

ASC(M)17/01  
Minutes: 01 - 17

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the  
Acute Services Committee held at  
9.00am on Tuesday, 17 January 2017 in the  
Board Room, J B Russell House, Gartnavel Royal Hospital,  
1055 Great Western Road,  
Glasgow, G12 0XH**

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**P R E S E N T**

Mr R Finnie (Committee Chair)

Ms M Brown	Mr J Legg
Dr H Cameron	Dr D Lyons
Councillor G Casey	Mrs A M Monaghan
Mrs J Donnelly	Dr R Reid
Mr I Fraser	Mr I Ritchie

**O T H E R B O A R D M E M B E R S I N A T T E N D A N C E**

Mr Brown	Dr M McGuire
	Mr M White

**I N A T T E N D A N C E**

Mr J Best	..	Interim Chief Officer, Acute
Mr P Cannon	..	Deputy Head of Administration
Mrs A MacPherson	..	Director of Human Resources & Organisational Development
Ms P Mullen	..	Head of Performance
Ms C Renfrew	..	Director of Planning & Policy
Dr D Stewart	..	Deputy Medical Director
Mr C Whyte	..	Team Leader, Property Disposals (Minute 11 to 13)
Ms H Dorrance	..	Consultant Colorectal Surgeon (Minute 1 to 4)
Mr D Loudon	..	Director of Property, Procurement & Facilities Management

**01. APOLOGIES, WELCOME AND PRELIMINARIES**

Apologies were intimated on behalf of Dr Armstrong, Mr Calderwood, Mr Carr, Mrs S Brimelow and Cllr MacMillan. Mr Finnie welcomed Ms Dorrance to the meeting.

**02. DECLARATIONS OF INTEREST**

There were no declarations of interest.

**03. MINUTES OF PREVIOUS MEETING**

On the motion of Mr Reid, and seconded by Dr Lyons, the Minutes of the Acute

Services Committee meeting held on 15 November 2016 [ASC(M)16/06] were approved as a correct record.

NOTED

#### **04. MATTERS ARISING**

##### **a) Rolling Action List**

It was noted that there were a number of items which could be updated or possibly removed from the Rolling Action List [Paper No 17/01] and officers were asked to liaise with Mr Cannon to update the list accordingly.

##### **b) Colorectal Cancer Pathways**

Ms Dorrance attended the meeting to provide members with a presentation setting out an overview of the colorectal cancer pathway. Members were reminded that this was first raised at the July 2016 meeting.

It was highlighted that Colorectal Cancer is the third most common cancer in Scotland. In the West of Scotland there were around 1,600 new cases diagnosed annually. A significant proportion of patients present as emergencies, with a poorer immediate and long-term outcome compared to those who present electively.

The purpose of the presentation to the Committee was to detail the pathway of both elective & emergency patients, from initial contact to definitive management.

Ms Dorrance covered in detail

- emergency presentations;
- the elective pathway;
- screening;
- colorectal referrals;
- investigations;
- staging & the multi disciplinary team;
- tertiary referral pathways; and
- current capacity issues.

Ms Dorrance highlighted the disparity between sectors in waiting times for endoscopy investigations, clinic capacity (especially seeing return patients) and the time required to undertake full and detailed patient consent. It was also noted that operating time could also be limited.

Ms Renfrew noted the disparity in endoscopy waiting times across sectors and highlighted the need to move towards a single waiting list for specialties to ensure that there was equity of access for patients across NHS GG&C.

Mrs Brown noted that capacity was highlighted as a general issue and encouraged the use of Nurse Practitioners, and others, to free up Consultant input if return patients did not require this level of clinical supervision, and to review the appropriateness of the range of tests undertaken.

In relation to consent issues, Ms Dorrance highlighted that this can take up to 1 hour and the service was looking at ways of accommodating this time and focus at an earlier part in the patient journey, rather than at the pre operative assessment stage.

Mr Best acknowledged that the service was under pressure and highlighted that, together with Directors and Chiefs of Medicine, this was being addressed from the point of view of capacity and demand, productivity benchmarking, and better use of the Ambulatory Hospitals to provide additional capacity, including weekend clinics / theatre lists. He added that the establishment of a single waiting list was also being assessed.

Mr Finnie thanked Ms Dorrance for her detailed and informative presentation, and he noted that Mr Best and others were seeking to address the issues raised. He looked forward to seeing improvements in performance being evidenced through the regular Integrated Performance Report which is presented to the Committee at each meeting.

