

NHSGG&C(M)11/05
Minutes: 87 – 104

NHS GREATER GLASGOW AND CLYDE

**Minutes of a Meeting of the
NHS Greater Glasgow and Clyde Board
held in the Board Room, Corporate Headquarters, J B Russell House,
Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH
on Tuesday, 18 October 2011 at 9.30 am**

P R E S E N T

Mr A O Robertson OBE (in the Chair)

| | |
|-----------------------------------|----------------------|
| Mr R Calderwood | Mr I Lee |
| Councillor J Coleman | Councillor R McColl |
| Dr B N Cowan (to Minute No. 95) | Councillor J McIlwee |
| Ms R Crocket (from Minute No. 95) | Mrs J Murray |
| Dr L de Caestecker | Dr R Reid |
| Ms R Dhir MBE | Rev Dr N Shanks |
| Prof A Dominiczak | Mr D Sime |
| Mr I Fraser | Mrs P Spencer |
| Mr P James | Councillor A Stewart |
| Councillor J Handibode | Mr B Williamson |
| Dr M Kapasi MBE | Mr K Winter |
| Councillor B Lawson | Councillor D Yates |

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

| | | |
|-----------------|----|---|
| Mrs F Dunlop | .. | Health Improvement Lead – Tobacco (for Minute No. 95) |
| Ms S Gordon | .. | Secretariat Manager |
| Mrs L Grant | .. | Public Health Pharmacist (for Minute No. 95) |
| Mr J C Hamilton | .. | Head of Board Administration |
| Ms A Harkness | .. | Director, Rehabilitation and Assessment |
| Mrs A Hawkins | .. | Director, Glasgow City CHP |
| Mr A McLaws | .. | Director of Corporate Communications |
| Mr I Reid | .. | Director of Human Resources |
| Ms C Renfrew | .. | Director of Corporate Planning and Policy |

ACTION BY

87. APOLOGIES

Apologies for absence were intimated on behalf of Dr C Benton MBE, Ms M Brown, Mr G Carson and Mr P Daniels OBE.

88. 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

89. CHAIR'S REPORT

- (i) Mr Robertson reported that he had met with representatives from the University of Glasgow on three occasions to take forward shared ambitious plans for the new South Side Hospital. This was very much work-in-progress at the moment and he would keep the NHS Board up to speed with developments.
- (ii) On 13 September 2011, Mr Robertson had presented Scottish Vocational Qualifications (SVQ) and European Computer Driving License (ECDL) certificates to 170 members of staff. This had been an impressive occasion and highlighted the appetite from staff to undertake further education some assisted by the staff bursary scheme funded by Endowments.
- (iii) On 16 September 2011, Mr Robertson and Ms A Harkness visited the Vale of Leven Hospital to meet with staff who had (or were scheduled to) give evidence to the Vale of Leven Inquiry.
- (iv) On 28 September 2011, Mr Robertson had visited staff and patients at Parkhead Hospital.
- (v) On 3 October 2011, the Cabinet Secretary had launched the seasonal influenza vaccination at the Princess Royal Maternity Hospital. That same day, Mr Robertson had visited the new Maggie's Centre at Gartnavel.
- (vi) On 17 October 2011, the Cabinet Secretary hosted the NHS Board's Annual Review 2011. This had been very well attended with a high level of interest from members of the public. The event began with the Chairman's awards which were prestigious for individual members of staff or teams who had identified ways to deliver improvements that benefited patients and service users, colleagues or the wider NHS Greater Glasgow and Clyde. Twelve awards were presented reflecting growing levels of interest and the variety of entries. They were presented by the Cabinet Secretary and Mr Robertson paid tribute to the range of entries and particularly the twelve winners.

NOTED**90. CHIEF EXECUTIVE'S UPDATE**

- (i) On 19 August 2011, Mr Calderwood had spoken on the challenges of managing in the public sector at the Holyrood summer school held at Stirling University.
- (ii) On 19 September 2011, Mr Calderwood had attended a meeting of Renfrewshire Council to discuss service provision at the Royal Alexandra Hospital and, in particular, proposals regarding paediatric services currently provided from Ward 15.
- (iii) On 21 September 2011, Mr Calderwood and Mr I Lee had attended the official opening by the Cabinet Secretary of the Healthcare Science Suite at Cardonald College.
- (iv) On 28 September 2011, Mr Calderwood had spoken at Strathclyde University on health technology and development.

- (v) On 30 September 2011, Mr Calderwood had attended the first meeting of the Public Services Reform Board.
- (vi) On 3 October 2011, Mr Calderwood had attended the official opening of the new Maggie's Centre at Gartnavel.
- (vii) On 6 October 2011, Mr Calderwood had attended the healthy working lives awards ceremony at Reid Kerr College and presented awards to fifty-seven organisations which had taken part and been successful in obtaining the Bronze, Silver or Gold awards.

