

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, 19 April 2011 at 9.30 am**

P R E S E N T

Mr A O Robertson OBE (in the Chair)

Mr C Bell	Councillor J Handibode
Dr C Benton MBE	Dr M Kapasi MBE
Ms M Brown	Mr I Lee
Mr R Calderwood	Councillor R McColl
Mr G Carson	Councillor J McIlwee
Councillor J Coleman	Mrs J Murray
Ms R Crocket	Dr R Reid
Mr P Daniels OBE	Mr D Sime
Dr L de Caestecker	Councillor A Stewart
Ms R Dhir MBE	Mr B Williamson
Mr D Griffin	Councillor D Yates

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

Dr J Dickson	..	Associate Medical Director (for Minutes No. 25 and 26)
Ms S Gordon	..	Secretariat Manager
Mrs J Grant	..	Chief Operating Officer, Acute Services Division
Mr J C Hamilton	..	Head of Board Administration
Mrs A Hawkins	..	Director of Mental Health Partnership/Director, Glasgow City CHP
Ms C Renfrew	..	Director of Corporate Planning and Policy
Ms S Laughlin	..	Head of Inequalities and Corporate Planning (for Minute No. 27)

ACTION BY

20. WELCOME AND APOLOGIES

Mr Robertson welcomed the two newly appointed non executive members, Dr R Reid and Ms M Brown, to their first NHS Board meeting.

Apologies for absence were intimated on behalf of Dr B N Cowan, Prof A Dominiczak, Mr I Fraser, Rev Dr N Shanks, Mrs E Smith and Mr K Winter.

Mr Robertson sought and received members approval to re-order the agenda and consider Item No. 21 "Pharmacy Practices Committee Minutes" following agenda Item No. 11 "Review of Mental Health Partnership".

21. CHAIR'S REPORT

- (i) On 22 February 2011, Mr Robertson met with Dr Denise Coia, the newly appointed Chair of Health Improvement Scotland which was the successor organisation to Quality Improvement Scotland and the Care Commission.
- (ii) On 25 February 2011 and 8 March 2011, Mr Robertson had visited Bridgeton Health Centre which was formally opened on 8 March 2011.
- (iii) On 3 March 2011, Mr Robertson attended the launch of the British Heart Foundation/Marie Curie "Caring Together". This was a joint initiative providing support including palliative care for patients.
- (iv) On 11 March 2011, Mr Robertson attended the opening of the new Pharmacy Distribution Centre at Ibrox. The Centre was formally opened by the Cabinet Secretary for Health and Wellbeing.
- (v) On 25 March 2011, Mr Robertson visited the Barrhead Health Centre with Lord Lieutenant of Renfrewshire, Guy Clarke and Councillor Douglas Yates. The Centre opened to patients on 18 April 2011 and Councillor Yates confirmed that staff and patients were delighted with their new facilities.
- (vi) On 4 April 2011, Mr Robertson commenced the annual appraisals with non Executive NHS Board members.
- (vii) Mr Robertson invited Mrs Grant to update the NHS Board on the closure of in-patient beds at Stobhill Hospital. Mrs Grant confirmed that the move of in-patient beds to Glasgow Royal Infirmary had gone smoothly and she paid tribute to all staff involved in the planning and organisation as any significant disruptions were minimised.

NOTED

22. CHIEF EXECUTIVE'S UPDATE

- (i) During February 2011, Mr Calderwood participated in the inspection of Glasgow City CHP Child Protection arrangements. Although many areas of success were identified, a work plan would be compiled to address areas where improvements had been suggested.
- (ii) On 21 March 2011, Mr Calderwood contributed to the Common Purpose Master Forum on exploring leadership challenges. At this event, he had spoken on older people's services and associated planning issues.
- (iii) On 29 March 2011, Mr Calderwood participated in the short-listing for the Director of Finance post. Interviews would take place on 9 May 2011.
- (iv) On 18 April 2011, NHS Greater Glasgow and Clyde hosted a visit from the Permanent Secretary, Sir Peter Housden. During this visit, the Permanent Secretary had visited the new South Glasgow Hospitals campus and had debated issues around the health of the population, Primary Care, Community services and Child Health.

The last session in the afternoon had afforded a general discussion around NHS policy and practical issues.

NOTED

23. MINUTES

On the motion of Dr M Kapasi, seconded by Mr D Sime, the Minutes of the NHS Board meeting held on Tuesday 15 February 2011 [NHSGG&C(M)11/01] were approved as an accurate record and signed by the Chair.

