

NHSGG&C(M)14/01

Minutes: 01 - 15

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, 18 February 2014 at 9:30a.m.**

**PRESENT**

Mr A O Robertson OBE (in the Chair)

Dr J Armstrong	Mr R Finnie
Dr C Benton MBE	Mr I Fraser
Ms M Brown	Dr M Kapasi MBE
Mr R Calderwood	Councillor A Lafferty
Dr H Cameron	Mr I Lee
Mr G Carson	Ms R Micklem
Ms R Crocket MBE	Councillor M O'Donnell (From Minute No:11)
Councillor M Cunning	Dr R Reid
Mr P Daniels OBE	Councillor M Rooney
Dr L De Caestecker	Rev Dr N Shanks
Councillor M Devlin	Mr D Sime
Prof A Dominiczak	Mr B Williamson

**IN ATTENDANCE**

Mr G Archibald	Lead Director, Acute Services Division
Dr E Crighton	Consultant in Public Health Medicine (For Minute No:09)
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Mrs A Hawkins	Director, Glasgow City CHP
Mr A McLaws	Director of Corporate Communications
Ms C Renfrew	Director of Corporate Planning and Policy

**ACTION BY**

**01. APOLOGIES**

Apologies for absence were intimated on behalf of Mr P James, Councillor M Macmillan, Councillor J McIlwee and Mr K Winter.

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. CHAIR'S REPORT**

- (i) On 20 December 2013, Mr Robertson visited the National Spinal Unit at the Southern General Hospital where he met with colleagues and two survivors of the Clutha helicopter tragedy.
- (ii) On 17 January 2014, Mr Robertson met with the new Principal of the West of Scotland University, Professor Craig Mahoney.
- (iii) On 21 January 2014, Mr Robertson attended a meeting of Glasgow Life and met its Chair, Councillor Archie Graham. This provided an excellent opportunity to better understand the wide range of services Glasgow Life delivered on behalf of Glasgow City Council for the benefit of citizens and visitors.
- (iv) On 30 January 2014, Mr Robertson attended the Annual General Meeting (AGM) of Credit Union. It was also Credit Union's 15<sup>th</sup> anniversary and they now had over 8,000 members which demonstrated how appreciated the function was.
- (v) On 31 January 2014, Mr Robertson and Mr Calderwood met with the Chair and newly appointed Director of the Beatson Cancer Charity.
- (vi) On 5 February 2014, Mr Robertson attended the launch of the Inspiring Cancer Charity at Glasgow City Chambers.
- (vii) On 13 and 14 February 2014, Mr Robertson attended the NHS Board Time-Out Session where NHS Board members heard excellent presentations that put into context the ambitious challenges and plans that lay ahead for NHSGGC from 2014/15 onwards.
- (viii) Since the last NHS Board meeting in December 2013, Mr Robertson reported that various meetings had taken place of the Endowments Sub-Committee to implement the new national guidance regarding the operation and possession of public organisations' endowments funds. Work was ongoing and he anticipated a paper outlining these developments to be presented to the April 2014 NHS Board meeting.

**Director of  
Finance**

NOTED

**04. CHIEF EXECUTIVE'S UPDATE**

- (i) On 17 December 2013, Mr Calderwood met with the Principal of the University of Glasgow and the Cabinet Secretary for Health and Wellbeing regarding the University of Glasgow/NHS Board's imaging strategy. Mr Calderwood was delighted to announce that the Cabinet Secretary had since agreed to make a £3m contribution towards this academic centre at the new Southern General Hospital campus for imaging services.
- (ii) On 30 December 2013, Mr Calderwood visited the New Lister Building on the Glasgow Royal Infirmary campus. It formally opened in January 2014 following a £15m refurbishment that included state-of-the-art equipment and facilities for staff and patients and also included two floors for the University of Glasgow.

