of meetings of the Equality, Diversity and Spirituality Committee and the Operating Management Committees, as follows:

- a) Equality, Diversity and Spirituality Committee – 20<sup>th</sup> January 2006
- b) Equality, Diversity and Spirituality Committee – 28<sup>th</sup> March 2006
- c) Community Health Partnership South Operating Management (Performance Management) Committee – 3<sup>rd</sup> April 2006
- d) Community Health Partnership South Operating Management (Performance Management) Committee – 22<sup>nd</sup> May 2006
- e) Community Health Partnership North Operating Management (Performance Management) Committee – 3<sup>rd</sup> April 2006
- f) Community Health Partnership North Operating Management (Performance Management) Committee – 3<sup>rd</sup> May 2006
- g) Acute Operating Management (Performance Management) Committee – 19<sup>th</sup> April 2006.
- h) Acute Operating Management (Performance Management) Committee – 29<sup>th</sup> June 2006.

The Chairman emphasised the requirement for Operating Management Committees to continue to ensure that the issues under consideration reflected the key priorities in relation to: health improvement; partnership working with local authorities; performance management; and public and patient and voluntary sector involvement. He reminded the Board of the commitment to review the operating arrangements for Community Health Partnerships, and confirmed that the first review would be undertaken after 6 months of their operation, with a report on the outcome of the review being brought to the Board.

80.

**DATE OF NEXT MEETING**

Wednesday 23<sup>rd</sup> August 2006 at 10.00am.

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