NOTED

- 91.** On the motion of Dr M Kapasi, seconded by Councillor D Yates, the Minutes of the NHS Board meeting held on Tuesday 16 August 2011 [NHSGG&C(M)11/04] were approved as an accurate record and signed by the Chair.

NOTED

92. MATTERS ARISING FROM THE MINUTES

- (i) The rolling action list of matters arising was circulated and noted.
- (ii) In respect of Minute No. 75, "The Future of Continuing Care in the West Area of NHS Greater Glasgow and Clyde and the Blawarthill Hospital Site", Councillor McColl asked how negotiations were proceeding with St Margaret's Hospice. Ms Renfrew confirmed that discussions were ongoing in an attempt to establish a formal Service Level Agreement (SLA) for continuing care beds provided there. This work had not yet concluded but proactive engagement was taking place. She would keep the NHS Board informed as these negotiation continued.

**Director of
Corporate
Planning and
Policy**

NOTED

93. SCOTTISH PATIENT SAFETY PROGRAMME UPDATE

A report of the NHS Board's Medical Director and Head of Clinical Governance [Board Paper No. 11/44] 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 Cowan reported that NHS Greater Glasgow and Clyde's SPSP aim had been amended slightly to reflect the paediatrics safety programme which was now well under way. This revision had been endorsed by the Quality and Performance Committee meeting held on 20 September 2011. In summary, therefore, the overall NHS Greater Glasgow and Clyde aim was to ensure the care provided to every patient was safe and reliable and local implementation of the SPSP Programme would contribute to this aim. The NHS Board's SPSP aim was to achieve full implementation of the core programme in NHS Greater Glasgow and Clyde's Acute Services Division by the end of December 2012.

This would include improved staff capability in all wards and the creation of reliable processes for every relevant element in every ward. Dr Cowan confirmed that the NHS Board would also achieve implementation of the Paediatric SPSP (meeting the national medium term goals by March 2012) and would also develop and fully describe SPSP style improvement programmes in Primary Care, Mental Health Services and Obstetrics in 2011/2012.

Dr Cowan led the NHS Board through the key progress points as follows:-

- The NHS Greater Glasgow and Clyde SPSP Team was delighted to welcome a visit from Swedish colleagues of Kalmar County. The County's Chief Medical Officer and his Strategic Quality Improvement Team visited NHS Greater Glasgow and Clyde to understand and learn from SPSP and, in particular, to hear a local perspective as well as share learning and insights in quality improvement in clinical care. The visitors had been most impressed with what they had seen at Glasgow Royal Infirmary and had reported their experience was beyond what they expected. They had been particularly impressed by the medical leadership for medicines reconciliation in Acute Medicine and the transparency of the improvement data displayed in the clinical areas.
- One of the major challenges was the spread of medicines reconciliation across all the Acute Services Division Directorates. Each Directorate had created individual short term roll out objectives. This would see the NHS Board broaden the existing successful work on admission but importantly extending the improvement activity to ensure it occurred across the full in-patient journey.
- The operation of the Global Trigger Tool (GTT) within NHS Greater Glasgow and Clyde had been a well reported challenge from the beginning of the programme. After completing a large scale internal assessment, the NHS Board was currently reviewing this with the national team to identify a jointly endorsed way forward.
- In terms of the Paediatric SPSP in NHS Greater Glasgow and Clyde, there were currently five active pilot teams who had been working on the programme for over a year. They were working on reliable processes across general wards, critical care and peri-operative care. All were submitting improvement data to the national database.

Dr Cowan noted four pilot team achievements so far and explained that some of the process reliability aims had already been achieved through the work of the pilot teams and discussions were underway to support wider spread for achievement of the medium term aims.

NOTED

94. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the Medical Director [Board Paper No. 11/45] 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 Cowan 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 revised as specified by the Scottish Government Health Directorates.

Dr Cowan highlighted key Healthcare Associated Infection headlines for August 2011 as follows:-

