Lanarkshire NHS Board

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Meeting of Lanarkshire NHS Board, Wednesday 22nd November 2006, at 9.30 am in the Board Room, NHS Lanarkshire, 14 Beckford Street, Hamilton

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

PRESENT:

Mr J A Anning, Non Executive Director
Dr J D Browning, Medical Director
Mr D Clark, Non Executive Director
Mr T Currie, Non Executive Director
Mrs S Goldsmith, Director of Finance
Mr M F Hill Modernisation Director
Mr A Lawrie, Director, South Lanarkshire Community Health Partnership
Mrs D McCormick, Non Executive Director
Mrs N Mahal, Non Executive Director
Dr D C Moir, CBE, Director of Public Health
Mrs M Nelson, Non Executive Director
Mr C Sloey, Director, North Lanarkshire Community Health Partnership
Mrs S Smith, Non Executive Director
Mr W Sutherland, Non Executive Director
Mr H Sweeney, Employee Director
Mr P Wilson, OBE, Director for Allied Health Professions, Nurses and Midwives

IN ATTENDANCE

Mr N J Agnew, Corporate Affairs Manager/ Board Secretary
Mrs K Hamilton, Communications Manager
Mrs R Lyness, General Manager, Acute Services
Mrs C McGee, Risk Manager
Mr E J H Mallinson, Consultant in Pharmaceutical Public Health
Mr K A Small, Director of Organisational Development
Dr V J Sonthalia, Chairman, Area Medical Advisory Committee
Ms V Tallon, Alcohol and Drug Action Team Co-ordinator (For item 112)
Miss M M Taylor, Consultant in Dental Public Health

APOLOGIES:

Mr T Davison, Chief Executive
Councillor E McAvoy, Non Executive Director
Councillor J McCabe, Non Executive Director
Mr I A Ross, Director, Acute Services
Mr G Walker, Director of Human Resources
Mr P MCrossan, Chairman, Area Allied Health Professions Advisory Committee

106. **CHAIRMAN'S REPORT**

The Chairman reported on the principal issues considered at the meeting of NHS Chairs with the Minister for Health and Community Care on 30th October 2006, including:

- Finance;
- Agenda for Change;
- Waiting Times, especially Cancer;
- Modernising Medical Careers;
- Quality Assurance of Blood Banks;
- Nutrition, especially for the Elderly;
- The Consultation on Public Health Legislation;
- Citizens Advice Bureau working in tandem with Boards on the provision of advice to people with concerns;
- Local Delivery Plan Targets; and Prevention 2010, the Keep Well Initiative, which was operating within Lanarkshire, in Airdrie, Coatbridge and Wishaw.

107. **MINUTES**

The minute of the meeting held on 25th October 2006 (circulated), was submitted for approval and signature.

THE BOARD:

1. Approved the minute for signature.

108. **A PICTURE OF HEALTH**

The Modernisation Director updated members on a number of aspects around implementation of A Picture of Health.

He confirmed that beyond the Board's decisions on Cancer and Dermatology at its meeting on 25th October 2006, recommendations in relation to these specialties had been submitted to the Deputy Minister for Health and Community Care for consideration and a response was awaited.

In relation to Palliative Care, he reported that a meeting had been held between Board representatives and representatives of Kilbryde Hospice Appeal Board. This had resulted in the development of Heads of Agreement, which would be the subject of a further report to the NHS Board when concluded.

The Modernisation Director reminded members that when, on 25th October 2006, the Board had given consideration to the Outline Business Case for Airdrie Resource Centre, two material issues remained to be resolved, viz: car parking and optimism bias.

The Director of Finance reported on further discussions with North Lanarkshire Council in relation to the car parking issue. She confirmed that North Lanarkshire Council had reviewed car parking requirements in Airdrie, and were considering the outcome. She advised that a further meeting of the Capital Investment Group was due to be held on 8th December 2006, and it was hoped that there would be further clarity from North Lanarkshire Council on the position prior to that date.

The Director of Finance reported also on discussions with SEHD about optimism bias. The Department had indicated that it may be possible to revise optimism bias downwards if the NHS Board could demonstrate the means by which it would mitigate the risks robustly. This issue was the subject of further consideration locally, and a further meeting was due to be held with the Department on 27th November 2006.

The Director of the North Lanarkshire Community Health Partnership advised that General Dental Practices within Airdrie had been formally invited to express interest in being accommodated within the Airdrie Resource Centre. Thus far, two practices had expressed an interest, and the Consultant in Dental Public Health was pursuing discussions with another three practices. The Director confirmed that the issue of

General Dental Practitioner input would be explicitly addressed within the Full Business Case for the Airdrie Resource Centre.

The Modernisation Director reported on progress in the development of a Programme Initial Agreement for the priority A Picture of Health developments. This would be brought to the NHS Board for approval, either in December or January, and would then be submitted to SEHD for approval. Thereafter, Business Cases for individual priority developments would require to be signed off by the Board against the Programme Initial Agreement.

The Modernisation Director confirmed that detailed discussions were being taken forward on cross boundary flow through the new, strengthened Steering Group arrangements with NHS Forth Valley and NHS Greater Glasgow and Clyde. He advised that the Full Business Case for the new Larbert Hospital was due to be considered by the Forth Valley NHS Board at its meeting in January 2007. He confirmed, also, that meetings would be held with General Practitioners in Coatbridge and in Cumbernauld and Kilsyth to explore in further detail the cross boundary flow implications for patients within those catchments. He reminded members of the stipulation within the 21st August 2006 letter of approval from the Deputy Minister for Health and Community Care that a Regional Plan, developed by the West of Scotland Regional Planning Group, should be submitted to him for approval. The Modernisation Director confirmed that the ongoing discussion on cross boundary flow, including dialogue with the Scottish Ambulance Service, should enable the relevant Boards and the Scottish Ambulance Service to sign off the Regional Plan for Acute Hospitals for submission to the Deputy Minister early in the New Year.

