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, 16 February 2016 at 9:30a.m.

PRESENT

Mr J Brown CBE (in the Chair)

Dr J Armstrong
Mrs S Brimelow OBE
Ms M Brown
Mr R Calderwood
Dr H Cameron
Mr S Carr
Councillor G Casey
Councillor M Devlin
Professor A Dominiczak OBE (To Minute 15)
Mr R Finnie
Councillor M Kerr (To Minute 15)
Councillor A Lafferty

IN ATTENDANCE

Mr G Archibald Chief Officer, Acute Services Division
Ms S Gordon Secretariat Manager
Mr J C Hamilton Head of Board Administration
Mr D Loudon Director of Facilities & Capital Planning (To Minute 15)
Mr B Moore Chief Officer, Inverclyde Health & Social Care Partnership
Mr A McLawns Director of Corporate Communications
Mrs A MacPherson Director of Human Resources & Organisational Development
Ms P Mullen Head of Performance
Mr K Redpath Chief Officer, West Dunbartonshire Health & Social Care Partnership
(Minute 15)
Ms C Renfrew Director of Planning & Policy
Mr D Williams Chief Officer, Glasgow City Health & Social Care Partnership
(To Minute 10)

ACTION BY

01. WELCOME AND APOLOGY

An apology for absence was intimated on behalf of Mr I Fraser.

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**

Mr J Brown summarised his one-to-one meetings with individuals and NHS Board Members, attendance at meetings and visits to meet frontline staff and services including the following:-

- Various one-to-one meetings with Executive Directors, Senior Staff, NHS Board Members, Scottish Government officials and other NHS Board Chairs.

- Various meetings with frontline staff including at the Vale of Leven Hospital, Oakview GP Practice, the Lister Building, the Intensive Care Unit (ICU) at Glasgow Royal Infirmary, Ward 6 at the Royal Hospital for Children, the Emergency Departments at the Royal Alexandra Hospital, Glasgow Royal Infirmary and the Queen Elizabeth University Hospital, the Beatson Oncology Cancer Centre and the Beatson Cancer Charity and Lightburn Hospital.

- Meetings with Senior Staff to discuss the Inspire Service at the Intensive Care Unit at Glasgow Royal Infirmary, employee engagement/i-matters, the Employability Public Social Partnership and attendance at the Healthy Working Lives Awards.

- Attendance at various committee meetings including the Glasgow Centre for Population Health Board, the Area Partnership Forum and the NHS/University of Glasgow Strategy Group.

- The Scotland NHS Chairs Meeting which included a session with the Cabinet Secretary for Health & Wellbeing.

Mr Brown referred to the recruitment of eight Non-Executive NHS Board Members to the Board of NHSGGC. The advert for these vacancies would come out on 4 March 2016 with a closing date of 25 March 2016.

**NOTED**

04. **CHIEF EXECUTIVE’S UPDATE**

(i) On 20 January 2016, the NHS Board had its mid-year review meeting with SGHD colleagues. A follow-up meeting to that was arranged for 22 February 2016.

(ii) On 8 February 2016, Mr Calderwood formed part of the cohort of NHSGGC and University of Glasgow staff who welcomed the First Minister to the Strathclyde Medicine Unit and Teaching & Learning Centre at the Queen Elizabeth University Hospital.

(iii) On 11 February 2016, Mr Calderwood and Dr J Armstrong met with consultants and medical staff at Inverclyde Royal Hospital to discuss local issues and build an understanding of the challenges going forward.

**NOTED**
05. MINUTES

On the motion of Councillor A Lafferty, seconded by Ms R Micklem, the minutes of the NHS Board meeting held on Tuesday, 15 December 2015 [NHSGGC(M)15/07] were approved as an accurate record and signed by the Chair.

NOTED

06. MATTERS ARISING FROM THE MINUTES

The Rolling Action List of matters arising was noted.

NOTED

07. SCOTTISH PATIENT SAFETY PROGRAMME (SPSP)

A report of the NHS Board’s Medical Director [Board Paper No 16/01] provided an overview of SPSP reporting for the Acute Adult Programme and, in particular, the Deteriorating Patient workstream.