NOTED

24. MATTERS ARISING FROM THE MINUTES

The rolling action list of matters arising was circulated and noted.

NOTED

25. SCOTTISH PATIENT SAFETY PROGRAMME UPDATE

A report of the NHS Board's Medical Director and Head of Clinical Governance [Board Paper No. 11/10] asked the NHS Board to review and comment on the progress achieved by NHS Greater Glasgow and Clyde in implementing the Scottish Patient Safety Programme (SPSP).

Dr Dickson reminded members of the overall NHS Greater Glasgow and Clyde aim to ensure the care provided to every patient was safe and reliable. The SPSP's aim was to achieve full implementation of the core programme in the Acute Services Division by the end of 2012.

Dr Dickson described the core programme as including improved staff capability in all wards and the creation of reliable processes for every relevant element in every ward. He confirmed that the NHS Board had also developed SPSP style improvement programmes in Paediatrics and Mental Health Services in 2010 and was working towards Primary Care and Obstetrics in 2011.

Dr Dickson referred to the previous report which indicated that NHS Greater Glasgow and Clyde believed it now met the conditions for the next point on the assessment scale, that being Level 3.5, and the national SPSP Team and advisers had been asked to review and confirm this local assessment. To date, the position had not yet been clarified but it was hoped that this would be resolved shortly.

The NHS Board had demonstrated sustained reliability in a pilot population for all elements in the programme. The major challenge for the NHS Board, over the next two years, was spreading these reliable practices to all applicable clinical teams.

Dr Dickson explained that, as the NHS Board began to look ahead to the end of the first five year phase of SPSP (December 2012), staff recognised the importance of understanding how current progress matched expectations.

As such, a major review of internal predictions against the SPSP first phase milestones as at 20 December 2012 was underway and due to be presented to the Acute Services Division Clinical Governance Forum. This would allow more detailed discussion to accelerate programme implementation.

After four waves of introduction to start teams into the programme, work was ongoing with 270 clinical teams from wards, theatres, critical care and high dependency. The final ten wards would be commencing in the next month, which meant the original start up plan, set in 2008, had been delivered four months ahead of schedule.

NOTED

26. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the Medical Director [Board Paper No. 11/11] asked the NHS Board to note the latest of the regular bi-monthly reports on Healthcare Associated Infection (HAI) in NHS Greater Glasgow and Clyde.

Dr Dickson explained that the report presented 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 the template used was that specified by the Scottish Government Health Directorates.

Dr Dickson highlighted four key Healthcare Associated Infection headlines for April 2011 as follows:-

- In 2007, the Scottish Government Health Directorates (SGHD) issued HEAT Targets in relation to S.aureus bacteraemias (SABs) which required NHS Greater Glasgow and Clyde to reduce SABs by at least 35% by April 2010. Dr Dickson was pleased to report that this target had been achieved. In 2010, this target was extended by an additional 15% to be achieved by the end of March 2011. The NHS Board was maintaining steady progress towards this target. Further, and more challenging, targets would be implemented from April 2011 and an update on this would be included in the next update report considered by the NHS Board in June 2011.
- The national report published in January 2011 (July – September 2010), showed the rate of C.difficile infection within NHS Greater Glasgow and Clyde as 0.38 per 1000 occupied bed days. This clearly placed the NHS Board below the national mean of 0.47 per 1000 occupied bed days in over 65s and also below the 0.6 per 1000 occupied bed days updated HEAT target for 2011. Dr Dickson reported that the most recently validated figure for NHS Greater Glasgow and Clyde showed the rate as 0.34 per 1000 occupied bed days.
- The Surgical Site Infection (SSI) rates in monitored procedures in NHS Greater Glasgow and Clyde, (for the last available quarter of 2010), remained below the national average for all categories.

- Cleanliness Champions Programme – the Cleanliness Champions Programme was part of the Scottish Government’s Action Plan to combat HAI within NHS Scotland. To date, NHS Greater Glasgow and Clyde had supported 2243 members of staff who were now registered Cleanliness Champions.