- (iii) On 6 January 2014, Mr Calderwood visited the new Southern General Hospital campus to tour the full site. He reported that significant internal works had also taken place and that the NHS Board could expect the buildings to be handed over from the contractor in January 2015. This would bring in to sharp focus how soon NHSGGC would see the realisation of this key milestone in the modernisation of Glasgow's Acute Hospital provision and the scale of the challenge that faced the NHS Board with the planned migration of services and staff into this world-class facility. The Cabinet Secretary for Health and Wellbeing had also visited the site last week and it was reported that a target of being fully operational by the end of July 2015 had been set.
- (iv) On 24 January 2014, Mr Calderwood met with Jackie Baillie MSP to discuss health issues in the West Dunbartonshire area and NHSGGC's Clinical Services Review.
- (v) On 29 January 2014, Mr Calderwood and Professor A Dominiczak met with representatives of Scottish Enterprise to discuss a series of issues, primarily focusing on bringing public and private monies together for the development of Research and Development facilities associated with the New South Glasgow Campus.
- (vi) On 6 February 2014, Mr Calderwood attended the Scottish Enterprise Life Sciences Awards Dinner. He congratulated Professor Chris Packard, who picked up a Special Recognition Award at the prestigious event. This was for his work in demonstrating the benefits that the Life Sciences Sector could bring to Scotland.
- (vii) On 11 February 2014, Mr Calderwood, Mr G Archibald and Mr P James met with colleagues from the Scottish Government Health Directorates to discuss the NHS Board's Mid-Year Review.
- (viii) On 17 February 2014, Mr Calderwood and Mr P Daniels conducted interviews for the Interim/Shadow Director post for Glasgow City CHP (due to the retirement of Mrs A Hawkins from 31 March 2014). He reported that Mr A MacKenzie (currently Director, North West Sector, Glasgow CHP) had been appointed from 1 March 2014 to allow him to shadow Mrs Hawkins for one month before taking up the substantive post on 1 April 2014.

NOTED**05. MINUTES**

On the motion of Mr I Fraser, seconded by Councillor M Devlin, the Minutes of the NHS Board meeting held on Tuesday, 17 December 2013 [NHSGG&C(M)13/06] were approved as an accurate record and signed by the Chair.

NOTED**06. MATTERS ARISING FROM THE MINUTES**

- (i) The rolling action list of matters arising was noted.
- (ii) In relation to Minute 110 "New Southside Hospital – Office Accommodation – Full Business Case and Community Benefit Programme", Mr Calderwood

confirmed that the Scottish Government Health Directorates had since approved the NHS Board's Full Business Case.

NOTED

**07. SCOTTISH PATIENT SAFETY PROGRAMME**

A report of the NHS Board's Medical Director [Board Paper No 14/01] asked the NHS Board to note an update on the Scottish Patient Safety Programme (SPSP) for mental health and the work being progressed in NHSGGC.

Dr Armstrong explained that Phase I of the mental health programme was a voluntary commitment from NHSGGC in which the NHS Board supported small scale process improvement to introduce and test the methods in mental health settings. Initially two pilot wards were committed to test one of the nationally described workstreams which related to risk assessment and safety planning.

Phase II of the programme, from October 2013 onwards, introduced mandatory expectations, and, building on the initial pilots, had seen an increase in the number of wards involved. 13 clinical teams were now participating in Phase II of the programme and the wards involved had representation from each inpatient sector in the NHS Board and included a cluster of wards on the Gartnavel Royal Hospital site.

Dr Armstrong described the five national workstreams, the first four of which related to clinical practice where the main focus would be risk assessment and safety planning. NHSGGC negotiated however, that at least one team focus on each of the four clinical workstreams so that a suitable scope of pilot work was underway. The fifth workstream, Leadership and Culture, applied to all pilots and extended to infrastructure in services such as the Staff Safety Climate tool, the Patient Safety Climate tool and Leadership Walkrounds. With regard to the mental health outcome measures, Dr Armstrong explained that a National Measurement Plan had been developed involving all participating wards to collect monthly outcome and balancing measures that were submitted to Health Improvement Scotland (HIS). A year's worth of retrospective data was also collected. She summarised the outcome measures and reported that work was underway to improve the reliability of the data with the new teams with a timescale to begin to submit data to the national team in February/March 2014. Furthermore, a quarterly progress report was being produced for HIS to include a summary of ongoing tests of change and accompanying data that was shared through the Knowledge Network site. HIS had visited NHSGGC on 13 December 2013, the purpose of which was to obtain an overview on Phase II of the programme and to discuss progress made. Areas were highlighted that were strengths and also areas for development for the delivery of the programme. HIS had agreed to fund and support the second local learning session in March 2014.