Dr Armstrong explained that the SPSP was initiated in 2008 within clinical settings in Acute Adult hospitals. The second phase of the Acute Adult Care Programme concluded in December 2015 and, in preparation for that landmark, Healthcare Improvement Scotland (HIS) commenced a review process with suggestions of a major refresh of SPSP envisaged. The NHS Board had not yet been advised by HIS on the shape of the new programme, however, the recent publication of the Local Delivery Plan (LDP), by the SGHD, made reference to an earlier communication from HIS indicating that the nine priorities of care would remain the national focus. The NHS Board awaited formal communication from HIS to clarify whether the communication in the LDP would be superseded by new guidance.

Dr Armstrong reported, however, that HIS had maintained requirements for data submission, on a quarterly basis, from NHS Boards to the national programme. Within NHSGGC, the Acute Adult dataset was reviewed and approved for release by the Acute Services Clinical Governance Forum. In the most recent submission, NHSGGC had continued to meet all of the national reporting requirements based on the HIS recommendation that an outcome measure (and at least one process measure for each core workstream) was submitted.

Although there was a hiatus in the national measurement programme, at a local level there remained an ongoing need for visibility and governance. As such (and as part of the revision to processes following organisational change in 2015) three reporting mechanisms had been set up to help this governance take place. Furthermore, as NHSGGC continued to redesign clinical governance programmes, following the organisational review, it had also reflected that there needed to be more visibility of other quality improvement programmes not driven by the SPSP priorities. As such, Dr Armstrong and Dr McGuire were currently taking forward a process of setting out an NHSGGC Safety Programme. This would draw on learning from SPSP and would seek to adopt its requirements and support structures within a locally defined quality improvement programme. As part of this process, it was proposed to overhaul the corporate reporting format and test proposals with a representative group of Non-Executive Directors with the intention of presenting a new clinical governance report to the April 2016 meeting of the NHS Board.

Medical Director
Dr Armstrong led the NHS Board through a summary of the Deteriorating Patient workstream and outlined the improvement in systems and processes of care for patients at risk of acute deterioration which was one of the key clinical safety priorities for the NHSGGC Quality Programme. She summarised the national aim of the workstream and explained that the outcome measure associated was the cardiac arrest count. She alluded to the process measures associated with the workstream and reported that the number of wards expected to become involved in the programme was currently estimated at 165. The Acute Services Division had been resetting its implementation plans to increase the number of clinical teams involved, however, these plans had been based on targeting those wards in which cardiac arrests occurred most frequently. The total number of teams involved may still be small but this selection approach maximised the clinical benefits to patients.

Mr Finnie welcomed a refresh of the format of the report in order to gain a better understanding of the detail and suggested that a focus be on key outcomes from the programmes rather than process-type information. Dr Lyons added that it would be useful to illustrate key outcomes with some case studies if possible.

In response to a question from Dr Lyons regarding the development of delirium being incorporated into the process measures associated with the Deteriorating Patient workstream, Dr Armstrong agreed that mental state/cognitive function was an indicator of deterioration and that, often, clinical acumen was used to determine this.

In response to Ms Micklem’s point regarding evaluation, Dr Armstrong reported that each ward would look at its own results. Implementation would be a mixture of bottom-up and top-down leadership approaches to convey the message that it was all staff’s responsibility. Mr Calderwood added that the national initiative of SPSP was that clinical teams would buy into the lessons being constantly learned as the programme evolved. He encouraged all staff to make suggestions via Facing the Future Together (FTFT) in relation to their ideas and/or how things could be carried out locally more efficiently and effectively.

Mr Sime welcomed the overall SPSP results since the programme commenced and its many benefits including looking at best practice and the reasons for variance. Mrs McAuley agreed and was positive about the approach, however, suggested the added benefit in seeing evidence in future reports.