Councillor Yates asked about the Scottish Government’s new national minimum MRSA screening recommendations. Dr Dickson confirmed that targeted MRSA screening, by specialty, would now be replaced by a universal Clinical Risk Assessment (CRA) followed by a nose and perineal screen (if the patient answered yes to any of the questions within the CRA). Funding had been agreed, in line with NHS Greater Glasgow and Clyde’s previous spend on MRSA screening, and the MRSA project team was working towards a deadline of 31 May 2011 for completion of the project plan. Thereafter, all NHS Boards would be asked to ensure local delivery against the operating protocol by the end of March 2012. Dr Dickson reported that this work was being led by the Infection Control Team and planning was going well albeit that further clarity was being sought around the need for perineal screening.

Dr Kapasi referred to the 45 wards closed between October 2010 and March 2011 due to suspected norovirus. In terms of coping with these ward closures, Mrs Grant reported that the challenges for elective and emergency workloads had been addressed to minimise disruption to patients and maximise the use of available beds.

Councillor McColl acknowledged the work of the Infection Control Team in taking this Programme forward and, in particular, referred to the marked improvements overall. He was conscious that such good results should be conveyed to local communities so that they could identify with the improved quality of service. Mr Calderwood agreed and confirmed that the NHS Board’s Communications Directorate worked with local media to ensure that positive news stories were put into the public domain.

**Director of
Corporate
Communications**

Dr Benton referred to the case of legionella identified at Glasgow Royal Infirmary. Mrs Grant reported that the infected patient was duly isolated and the outcome of an investigation was awaited. She summarised the various tests that had been undertaken to identify the source and confirmed that this included testing water access to wards.

In looking at the Statistical Progress Charts for each hospital site, Mr Sime sought clarity on the setting of the upper and lower control limits and the centre line (mean). Dr Dickson explained that the setting of the upper control limit allowed the local teams to “trigger” actions promptly in response to any increase in the number of patients identified. Dr Cowan would report at the June 2011 meeting on how the mean line was lowered.

**Medical
Director**

NOTED

**27. EQUALITIES LEGISLATION - NHS GREATER GLASGOW AND CLYDE
EQUALITY SCHEME 2010–13: FIRST ANNUAL REPORT**

A report of the Head of Inequalities and Corporate Planning [Board Paper No. 11/12] asked the NHS Board to approve the NHS Greater Glasgow and Clyde Equality Scheme 2010-13, First Monitoring Report and note the issues requiring further progress for 2011/2012.

Ms Laughlin explained that the Equality Act 2010, which came into force on 5 April 2011, brought together 116 separate pieces of legislation into a single source to ensure that everyone protected by pre-existing Equalities Legislation was afforded the same level of protection. It also introduced the concept of protected characteristics, previously referred to as equality groups or equality strands.

These protected characteristics were age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation. Legal protection was afforded in relation to direct discrimination, indirect discrimination and discrimination arising from disability, harassment, third party harassment and victimisation.

Ms Laughlin emphasised that the legislation imposed general and specific duties on public authorities. She summarised the general duty requirements and explained that the specific duties for public authorities in Scotland were currently being finalised.

Ms Laughlin led the NHS Board through the monitoring report which was constructed in two parts with both an internal and an external audience, particularly the Equality and Human Rights Commission, in mind. Firstly, in line with previous reports, it considered progress in applying an understanding of discrimination into mainstream organisational activity such as planning, performance, service management and service redesign. As part of this, it highlighted the exemplar work that was being carried out by the North West Sector of Glasgow CHP which was attempting to test the methodology for mainstreaming an inequalities sensitive and anti-discriminatory approach into all its business.

Secondly, Ms Laughlin described progress against the action plan using a pre-agreed set of yearly milestones as the marker. Further, the specific work carried out within the Mental Health and Addictions Partnerships was included as a case study. Equality Impact Assessment (EQIA) was a requirement and tool for identifying where change needed to be made.

In concluding, Ms Laughlin reported that the response by NHS Greater Glasgow and Clyde to the legislation was proportionate and relevant to the size and nature of the organisation and that there had been further incremental progress over the course of the previous year. Most of the identified milestones had been reached and there were key new achievements. Despite this, it had to be recognised that the number of staff and the volume of activity undertaken by NHS Greater Glasgow and Clyde remained an ongoing challenge in ensuring legal compliance. The Corporate Inequalities Team would continue to facilitate further change and monitor the extent of further progress in relation to these challenges.