Dr Armstrong emphasised the importance in learning sessions – both at local and national level and confirmed that, so far, two *local* learning sessions had taken place and four *national* learning sessions.

Councillor Rooney asked about one of the mental health outcome measures “days between inpatient suicide”. Dr Armstrong reported that this would result in a Significant Incident with a full team set up to investigate the circumstances thoroughly.

Mr Fraser also asked about the mental health outcome measures and Dr Armstrong explained that these were nationally-determined and agreed that, as the programme was in its infancy, there may be other outcomes collected and measured in the future.

Mrs Hawkins agreed with this point, explaining that, as SPSP in mental health services

became more established, outcome measures could be added.

Mr Williamson referred to an outcome measure in palliative care which looked at quality of life and suggested that it may be adapted for mental health. Mrs Hawkins thanked Mr Williamson for the suggestion and agreed that this would be fed back to the national team to reflect on.

**Medical  
Director**

NOTED

**08. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)**

A report of the NHS Board's Medical Director [Board Paper No 14/02] asked the NHS Board to note the latest in the regular bi-monthly reports on Healthcare Associated Infection (HAI) in NHS Greater Glasgow and Clyde.

Dr Armstrong explained that the report represented data on the performance of NHS Greater Glasgow and Clyde on a range of key HAI indicators at national and individual hospital site level.

In 2007, the SGHD issued a Local Delivery Plan (LDP) HEAT target in relation to staphylococcus aureus bacteraemias (SABs) in which NHS Greater Glasgow and Clyde successfully reduced SABs by 35% by April 2010. This target was extended by an additional 15% reduction which was also successfully achieved by 31 March 2011. This target was extended once again, and NHS Boards were required to achieve a rate of 26 cases per 100,000 Acute Occupied Bed Days (AOBDs) by April 2013. For the last available reporting quarter (July to September 2013), NHSGGC reported 36.8 cases per 100,000 AOBDs. NHS Scotland reported 31.4 cases per 100,000 AOBDs. The revised national HEAT target required all NHS Boards in Scotland to now achieve a rate of 24 cases per 100,000 AOBDs or lower by 31 March 2015.

NHSGGC successfully achieved the 2013 Clodistrium Difficile HEAT target of less than 39 cases per 100,000 AOBDs in the over-65s age group. The new target for future attainment included cases in ages 15 and over and this was subsequently revised in 2013 by the Scottish Government following a change in the calculation of bed day data and now required NHS Boards to achieve a rate of 32 cases or less per 100,000 AOBDs to be attained by 31 March 2015. For the last available reporting quarter, July to September 2013, NHSGGC reported 34.1 cases per 100,000 AOBDs, combined rate for all ages. This placed the NHS Board below the national average of 41.6 per 100,000 AOBDs.

For the last available quarter (July to September 2013), the surgical site infection (SSI) rate for hip arthroplasty procedures remained below the national average, repair of neck and femur procedures matched the national rate of 2.1%, while the SSI rate for knee arthroplasty and caesarean section procedures were above the national average although both remained within the 95% confidence intervals.

The Cleanliness Champions Programme was part of the Scottish Government's Action Plan to combat HAI within NHS Scotland. To date, NHSGGC had supported 3,003 members of staff who were now registered as Cleanliness Champions.

With regard to the increase in reported SAB cases, Dr Armstrong alluded to some of the possible contributors to this and the actions being taken by NHSGGC clinical and infection control teams to address this. She highlighted, in particular, enhanced surveillance and reporting and emphasised that sustaining a reduction in cases (which were amenable to improvement) required the continued support of all clinical staff within the Acute Directorates to ensure that optimal practice was applied in the

procedures which required an aseptic technique.