NOTED

08. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board’s Medical Director [Board Paper No 16/02] 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 and led the NHS Board through a summary of performance in relation to:-

- Staphylococcus aureus bacteraemias (SABs)
- Clostridium Difficile (C.Diff)
- Surgical Site Infection (SSI) rates for caesarean section, knee anthroplasty, repair of neck of femur procedures and hip anthroplasty procedures
- The Cleanliness Champions Programme
• Healthcare Environment Inspectorate (HEI) inspections

Dr Armstrong led the NHS Board through the actions being taken to address the disappointing SAB rate and increase in C.Diff reported cases, and summarised the NHS Board-wide actions being taken to address performance. In looking at the outbreaks/exception reporting, Dr Armstrong summarised the following:-

• Norovirus activity
• Increased incidence of serratia marcescens in patients in the Royal Hospital for Children
• Increased incidence of respiratory syncytial virus (RSV) in patients in the Beatson Oncology Centre
• Tuberculosis (TB) maternity unit at the QEUH campus
• Increased incidence of surgical site infection at the QEUH Orthopaedic Surgery
• Increased incidence of surgical site infection at the Royal Alexandra Hospital Orthopaedic Surgery

She summarised the actions being taken locally by the Infection Prevention & Control Team and local clinical teams as well as ongoing scrutiny by the Incident Management Team meetings.

Rev Dr Shanks recognised the huge effort that had gone into this work and the associated actions to produce the results Dr Armstrong alluded to. He made some suggestions around the presentation of the information to make it easier to understand and to provide a reflection and analysis on increases in incidences when they occurred.

Dr Armstrong explained that the report followed a national format but agreed that it could be tailored to meet the needs of the NHS Board.

In response to a question from Mr Finnie, Dr Armstrong explained how the alert systems worked in terms of triggers in the event of an increased incidence of infection. Local wards were constantly revisiting and monitoring their own performances and taking action to reduce infection rates, however, there was a reasonable level of expectation, despite rigorous assessment, that there would be peaks and troughs in performance. This was mainly due to the fact that it did not take many cases to activate the triggers locally. There was a need to continually reinforce the key messages especially as junior doctors rotated every six months.

Mrs McAuley commended the ongoing work in infection control areas but recognised, from the reports, some clear themes and wondered what long-term measures could be taken to facilitate change and increase compliance. Dr Armstrong suggested that future reports provide evidence in terms of the actions being taken to embed best practice.

Mr Lee referred to a previous NHS Board decision to change the method of dating central vascular catheters (CVCs) and wondered whether this decision should be revisited. Dr Armstrong described how CVCs were dated previously, but agreed that this could be looked at again. Mr Lee also suggested that a separate executive summary of the paper may be useful, showing key issues and highlights. This may make the report more digestible and understandable for NHS Board Members and members of the public.

In response to a question from Ms Micklem regarding NHS Board prescribing, Dr Armstrong described the use of the NHS Board’s prescribing guidance locally and agreed that it may need reinforced within local teams.

NOTED
09. **2016-17 LOCAL DELIVERY PLAN - DRAFT**

A report of the Chief Executive [Board Paper No 16/03] asked the NHS Board to note the process in place to draft the Local Delivery Plan 2016/17.

Mr Calderwood explained that the NHS Board was required to produce a draft Local Delivery Plan (LDP) in March 2016. Initial discussion on the framing of the LDP took place with NHS Board Members at the NHS Board Away Day on 22 December 2015 and this was followed up with more detailed discussions at the NHS Board Seminar on 1 February 2016.

Mr Calderwood reported that the NHS Board now shared responsibility for strategic planning with the Integrated Joint Partnership Boards (IJBs) but retained responsibility for the allocation of the NHS budget between the services for which it retained direct operational responsibility and those managed by IJBs. IJBs needed to develop and approve integrated services and financial plans for the NHS and Social Care services.

Mr Calderwood outlined that the aim of the LDP 2016/17 was to progress the detailed service change plans which had been developed to deliver the NHS Board's overall purpose and priorities. Those plans would deliver better services for patients, however, in 2016/17, the NHS Board needed to make the service changes which that direction and priorities required while addressing a challenging financial position. The aim of the approach was to make changes which aligned to the strategic direction, priorities and clinical strategies and enabled the NHS Board to deliver financial balance.