In discussion, members raised for clarification issues in relation to reconciling the principle of managed catchments with patient choice, and choice in relation to the destination for planned care.

The Modernisation Director acknowledged the extent to which choice existed currently, both in relation to emergency care and planned care. He re-stated the importance of maintaining close dialogue with General Medical Practitioners on this issue, as part of the further detailed consideration being given to the overall issue of cross boundary flow. He acknowledged that the position of Monklands Hospital as the main point for referral for planned care would require further detailed discussions with General Medical Practitioners in the Cumbernauld and Kilsyth area in particular. He also emphasised the requirement, overall, for explicit, joined up planning in relation to the cross boundary flow arrangements.

The Medical Director reminded members that a high level risk assessment had already been undertaken to identify the key areas of risk. He advised that further, detailed consideration was being given to the output from the high level risk assessment, and confirmed that this encompassed risk assessment in relation to the cross boundary flow assumptions and managed catchments.

The Chairman stressed the importance of the NHS Board receiving regular progress reports on all of the priority A Picture of Health Projects, and suggested that this might usefully form the basis for consideration at a Board Seminar. The Modernisation Director advised that this would sit well with the agreed quarterly reporting to the Performance Management Group on the progress of all of the priority projects.

THE BOARD:

1. Noted the progress report on A Picture of Health Implementation.
2. Asked to receive further reports.

Modernisation Director

109. **DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT**

The NHS Board considered the Annual Report of the Director of Public Health 2005 on the Health of the People Within the Lanarkshire NHS Board area (circulated).

The Director of Public Health gave a detailed presentation in the areas of: health improvement (health of the people of Lanarkshire; improving health in Lanarkshire; working together to promote health; clearing the air); health protection (communicable disease and environment health; emergency planning/preparedness; neonatal screening programmes in Lanarkshire); and health service provision (implementing health needs assessments in the areas of healthy working lives, epilepsy, vascular surgical services, mental health stigma, discrimination and prejudice) and needs assessments, in the areas of gambling, colorectal cancer screening, cancer in children, children with additional support needs, depression, minority ethnic groups, and homeless people.

The Director of Public Health highlighted smoking in pregnancy as one of the causes of low birth weight and prematurity, with pregnant women who smoked at booking being two and a half times more likely to give birth to low birth weight babies than non smokers.

She highlighted the extent to which alcohol remained a serious problem, with 3,827 alcohol-related general hospital in-patient discharges in 2004/05, representing a 22% increase over the previous 5 years. The diagnoses in these cases showed 31% with harmful alcohol use, 21% with acute intoxication, and 19% with alcoholic liver disease, mostly aged between 45-54. This was a particular problem amongst deprived communities.

The Director of Public Health highlighted the extent to which deaths from coronary heart disease and deaths from cerebrovascular disease and chronic obstructive pulmonary disease in persons under 75 years had shown a downward trend since 1990, but had not reduced at the same rate as for Scotland as a whole.

In the area of lifestyle, the Director of Public Health highlighted smoking, a diet rich in fat and sugar, and a lack of physical activity resulting in obesity, as major causes of disease and death. In particular, she expressed concern at the results of the Scottish Schools Adolescent Survey, which showed significant levels of smoking and alcohol consumption in pupils by the age of 15, as well as high levels of consumption of sweets and chocolates and sugary drinks, low consumption of fruit, use of illegal drugs and significant percentages of girls who were not physically active.

In the area of health care, she highlighted effective treatment for patients with cancer, (lung, breast, colorectal, ovarian;) coronary heart disease; cerebrovascular disease (stroke); chronic obstructive airways disease and asthma; and mental illness.

The Director of Public Health highlighted the extent of working together to promote health, including with the Local Authorities through health promoting nurseries; the voluntary sector through the North Lanarkshire Federation of Food Co-operatives; and Motherwell Football Club, to promote health through an ‘Eat with the Players’ Event.

The Director of Public Health highlighted the trends in relation to notified or reported communicable disease, and whilst this was encouraging in some areas, there remained significant challenges for public health in this area. She highlighted particular issues in relation to: antenatal screening for communicable disease; bloodborne viruses; the withdrawal of the BCG vaccination in favour of a targeted programme; and childhood vaccine uptake.

In the area of environmental health, she highlighted the identification of contaminated land; the monitoring of air quality; the introduction of food safety management systems and the provision of food safety training; and the sampling of private water supplies, with improvement orders issued, as required.

The Director of Public Health highlighted the extent to which emergency planning and preparedness had gained an increased profile both nationally and locally. She reported on the major challenges for 2005, in relation to: the G8 Summit; Pandemic Influenza planning; Avian Influenza; and Smallpox planning, and on awareness – raising training and exercising, involving the emergency planning partners.

She reported on key issues and developments in relation to: cervical screening; breast screening; the introduction of the universal newborn hearing programme in 2005 and the planning for pre-school orthoptist vision screening, which had begun during the year. She reported on the work undertaken in implementing Health Needs Assessment, with particular regard to: *Healthy Working Lives* (Scottish Executive 2004), taken forward through the Lanarkshire Healthy Working Lives Group; *Routes to Health* and *Healthy Working Lives*, bringing together health and employability, providing health-related interventions within existing community premises. She also highlighted the national targets set within *Scotland's Health at Work*, and the focus on retaining the capacity to deliver across Lanarkshire including *Supporting Pathways 2 Work*.

