NHSGG&C(M)12/02
Minutes: 22 – 36

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, 17 April 2012 at 11.15 am

P R E S E N T

Mr A O Robertson OBE (in the Chair)

Dr J Armstrong
Dr C Benton MBE
Ms M Brown
Mr R Calderwood
Councillor J Coleman
Ms R Crocket
Mr P Daniels OBE
Prof A Dominiczak
Mr I Fraser
Mr P James
Councillor J Handibode
Dr M Kapasi MBE
Councillor B Lawson
Mr I Lee
Councillor J McIlwee
Mr D Sime
Councillor A Stewart
Mr B Williamson
Mr K Winter
Councillor D Yates

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

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, 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

22. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Mr G Carson, Councillor J Coleman, Dr L de Caestecker, Councillor R McColl, Dr R Reid, Rev Dr N Shanks and Mrs P Spencer.

Mr Robertson welcomed the newly appointed Board Medical Director, Dr J Armstrong, to her first NHS Board meeting.

In accordance with the statutory procedures for Council elections, the seven Councillor NHS Board Members were demitting office prior to the Council elections scheduled for 3 May 2012. As such, Mr Robertson recorded his appreciation, on behalf of the NHS Board, for their support and input throughout their membership terms.

NOTED

23. 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

24. CHAIR'S REPORT

(i) Mr Robertson referred to the following key milestones since the last NHS Board meeting:-

- On 12 March 2012, he officially opened Claythorn House, a new unit in the grounds of Gartnavel Royal Hospital that provided hospital-based assessment and treatment services for people with learning disabilities.
- On 21 March 2012, the keys to the new £90million laboratory on the new South Glasgow campus had been officially handed over by the Managing Director of the main contractor, Brookfield Multiplex.
- On 27 March 2012, Mr Robertson cut the first sod of the new Vale of Leven Centre for Health and Care, marking the beginning of construction. This significant development would see an investment of over £20million on one of the most modern state-of-the-art health centres in Scotland.
- On 4 April 2012, Mr Robertson officially opened the new Langhill Clinic; a new intensive psychiatric care unit at Inverclyde Royal Hospital. This would greatly improve mental health facilities in the area and completed the NHS Board's mental health strategy for Inverclyde.

(ii) On 23 February 2012, Mr Robertson attended the "Boards on Board" event. This focused on a Scottish Patient Safety Programme (SPSP) update and the sharing of experiences between NHS Scotland's Boards (both members and senior managers). In looking at progress and successes to date, there was discussion around how to build on this momentum and take the principles of patient safety into other settings such as primary care.

(iii) Saturday 21 April 2012, marked "Armed Forces Day". In this regard, Mr Robertson reported that he had signed covenants with at least four of the NHS Board's neighbouring local authorities. This outlined the commitment of the local authority, NHS Board and third sector in service delivery for armed forces personnel.

(iv) On 27 and 28 March 2012, Mr Robertson, accompanied by Professor A Dominiczak, attended an Industry Day event hosted by the Medical and Life Sciences School at the University of Glasgow. This event facilitated the engagement with those industries that were key to financing and developing research.

(v) Mr Robertson had visited both Shawpark Resource Centre and Barlanark Community Health Shop where he had been most impressed with the input of the local communities and staff.

NOTED

25. CHIEF EXECUTIVE'S UPDATE

(i) Mr Calderwood reported that he had been appointed to the position of Chair of the Institute of Healthcare Management (IHM) Scotland. This appointment had been approved at their Annual General Meeting (AGM) on 10 February 2012.

(ii) On 2 March 2012, Mr Calderwood attended the Scottish Leadership Forum alongside other public sector Chief Executives and the Permanent Secretary, Sir Peter Housden.

(iii) On 23 March 2012, Mr Calderwood sat, as external assessor, on the interview panel for the West of Scotland Postgraduate Dean position.

(iv) On 27 March 2012, Mr Calderwood met with Mr G Black, Chief Executive, Glasgow City Council and other Council senior executives to discuss "One Glasgow".

(v) On 29 March 2012, Mr Calderwood sat on the interview panel for the post of Director, Inverclyde CHCP. The current Head of Community Care and Health, Mr B Moore, had been appointed to this post and would begin in June 2012.

(vi) On 2 April 2012, Mr Calderwood held a series of meetings with local MSPs/MPs.

(vii) On 5 April 2012, Mr Calderwood was a guest of the Lord Provost, Mr B Winter, at a civic dinner held in the City Chambers.

NOTED

26. MINUTES

On the motion of Dr M Kapasi, seconded by Mr K Winter, the Minutes of the NHS Board meeting held on Tuesday 21 February 2012 [NHSGG&C(M)12/01] were approved as an accurate record and signed by the Chair.