- In 2007, the Scottish Government Health Directorates issued HEAT targets in relation to Staphylococcus Aureus Bacteraemias (SABs) in which NHS Greater Glasgow and Clyde successfully reduced SABs by 35% by April 2010. This target was extended by an additional 15% reduction which was also successfully achieved by 31 March 2011. The revised national HEAT target required all Boards in Scotland to achieve a rate of 0.26 cases per 1000 Acute Occupied Bed Days (AOBDs), or lower, by 31 March 2013. For the last available reporting quarter (April - June 2011), NHS Greater Glasgow and Clyde reported 0.291 cases per 1000 AOBDs with NHS Scotland reporting an average of 0.309 per 1000 AOBDs. The revised target would be a challenging one as analysis of these infections had highlighted that a significant number originated in the community. Dr Cowan confirmed that subsequent reports would update on the NHS Board's progress towards this challenging target.
- The national report published in October 2011 (April - June 2011), showed the rate of C.difficile infection within NHS Greater Glasgow and Clyde as 0.25 per 1000 occupied bed days in over 65s. This clearly placed the NHS Board below the national mean of 0.31 per 1000 occupied bed days in over 65s and also below the revised target, in patients aged 65 and over, to be attained by 31 March 2013 of 0.39 cases per 1000 occupied bed days. Subsequent HAIRT Reports would update on the NHS Board's progress towards this target.
- The Surgical Site Infection (SSI) rates for all procedure categories, apart from knee arthroplasty, remained below the national average.
- 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 2447 members of staff who were now registered Cleanliness Champions.
- The second national HAI and antimicrobial prescribing prevalence survey was currently underway within NHS Greater Glasgow and Clyde. All acute in-patient wards and a 25% sample of non acute wards would be surveyed between 1 September and 31 October 2011. Infection Control staff were working collaboratively with antimicrobial pharmacists to collect the mandatory data set. A total of 252 wards would be visited and, to date, information on over 2,500 patients had been collected.

**Medical
Director**

**Medical
Director**

Dr Cowan referred to two announced and one unannounced Healthcare Environment Inspectorate (HEI) visits as follows:-

- Announced inspection - Western Infirmary – 28 and 29 June 2011.
- Announced inspection - Vale of Leven Hospital– 10 and 11 August 2011.
- Unannounced inspection - Southern General Hospital – 22 August and 2 September 2011.

He was disappointed to note some of the requirements and recommendations made from these visits but reassured NHS Board members that work was in progress to improve practice locally.

Mr Williamson asked about the enhanced surveillance methodology in relation to MSSA as opposed to MRSA. Dr Cowan responded by confirming that he hoped enhanced surveillance would provide NHS Greater Glasgow and Clyde with vital information in regard to where and why this infection was occurring. MSSA was particularly difficult to trace back as it often came into hospitals from the community. He was hopeful that the information would allow the NHS Board to target appropriate interventions and, as such, each of the Acute Services Division Directorates reviewed this information to plan strategies to prevent avoidable infections locally.

Ms Dhir asked about the HEI inspections and, in particular, what triggered them. Dr Cowan confirmed that often public and/or media interest would stimulate a visit although the HEI had an organised programme of visits. It was often the case that visits with poorer outcomes would be subject to an unannounced visit a couple of months later.

Councillor Yates reflected on the journey over the last three years to reach this vastly improved report. Improvements had been significant and he paid tribute to all staff involved. Mr Robertson echoed this view and confirmed that the Cabinet Secretary had also referred to the good progress made by NHS Greater Glasgow and Clyde at the Annual Review held on 17 October 2011.

In respect of the national HAI and antimicrobial prescribing prevalence survey, Mrs Spencer sought clarification around the 25% sample of non acute wards. Ms Harkness confirmed that this sample had been drawn from rehabilitation and assessment wards.

NOTED

95. TACKLING TOBACCO WITHIN NHS GREATER GLASGOW AND CLYDE

A report of the Director of Public Health [Board Paper No. 11/46] asked the NHS Board to note progress made in tackling tobacco use as well as noting the future direction of NHS Greater Glasgow and Clyde's Tobacco Programme.

Dr de Caestecker reported that there had been significant progress in tobacco control in Scotland over the past decade with successive Governments recognising the importance of tackling tobacco as part of wider action to improve the health of the population and reduce health inequalities.

There was smoke free legislation in place to protect workers from second hand smoke, comprehensive stop smoking services to support people who wanted to stop smoking and a wide range of initiatives to reduce smoking uptake in young people. As a result, smoking had, over the past decade, fallen considerably in Scotland with adult prevalence falling to just over 24% of the population in 2009. Despite this, smoking rates in Scotland remained higher than equivalent figures for England and Wales (21% of all adults). Smoking levels in NHS Greater Glasgow and Clyde were higher than this at 26% with levels above 50% in some of the NHS Board's most deprived communities.

Dr de Caestecker explained that the adverse health effects, both of active smoking and exposure to second hand smoke, were well established and, together, they inflicted a significant burden of death and disease nationally on Scotland's population and, locally, within NHS Greater Glasgow and Clyde. Of most concern, was the fact that smoking had become concentrated in the poorest communities.