She highlighted the extent of recorded epilepsy, with 4000 adults aged 16 years and over. She explained that the 2000 Annual Report had emphasised the role of Primary Care in the management of uncomplicated epilepsy and the establishment of a first seizure assessment service and epilepsy specialist nurse to improve care. She reported the finding that approximately 23% of people in England and Wales who had been diagnosed with epilepsy did not actually have epilepsy. This finding had been endorsed by the Scottish Intercolegic Guidelines Network (SIGN), which would equate to a figure closer to 1000 adults in Lanarkshire aged 16 years and over, with epilepsy.

The Director of Public Health highlighted the extent to which Gambling was an issue, with estimates of approximately 3000 problem gamblers, and 45,000 people negatively affected by this problem. She highlighted the personal costs and health consequences of problem gambling, including violence against partners, as well as the implications for GP addiction staff, social workers and debt management. She outlined the national approach to this issue, involving pro-active preventive public health programmes, targetted low income groups, adolescence, women and the elderly and the focus for local action, involving the voluntary sector, the NHS and Local Authorities.

The Director of Public Health explained that Scotland was a high incidence country for colorectal cancer with poorer than average five-year survival, and increased risk with age, in men more so than women. She reported that a colorectal screening pilot had resulted in a 10% increase in colorectal cancer registrations. She advised that, in Lanarkshire, 150,000 men and women would be eligible for colorectal screening during the two year period of the pilot, bringing demands on the system for additional endoscopy, radiology, pathology and surgery.

She explained that in Scotland, cancer in children accounted for 5% of all childhood deaths. In Lanarkshire, there were 14 new cases of cancer in children each year, with five deaths per year. She explained that Lanarkshire children with cancer were referred to the Royal Hospital for Sick Children in Glasgow which had a full range of facilities with waiting times being minimal and treatment within a month. She explained that long term survival was good with 1 in 1000 of the young adult population being survivors. She highlighted issues in relation to long term follow up and the requirement for palliative care services. She explained that the approach to dealing with cancer in children met National Institute for Clinical Excellence (NICE),

standards, with a multi-agency team approach, and children's' anaesthetist research trials, as well as agreed treatment protocols and the availability of sufficient specialist staff through cancer networks.

The Director of Public Health highlighted the position of children with additional support needs, as a result of family circumstances, social and emotional, disability or health needs. She highlighted, in particular, the additional support required in relation to children with: asthma; diabetes; epilepsy; Down's Syndrome; attention deficit hyperactivity disorder; autistic spectrum disorder; and mental health problems. She advised that support was available from within the school, education, and through external multi-agency support, with personal learning, individualised educational programmes and a co-ordinated support plan.

She advised that minority ethnic groups accounted for approximately 1.2% of the Lanarkshire population, although she acknowledged that local information was incomplete, since ethnicity in Standardised Mortality Ratio (SMR) returns was not mandatory. She advised that in Lanarkshire, there were higher minority ethnic levels associated with affluent areas, and that evidence on ethnic health came from ethnicity positively associated with deprivation. She explained that a Primary Care survey had highlighted the lack of available information, a lack of auditing, some lack of cultural awareness and the need for professional training, as issues that required to be addressed in relation to minority ethnic groups.

The Director of Public Health explained that 'Homeless' was a wide-ranging definition. She highlighted the increase in housing applications since 2002/03, and the results of a homeless survey, which identified reduced access to primary medical and dental health care, with preventive care lessened and 50% of respondents identifying long-standing illness. She reported that there was a homeless unit in Blantyre funded by North Lanarkshire Council. She also highlighted the extent of Accident and Emergency visits by the Homeless. She reported key developments, in the areas of: access for the homeless to general medical practices without appointments; the availability of multi-disciplinary care, focussing on the needs of children; the uptake of preventative services; the establishment of a database; the identification of a series of vulnerability indicators to anticipate potential cases of homelessness and education for NHS staff in understanding the issues for the homeless and meeting their needs.

The Consultant in Dental Public Health explained that the section on oral health within the Annual Report, this year, focussed on the early health of children. She advised that childrens oral health, despite improvements in the last 20 years, remained an ongoing challenge for NHS Lanarkshire, with dental disease occurring more frequently in children from deprived backgrounds, where five year olds were more likely to suffer from severe dental decay.

She highlighted the National Dental Inspection Programme, involving two key age groups, viz: Primary One children, at school entry, and Primary Seven, before entry to secondary education, with the programme having two levels: a 'basic inspection' which all children received, and a 'detailed inspection', for a representative sample only. The Consultant in Dental Public Health stressed the extent to which monitoring childrens dental health at a National and Regional level provided reliable information for planning and evaluating initiatives directed towards improvements, and served to show progress towards meeting national targets.

She highlighted the percentage of five and eleven year olds who were decay-free for Scotland and Lanarkshire, tracking the trend in this area from 1993/94 to 2004/05. This showed that whilst the position in Lanarkshire was improving, it was not improving at the same rate as for Scotland. She also highlighted the fact that the greatest proportion of children requiring immediate dental care were in the Airdrie and Hamilton areas, with Cumbernauld and Kilsyth having the least need. She reported changes since the last measurement of risk categories, with Coatbridge

showing the most improvement, whilst the position in most other localities had remained reasonably stable.