In response to a series of questions from Dr Kapasi, Ms Laughlin agreed that changing the culture of the organisation posed a significant challenge. The makeup of the workforce had changed through time and information would continue to be gathered via periodic surveys of staff and focus group sessions with various staff groups. The Knowledge Skills Framework (KSF) also helped evaluate (and, if need be, identify training needs) staff adherence to the equality legislation as it reminded all staff of their obligations to meet the requirements.

Mr Carson agreed that the workforce of NHS Greater Glasgow and Clyde had to be representative of the diverse population served by NHS Greater Glasgow and Clyde. He also referred to the Accessible Information Policy (AIP) which was an invaluable initiative highlighting best practice and inquired as to whether the Scottish Accessible Information Forum (SAIF) Guidelines had been used for this. Ms Laughlin agreed and confirmed that the NHS Board used and applied these Guidelines.

In response to a question from Mr Williamson about data collection systems within community and hospital settings (and also *between* Primary and Secondary Care), Ms Laughlin reported that, at the moment, information gathering was disaggregated. IT systems were, however, improving and work was ongoing towards collecting ethnicity data and information on protected characteristics. It was hoped that the upgraded IT infrastructure would eventually be able to follow a patient from Primary to Secondary Care so that individual patient information gathering did not have to be repeated at each stage of treatment.

In terms of operational practice to identify what language a patient spoke, Ms Laughlin confirmed that a vast range of techniques and methods were used by staff to identify this. Once a language had been confirmed, interpreting arrangements could then be made.

Councillor Yates asked if inequalities issues were often raised in complaints received by the NHS Board. Ms Laughlin responded by firstly confirming that an EQIA had been undertaken with the most recently revised Complaints Handling Policy. Furthermore, the content of complaints was scrutinised to identify any inequalities issues being raised.

In response to a question from Councillor McIlwee regarding the in-house interpreting service, Ms Renfrew reported that this was currently being developed to be more responsive and to improve the quality of services to patients. She outlined some changes that could be made to the existing service and confirmed that the new in-house service would be implemented from 1 October 2011. In response to a further question from Dr Kapasi, Ms Renfrew confirmed that the current telephone interpreting service was being developed and had the potential to provide excellent flexibility especially in emergency situations. She agreed that the need for the translation of clinical letters (received by Primary and Secondary Care Clinicians) would be addressed in the setting up of the new in-house service.

Ms Laughlin agreed with the point made by Ms Brown in that, to drive many of the recommendations, culture change within the organisation was essential. She confirmed that the Inequalities Team worked closely with the performance team to put in place relevant indicators to measure progress and attitudes.

DECIDED

- That the NHS Equality Scheme 2010-13, First Monitoring Report be approved.
- That the issues requiring further progress for 2011/2012 be noted.

**Head of
Inequalities and
Corporate
Planning**

28. NHS SCOTLAND QUALITY STRATEGY – IMPLEMENTATION IN NHS GREATER GLASGOW AND CLYDE

A report of the Board Nurse Director [Board Paper No. 11/13] provided an update on the approach in NHS Greater Glasgow and Clyde to improving quality and, in particular, the NHS Scotland Quality Strategy.

Ms Crocket explained that the NHS Scotland Quality Strategy was launched in May 2010, with the aim of achieving world leading quality healthcare services across Scotland, underpinned by three healthcare quality ambitions, namely, person centred, safe and clinically effective. The strategy set out a range of initiatives at national and NHS Board level to improve services to meet these ambitions.

Work was under development on a set of outcomes and performance indicators, linked to HEAT targets, to enable progress on the Quality Strategy to be measured at national level.

Ms Crocket explained that the Quality Strategy and the NHS Board's local response was not a new or separate set of activities but a way of pulling together a whole range of activities under one umbrella to ensure that the NHS Board was focussed on improving quality.

Ms Crocket led the NHS Board through the approach being taken to improve quality in NHS Greater Glasgow and Clyde focussing on balancing all six dimensions (safe, effective, person centred, timely, efficient, equitable) and supporting the organisation to manage the tensions between them with a particular focus on how to maintain quality within a constrained financial environment.

Three main strands of work were being undertaken in NHS Greater Glasgow and Clyde to improve quality:-

- Quality Policy Development Group – this Group had been established to drive and support quality improvement across the organisation and the Group had established a work plan.
- Specific quality programmes and initiatives – there was a comprehensive range of programmes and initiatives supporting quality improvement across the organisation and ensuring the delivery of the actions set out in the NHS Scotland strategy. Many of these programmes were substantial in their own right and were the subject of regular reporting to the NHS Board. The Quality Policy Development Group would maintain an overview of these programmes of work to ensure that any gaps or duplication were identified and to ensure that collectively they were making a real difference to patients.
- Outcomes focussed planning and performance arrangements – NHS Greater Glasgow and Clyde's planning approach was now characterised by a shift to outcomes based planning where it established clear outcomes to be delivered over the three year planning cycle. This helped to ensure that across the full range of services and functions, the NHS Board was focussing on improving quality and outcomes for individuals.