Dr de Caestecker led the NHS Board through the incidence and impact of smoking in NHS Greater Glasgow and Clyde referring, in particular, to national and local prevalence information. She highlighted that smoking was responsible for 13,321 deaths in Scotland in 2008. This was around a quarter of all deaths with men and women who died in middle age losing, on average, 22 years of healthy life. Furthermore, smoking caused, or increased the risk of contracting many diseases and conditions and treatment of those all incurred costs. As the reasons for smoking were many and varied, however, no single approach to tackling smoking would be successful; instead she explained there was clear evidence that the most effective tobacco control strategies involved taking a multi-faceted and comprehensive approach at both national and local level. As such, and in line with national policy, a comprehensive approach tackling prevention, stop smoking services and second hand smoke had been adopted within NHS Greater Glasgow and Clyde with a range of programmes in place addressing cessation, prevention and protection. This work was led by the Tobacco Planning and Implementation Group and Dr de Caestecker highlighted that the workplan of this Group was strongly linked to national policy. Furthermore, each CH(C)P area had its own tobacco control plan and monitoring structure in place in partnership with local authority colleagues and other organisations.

Dr de Caestecker summarised key elements of NHS Greater Glasgow and Clyde's tobacco programme as follows:-

- Stop smoking services
- Prevention programmes
- Second hand smoke
- New developments – targeting 16-24 year olds
- Media campaigns and national events

In terms of going forward, Dr de Caestecker emphasised the importance in maintaining links with national tobacco control policy and evidence base on effective tobacco control to ensure effective delivery at a local level. She described some opportunities to influence national policy and ensure a focus on the delivery of the NHS Board's HEAT target whilst providing support to partner organisation to deliver tobacco control.

Mr Shanks was impressed and encouraged by this report and, in particular, Dr de Caestecker's résumé of next steps. In terms of taking this forward, especially with young people, he wondered how secure these initiatives and projects could be given tighter public expenditure.

Dr de Caestecker agreed that there were always risks with this kind of work but was confident that, given ring-fenced money and/or bundle allocation funds, the Scottish Government would continue to target the area of tobacco. She conceded that there would be no uplift to these funds and much work would continue with local authorities (particularly education) so that they also regarded tobacco as priority.

Prof Dominiczak referred to the ban in smoking in public places in Scotland. She alluded to internationally published information, following this ban which suggested that there had been a significant reduction in adult heart attacks. She asked whether this extremely interesting outcome was true and whether such data was evidenced for NHS Greater Glasgow and Clyde. Dr de Caestecker confirmed that the NHS Board was extrapolating such data to establish if locally, this was indeed the case. She referred to the fact that the ban in smoking in public places had significantly reduced second hand smoke and, as such, agreed that evidence existed showing that the smoke free legislation had had a positive impact on health. Mr Williamson echoed the point that, if this was the case, and second hand smoke inhalation had such a significant impact, this was a very persuasive tool in tackling tobacco in the future.

Ms Dhir welcomed the partnership approach being taken to tackle tobacco and referred, in particular, to work ongoing with local authorities, trading standards and customs and excise. This demonstrated the wide range of people involved to make this work successfully.

Mr Lee commended the report but had been concerned to note continued smoking on NHS grounds. Dr de Caestecker reported that this remained a challenge. Some revisions had been made to the NHS Board's No Smoking Policy and increased signage in hospital grounds was planned. She also hoped to learn lessons from a pilot project undertaken in NHS Tayside but cautioned that smoking on NHS grounds was not, in fact, illegal and it was not the intention of the Scottish Government to enforce this.

In terms of work undertaken with schools, Mrs Dunlop confirmed that much work was carried out with primary and secondary schools and, furthermore, NHS Greater Glasgow and Clyde was working with partners to develop a specific tobacco action plan for 16-24 year olds focussing on prevention, cessation and second hand smoke. Much of these local services were delivered by local people to address territorial issues and the fact that many were reluctant to travel outwith their area to access services.

In response to a question from Mr Fraser concerning smoke free pregnancy services, Dr de Caestecker explained that a specialist stop smoking service, offering tailored one-to-one support for pregnant women was in existence. All pregnant women were carbon monoxide tested and all those identified as smokers were referred to the smoke free pregnancy service. She agreed that this service could be marketed further in public campaigns.

Dr Reid referred to smoking prevalence in Inverclyde comparing 2007/08 (25%) to 2009/10 (31%). This was a very disappointing increase in smoking prevalence in the area. Dr de Caestecker confirmed that this appeared to be an outlier and would be meeting with representatives from Inverclyde Council to take this forward. She confirmed that the data came from the household survey just released. Councillor McIlwee confirmed that there had been some surprise locally about this disappointing statistic and Inverclyde Council would look at it further.

Given the vast interest in the information, the various initiatives and pilots, the cost implications and local prevalence information, Councillor McColl suggested that the NHS Board discuss this further at a Board seminar. Mr Robertson agreed that some very important issues had been raised and this suggestion would be programmed in to the 2012 seminar schedule accordingly.