The Consultant in Dental Public Health reinforced the finding that the majority of dental disease occurred in children from more deprived backgrounds, where five year olds were more than three times as likely to suffer from severe dental caries and missing teeth, than children of a similar age from more affluent areas. She highlighted the detailed epidemiological survey of Scottish children in Primary Seven undertaken during the year, which showed that this general trend was obvious at this age also. She also highlighted the comparison between Lanarkshire and other areas in Scotland for decay experience at eleven years of age where the level was high, with only about 40% being treated conservatively. This meant that 60% of the affected teeth were either so badly decayed that they needed to be extracted, or that the teeth were being left untreated.

She stressed the importance of regular dental attendance to ensuring that teeth were conservatively treated at an early stage of disease, and reported that there had been a small increase in dental registrations in this age group, with approximately 71% of six to twelve year olds currently registered with a dentist. She advised, also, that registration rates for adults, as with children, were increasing in Lanarkshire.

The Consultant in Dental Public Health reported that 2005 represented the first full year of the implementation of *An Action Plan for Improving Oral Health and Modernising NHS Dental Services in Scotland.* She highlighted the initial targets within the Action Plan, ensuring that there was: distribution of preventive packs, toothbrush and toothpaste, and associated literature on diet and oral care to children, up to and including starting school; daily nursery toothbrushing in all nursery years; daily toothbrushing for Primary One and Primary Two children in the most deprived quintile of schools; full implementation of the National Dental Inspection Programme, with inspection of all Primary One and Primary Seven children annually; and linking of oral health programmes to generic health promoting programmes.

She explained that good progress had been made towards meeting the Dental Action Plan targets, with 65% of children in the first year of life, and 73% of children at nursery schools, receiving their oral health packs. All of the nursery schools had been offered daily toothbrushing programmes, and currently 95% were on the scheme, involving 14,000 children. The National Dental Inspection Programme had been implemented across Lanarkshire, and 99% of children starting Primary school had received their toothbrushing packs (over 6,000 packs).

The Consultant in Pharmaceutical Public Health highlighted the pharmaceutical elements of the Annual Report. He stressed the extent to which medicines formed an integral part of patient care, and explained that the vast majority of patients accessing NHS services were on medication. He stressed the importance of ensuring that patients received the right medicine in the right dose at the right time. He explained that on average, each Lanarkshire resident received 17.2 prescriptions per annum, compared to a level of 15.2 for Scotland and that, regrettably, many patients did not take their medicines correctly or even at all – this was reflected in the approximately 3 metric tonnes of unwanted medicines returned to Community Pharmacies per annum. He highlighted the focussed, proactive campaign aimed at reducing wasted medicines in Lanarkshire and explained that over £15m worth of prescribed medicines were wasted in Scotland every year.

He highlighted the Lanarkshire performance against other NHS systems in Scotland in relation to generic prescribing, as well as the performance, by Lanarkshire locality, in relation to the prescribing of Hypnotics, Anxiolytics, Antimicrobials, and Ulcer Healing drugs.

The Chairman of the Area Medical Committee endorsed the Annual Report finding in relation to the extent to which alcohol abuse was an issue, placing substantial demands on primary care services. The Chair of the Area Clinical Forum endorsed this view. She highlighted the particular issue of epilepsy and alcohol, as an area where poly-pharmacy and person self management were important, drawing on nurse experience of chronic disease management, using models of care which demonstrably worked well. She stressed the need for objective, informed decisions about investment in addressing key issues, and the need for careful planning to underpin the delivery of services to patient groups.

There was recognition that NHS Lanarkshire was managing long term conditions on an ongoing basis, including through the contribution of specialist nurses who understood particular conditions. The role of the Care Management Pilots in this regard was also noted. The Director of the North Lanarkshire Community Health Partnership highlighted the £3.133m of investment to support the Long-term Conditions Strategy. He also highlighted Keep Well (Prevention 2010), which focussed on anticipatory care, and included patient self management. The Director of the South Lanarkshire Community Health Partnership highlighted the work of Programme 2 within the Modernisation Board, which was focussed on the development and delivery of a revised Primary Care Strategy. These approaches were taken forward in partnership with North and South Lanarkshire Councils through the existing Community Planning arrangements.

There was recognition of the need to synchronise the range of factors highlighted in the Annual Report with the strategic direction set out in A Picture of Health. There was recognition, also, of the need to continue to review prescribing, in order to ensure that the benefits of investment in this area were maximised. The Director of Public Health acknowledged the need to synchronise the principal conclusions within the Annual Report with the strategic direction set out in A Picture of Health. Whilst acknowledging that there were areas, which would require investment, she stressed that a number of key issues were capable of being addressed either without investment or with only minimal investment.

The Consultant in Pharmaceutical Public Health highlighted the substantial investment in critically reviewing describing which, to date, had delivered improvements. He highlighted the need, however, for further investment and additional pharmacy staff to continue this work, especially in relation to interaction with prescribers. He also stressed the need to continue to educate the public about adopting a responsible attitude to the use of prescribed medications.

The Chairman sought clarification on the mechanism through which to take forward the service development issues and other actions highlighted within the Annual Report.

It was agreed that the Annual Report, along with the Health and Clinical Governance Annual Report, which appeared later in the agenda, should be considered further by the Corporate Management Team, with a view to identifying the priority actions, and the means through which they would be taken forward.

THE BOARD:

1. Endorsed the Annual Report of the Director of Public Health 2005 on the Health of the People Within the Lanarkshire NHS Board area.

2. Remitted to the Corporate Management Team the task of considering further the actions within the Annual Report and the means through which these would be taken forward.