In response to a question, Mr Calderwood agreed that there were two key financial challenges, namely, achieving financial break-even in 2015/16 and planning ahead for 2016/17 onwards.

**NOTED**

10. **GP OUT OF HOURS SERVICES: CHANGES TO DRUMCHAPEL SERVICE AND WIDER REVIEW**

A report of the Director of Planning & Policy [Board Paper No 16/04] asked the NHS Board to agreed a process to be developed with its Partnerships to deliver appropriate engagement on the relocation of the Primary Care Emergency Centre (PCEC) at Drumchapel Hospital to Gartnavel General Hospital and note the review which was underway, of the wider GP Out of Hours Service.

Ms Renfrew set out the proposals to relocate the current PCEC from Drumchapel Hospital as the transfer of Older People's Services from Drumchapel Hospital meant that NHSGGC needed to relocate the PCEC from there and the proposal was to relocate it at Gartnave General Hospital.

Ms Renfrew led the NHS Board through the postcode review of attendances to both Out of Hours Centres in the West (currently based at Drumchapel and Gartnavel General Hospitals). She explained that the West GP Out of Hours Services were currently under considerable pressure to continue to maintain two centres and, on a number of occasions, patients had to be transported from one site to another dependent upon GP availability. Merging the two West services at Gartnavel General Hospital would create a service which was similar in size to that of the service provided at Stobhill Hospital. The service would be staffed by GPs and nurse practitioners and would be supported by a home visiting GP.
Ms Renfrew explained that the Acute Services Division managed the GP Out of Hours Service but the legislation which established Integration Joint Boards (IJBs) gave the Partnerships responsibility for planning the service. As such, NHSGGC had been working with the Lead Chief Officer for Primary Care to develop the planning for Out of Hours and an engagement process had still to be agreed. In addition to an appropriate engagement process, an Equality Impact Assessment (EQIA) of the proposed transfer would be carried out.

In terms of the wider service review, Ms Renfrew reported that a national review of GP Out of Hours Services had been completed. The key recommendations focused on the need to review both In and Out of Hours provision of urgent care across a spectrum of care providers. The recommendations from this report were being considered jointly by the Acute Services Division and the IJBs. Consideration would be given as to whether Sir Lewis Ritchie be invited to the NHS Board to discuss the national review. A key aim within NHSGGC was to achieve, as far as possible, the co-location of GP Out of Hours Services at sites with an Emergency Department/Minor Injuries Unit. Ensuring safe, accessible services to patients and staff during the out-of-hours period was a key factor in ensuring high quality services to the population of NHSGGC.

In response to a question from Rev Dr Shanks concerning the engagement process to be carried out, Ms Renfrew confirmed that this would include public engagement as well as liaison with the Scottish Health Council.

Ms Brimelow would have liked to have seen the national review first in order to see this within the wider context. She asked why the Drumchapel Out of Hours Service had been chosen to transfer and Ms Renfrew explained that this was because, following the transfer of Older People’s Services from Drumchapel Hospital, the hospital now no longer had any other clinical activity based there. In response to Ms Brimelow’s further question about any likelihood of an increase in A&E attendances due to the Drumchapel Out-of-Hours Service relocating, Ms Renfrew reported that part of the engagement process would look at patient flows. She also added, however, that access to the Primary Care Out of Hours Services was via telephone triage with NHS24.

In response to a question, Ms Renfrew confirmed that NHSGGC was the only NHS Board to offer patient transport to pick up and return patients from their homes to an Out of Hours centre if they had no other alternative.

Ms Brown highlighted the locations currently using this service and suggested that a cost benefits analysis should be undertaken as well as the EQIA to ensure a full strategic insight into this before any decision was made within the wider context.

In response to a question from Mrs McAuley regarding the EQIA, Ms Renfrew confirmed that this would include poverty characteristics. Ms Renfrew added that the wider service review would pick up on the added benefits, sought by clinical staff, of having an Out of Hours Service co-located with an Emergency Department or Minor Injuries Unit. She added, in response to Dr R Reid, that information was available on patients who attended a GP Out of Hours Service then were transferred into an Acute Service. This data would form part of the wider service review.