**Head of Board
Administration**

Councillor Handibode wondered if any evidence existed to suggest that the difficult economic times had an impact on use of tobacco. Dr de Caestecker confirmed that there were two schools of thought, firstly, that yes, perhaps if people had less money to spend then tobacco use would decrease but, secondly, if people were more stressed due to their financial situation, tobacco reliability may increase. She agreed it would be important to continue to monitor tobacco usage throughout this economic climate. On a similar vein, Councillor Coleman expressed concern that Glasgow City Council had seen significant growth of illicit tobacco use throughout the recession and confirmed that the Council was, at the moment, reviewing its tobacco strategy.

Mr Robertson, while encouraged by the progress made by the NHS Board, agreed that there was no room for complacency in tackling what was the single most preventable cause of ill health.

NOTED

96. OUTCOME OF REVIEW OF CONTINUING CARE – WEST SECTOR, GLASGOW

Ms Renfrew referred to the discussion at the August 2011 NHS Board meeting concerning the future of continuing care in the West Sector of NHS Greater Glasgow and Clyde and the Blawarthill Hospital site. It was agreed, at that time, to note the outcome of the engagement process, approve the establishment and completion of due process required to consult on a proposal to cease the provision of NHS continuing care on the Blawarthill Hospital site and that ongoing negotiations would take place with Glasgow City Council on a potential future use of the site.

Ms Renfrew reported that, subsequent to the NHS Board meeting, a further submission to the Scottish Health Council (SHC) on the proposals had led the SHC to conclude that the closure of the site was not major service change, requiring full consultation. This advice was now being considered by the Scottish Government who would make a final decision.

In terms of the future of the site, negotiations were progressing very positively with Glasgow City Council to undertake a land swap to enable the site to be redeveloped as a Council care home. The NHS Board expected to reach an agreement within the next few weeks.

The final outcome on both issues would be reported to the December 2011 NHS Board meeting.

**Director of
Corporate
Planning and
Policy**

NOTED

97. APPROVAL OF WINTER PLAN PROCESS 2011/12

A report of the Director of Emergency Care and Medical Services [Board Paper No. 11/48] asked the NHS Board to receive an update on and approve the approach to Winter Planning for 2011/12.

Ms Harkness reported that the Scottish Government had provided NHS Boards with guidance on the preparation of winter plans 2011/12 and had identified seven key areas which NHS Boards were required to address within these plans. She outlined these priority actions and confirmed that they were being addressed in the NHS Greater Glasgow and Clyde's Winter Plan.

This was now the sixth year that NHS Greater Glasgow and Clyde had progressed winter planning as a single system approach and the well established Winter Planning Group had overseen the formulation of the Winter Plan 2011/12 taking in to account lessons learned from 2010/11 and Scottish Government advice. The escalation plan was also being revised and the NHS Board and other agencies' continuity plans had all been updated recently.

Ms Harkness led the NHS Board through the key components in the Winter Plan and explained that, as with previous years, a major concern regarding winter 2011/12 related to the two four day holiday periods during the festive season. Discussions were ongoing nationally with GPs to review the practice of closure over the four day holiday period and, whilst outcomes of these decisions would not be effected this winter, it was hoped that, in future years, alternative ways of working could be identified.

Winter 2010/11 had been extremely challenging for all agencies due to huge spikes of activity over the winter period and, in particular, the extreme weather conditions which were experienced. In planning for winter 2011/12, there was recognition of these challenges.

Mr Reid alluded to the proposed industrial action concerning NHS pensions. The outcome of the Union's ballot was awaited but contingency plans were being worked through.

In response to a question from Councillor Stewart, Mr McLaws confirmed that, as with previous years, NHS 24 was leading on the national advertising campaign and NHS Greater Glasgow and Clyde's Communications Department was working with colleagues from there and other Boards to deliver this campaign which would include TV, radio and outdoor advertising.

In terms of the information booklet (service directory), he confirmed this was in draft and a poster was also being developed outlining service availability and advice to patients which would be made widely available from the end of October 2011.

NOTED

98. MODERNISING AND IMPROVING MENTAL HEALTH SERVICES IN WEST DUNBARTONSHIRE

A report of the Director, Glasgow City CHP [Board Paper No. 11/49] asked the NHS Board to note temporary arrangements that had been made for the catchment of the former Christie Ward since July 2010, the monitoring that had taken place regarding in-patient beds temporarily transferred to Gartnavel and agree to seek the Cabinet Secretary's approval for the permanent transfer of adult acute in-patient services formally provided at the Vale of Leven Hospital to Gartnavel Hospital.

Mr Robertson referred to a letter submitted by Councillor V R Dance, Argyll and Bute Council, dated 11 October 2011 that had already been circulated to NHS Board members for consideration under this item.

Mrs Hawkins provided a summary overview of the timeline and sequence of the main actions in relation to the proposals to close the mental health adult acute in-patient beds at the Vale of Leven Hospital and transfer them to twelve beds at Gartnavel Royal Hospital. Throughout this timeline from August 2009 to September 2011, she also highlighted the detail of these actions and concerns of the Vale Monitoring Group which had been set up by the Cabinet Secretary to oversee the development and delivery of the service change plans relating to South Clyde.