Chief Executive

110. **MODERNISING MEDICAL CAREERS**

The NHS Board considered an update report on Modernising Medical Careers (circulated).

The Medical Director explained that the report contained considerable detail in relation to Modernising Medical Careers, New Deal Standards and the European Working Time Directive, as they applied to junior doctors, and Medical Workforce Planning, all of which were inextricably linked. He highlighted the principal conclusions within the paper, which were that the introduction of modernising medical careers would produce significant benefits for patient care through:

- Ensuring more focussed post graduate training of medical staff within more clearly defined timescales.

- Creating far more training posts.

- Providing an opportunity to redress the imbalance of senior training posts in Scotland and within the West of Scotland.

- Ensuring a better supply of suitable applicants for Consultant and General Practitioner appointments.

- Allowing the Acute Service to move towards a Consultant based service.

The Medical Director explained that there were numerous risks associated with the implementation of modernising medical careers, including:

- Short-term risk to service provision from the recruitment process denuding the service of staff at the end of the financial year 2006/07 leading to failure to achieve waiting times targets.

- Risk of failure of the MTAS system on which the process of recruitment was dependent.

- Potential shortfall in service provision as a result of loss of service input from trainees.

- Financial risks associated with any solution to backfilling service loss, which would vary with the medical workforce model adopted.

He highlighted the next steps which had been identified in relation to implementation of Modernising Medical Careers, including:

- Local NHS Lanarkshire specialty meetings from December 2006 to identify potential service shortfall and solutions, and to take account of the European Working Time Directive.

- Involvement of other professional disciplines in wider thinking about workforce redesign through Area Clinical Forum meetings; specialty discussions; a Picture of Health Programme Boards, etc.

- NHS Lanarkshire Medical Workforce Planning Group co-ordinating the approach to Modernising Medical Careers Implementation; implementation of the European Working Time Directive; continuing compliance with New Deal Standards and Medical Workforce Planning linking into the NHS Lanarkshire Workforce Planning Group.

- West Regional Medical Workforce Project Board identifying potential service gaps and solutions; driving Medical Workforce Planning and monitoring the distribution of trainees, and linking to the Regional Planning Group and National Workforce Planning.

- Development of the NHS Lanarkshire Modernising Medical Careers Risk Register and Action Plan, linking to the Manpower Services Group of the Scottish Executive Health Department.

- Clarification of which medical workforce model should be embraced in Scotland through discussions between Chief Executives and Chairmen and the Scottish Executive Health Department and the Minister.

The Medical Director highlighted the Chief Medical Officer's commitment to a Consultant based Model of Care throughout the NHS in Scotland. He stressed that whilst the implementation of Modernising Medical Careers would, ultimately, lead to an improved service and better service quality, there would be a need to carefully manage the risk associated with the transition. He highlighted the consideration being given to situations where service provision was significantly reliant on training posts, including the discussions with National Education Scotland in this regard. This would produce greater clarity, shortly, about the numbers of trainees required. He also highlighted the need to align the change and the transition with service change across the NHS in Scotland.

THE BOARD:

1. Noted the update report on Modernising Medical Careers.
2. Asked to receive a further report. — Medical Director

111. **EQUALITY, DIVERSITY AND SPIRITUALITY**

The NHS Board considered the Equality, Diversity and Spirituality Strategy and Action Plan 2006/07 (circulated).

Mrs. Mahal, as Chair of the Equality, Diversity and Spirituality Committee, reminded members that at its meeting in September 2006, the Board had agreed that fuller consideration would be given to progress in the areas of equality, diversity and spirituality at the November Board meeting. She explained that the report and papers before the Board sought to highlight areas of progress and achievement to date, set out the Board's strategic intent and confirmed the content of the Annual Action Plan for 2006/07.

The Director of Organisational Development gave a detailed presentation to the NHS Board, which included a summary of progress and achievements to date, in the areas of: energising the organisation; demography and health; access and service delivery; human resources/workforce; community development; and performance monitoring.

He highlighted a number of matters, which were of immediate significance to maintaining good progress, which either required Board endorsement or Board support. The issues, which required Board endorsement, were: the Equality Diversity and Spirituality Strategy and 2006/07 Action Plan; Equality Impact Assessment; and the Disability Scheme. The issues which required Board support, were: public health specialist input; alignment of the governance and leadership of the Equality, Diversity and Spirituality and patient focus public involvement agendas; workforce information; and engagement/ownership across NHS Lanarkshire.

The Director of Organisational Development stressed that the Board was involved in many activities and areas of good practice within the areas of Equality, Diversity and Spirituality. He stressed the importance of continuing to take opportunities to

celebrate success and achievement, and the importance of good communications and continued engagement with staff and communities across Lanarkshire. He acknowledged that many challenges remained to be addressed as the Board continued to lead and drive cultural change and the delivery of continued progress and achievement in this important area of work. He confirmed that the Equality, Diversity and Spirituality Strategy and Programme of Annual Implementation Plans had been designed to provide direction and reassurance to the Board.

In discussion, there was recognition of the need for clarity about prioritisation, timescales, dependencies and the resources required to support the ongoing implementation of the Strategy, and for clarity about identifiable benefits to the organisation and the wider community from the implementation of the Strategy, including the overlap between these two important areas.