Dr Armstrong explained that the enhanced surveillance included a clinical review on each hospital acquired case and community onset healthcare associated case that was linked to a clinical specialty or had a feature that was amenable to improvement. Councillor Rooney asked if this included care homes and Dr Armstrong responded in the affirmative.

NOTED

**09. PUBLIC HEALTH SCREENING PROGRAMMES ANNUAL REPORT –  
1 APRIL 2012 TO 31 MARCH 2013**

A report of the Director of Public Health [Board Paper No. 14/03] asked the NHS Board to note the Public Health Screening Programme Annual Report from 1 April 2012 to 31 March 2013.

Dr De Caestecker presented information about the following screening programmes offered to residents across NHSGGC for the period 2012/13:-

- Cervical screening
- Breast screening
- Bowel screening
- Pregnancy screening:-
  - Communicable diseases in pregnancy
  - Haemoglobin apothics in screening
  - Downs syndrome and other congenital anomalies
- New born screening:-
  - New born blood spot
  - Universal new born hearing
- Diabetic retinopathy screening
- Preschool vision screening
- Interim report in aortic abdominal aneurysm screening

Dr Crighton explained that screening was a public health service offered to specific population groups to detect potential health conditions before symptoms appeared. Screening had the potential to save lives and improve quality of life through early diagnosis of serious conditions.

In NHSGGC, the co-ordination of all screening programmes was the responsibility of the Public Health Screening Unit led by a consultant in public health medicine. Multi Disciplinary Steering Groups for the programmes were in place and the remit was to monitor performance, uptake and quality assurance.

Dr Crighton highlighted that, as the screening programmes stretched across the whole organisation, successful delivery relied on a large number of individuals working in a co-ordinated manner towards common goals in a quality assured environment. It was essential that good information management systems were in place to monitor and evaluate each component and the overall performance of every screening programme offered to NHSGGC residents. All the screening programmes, with the exception of preschool vision screening, had clinical standards set by Health Improvement Scotland. Dr Crighton explained, however, that reporting structures for Scottish Public Health Screening programmes were currently under review and she led the NHS Board through the proposed governance arrangements; comparing these with the current governance arrangements in NHSGGC.

NHSGGC's Public Health Screening Unit was committed to working in partnership

with voluntary and statutory services to identify innovative ways to tackle inequalities in health and encourage uptake of screening programmes. For the second year, the report also included analysis on uptake among people with learning disabilities but Dr Crighton reported that screening activity by ethnicity could not, as yet, be provided as this data was not available.

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

- Posters and advertisement cards had been circulated that would be used for a pilot in Glasgow North West to increase the uptake rates for cervical screening in the 21-35 year old age group. It would be launched at the beginning of March 2014 and the key message was to allay any fear and/or embarrassment about cervical screening.
- The overall uptake across NHSGGC for the first dose of the HPV vaccination was 94.6% and 93.1% for the second dose. This was above the Scottish average, however, uptake for the third dose was 78.8% which was below the Scottish average. Dr Crighton agreed that this was disappointing and alluded to a poorer uptake of the vaccination in areas of deprivation. As such, work was ongoing to address the barriers to low uptake and, in particular, a lot of work was being undertaken with looked-after children.
- General uptake rates and addressing inequalities was a priority in order to close the inequality gap. This was a major concern and campaigns were now being designed and developed with particular target groups/age groups in mind. Dr De Caestecker cited the example of visual screening which was undertaken in nurseries but, in doing so, missed children who may not attend a nursery. That patient group often did not attend clinic/hospital appointments either and work was ongoing to enhance family support with Primary Care Development workers becoming involved with families.
- Abdominal aortic aneurysm screening was implemented in February 2013 and male residents aged 65 in NHSGGC would be invited to participate in this screening programme. Based on evidence, one scan was sufficient and this was the best way to detect the presence of an abdominal aortic aneurysm. Based on research, no evidence was apparent, at the moment, to suggest further screening thereafter. Dr Crighton reported that males over 65 years of age could self-refer and, although not widely publicised just now, a communications strategy was now in place to address this. To date, these men tended to find out by word-of-mouth.
- Breast screening audit reporting would be available late in March 2014. From the data available, Dr Crighton advised that, in NHSGGC compared to that for Scotland, breast cancer incidence rates were lower but deaths from breast cancer were higher. To capitalise on the planned national Detect Cancer Early (DCE) social marketing campaign of 2013, NHSGGC had developed a local social marketing campaign to reinforce the DCE breast cancer messages and encourage women to take up breast screening.
- The wealth of information was welcomed and engaging the support of celebrities to boost uptake in the screening programmes was raised. Dr Crighton alluded to some celebrities being used at a *national* level as celebrities did have pulling power if they were relevant to particular age groups.
- In relation to the bowel screening programme and improving the uptake rate