The Vale Monitoring Group met for the first time on 23 November 2009 and had subsequently met on thirteen occasions receiving, at each meeting, a report on mental health activity. At the Vale Monitoring Group meeting held on 7 June 2010, it was identified that bed usage at the Christie Ward was dropping steadily and that it was anticipated that a report would be submitted to the October 2010 NHS Board meeting indicating that twelve or less beds were being utilised and that a report should be submitted to the Cabinet Secretary supporting closure and transfer of the beds to Gartnavel Royal Hospital. On 11 July 2010, a patient set fire to their room in Christie Ward causing extensive damage. This necessitated the rapid movement of all patients who were temporarily accommodated that night at the Vale of Leven Hospital. On 12 July 2010, twelve patients were moved to Gartnavel Royal Hospital and one to the Intensive Psychiatric Care Unit (IPCU) at Stobhill Hospital.

At their July 2010 meeting, the Monitoring Group, received a report on the consequences of the fire and it was agreed, at the meeting, that the Chair would write to the Cabinet Secretary allaying their concerns. The Cabinet Secretary responded on 16 August 2010 confirming, amongst other things, a further monitoring period of eight to ten months. As such, meetings of the Monitoring Group continued and discussions remained wide ranging and detailed.

Mrs Hawkins summarised briefly details from the October 2010 NHS Board paper and results from an initial survey of patients and carers views of experience of in-patient services after the fire. She also explained that staff had been accommodated at both Gartnavel Royal Hospital and the Vale of Leven Hospital as part of an initial staff deployment exercise. Despite this, the lay members of the Monitoring Group had, at every meeting, expressed concerns about the sustainability and clinical effectiveness for the service and had not accepted the NHS Board's view that an average of twelve acute admission beds would meet the needs of the population.

This resulted in all but three of the lay members resigning as they were completely opposed to the closure of the Christie Ward and did not believe that a case had been made for the removal of the local in-patient service from the Vale of Leven Hospital.

In response to the Monitoring Group's further concerns about patient activity trends, Mrs Hawkins explained that although admissions rose in August 2011 to thirteen, the most recent three month period to 31 August 2011, had seen admissions increase from seven to twelve per month. She updated the NHS Board by confirming that, in September 2011, admissions had been eleven (with an average occupied bed stay of ten days). In response to the Monitoring Group's concerns about the withdrawal of a local service from the Vale of Leven Hospital (being felt by the lay members to be contrary to the Scottish Government commitments to keep services local), Mrs Hawkins highlighted the Cabinet Secretary's preconditions and parameters and conveyed how the NHS Board had duly complied with these. She emphasised that an extended period of monitoring in-patient demand, following significant investment in community mental health services during recent years, had shown that in-patient needs had reduced dramatically.

Less than 1% of mental health patients in the Vale area required in-patient care and the ones who did were delivered a far better standard of clinical care at Gartnavel Royal Hospital than they were being offered in the former Christie Ward before it was destroyed by the fire more than a year ago.

Mr Williamson recalled this issue being discussed in detail previously by the NHS Board. He remained of the view that the clinical advantages for patients being treated at the Gartnavel Royal Hospital outweighed any other concern. For patients to be offered anything less than the standard of Gartnavel Royal would be a disservice to them. Ms Dhir agreed and recalled when she was Chair of West Dunbartonshire CH(C)P she saw first hand the huge improvement in community services offered to this patient group and she commended delivery of local mental health services in the area now. In response to her question about the "out-boarding" of patients to other NHS Board areas, Mrs Hawkins confirmed that although this process existed, it was kept to a minimum. The "in-boarding" of patients to NHS Greater Glasgow and Clyde from other areas also occurred but, similarly, this was avoided where possible.

Councillor McColl concurred with Mr Williamson's view and suggested that, prior to approval being sought by the Cabinet Secretary, Mrs Hawkins include the September 2011 admission figure as this was useful in showing the in-patient admissions of thirteen patients in August 2011 was an exception. Mrs Hawkins agreed that this would be included. Councillor McColl also took the opportunity echo Ms Dhir's comments in that mental health services as provided in the local community had significantly improved. Dr Kapasi agreed and, in commending local community services, considered that there may be even less need for in-patient services in the future.

**Director,
Glasgow City
CHP**

DECIDED

- That the provision of adult acute in-patient services for the catchment of the former Christie Ward had been temporarily in place at Gartnavel Royal Hospital for more than a year since July 2010 be noted.
- That, throughout that period, the Cabinet Secretary's preconditions for final consideration of the future arrangements of the provision of adult Acute in-patient services had been met and the average daily bed use for the twelve month period to 31 August 2011 had been ten beds be noted.
- That the Cabinet Secretary's approval be sought to the permanent transfer of mental health adult acute in-patient services, formally provided at the Vale of Leven, Hospital to Gartnavel Hospital be agreed.