THE BOARD:

1. Endorsed the Equality, Diversity and Spirituality Strategy and the creation and implementation of associated Annual Action Plans.
2. Agreed to a formal position whereby no strategy, policy, procedure, protocol or service development change proposals would be endorsed without appropriate completion of Equality Impact Assessment.
3. Remitted sign-off of the Board's Disability Scheme to the Equality, Diversity and Spirituality Committee in order that the statutory requirement to publish the Scheme by 4th December 2006 would be met.
4. Supported the development of a more explicit linkage between the work of the Equality, Diversity and Spirituality Committee and the Directorate of Public Health/Health Improvement Teams, to enhance knowledge and understanding of health morbidity and demography in Lanarkshire's ethnic minority and potentially excluded communities to influence health care provision.
5. Supported the alignment of the governance and leadership arrangements for Equality, Diversity and Spirituality and Patient Focus Public Involvement to optimise synergy and minimise duplication of effort.
6. Supported continued efforts at national and local levels to refresh and optimise use of the Scottish Computerised Information System to provide intelligence, understanding and enhanced diversity in the workforce.
7. Supported continued use of the Annual Equality, Diversity and Spirituality Action Plan approach to progress and achievement, recognising the importance of effective engagement with the Acute Division, Community Health Partnerships and Corporate Directorates, to ensure ownership and creation of a structure of Equality, Diversity and Spirituality Delivery Plans.

112. **ALCOHOL AND DRUG ACTION TEAM**

The NHS Board considered a report on the Alcohol and Drug Action Team Strategy 2007/2010 and Corporate Action Plan 2006/07 (circulated).

The Director of the North Lanarkshire Community Health Partnership, who chaired the Alcohol and Drug Action Team, explained that the report before the Board had been prepared to inform members of the key strategic priorities which Alcohol and Drug Action Teams were required to address, and to advise the Board on progress being made in achieving performance targets defined by the Scottish Executive.

The ADAT Co-ordinator gave a presentation to the NHS Board which: highlighted the scale of the problem within Lanarkshire; highlighted the Scottish Executive targets and objectives; outlined the structures in place within Lanarkshire; reported on results to date; and outlined the governance and accountability arrangements.

She highlighted the extent to which alcohol was a problem in Lanarkshire, as it was for Scotland, and the steady increase in the numbers of alcohol related deaths from 1997 to 2005. She also highlighted the estimated number of problem drug users by locality in Lanarkshire, and the increase in drug related deaths from 1997 to 2005. She highlighted the worrying trend in alcohol consumption by young people and the 84% rise between 1990 and 2004 in young peoples' reported drinking, amongst 15 year old girls, as well as the profound effects of alcohol consumption on these individuals. She also highlighted the particular problem of children and families affected by parental substance misuse, and the range of consequences for children and families.

She highlighted the key Scottish Executive targets, in relation to: young people, children and families; adults within the treatment and care system; and the wider community, and the contribution of community planning; the integrated Childrens' Service within South Lanarkshire Council and the Adults Within the Treatment and Care System in North Lanarkshire Council, to the delivery of these targets.

The ADAT Co-ordinator highlighted the principal results in the areas of: improved access to services; increases in the number of clients with treatment and care services; waiting times for alcohol and drug services; and Alcohol and Drug Action Team investment in alcohol and drug services. She highlighted, in particular, ADAT investment in children, young people and family services, and ADAT investment in the wider community.

In the area of Governance and Accountability, she stressed the need to safeguard and promote the interests of children and young people affected by substance misuse, to reduce the level of alcohol and drug related harm within Lanarkshire, and to develop appropriate services and support for people with alcohol and drug related problems. She also outlined for members the governance and accountability framework in place.

THE BOARD:

1. Noted the Alcohol and Drug Action Team Strategy 2007/2010 and Corporate Action Plan 2006/2007, and the substantial process locally to underpin the delivery of Scottish Executive target and objectives.
2. Agreed to consider further progress in the delivery of targets and objectives, at a future Board Seminar.

113. **HEALTH AND CLINICAL GOVERNANCE ANNUAL REPORT 2005/2006**

The NHS Board considered the Health and Clinical Governance Annual Report 2005/06 (circulated).

Mrs. Nelson, Chair of the Health and Clinical Governance Committee, explained that the report included: health improvement initiatives; summary annual reports from departments supporting clinical governance; managed clinical network annual reports; mental health governance initiatives; primary care clinical governance initiatives and a department of clinical effectiveness annual report, incorporating research and development. She highlighted the extent to which the report focussed on outcomes and improvement, which would further inform the Committee's agenda

The Medical Director explained that the Annual Report demonstrated the extent of the effort being made across the service in improving quality of care, with less focus on process and more focus on demonstrating improvements in patient care. He advised that the report took account of health and clinical governance issues associated with A Picture of Health and reflected management activities in relation to delivering improvements. He confirmed that the Annual Report would be used with the Director of Public Health Annual Report to plan objectives for future years.

In response to a question from the Chairman, the Director of the North Lanarkshire Community Health Partnership explained that there were clinical governance sub structures for Primary Care, Mental Health and Learning Disabilities with, below that, service specialty areas addressed through clinical leadership groups.

The Medical Director acknowledged the link between the Health and Clinical Governance Annual Report and the report of the NHS QIS Healthcare Governance and Risk Management Review; however, he advised that the NHS QIS Review was focussed, to a greater extent, on governance arrangements.

THE BOARD:

1. Approved the Health and Clinical Governance Annual Report 2005/06.
2. Remitted to the Corporate Management Team the task of further considering the issues and actions arising from the Annual Report, together with the Director of Public Health Annual Report which featured earlier in the meeting. — Chief Executive

114. **RISK MANAGEMENT**

The NHS Board considered the Risk Management Strategy (circulated).