NOTED

## **05. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT**

There was submitted a paper [Paper No 17/02] by the Interim Chief Officer setting out the integrated overview of NHSGGC Acute Services Division's performance. Of the 23 measures which had been assessed against a performance status based on their variation from trajectory and/or target, 10 were assessed as green, 6 as amber (performance within 5% of trajectory) and 7 as red (performance 5% outwith meeting trajectory). Exception reports had been provided for those measures which had been assessed as red.

It was noted that, while improvements were evident across a range of measures, there were key measures where the trend was showing reduced compliance with targets in areas including the 12 week Treatment Time Guarantee (TTG), new outpatient waiting >12 weeks for a new outpatient appointment, and the number of patients waiting >6 weeks for a key diagnostic test.

In relation to unscheduled care it was noted that the Programme Board was continuing to finalise a report of the range of activities being undertaken and their assessment of the future steps required. It was also noted that the Programme Board would be reporting their findings in April 2017, with the intention to share this with Board Members at a Board Finance Workshop in April 2017. Dr Stewart also reported that the post of Deputy Director in the South Sector had been established as part of this ongoing review of capacity within the Sector, and that candidates were being interviewed shortly.

In response to a question from Dr Cameron, Dr Stewart highlighted the analysis of the numbers of patient being admitted at GG&C Hospitals, when compared to national benchmarks. It was evident that a higher proportion of patients were being admitted in GG&C Hospitals when compared with other similar organisations.

Dr Stewart emphasised that the first phase of the work of the Unscheduled Care Programme Board was coming to an end and that this had necessarily focussed on a root and branch review of local patient flow and procedures underpinning unscheduled care, and efficiencies that could be put in place. Mr Best underlined this point stating that the Programme Board had tried to identify and distil best practice, both locally and nationally.

In relation to sickness absence, Mrs MacPherson reported that this was subject to a deep dive assessment and that short term and long term hot spots were being identified and addressed. It was noted that the focus of efforts was on ensuring that the Board's Attendance Management Policy was followed and staff were supported

and encouraged to return to work as quickly as possible. Occupational Health Managers were working closely with local Managers to streamline the process of review so that there were no delays in dealing with individual cases.

Mr Finnie highlighted the significant cost being incurred by the Board and commended the targeted approach being adopted.

In response to a question from Mrs Brown, Dr McGuire highlighted that there were differences in sickness absence rates between Registered and Unregistered Nurses, and that the approach by the Board needed to be sensitive, and address work life balance and shift patterns. It was also noted that Paid As If At Work also had an impact on sickness rates.

Mr Fraser commended the approach adopted and asked that long term absence should be prioritised. Members noted the range of measures being adopted and the role of the Staff Governance Committee in monitoring these trends in greater detail.

In relation to Delayed Discharges, it was noted that discussion were being taken forward between the Board and the Glasgow City Health & Social Care Partnership to deliver the anticipated reductions in the number of patients experiencing a delayed transfer of care. It was also noted that discussions were also being taken forward with neighbouring NHS Boards.

Mr Best highlighted the Detect Cancer Early project, which Scottish Government had brought to a close in December 2016, the steps being taken to continue to record and manage local performance going forward, and the impact of the forthcoming National Cancer Plan on local service provision. Mr Best also reported that a detailed analysis of the 62 day cancer pathway was underway, and the result of this analysis would be shared with the Committee in March 2017.

**Interim Chief  
Officer, Acute**

A specific update was provided on the Urology Cancer pathway, and the improvement plan in place to improve this service. It was noted that 2 Consultants had been recruited and one would be deployed in the South Sector in January 2017, the second in the North Sector in February 2017. In relation to Breast Cancer it was noted that pathway redesign was underway to increase the available number of clinics.

Mrs Mullen referred members to the TTG exception report which showed that the Orthopaedic, General Surgery and Urology services were all under significant pressure and inpatients were being seen outwith the 12 week target. The recent changes to cease the use of locational unavailability codes had also had an impact on the number of patients on the waiting lists in these specialties.

NOTED

## **06. NATIONAL WAITING TIMES**

There was submitted a paper [Paper No 17/03] by the Interim Chief Officer setting out a report comparing NHS Greater Glasgow & Clyde's (NHS GG&C) performance with that of NHS Scotland and other comparable Health Boards in relation to a number of key national waiting times standards, to provide a wider context to NHSGG&C's performance.

The report provided that comparison and demonstrated NHS GG&C's contribution to Scotland's overall performance using the latest published data relating to September

2016. The measures included in the report covered 18 week Referral To Treatment, New outpatients waiting >12 weeks for a new outpatient appointment, the 12 Week Treatment Time Guarantee, the Cancer 62 day wait, the Cancer 31 day wait, and the A&E 4 hour waiting time.