**Director,
Glasgow City
CHP**

99. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer (Acute Services Division) [Board Paper No. 11/50] asked the NHS Board to note progress against the national targets as at the end of August 2011.

Ms Harkness led the NHS Board through the report highlighting the actions being taken to deliver the waiting times and access targets. The Scottish Government target for waiting times for out-patient appointments, in-patients/day cases treatment and diagnostic tests was that, by December 2011, the total maximum journey time would be 18 weeks from referral to treatment, referred to as the 18 weeks RTT target. The national target required the NHS Board to deliver 90% performance for combined admitted/non admitted performance by 31 December 2011. The clock started for a RTT period at the date of receipt of a referral to a consultant led service.

Ms Harkness explained that there were two main components which were routinely assessed in relation to the 18 week RTT standard as follows:-

- Combined admitted/non admitted performance – this measure outlined the NHS Board’s performance against the agreed trajectory for both the admitted and non admitted pathways. The NHS Board was currently achieving 87.3% performance against an agreed trajectory of 84% as an interim target towards delivery of the 90% position by December 2011.
- Linked pathways – this was a measure of the percentage of patients where the total pathway was being linked at present. The NHS Board had achieved 73.9% against an agreed trajectory of 68% in August 2011.

The national “stage of treatment” backstop guarantee of 12 weeks for in-patient and day cases had been met for all available patients. With the exception of orthopaedics, all specialties continued to meet the NHS Greater Glasgow and Clyde target of 10 weeks for new out-patients and eight weeks for in-patients and day cases. Orthopaedics remained within the maximum waiting of 12 weeks for out-patients and 12 weeks for in-patient/day cases. Ms Harkness led the NHS Board through the remaining measured waiting times including accident and emergency, cancer, chest pain, stroke and delayed discharges.

In response to a question from Mr Williamson concerning Accident and Emergency waiting times at the Royal Alexandra Hospital (current performance in June 2011 was 92% of Accident and Emergency patients being admitted, discharged or transferred in four hours), Ms Harkness confirmed that a series of service changes to target areas of low performance had been developed.

These included reconfiguring staff to manage the problems of breachers out of core hours, allied to revised arrangements for non accident and emergency surgical support and the operational policies of the Medical Assessment Unit. That said, she agreed, that there was still significant fluctuations in performance and, as such, this focussed work required to continue.

Councillor Lawson suggested that the table illustrating the number of bed days occupied by people over the age of 65 in Acute Hospitals in the month from August 2011, from the point at which they were declared fit for discharge (on page 104 of the NHS Board papers), be amended to include a further column showing the target.

**Chief
Operating
Officer, Acute
Services
Division**

Mrs Spencer reported that at the joint Area Clinical Forum/Area Partnership Forum session with the Cabinet Secretary at the NHS Board's Annual Review on 17 October 2011, the issue of delayed discharges and the legal processes for adults with incapacity was discussed. Work on this issue was being led by the Scottish Government and local authority colleagues.

In response to a question from Mrs Murray regarding the reporting of screened and non screened cancer types separately, Mr Calderwood confirmed that this was done to collate information on where exactly patients were being referred from so that data could be captured for analysis of the NHS Board's screening programmes.

NOTED

100. FINANCIAL MONITORING REPORT FOR THE 5 MONTH PERIOD TO 31 AUGUST 2011

A report of the Director of Finance [Board Paper No. 11/51] asked the NHS Board to note the financial performance for the first five months of the financial year.

Mr James explained that the NHS Board was currently reporting an expenditure outturn of £4m in excess of its budget for the first five months of the year. At this stage, the NHS Board considered that a year end breakeven position remained achievable.

The NHS Board continued to work to confirm the extent to which its Acute Division, NHS Partnerships and Corporate Services could offset additional expenditure against budget through catch up in implementing existing cost reduction/cost saving measures. Mr James reported that this work would be completed by the mid year point so that the NHS Board was able to assess, at that stage, whether it remained on track to deliver a breakeven outturn for 2011/12. At this stage, it was assumed that the NHS Board would be able to identify and implement any necessary measures and in reporting to the Scottish Government, it would continue to forecast a breakeven outturn for 2011/12.

Mr James was particularly reassured to note that the latest information reporting on the first *six* months of the year suggested a £3.6m overspend which was a reduction between month five and month six of £0.4m. This was a shared improvement reflected across both the Acute Services Division and the Partnerships.

In response to a question from Mrs Spencer regarding the overspend within nursing pay budgets, Mr James confirmed that this still represented a significant improvement from the position reported this time last year mainly due to a significant reduction in bank and agency nursing costs. In terms of addressing nursing staff absence rates, work was ongoing with Human Resources colleagues.