The Medical Director reported that the Risk Management Strategy had been the subject of discussion, over a number of months, within a range of Committees and groups, including: the Audit Committee; the Health and Clinical Governance Committee; the Risk Management Steering Group; the Occupational Health and Safety Management Group; the Acute Divisional Management Team; the North Lanarkshire CHP Partnership Forum; the South Lanarkshire CHP Partnership Forum; the+ Acute Partnership Forum; the Acute Clinical Board; the Primary Care Clinical Effectiveness and Risk Management Group; the Acute Clinical Directorate Management Teams; the Acute Hospital Site Risk Groups, and had been posted on the NHS Lanarkshire Intranet site.

The Risk Manager highlighted the principal elements of the Risk Management Strategy, in relation to Organisation Responsibility and Accountability (Scheme of Delegation); Risk Management aims and objectives; implementation of the Risk Management Strategy; and communication of the Risk Management Strategy and Framework. She also highlighted the Risk Management Steering Group, Terms of Reference, and the Risk Management Reporting Structure.

The Chairman of the Audit Committee acknowledged the consideration of the Strategy by the Committee, when members had welcomed the sense of clarity, confirmed by Pricewaterhouse Coopers as the Board's new Appointed Auditor, that the Strategy brought to the arrangements for risk management. He stressed the role of the Audit Committee in providing assurance to the NHS Board about the extent of coverage of risk management issues across the system, reported through the Risk Management Steering Group, and the Health and Clinical Governance and Staff Governance Committees. He also emphasised the interaction between the Risk Management Steering Group and the Health and Clinical Governance Staff Governance and Audit Committees that would enable the Audit Committee to provide the necessary assurances to the NHS Board. He acknowledged the role of the Equality, Diversity and Spirituality Committee as one of the Board's key governance committee's. He highlighted the concern expressed by the Audit Committee, and by the Health and Clinical Governance Committee, that the system was reliant on only one designated risk manager, although the responsibility of a number of individuals across the system for risk management had also to be recognised.

The Medical Director highlighted the role of the Risk Management Steering Group in relation to ownership of the Annual Workplan and the Annual Report. He also reinforced the role of the Health and Clinical Governance Committee and the Staff

Governance Committee in giving the necessary assurances to the Audit Committee, such that the Audit Committee assure the NHS Board about overall Controls Assurance.

The Director of Finance would have further discussions with Pricewaterhouse Coopers about the Risk Management Strategy, with particular regard to the issues highlighted in discussion. — Director of Finance

The Chairman would also have further discussions about the risk management structures with the Chief Executive. — Chairman

THE BOARD:

1. Approved the Risk Management Strategy.
2. Asked to receive a further report on the outcome of the further discussions highlighted. — Medical Director

115. **PERFORMANCE MANAGEMENT/ LOCAL DELIVERY PLAN**

a) Performance Management Group

The NHS Board considered the Minute of the Inaugural meeting of the Performance Management Group on 2nd November 2006 and accompanying report (circulated).

The Modernisation Director reported that the new corporate performance arrangements had been successfully launched with the initial meeting of the Performance Management Group receiving and considering performance reports on the HEAT targets, as well as the Delivering for Health Quarterly Report, and the recently reinstated SEHD Quarterly Factsheet. He advised that consideration had been given to possible supplementary indicators and reports, and to future reporting arrangements for progress in relation to the top priorities under A Picture of Health. He confirmed the agreement that, each month, the Board's attention would be drawn to any particular highlights, and to any targets where achievement was proving particularly challenging. He highlighted the key issues arising from the first meeting of the Performance Management Group, including highlights (Accident and Emergency and Cancer Waiting Times) and challenges (Financial Performance, Availability Status Codes, and Outpatient Waiting Times).

The Modernisation Director reported that the Director of Performance Management at SEHD had visited Lanarkshire on 20th November 2006, both to review performance during 2006/07 and to discuss preparations for 2007/08. He advised that a national meeting with NHS Systems across Scotland to discuss the 2007/2008 performance targets would be held during December. He also reported that NHS Lanarkshire had been confirmed to join the second phase of Citistat Early Adopters.

THE BOARD:

1. Noted the minute of the Inaugural Meeting of the Performance Management Group on 2nd November 2006 and the accompanying report.
2. Asked to receive a further report. — Modernisation Director

b) Finance

The NHS Board considered a report on financial performance to 31st October 2006 (circulated).

The Director of Finance reported that the actual financial position to the end of October showed an overspend of £0.43m, compared with an overspend of £0.901m at the end of September, representing a significant improvement and reflecting the move towards financial balance for the year. She advised that, following the mid-year

review, additional funding had been allocated to the Acute Division, to North and South Lanarkshire Community Health Partnerships and to corporate budgets, to recognise a number of cost pressures highlighted earlier in the year, including: clinical compensation claims; original pack dispensing; out of hours funding shortfall; waiting times; stoma appliances and the shortfall in the delivery of the Corporate Recovery Plan. She stressed that the financial position remained extremely tight, and highlighted the imperative that the management actions outlined previously continued and were reinforced across the system, to ensure the position was brought into line with the year-end forecast per the mid-year review. She advised that the assessment of financial performance undertaken through the mid-year review process was sufficiently robust to give a degree of confidence in the delivery of financial balance in 2006/07, with current estimates placing the year end position at a surplus of £0.219m.

The Director of Finance highlighted the principal issues in relation to the year-end forecast, as well as the key issues in relation to: revenue resources; the Acute Division; Primary Care; Headquarters/area wide Departments; Service Agreements/other Health Care providers; the Corporate Recovery Programme; and Capital.

In discussion, she advised that at least one of the 'residual' claims, which were outwith the scope of the Clinical Negligence and Other Risks Scheme, was substantial.