Mr Williamson commended the approach being taken to meet the ambitions of the Quality Strategy. He suggested, however, the inclusion of a dimension covering "quality of life" as this was key to improving person centred care. Ms Crocket thanked Mr Williamson for this suggestion and confirmed that the next meeting of the Quality Policy Development Group was scheduled for 20 April 2011 when she would raise this point.

Nurse Director

NOTED

29. NATIONAL CATERING AND NUTRITIONAL SERVICES SPECIFICATION: HALF YEARLY COMPLIANCE REPORT (RESULTS FOR JULY – DECEMBER 2010)

A report of the Board Nurse Director [Board Paper No. 11/14] provided the NHS Board's monitoring data and compliance with the requirements set out in the "NHS Scotland Food in Hospitals National Catering and Nutrition Specification for Food and Fluid in Hospitals in Scotland 2008"

Ms Crocket explained that the nutritional wellbeing of the patient population in hospitals remained a priority issue for NHS Scotland and the specification was developed to ensure that the catering and nutritional services were clear as to the requirements of the new specification.

Catering and nutritional services were an essential part of the multi-disciplinary approach to tackling issues affecting the nutritional wellbeing of the patient population. As part of the NHS Board's ongoing assessment of compliance with the national standards, Ms Crocket led the NHS Board through its performance covering the periods July 2009 - December 2009, January – June 2010 and the most recent results of July – December 2010.

Ms Crocket illustrated that the NHS Board's performance had improved with each audit which positively demonstrated continuous quality improvement in this area. Two standards remained below the national average score (menu planning and menu planning guidance) and she described work being undertaken in both of these areas to reach the national average scores.

In response to a question from a member regarding the overall patient experience of food in hospitals, Ms Crocket confirmed that a lot of work was underway to measure this including patient surveys and working with Patient Public Forum (PPF) members to "test" hospital food. She agreed with Mr Sime's point that it would be useful to see the information presented on a site-by-site basis and future reports would include this.

Nurse Director

In response to a question from Mrs Murray, Ms Crocket explained that one example of a therapeutic diet was the provision of a special diet for someone who may have difficulty swallowing. One reason for the stark increase in performance between December 2009 and June 2010 in the provision of therapeutic diets was that this had been an area of significant investment.

Ms Crocket reported that in NHS Greater Glasgow and Clyde, over 15,000 patient meals were provided a day. This was a massive logistical exercise and shortly all catering would be provided in-house from Inverclyde Royal Hospital and the Royal Alexandra Hospital. Mr Calderwood was confident that this investment would see improvements with food production and in-house kitchen services but conceded that work still had to be done to finalise how best the food could then be distributed from these two production centres to individual patients throughout NHS Greater Glasgow and Clyde.

Councillor Yates welcomed the likely improvements to the quality of food prepared in the two in-house kitchens and hoped it would also be improved by the time it reached the ward/patient.

In response to further questioning, Mr Calderwood confirmed that future reports would also include detail on local spending, dietetic input and food costs.

Nurse Director

NOTED

30. REVIEW OF MENTAL HEALTH PARTNERSHIP

A report of the Director, Glasgow City CHP [Board Paper No. 11/15] summarised comments received on the recent Review of the Mental Health Partnership and outlined proposed changes to the arrangements for the management of adult mental health services.

Mrs Hawkins reported that respondents were generally supportive of the proposals in the discussion paper and she summarised some of the points raised. Although a number of respondents commented on the lack of detailed information on how the new system would work, she confirmed that a paper outlining more detail on the arrangements was currently being prepared for agreement with CH(C)P Directors; the intention being that the new arrangements would be implemented on 1 May 2011.

She led the NHS Board through the key themes arising from the discussion document including:-

- Management arrangements
- Clinical Governance/Leadership
- Planning
- Health Improvement
- Service user involvement
- Carers
- Staff Governance
- Governance
- Monitoring and Evaluation

To provide the NHS Board with confidence about the new arrangements, Mrs Hawkins explained it was intended that the Corporate Management Team and the organisational performance review process would review the impact of the new arrangements against a set criteria (these being the principles which the new mental health system-wide team would work to).