Mr Shanks asked how the NHS Board addressed the Primary Care prescribing expenditure which was currently reported at £1.5m in excess of budget for the first five months of the year. Mr James confirmed that proactive action was taken by the NHS Board to reduce prescribing costs. As General Practitioners were independent contractors, their performance was measured. This afforded the opportunity to look at any outliers in terms of prescribing expenditure and pharmacists were able to visit GP practices to offer advice on the prescribing of generic branded drugs. Mr James confirmed that much of this work was led by the NHS Board's Prescribing Management Group.

In response to a question from Councillor Yates regarding actions resulting from the Acute Services Division's Directorates patient safety walk-arounds, Ms Harkness clarified that these were governed by the Acute Services Division's internal processes and that Directors were responsible for ensuring that actions were completed.

In response to a question from Mr Fraser regarding the expenditure in corporate services currently running ahead of budget by £1m, Mr Calderwood reported that this was mainly due to additional legal costs being incurred in connection with the Vale of Leven Hospital Public Inquiry. This Inquiry was carrying significant costs which were not budgeted for. The NHS Board had employed senior council, junior council and solicitors to work with daily as the Inquiry progressed.

Councillor Yates sought some clarification around the NHS Board's interpreting service which was now provided in-house. It was agreed that this new arrangement from 1 October 2011 be further reported in more detail at a future Board seminar.

**Director of
Corporate
Planning and
Policy**

NOTED

101. QUARTERLY REPORT ON COMPLAINTS : 1 APRIL TO 30 JUNE 2011

A report of the Head of Board Administration, Chief Operating Officer (Acute Services Division) and the Director, Glasgow City CHP [Board Paper No. 11/52] asked the NHS Board to note the quarterly report on NHS complaints in Greater Glasgow and Clyde for the period 1 April to 30 June 2011.

Mr Hamilton led the NHS Board through the number of complaints received and completed in the quarter. In terms of performance, 72% of all complaints were responded to within 20 working days.

Four reports had been laid before the Scottish Parliament by the Scottish Public Services Ombudsman concerning NHS Greater Glasgow and Clyde cases. Additionally, seven decision letters were raised by the Ombudsmen (four relating to partnerships and three relating to the Acute Services Division). Mr Hamilton referred to an investigation undertaken by the Ombudsman in June 2011, whereby, he recommended that NHS Greater Glasgow and Clyde review its complaints procedures to ensure complaints were dealt with in accordance with the NHS Greater Glasgow and Clyde complaints procedure.

The complaint itself related to events that occurred prior to the 2010 revision of the complaints policy and supporting guidance. A further review was undertaken to ensure that the policy and procedures were as robust as possible in view of the specific criticisms made by the Ombudsman. As a result of the review, some revisions were made to the policy and guidance which had been implemented from 1 September 2011.

Mr Hamilton reported that the NHS Board had submitted a response to the Scottish Government consultation on secondary legislation in respect of the Patients Rights (Scotland) Act 2011.

Councillor Handibode commended the good performance of all staff highlighting that, in ratio terms, one complaint was made to every 1,986 patient attendances. Ms Dhir, however, wondered whether some complaints, particularly those handled informally were not recorded. Mr Hamilton alluded to some revisions made in the new Public Rights Act which widened the collection of complaint statistics.

Councillor Yates noted that from 1 November 2011, the NHS would accept responsibility for the provision of healthcare within the prison service. He asked how many existing complaints would transfer to the NHS. Mrs Hawkins had identified this to be dealt with by Glasgow City CHP. Prisoners would be entitled to make complaints against the service provided by the NHS in the same way as other patients, with an emphasis on securing local resolution at prison health centre level. Statistics on complaints received would be aggregated into the future reports to the NHS Board.

Dr Kapasi referred to an earlier comment made by Ms Dhir and agreed that often complaints made in a primary care setting were made direct to practices and handled in-house. Mr Hamilton acknowledged this point and confirmed that the new Patients Rights Legislation sought greater transparency on contractor complaints and how these statistics were reported to the NHS Board.

NOTED

102. 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. 11/53] 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 twenty-two Medical Practitioners listed in the NHS Board paper for the purposes of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003 be approved.

**Director of
Public Health**

103. AREA CLINICAL FORUM MINUTES: : 4 AUGUST 2011

The Minutes of the Area Clinical Forum meeting held on 4 August 2011 [ACF(M)11/04] were noted.

NOTED

104. QUALITY AND PERFORMANCE COMMITTEE MINUTES: 20 SEPTEMBER 2011

The Minutes of the Quality and Performance Committee held on 20 September 2011 [QPC(M) 11/02] were noted.

NOTED

The meeting ended at 12:10 p.m.