for those with learning disabilities, Dr Crighton agreed that this particular uptake rate was very poor and, historically, this group of patients had been difficult to engage with in the past. Given that, good engaging materials were being pulled together and a more proactive approach would be taken to communicate/engage with that group of patients and/or their carers.

Mr Robertson, on behalf of the NHS Board, thanked Dr De Caestecker and Dr Crighton for their comprehensive summary of the Annual Report.

NOTED

#### 10. **HEALTH AND SOCIAL CARE INTEGRATION:- GLASGOW CITY AND EAST DUNBARTONSHIRE**

A report of the Director of Corporate Planning and Policy [Board Paper No 14/04] asked the NHS Board to note progress to move to Shadow Health and Social Care Partnerships with Glasgow City Council and East Dunbartonshire Council.

Ms Renfrew apologised for circulating the paper so late but explained that this had been due to the respective Councils approving the arrangements. That had now been completed and she explained that agreement had been reached to establish a Body Corporate Model Partnership as follows:-

- Glasgow City – covering all health and social care services. Furthermore, as Mr Calderwood referred earlier, arrangements had been made in that Mr A MacKenzie had been appointed Interim Director of Glasgow CHP and an Integration agreement was being drafted which would come to the NHS Board and Council for approval and would provide the basis of operation for the Partnership in its shadow year.
- East Dunbartonshire – covering adult health and social care services. Furthermore, Karen Murray, currently CHP Director, had been appointed as Shadow/Interim Chief Officer to lead the development of the new Partnership. A shadow integration agreement was being drafted which would come to the NHS Board and Council for approval and would provide the basis of operation for the Partnership in its shadow year.

**Director of  
Corporate  
Planning &  
Policy**

**Director of  
Corporate  
Planning &  
Policy**

NOTED

#### 11. **WAITING TIMES AND ACCESS TARGETS**

A report of the Lead Director, Acute Services Division [Board Paper No 14/05] asked the NHS Board to note progress against the national targets as at the end of December 2013.

Mr Archibald led the NHS Board through the report highlighting the actions being taken to deliver the waiting times and access targets. This included general waiting times/18 Weeks Referral to Treatment (RTT) and the waiting times for various specific treatments including accident and emergency, cancer, chest pain and stroke. He also highlighted the number of patients awaiting discharge from hospital beds across NHS GGC.

Mr Williamson commended continued performance in linked pathways (a measure of the percentage of patients where their total pathway was being linked). NHS GGC continued to exceed the target of 80%. In paying tribute to the Acute Division's teams in achieving this, he wondered if it was now timely to suggest increasing the target.

Mr Archibald noted that there was significant complexity involved in improving performance for this indicator, due in part to NHSGGC's status as a tertiary service provider for other NHS Boards and the cross-boundary referrals that occurred. Work, however, continued nationally to develop more robust inter-board processes to allow appropriate pathway linkages to be facilitated.

Councillor Lafferty welcomed the comprehensive information provided in the report on Accident and Emergency waiting times. In response to his question, Mr Archibald observed that different pressures occurred at different A&E hospital locations and he described that this was mainly due to the demography and morbidity being different for each hospital which resulted in admission levels/attendances differing.