In response to a question from Mr Daniels concerning the proposed management structure, Mrs Hawkins outlined how these post holders would function system-wide. She explained, however, that the roles and responsibilities of the post holders would be much clearer in the detailed paper currently being prepared. By way of comparison, she explained that each of the CH(C)P Directors reported directly to the Chief Executive, and should have delegated responsibilities for particular functions Board-wide.

DECIDED

- That the summary of responses received to the recent discussion paper on the future of the Mental Health Partnership be noted.
- That the responsibilities of the Mental Health Partnership be delivered by CH(C)Ps as detailed in the discussion paper be agreed.
- That the new arrangements for delivery of Mental Health Services would be monitored against the criteria detailed at paragraph 11.1 be agreed.

**Director,
Glasgow City
CHP**

**Director,
Glasgow City
CHP**

31. PHARMACY PRACTICES COMMITTEE MINUTES: 10 FEBRUARY 2011, 17 FEBRUARY 2011, 3 MARCH 2011 AND 14 MARCH 2011

The Minutes of the Pharmacy Practices Committee meetings held on 10 February 2011, 17 February 2011, 3 March 2011 and 14 March 2011 [PPC(M)11/03, 11/04, 11/05, 11/06] were noted.

Mr Daniels referred to a change in the pharmaceutical regulations from 1 April 2011. As a result of this, the existing Pharmacy Practices Committee was working its way through a back log of applications. Mr Robertson recorded his appreciation of Mr Daniels as Chair of the PPC and Dr Benton as Vice Chair for their continuing efforts.

NOTED

32. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer (Acute Services Division) [Board Paper No. 11/16] asked the NHS Board to note progress against the national targets as at the end of February 2011.

Mrs Grant led the NHS Board through the report highlighting the actions being taken to deliver the waiting times and access targets including out-patient waiting times, in-patient/daycase waiting times, diagnostic waiting times, accident and emergency four hour wait, cancer waiting times, chest pain, delayed discharge and stroke.

As previously reported, late 2010 and early 2011 was characterised by increased demand and particularly challenging weather. Due to this, the accident and emergency four hour wait had been significantly challenged. The position through February 2011 and beyond, however, was that activity levels had returned to expected seasonal norms and performance levels were beginning to reflect this change with five sites reporting 95% compliance or better in February 2011 as opposed to three sites in the previous month. In response to these challenges, Mrs Grant reported that the NHS Board was pursuing a series of targeted actions and had established an Accident and Emergency Attendances Steering Group to review alternatives to A&E attendance and hospital admission. Furthermore, the NHS Board had commissioned a Scottish Government sponsored survey of self presenting patients at four of the Board's largest A&E Departments which identified patients stated reasons for self presentation at A&E Departments rather than accessing other services such as NHS 24. This information was being considered by the Accident and Emergency Attendances Steering Group.

In response to a question from Mr Robertson, Mrs Grant confirmed that the NHS Board commissioned a LEAN project focussing on emergency admission processes which would start in May 2011. This would focus on those sites with the lowest current performance, namely, Western Infirmary, Glasgow Royal Infirmary and Royal Alexandra Hospital and would incorporate patient flows throughout Primary and Secondary Care.

Mr Lee welcomed work ongoing to increase the percentage of patients attending the Minor Injury Units at the Victoria and Stobhill Hospitals and acknowledged the concerted effort being made in the resultant increased activity in these facilities particularly as these patients may normally have attended Accident and Emergency.

Mr Williamson referred to the patient's journey should they attend as an out-patient, in-patient and for diagnostic tests. To go through all three stages, the overall waiting time would accumulate to a minimum of 21 weeks. Mrs Grant confirmed that this was indeed the pathway for non emergency treatment and she described the new end-to-end 18 week Referral to Treatment (RTT) pathway measurement which was due to be delivered by December 2011. As a number of new targets required to be delivered during 2011, Mrs Grant confirmed that the format of the waiting times report in the forthcoming period would be revised to ensure new targets were duly reported.

NOTED

33. FINANCIAL MONITORING REPORT FOR THE 11 MONTH PERIOD TO 28 FEBRUARY 2011

A report of the Director of Finance [Board Paper No. 11/17] asked the NHS Board to note the Board's financial performance for the first eleven months of the financial year and its details of expenditure to date against the Board's 2010/11 capital allocation.