Members welcomed the report and the useful data that was presented to contextualise the NHS GG&C performance data.

NOTED

**07. QUARTERLY REPORT ON CASES CONSIDERED BY THE SCOTTISH PUBLIC SERVICES OMBUDSMAN (1 JULY 2016 – 30 SEPTEMBER 2016)**

There was submitted a paper [Paper No 17/04] from the Nurse Director which set out a summary of those Ombudsman cases that required the Board to respond to a recommendation contained within the Investigation Report or Decision Letter covering the period 1 July 2016 to 30 September 2016.

It was noted that during the period covered by the report no Investigation Reports had been received. The Ombudsman had also advised the Board that during the period covered they had decided not to take forward 5 complaints. A total of 15 Decision Letters had however been received.

Within the 15 Decision Letters received, a total of 27 recommendations had been made and the report set out the complaint(s) investigated by the Ombudsman, each recommendation and the date by which a response was required, the response made by the Board to each recommendation, and the date on which the response had been submitted to the Ombudsman.

Dr McGuire highlighted developments in complaint handling, including a new Complaints Procedure from 1 April 2017, which will introduce an obligation on NHS Boards to try to resolve complaints within 5 working days, and also the legislation expected to be in force from 1 April 2018 around the Duty of Candour, both of which were noted.

Mr Ritchie acknowledged that it was regrettable that patients and their families had cause to complain to the Ombudsman about the handling of their complaint, but he noted that within the wider context of the number of complaints received, and the number of discrete patient interactions every day, the number of Decision Letters received had to be set in that context.

NOTED

**08. TRANSFORMING ACUTE SERVICES**

There was submitted a paper [Paper No 17/05] by the Director of Planning & Policy which provided a revised draft of the paper to establish the detailed programmes of clinical service planning required to deliver the transformation described and reshape the delivery of acute services across NHS Greater Glasgow and Clyde. The intentions to deliver extensive internal communication, and the plans to develop external communications were also noted.

Ms Renfrew took Members through the report in detail, which was still being developed, with a view to being discussed again at the February 2017 Board Seminar

and the February 2017 Board meeting.

Members made a number of detailed contributions to improve the tone and language used and it was agreed that the draft had been a useful and positive contribution to the development of a final paper.

It was also acknowledged that a public facing version of the paper would be required and that the Board's Communications Team were working on this separately.

NOTED

**09. UPDATE ON DELIVERY PLAN**

There was submitted a paper [Paper No 17/06] from the Director of Policy & Planning which set out an update on the progress being made in respect of the Acute Division Delivery Plan. Ms Renfrew reminded Members that the Committee last reviewed the Plan in September 2016.

Ms Renfrew reported that the purpose of the Plan was to ensure that the Division was able to deliver safe, high quality and effective clinical services within the agreed financial allocation, by identifying and resolving challenges to the provision of services.

The Plan also played an important part of the architecture to ensure that the Division functioned as a single, coherent entity and it provided a basis for performance management across the Division, ensuring delivery of key commitments, and enabled the Divisional Leadership team to exercise collective oversight of the wide range of planning activity which is required to underpin effective delivery by shaping reporting to the Strategic Management Group.

The grid attached to the paper showed progress on the key components of the 16/17 plan. In a number of these areas it was noted that the Board was working with HSCPs as changes to acute services need to be driven by the reshaping and redesign of community services led by HSCPs, and changes to community services need to be driven by the need to reshape acute services.

In addition to this activity, the Division also had a series of programmes of work to look at productivity and efficiency to assess how proposals can be brought forward to address the financial challenge which the Division needs to meet from the start of the new financial year.

NOTED

**10. FINAL OUTPUT OF DIVISIONAL LEADERSHIP EVENT**

There was submitted a paper [Paper No 17/07] from the Director of Policy & Planning which summarised the output of the Acute Division Leadership Event held at the end of October 2016, to discuss the unprecedented challenges which the Division is facing through this year, and into 2017/18.

Ms Renfrew reminded Members that the Acute Services Committee received the draft report of the Divisional Leadership Event in November 2016, and the report attached to the paper provided the detailed final report.

It was acknowledged that the event had been a very worthwhile endeavour and would

be repeated in March 2017.

NOTED

**11. QEUH CAMPUS DEVELOPMENT UPDATE**

There was submitted a paper [Paper No 17/08] by the Director of Property, Procurement and Facilities Management which set out the progress achieved on the QEUH campus of the Phase 3A works, the construction of the new Imaging Centre of Excellence, the improvements being made to older buildings to be retained on the campus such as the Institute of Neurosurgical which is being transformed with the addition of a new entrance and over-cladding, and improvements to the site infrastructure.