DECIDED

- Agreement that a process be developed with NHSGGC’s Partnerships to deliver appropriate engagement on the relocation of the Primary Care Emergency Centre (PCEC) at Drumchapel Hospital to Gartnavel General Hospital and reported back to the NHS Board.

- That the review which was underway of the wider GP Out of Hours Service be noted.
11. **INITIAL AGREEMENTS FOR GREENOCK HEALTH & CARE CENTRE AND CLYDEBANK HEALTH & CARE CENTRE**

A report of the Chief Officer, Inverclyde HSCP and Chief Officer, West Dunbartonshire HSCP [Board Paper No 16/05] asked the NHS Board to approve the proposals to deliver improvements in health and social care services in Greenock and Clydebank for onward submission to the Scottish Government Capital Investment Group.

Mr Moore set out a summary of the proposals to deliver improvements to health and social care services in Greenock and Clydebank. He explained that an initial agreement had been prepared for the investment proposals in each of the two areas and this described the background, the status quo, the proposals for improvement, the service changes required to deliver these and the benefits that would be realised in doing so.

He explained that both proposals centred on service provision in towns which were recovering from significant post-industrial change. Both sought to find ways to improve services to meet current and future demand as well as support regeneration of the physical and economic environment to help bring about significant health improvements. Whilst each had its own specific circumstances and objectives, there was significant overlap on the investment objectives of each.

Mr Redpath added that each individual initial agreement examined how the benefits could be delivered and each concluded that the delivery of a new Health & Care Centre offered the best opportunity to do so. Each proposed centre had been estimated to require circa £19-20m of investment to deliver and he highlighted the benefits of procuring these two proposals as a single project and summarised the financial benefits of doing so. He explained that it was proposed that these projects were bundled into one contract to be provided by Hub West Scotland as part of the Scottish Government’s approach to the delivery of new community infrastructure.

In response to a question from Mr Carr, Mr Moore confirmed that further debate would take place with both IJBs, in particular, looking at sustainability of the new buildings, as well as future (rather than current) attendances/usage. Mr Moore referred to NHSGGC’s exemplar for health and social care centres and in looking at a building’s design, to not only meet the needs of the local community but staff and new ways of working.

Mrs McAuley asked about the IJB’s responsibility for the new centres and Mr Calderwood clarified that NHS Boards remained responsible for all health premises. In instances such as health and social care centres, there was a split responsibility as the premises/buildings remained the NHS Board’s responsibility whereas the financial implications lay with IJBs.

Dr Lyons conveyed his condolences to the family of the architect involved with the design of the buildings, Mr G Williams, who had sadly passed away.

**DECIDED**

- That the proposals to deliver improvements in health and social care services in Greenock and Clydebank for onward submission to the Scottish Government Capital Investment Group be approved.
12. **2016/17 – FINANCIAL PROJECTIONS AND FINANCIAL PLANNING PROCESS**

A report of the Director of Finance [Board Paper No 16/06] asked the NHS Board to note the financial projection into 2016/17 and the planning process currently underway.

Mr White explained that the projection was based on the NHS Board’s own assessment of the financial landscape and incorporated the outcome of the Scottish Government’s budget to the Scottish Parliament in December 2015. He highlighted the significant financial challenge facing NHSGGC in 2016/17 and, given this, the NHS Board was required to deliver cash releasing savings of £69m in-year to break even.

Mr White highlighted the key elements of income and expenditure underpinning the financial challenge together with an explanation of the financial pressures and potential investments. He explained that Directors and Senior Managers were working to identify and design savings schemes to address the financial gap and that these would be finalised and presented to the NHS Board in due course together with analysis of impacts and risks.

Mrs McAuley welcomed the clarity of information provided, particularly in outlining the difficult financial challenges ahead. She asked for further information about the process for finalising allocations to IJBs. Mr White advised that the process of developing and funding allocations for IJBs in 2016/17 was well underway and IJBs were developing integrated service and financial plans for NHS and Council services.