THE BOARD:

1. Noted the Finance Report for the period to 31st October 2006.
2. Asked to receive a further report. — Director of Finance

c) Waiting Times

The NHS Board considered a report on the waiting times position at 31st October 2006. (circulated).

The General Manager, Acute Services, advised that the report reflected performance in waiting times compared to the planned trajectory identified in the Local Delivery Plan 2006/07. She advised that the six month guarantee for inpatients and daycases had been maintained, and that good progress continued to be made to reduce the number of patients waiting over 18 weeks, with the system in line to deliver the guarantee that no patient would wait over 18 weeks by the end of calendar year 2006.

She stressed that orthopaedics continued to represent a pressure, and highlighted the considerable work in progress around service redesign, recruitment of further permanent staff, with access also to additional capacity at the Golden Jubilee National Hospital, as well as continued reliance on some internal and external waiting list initiatives to address these pressures. She reported that the Cataract Collaborative had introduced a number of measures to improve the patient pathway and that with immediate effect optometrists would make all future cataract referrals, channelled by fax, to a central referral point.

The General Manager reported that the number of outpatients waiting over 18 weeks had decreased, although it remained above the trajectory. She advised that there continued to be pressures in a number of specialties, including: dermatology; respiratory; and orthopaedics, and emphasised the extent of work in progress through specialty groups to examine the current patient pathway, opportunities for service redesign, including increased involvement of Allied Health Professionals and specialist nursing staff with identification also of good process and practice operating across the country. She also highlighted the reliance on internal and external waiting list initiatives to sustain and improve the current performance, and the exploration of

the contribution that Primary Care could make to demand management.

The General Manager reported a reduction in the number of inpatients/daycases with an Availability Status Code, reflecting more robust management of the ASC list, linked to the implementation of the New Ways Guidance. She highlighted the role of the Project Board in overseeing delivery of the guarantee for patients with an ASC by 31st December 2007.

She reported that performance in breast cancer had met the expected target, but that the figures for lung and colorectal were below the trajectory. She advised that seven lung cancer patients had not received their first treatment within the sixty two days target, and confirmed that this was attributable to identified 'bottlenecks' in the system that were currently being investigated.

In the area of diagnostics, the General Manager confirmed that Action Plans for endoscopy and radiology were being implemented as reflected in the reduced maximum waits in line with the trajectory. For unscheduled care, she reported that performance had increased during October in line with the trajectory, reflecting implementation of the Action Plan to improve patient throughput by the appointment of additional nursing staff, increased clarity of the junior doctor role, improved discharge arrangements and improved communication.

THE BOARD:

1. Noted the report on Waiting Times Performance.
2. Asked to receive a further report. — Director Acute Services

d) Delayed Discharges

The General Manager, Acute Services, reported that at 15th November 2006 there were eleven patients occupying short stay beds, against a target of a maximum of ten delayed discharges in this category by April 2007. She reported, also, that there were 25 patients waiting longer than six weeks for discharge, against a target of a maximum of ten by April 2007. She stressed the management effort being applied through the Partnership to achieving solutions to these pressures, and to moving towards delivery of the April 2007 targets.

THE BOARD:

1. Noted the report on Delayed Discharges.
2. Asked to receive a further report. — Director Acute Services

116. GOVERNANCE MINUTES

The NHS Board considered Governance Minutes, as follows:

a) Audit Committee: 12th September 2006

Mr. Sutherland, Chairman of the Audit Committee, highlighted the report to the Committee on progress in appointing an audit firm to manage the Internal Audit Service. He confirmed the appointment of Bentley Jenison as Managers of the Internal Audit Service, as a result of a competitive process.

b) Health and Clinical Governance Committee: 30th October 2006

Mrs. Nelson, Chair of the Health and Clinical Governance Committee, highlighted the ongoing consideration being given to the issue of Food, Fluid and Nutrition, and the intention that the Director for Allied Health Professions Nurses and Midwives would

bring a policy to a future meeting of the Committee. She highlighted, also, the consideration given to reports of insulin incidents, and the acknowledged contribution that a computerised Prescribing Management System could make to reducing such incidents. She advised that progress in introducing such a system was dependent on the outcome of ongoing discussions at a national level, and exhorted the Board to exert whatever influence it could on the timetable for implementation of the system across the service.

c) Acute Operating Management Committee: 19th October 2006

Mr. Currie, Chairman of the Acute Operating Management Committee, advised that the availability of the Minute confirmed the issues which he had previously reported verbally to the Board.

117. **DATE OF NEXT MEETING**

Wednesday 20th December 2006.

118. **MOTION TO MOVE INTO PRIVATE SESSION**

The NHS Board approved a Motion to move into Private Session for the remaining agenda items which were 'commercial – in confidence'.

119. **PHARMACY PRACTICES COMMITTEE**

a) Pharmacy Practices Committee: 29th August 2006

The NHS Board considered the minute of the meeting of the Pharmacy Practices Committee held on 29th August 2006 (circulated).

Mr. Sutherland, Chairman of the Pharmacy Practices Committee, highlighted the purpose for which the Committee had met, and its conclusions and recommendations.

THE BOARD:

1. Approved the minute.

b) Pharmacy Practices Committee: 5th September 2006

The NHS Board considered the minute of the meeting of the Pharmacy Practices Committee held on 5th September 2006.

Mr. Sutherland, Chairman of the Pharmacy Practices Committee, highlighted the purpose for which the Committee had met, and its conclusions and recommendations.

THE BOARD:

1. Approved the minute.

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