Mr Griffin explained that, as at 28 February 2011, the NHS Board was reporting expenditure levels running £1.7M ahead of budget. This represented a significant improvement on the position reported at 31 January 2011 and was attributed to the implementation of a series of actions by the NHS Board during the final quarter of the year to offset additional cost pressures arising during the year. Actions included a mix of supplementary cost savings schemes, release of funding allocations not fully required in 2010/11 and the release of non recurring funds from provisions carried forward from 2009/10 which were not fully required in 2010/11. These measures continued to have a positive impact on the NHS Board's outturn for March 2011 and could reasonably be expected to bring the outturn to a breakeven position by the year end.

In relation to cost savings, at 28 February 2011, the NHS Board had reported achievement of cost savings of £46.6M against a year to date target of £46.6M. At this stage, therefore, the NHS Board was forecasting full achievement of its 2010/11 cost savings plan. This would continue to be closely monitored until the year end as delivery of its savings target was crucial to achievement of the NHS Board's revenue plan for the year.

With regard to capital expenditure, this was in line with plan and reflected the timing of expenditure across a wide range of programmes. The level of slippage required to be generated in year increased to £16.5M at 30 November 2010 following a review by the Scottish Government Health Directorate of forecast expenditure against funding allocations across NHS Scotland. This had led to the NHS Board's capital resource limit being adjusted to reflect forecast spend on a range of specific capital funding allocations in 2010/11. Expenditure plans for all remaining schemes had been reviewed and the slippage target had been identified in full. As a result, the NHS Board was on track to achieve its capital resource limit.

In conclusion, Mr Griffin reported that in the lead up to the year end, the NHS Board would continue to work closely with Scottish Government Health Directorate colleagues in order to try and secure a balanced outcome across NHS Scotland with regard to capital expenditure levels.

This may lead to the adjustment of the NHS Board's Capital Resource Limit (CRL) for 2010/11, however, in the event of this outcome, there would be a compensating adjustment to the NHS Board's CRL agreed with the Scottish Government Health Directorate for 2011/12.

Mr Lee commended Mr Griffin and his finance team and was extremely encouraged to see the significant reduction in deficit levels month on month.

In response to a question from Ms Dhir regarding the Acute prescribing expenditure being above budget for the year to date, Mr Griffin summarised some of the reasons for this including the use of new cancer drugs and the exponential growth in prescribing of anti Tumour Necrosis Factor (anti-TNF) drugs which had proved to be a very effective form of treatment.

Dr Dickson agreed and explained that the NHS Board was currently looking at the criteria for patients being prescribed anti-TNF drugs as well as the upward trend in overall general usage.

NOTED

34. QUARTERLY REPORT ON COMPLAINTS – 1 OCTOBER 2010 TO 31 DECEMBER 2010

A report of the Head of Board Administration, Chief Operating Officer (Acute Services Division) and Director, Glasgow City CHP [Board Paper No. 11/18] asked the NHS Board to note the quarterly report on NHS complaints in Greater Glasgow and Clyde for the period 1 October – 31 December 2010.

Mr Hamilton summarised the commentary and statistics on complaints handling throughout the NHS Board's area for the period October to December 2010. He reported that in terms of performance, the NHS Board responded to 74% of all complaints within 20 working days.

He updated the NHS Board on the status of the Patients Rights (Scotland) Act and, in particular, the provision of the Patient Advice And Support Service (PASS). This service was currently delivered by the Independent Advice and Support Service (IASS). It was hoped that PASS would replace IASS from 1 April 2011, however, delays in the national commissioning arrangements would now mean to the existing IASS arrangements would continue for another three months until the end of June 2011.

Councillor Handibode referred to the ratio of complaints completed pro rata to patient activity levels – currently approximately, 1 complaint to 2401 episodes of patient activity. Given this, a 74% complaints handling performance represented an excellent output and he commended complaints handling staff for their robust investigation and processes.

NOTED

35. NHS GREATER GLASGOW AND CLYDE – ANNUAL REVIEW OF GOVERNANCE ARRANGEMENTS

A report of the Head of Board Administration [Board Paper No. 11/19] asked the NHS Board to approve, note and agree any revisions to the governance arrangements in place within NHS Greater Glasgow and Clyde.