Mr Loudon took Members through the paper in detail illustrated by updated photographs of the site campus, and the developments highlighted, which included:-

- Central Park
- Formation of the SUDS (Sustainable Drainage System) pond
- New roadway between the old and new Govan Road entrances
- Demolitions
- Extension to existing surface car park at Govan Road Entrance
- Imaging Centre of Excellence
- Institute of Neurosurgical (INS) - Over-cladding project
- Institute of Neurosurgical - New Entrance
- Pedestrianisation of area between Multi Storey Care Park and Office Block
- Covered walkway on Arrival Square
- Surface Car Park at the rear of the Central Medical Block

NOTED

**12. QEUH CAMPUS: THE PROVISION OF FACILITIES MANAGEMENT SERVICES AT THE IMAGING CENTRE OF EXCELLENCE (ICE) BUILDING**

There was submitted a paper [Paper No 17/09] by the Director of Property, Procurement and Facilities Management which sought approval to the proposal that the Property, Procurement and Facilities Management Directorate provide facilities management services in accordance with agreed specifications and prices to the University of Glasgow for the Imaging Centre of Excellence (ICE) building.

It was noted that the Property, Procurement & Facilities Management Directorate was proposing to enter into a formal contract with the University Court of the University of Glasgow to provide a range of facilities management services over an initial period of two years with an option to extend on a yearly basis.

It was highlighted that the Board would be required to recruit additional Facilities Management (FM) staff to provide the services specified in the contract, if successful. The costs of any additional staff required to deliver the FM services will be recharged to the University as a result of service provision.

Mr Loudon explained that the University of Glasgow is a significant strategic partner of NHS Greater Glasgow & Clyde with a demonstrable track record of delivering high standards of research and development, and that the ICE will be a world class

facility that incorporates a new neurosurgical theatre suite to be utilised by NHS Greater Glasgow & Clyde.

Mr Loudon highlighted that the Property, Procurement & Facilities Management Directorate already provided a range of FM services to the University in the Stratified Medicine floor of the Teaching and Learning Building. The proposal contained in the paper built upon this arrangement albeit, in a more commercial and formal contractual structure.

Members acknowledged the attendant risks in establishing a commercial contract, but commended the approach.

APPROVED

- That the Property, Procurement and Facilities Management Directorate should provide facilities management services in accordance with agreed specifications and prices to the University of Glasgow for the Imaging Centre of Excellence (ICE) building.

**13. YORKHILL DISPOSAL PLAN UPDATE**

There was submitted a paper [Paper No 17/10] by the Director of Property, Procurement and Facilities Management which asked Members to note that the Property Disposal Team were progressing with the review of options for relocating the temporary clinical and non-clinical facilities and staff currently based on site to permanent locations, seeking an appropriate disposal strategy that addresses the conflicting needs of, an early disposal, best value and risks. Mr Whyte attended the meeting to take Members through the progress report in detail.

It was noted that as well as staff and facilities, there was a requirement to relocate a significant amount of storage required (e.g. blocks and slides / historic artefacts), but that limited work had been done on this so far.

It was noted that two options being considered, these being sale and leaseback, and joint venture. The advantages and disadvantages of each approach were discussed with Members.

It was noted that the Property Disposals team will report back in due course to the Committee on the preferred procurement vehicle and associated risks to optimise receipts from the disposal of the site.

**Director of  
Property,  
Procurement  
and Facilities  
Management**

NOTED

**14. FINANCIAL MONITORING REPORT**

There was submitted a report [Paper No 17/11] by the Director of Finance setting out the financial position within the Board for the 8 month period to 30 November 2016.

Mr White took members through the report in detail which it was noted was showing an adverse variance of £14.5m at the end of November 2016 after taking account of non recurring relief. The pressures being experienced in the Acute Services Division continued to be in Medical Pay, Nursing Pay, prescribing costs, surgical sundries and CSSD supplies.

Members acknowledged that the Board's financial position had been discussed in

great detail at the recent Board Away Day, at Board Seminars, and at the Decemebr 2016 Board meeting.

NOTED

**15. ACUTE STRATEGIC MANAGEMENT GROUP MINUTES OF MEETINGS HELD ON 27 OCTOBER 2016 & 24 NOVEMBER 2016**

NOTED

**16. AREA PARTNERSHIP FORUM MINUTES OF MEETING HELD ON 3 OCTOBER 2016**

NOTED

**17. DATE OF NEXT MEETING**

9.00am on Tuesday 21 March 2017 in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 1.30pm