Mr Finnie welcomed the detail provided in the report and Mr Sime, in welcoming the detail, stressed the engagement work with the Area Partnership Forum. He enquired about the use of non-recurrent funds and Mr White advised that non-recurrent funds were received and the issue was not to become reliant on them.

**NOTED**

13. **ATTENDANCE MANAGEMENT ACTIVITY AND PLANNING ACROSS NHSGGC**

A report of the Director of Human Resources & Organisational Development [Board Paper No 16/07] asked the NHS Board to note the activity in place across all service areas within NHSGGC to support the required improvement in staff attendance.

Mrs MacPherson led the NHS Board through the detail of current absence levels, trends across the organisation as well as providing detail at an NHS Scotland and local level. She outlined existing and planned activity to seek an improvement on current absence levels across all NHS Board services.

Mrs MacPherson summarised the range of interventions in place to seek to achieve an improvement in staff attendance levels across the Acute Sectors, Directorates and Partnership areas. She provided detail on absence trends across the NHS Board area and information on the performance of Acute Sectors, Directorates and Partnerships based on available workforce data.

She went on to provide detail regarding the NHS Scotland-wide position and specific detail regarding junior doctor absence levels and the reasons for this.
In response to a question from Dr Reid, Mrs MacPherson confirmed that there was no rapid access into Mental Health Community Services for NHS staff. She outlined the Occupational Health Mental Health sessions for staff, and Mr Sime confirmed there had been previous national discussions regarding priority for NHS staff to access some services in a similar way to reservists; this, however, was not agreed. The Chair emphasised the need to focus on improving attendance rather than managing absence.

**NOTED**

14. **NHSGGC’S INTEGRATED PERFORMANCE REPORT (INCLUDES WAITING TIMES AND ACCESS TARGETS)**

A report of the Head of Performance [Board Paper No 16/08] asked the NHS Board to note the content and format of the NHS Board’s Integrated Performance Report.

Ms Mullen explained that this report brought together high-level system-wide performance information (including all of the waiting times and access targets previously reported to the NHS Board) with the aim of providing the NHS Board with a clear overview of the organisation’s performance in the context of the 2015/16 Strategic Direction – Local Delivery Plan. An exceptions report accompanied all indicators with an adverse variance of 5% or more, detailing the actions in place to address performance and indicating a timeline for when to expect improvement.

Ms Mullen provided:-

- A summary providing a performance overview of current position.
- A single scorecard containing actual performance against target for all indicators. These had been grouped under the five strategic priorities identified in the 2015/16 Strategic Direction.
- An exception report for each measure where performance had an adverse variance of >5%.

Ms Mullen summarised performance and highlighted key performance status changes since the last report to the NHS Board including performance improvements, performance deterioration and measures rated as red.

In response to a question from Dr Reid regarding Detect Cancer Early, where current performance was lower than the trajectory, Mr Archibald confirmed that more information could be included in future reports showing raw figures as well as percentages. He also agreed to work further with the NHS Board’s statistician to look at this in greater detail.

Ms Brimelow welcomed the improved percentage of patients waiting four hours or less at A&E and enquired about the effect on waiting times targets of postponing elective operations. Mr Archibald reported that the NHS Board continued to ensure available emergency capacity was maximised and would cover the latter point in the paper to the April 2016 NHS Board meeting.
In response to a question from Mrs McAuley regarding the new service model that had been implemented in the South Sector where the majority of inpatient services were provided at the Queen Elizabeth University Hospital, Mr Archibald reported that this had led to considerable changes in working arrangements for senior and junior medical staff.

**NOTED**

**15. FINANCIAL MONITORING REPORT FOR THE 9 MONTH PERIOD TO 31 DECEMBER 2015**

A report of the Director of Finance [Board Paper No 16/09] asked the NHS Board to note the financial performance for the nine month period to 31 December 2015.

Mr White reported that the NHS Board was currently reporting an overspend outturn against budget of £7.5m. At this stage, however, the NHS Board forecast that a year-end break even outturn remained achievable through additional savings and non-recurrent coverage.