Mr Hamilton reminded the NHS Board, that in February 2005, it approved the new organisational arrangements to implement the white paper “Partnership for Care”. Subsequently, two significant reviews of the governance arrangements took place as the moves to single system working and integration of Clyde were carried out and, as a result, the NHS Board approved in December 2006, a detailed set of new governance arrangements to support the new organisation.

In response to the launch of the Quality Strategy and the need to embed its requirements within corporate reporting and governance structures, the NHS Board had considered an integrated approach to governance together with a high visibility of the full range of quality issues at NHS Board member level. The proposals to revise the NHS Board’s standing committee arrangements, as a result of this, had been developed with NHS Board members at three NHS Board seminars.

In addition, the Audit Committee meeting in March 2011 considered the draft Annual Review Of Corporate Governance paper including the proposals to revise the standing committee arrangements in light of the Quality Strategy and integrated approach to governance. The Audit Committee supported the establishment of a single integrated governance committee arrangement.

Mr Hamilton led the NHS Board through the changes which provided a solid governance framework for the NHS Board properly to discharge its responsibilities and statutory functions.

DECIDED

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| (i) That the Standing Orders for the Proceedings and Business of the NHS Board and the Decisions Reserved for the NHS Board [Appendix 1] be approved. | Head of Board Administration |
| (ii) That the revisions to the Standing Financial Instructions be approved. | Director of Finance |
| (iii) That the remits of the Standing Committees – Quality and Performance Committee [Appendix 2], Audit Committee [Appendix 3], Pharmacy Practices Committee [Appendix 4] and Area Clinical Forum [Appendix 5] be approved. | Head of Board Administration |
| (iv) That the memberships of the Standing and Partnership Committees [Appendix 6] be approved. | Head of Board Administration |
| (v) That the membership of the Adults with Incapacity Supervisory Body [Appendix 7] be approved. | Head of Board Administration |
| (vi) That the list of Authorised Officers to sign Healthcare Agreements and related contracts [Appendix 8] be approved. | Head of Board Administration |

36. FREEDOM OF INFORMATION: PRACTICE ASSESSMENT 2011

A report of the Head of Board Administration [Board Paper No. 11/20] asked the NHS Board to note the outcome of the practice assessment undertaken by the Office of the Scottish Information Commissioner into the NHS Board's handling of information requests in relation to compliance with the Freedom of Information (Scotland) Act 2002 and the Environmental Information (Scotland) Regulations 2004 and Associated Codes.

Mr Hamilton reported that the Information Commissioner wrote in April 2010 advising that NHS Greater Glasgow and Clyde's Freedom of Information practices were to be reviewed as part of his programme of work for 2010/11. In May 2010, it was confirmed that a practice assessment would take place over two days, 10 and 11 January 2011.

Mr Hamilton led the NHS Board through the preparation for the review and details of how the review was conducted. The final report on the assessment was issued on 16 March 2011 and a copy of the action plan was published at the same time. Mr Hamilton summarised some of the areas of good practice identified by the Commissioner and highlighted areas requiring action by the NHS Board. Overall the Commissioner reported that NHS Greater Glasgow and Clyde had embraced Freedom of Information and had developed a culture of openness supported by senior management and several areas of good practice had been identified. NHS Greater Glasgow and Clyde was required to provide the Commissioner's office with an up-to-date plan by 16 September 2011 detailing the actions taken and completed in relation to the action plan. This was to include any evidence to demonstrate any successful completion of the action plan points.

NOTED

37. 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. 11/21] 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 three 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**

38. AUDIT COMMITTEE MINUTES: 25 JANUARY 2011

The Minutes of the Audit Committee meeting held on 25 January 2011 [A(M)11/01] were noted.

NOTED

39. CLINICAL GOVERNANCE COMMITTEE MINUTES: 1 FEBRUARY 2011

The Minutes of the Clinical Governance Committee meeting held on 1 February 2011 [CGC(M)11/01] were noted.

NOTED

40. AREA CLINICAL FORUM MINUTES: 3 FEBRUARY 2011

The Minutes of the Area Clinical Forum meeting held on 3 February 2011 [ACF(M)11/01] were noted.

NOTED

41. PERFORMANCE REVIEW GROUP MINUTES: 15 MARCH 2011

The Minutes of the Performance Review Group meeting held on 15 March 2011 [PRG(M)11/02] were noted.

NOTED

The meeting ended at 12:00 p.m.