Ms Micklem noted that, nationally, inpatient/day case spinal surgery had been excluded from the 12 week treatment time guarantee (TTG) and that there were a number of patients in this category within NHSGGC. She wondered if there were any other exclusions from the 12 week TTG. Mr Archibald confirmed that was the only exclusion albeit that, locally, the Institute of Neurosciences Management and clinical teams continued work to bring such services within 12 weeks.

NOTED

**12. FINANCIAL MONITORING REPORT FOR THE 9 MONTH PERIOD TO 31 DECEMBER 2013**

A report of the Director of Finance [Board Paper No 14/06] asked the NHS Board to note the financial performance for the first nine months of the financial year.

Mr Calderwood explained that the NHS Board was currently reporting a surplus of £5m for the first nine months of the year. At this stage, therefore, the NHS Board was forecasting that a year-end surplus of £8m would be achieved. Mr Calderwood led the NHS Board through further information in relation to expenditure in Acute Services, NHS Partnerships and Corporate Services, and included details of expenditure to date against the NHS Board's 2013/14 Capital Plan.

Mr Calderwood also reported that the month ten figure suggested a surplus of £7.1m.

Mr Finnie wondered if there was any way to relate operational activity to financial reporting as, given discussions earlier concerning pressures on operational teams, he thought it would be useful to see this reflected in the financial monitoring reports. Mr Calderwood agreed that it would be useful to see the financial monitoring report form a core relationship with the other NHS Board papers and mused on how accounts could be described and illustrated in a more helpful way. He agreed to discuss this further with Mr James.

**Director of  
Finance**

Councillor Rooney asked about the arrangements for transition to the New Southern General Hospital. Mr Calderwood reported that £8m had been set aside for this and outlined some examples for the migration which included:-

- From late January 2015 onwards, the need to employ around 250 people to deal with the commissioning of the new hospital;
- Staff being released for induction training and for familiarisation purposes at the new hospital (and their associated backfill for their shifts at the Victoria Infirmary, existing Southern General Hospital, Western Infirmary and Royal Hospital for Sick Children);
- Double running costs for a short period of time at the sites;
- From Spring 2015 onwards, release costs from the Victoria Infirmary, Western Infirmary, Southern General Hospital and Royal Hospital for Sick Children;

- Decommissioning of these sites which would lead to their vacation and onward disposal.

In response to a further question from Councillor Rooney concerning future capital available for any potential new medical centre for Clydebank, Mrs Hawkins explained that the NHS Board had drawn up a list of major refurbishment (and/or replacement) proposals so that a feasibility study could be undertaken. This would be completed by the end of March 2014 when it could then be reprioritised for consideration by the NHS Board. She did explain however, that supporting the revenue in any new capital investment would be a challenge and described how the Scottish Government Health Directorates Hub funding operated and it was anticipated that business cases would be pulled together once the priorities had been considered so that bidding for Hub funding could be undertaken.

NOTED

**13. MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003: LIST OF SECTION 22 APPROVED MEDICAL PRACTITIONERS**

A report of the Director of Public Health [Board Paper No. 14/07] asked the NHS Board to approve the list of Medical Practitioners employed by the NHS Board to be authorised for the purpose of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

DECIDED

That the two Medical Practitioners listed in the NHS Board paper for the purposes of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003 be approved.

**Director of  
Public Health**

**14. QUALITY AND PERFORMANCE COMMITTEE MINUTES: 21 JANUARY 2014**

The Minutes of the Quality and Performance Committee meeting held on 21 January 2014 [QPC(M)14/01] were noted.

NOTED

**15. ANY OTHER COMPETENT BUSINESS**

Retiral of Mrs A Hawkins – Mr Robertson reported that this would be the last meeting of Mrs Hawkins prior to her retiral. She had worked in the NHS for over 20 years (including a period in NHS Forth Valley). She had led NHSGGC's integration with "Clyde", providing guidance and leadership to the Mental Health Partnership and, latterly, led Glasgow CHP. She would be greatly missed and, on behalf of the NHS Board, he extended his tremendous appreciation of the work she had done. Mrs Hawkins thanked Mr Robertson and NHS Board members for their kind remarks and wished the NHS Board luck in the future.

NOTED

The meeting ended at 11.40am