He led the NHS Board through expenditure on Acute Services, NHS Partnerships, Corporate Services and other budgets.

Capital expenditure in the year to date amounted to £34.4m and it was anticipated that a balanced year-end position would be achieved against the NHS Board’s Capital Resource Limit.

At this stage in the year, the NHS Board was behind its year to date cost savings target against plan.

Rev Dr Shanks enquired about the plans to ensure break even at the end of the year. The Chair advised that the Vice Chair, Chair of the Audit Committee and Mr A Macleod had reviewed the year end position with the Director of Finance. While this was welcomed by Members, it was important to ensure that governance processes were utilised to ensure appropriate assurance was provided to all NHS Board Members. In taking this forward, consideration would be given to the future committee structure and reporting relationships to the NHS Board.

In response to a question from Dr Lyons, Mr White reported that any additional measures identified or services changes to meet the shortfall would be for NHS Board consideration.

**NOTED**

**16. PATIENTS PRIVATE FUNDS – ANNUAL ACCOUNTS 2014/15**

A report of the Director of Finance [Board Paper No 16/10] asked the NHS Board to adopt and approve, for submission to the Scottish Government Health Directorates, the 2014/15 Patients Private Funds Annual Accounts for NHS Greater Glasgow and Clyde.

Mr White advised that the NHS Board held the private funds of many of its patients, especially those who were in long term residence and who would have no ready alternative for the safe-keeping and management of their funds.
Each of the NHS Board’s hospitals had arrangements in place to receive and hold and, where appropriate, manage the funds of any patients requiring this service. Any funds that were not required for immediate use were invested to generate interest which was then distributed to the patients’ accounts based on each individual’s balance of funds held.

NHS Boards were required to submit audited annual accounts for these funds in the form of an Abstract of Receipts and Payments to the Scottish Government Health Directorates. The funds had been audited and now required NHS Board approval prior to the auditors then signing their report, which had no qualifications.

Ms Brimelow highlighted that the Audit Committee minutes of the 7 December meeting raised concerns about the design and control of Patients Private Funds. Three medium risks had been highlighted by the internal auditors. Mr White advised that these were two different processes and the Auditor, KPMG LLP, had confirmed that, in their opinion, the abstract of receipts and payments for the year ending 31 March 2015 had been properly prepared, in all material aspects, in accordance with the requirements with the NHS Board Accounts Manual. The internal auditors, PWC, had highlighted in-year (2015/16) improvements which could be made.

Mr Finnie suggested that it would be more helpful if these accounts were submitted to the NHS Board earlier in future. Mr White agreed to make such arrangements going forward.

In response to a question from Mrs McAuley, Mr White confirmed that these accounts included patients managed locally by IJBs.

**DECIDED**

1) That the Patients’ Private Funds Annual Accounts for 2014/15 be adopted and approved for submission to the Scottish Government Health Directorates.

2) That the Director of Finance and Chief Executive be authorised to sign the Abstracts of Receipts and Payments for 2014/15.

3) That the Chair and Director of Finance be authorised to sign the Statements of Board Members’ Responsibilities for 2014/15.

4) That the Chief Executive be authorised to sign the Letter of Representation to KPMG LLP on behalf of the NHS Board.

**17. ACUTE SERVICES COMMITTEE MINUTES: 17 NOVEMBER 2015**

The minutes of the Acute Services Committee meeting held on 17 November 2015 [ASC(M)15/03] were noted.

**NOTED**
18.  AREA CLINICAL FORUM MINUTES: 3 DECEMBER 2015

The minutes of the Area Clinical Forum meeting held on 3 December 2015 [ACF(M)15/06] were noted.

NOTED

19.  AUDIT COMMITTEE MINUTES: 22 SEPTEMBER & 7 DECEMBER 2015

The minutes of the Audit Committee meetings held on 22 September and 7 December 2015 [A(M)15/04] and [A(M)15/05] were noted.

NOTED

The meeting ended at 12:45pm.