NOTED

27. MATTERS ARISING FROM THE MINUTES

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

NOTED

28. SCOTTISH PATIENT SAFETY PROGRAMME UPDATE

A report of the NHS Board's Medical Director [Board Paper No. 12/12] 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 Armstrong reminded the NHS Board that 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 SPSP would contribute to this aim.

The key progress points were as follows:-

- Acute Adult Inpatient SPSP implementation was progressing well with reliability demonstrated in 25 distinct measures of clinical and communication processes in pilot teams. Current predictions showed that in 11 out of 18 key areas, the NHS Board would achieve greater than 90% spread of this work. Assessment of this position was ongoing at the moment.

- The paediatric programme had made good progress in relation to the national short-term aims. For good clinical reason, however, some of the programmes were still testing the proposed approaches and adapting them for use in children.

- Sepsis and venous thromboembolism (VTE) programmes had been launched with plans presented to the national team at a site visit as to how this work would be progressed locally. Feedback on the day was positive and a formal report was awaited.

- Testing of the cardiac congestive heart failure care bundle continued.

- The primary care programme had several active areas with some supporting developmental work of a bundle for change and others testing implementation of agreed care bundles.

- Mental health had expressed an interest in supporting Phase 1 of the national programme to develop the interventions and a support structure was being developed.

Mr Williamson asked when data would be available on outcomes to show that, due to SPSP investment, outcomes had improved. Dr Armstrong responded in the affirmative agreeing that it was important to have a "before and after picture" to illustrate the improvements made since the introduction of SPSP.

In response to a question from Dr Kapasi, Dr Armstrong reported that, in terms of taking the primary care programme forward, work had begun with those general practices who were most enthused about the project. Thereafter, following evaluation of that phase, the intention was to roll out the programme to other general practices.

NOTED

29. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No. 12/13] asked the NHS Board to note the latest in the regular bi-monthly reports on Healthcare Associated Infection (HAI) in NHS Greater Glasgow and Clyde.

Dr Armstrong explained that the report 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 Armstrong highlighted key Healthcare Associated Infection headlines for April 2012 as follows:-

- In 2007, the Scottish Government Health Directorates issued HEAT targets in relation to the reduction in Staphylococcus Aureus Bacteraemias (SABs) against which NHS Greater Glasgow and Clyde successfully reduced SABs by 35% by April 2010. This target was extended to achieve 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 (October - December 2011), NHS Greater Glasgow and Clyde reported 0.296 cases per 1000 AOBDs with NHS Scotland reporting an average of 0.322 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.

- The national report published in April 2012 (October – December 2011), showed the rate of C.difficile infection within NHS Greater Glasgow and Clyde as 0.21 per 1000 occupied bed days in over 65year olds. This clearly placed the NHS Board below the national mean of 0.28 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.

- The Surgical Site Infection (SSI) rates for all procedure categories, apart from reduction of long bone fracture, 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 2621 members of staff who were now registered Cleanliness Champions.

A proposal had been approved to examine the rates of community acquired SABs and C. difficile. The findings would help target community approaches to reducing these infections.

In response to a question from Dr Benton concerning the data presented for Glasgow Royal Infirmary, Dr Armstrong confirmed that she received a weekly report on all wards/hospitals. She noted that, as at February 2012, five patients had staphylococcus aureus bacteraemia at Glasgow Royal Infirmary. Dr Armstrong would check if this had decreased for the period to the end of March 2012. Mrs Grant added that, in respect of cleaning compliance, work was ongoing to ensure that all non-clinical areas complied. **Medical Director**

In response to a question from Dr Kapasi, Dr Armstrong reported that medical staff hand hygiene compliance was circa 89%. She agreed that this was lower than hoped and some work was required to target that staff grouping. **Medical Director**

Dr Benton asked about the Healthcare Environment Inspectorate (HEI) unannounced inspections at the Victoria Infirmary (7 February 2012) and the Southern General Hospital (14 February 2012).

Mrs Grant briefly summarised the three requirements and one recommendation to be actioned from the Victoria Infirmary visit and the two requirements to be actioned from the Southern General Hospital visit.

NOTED

30. SUICIDE PREVENTION IN GREATER GLASGOW AND CLYDE

A report of the Director of Public Health [Board Paper No. 12/14] asked the NHS Board to note ongoing work to address suicide prevention and the establishment of a Suicide Prevention Group to strengthen the NHS Board's overall approach to address this issue.

Mrs Hawkins led the NHS Board through the nature and scale of the challenge of suicide prevention, providing an overview of its policy context, an update on progress across the NHS Board's area and a summary of future approaches, challenges and opportunities. She explained that suicide represented a major public health issue and was a complex social challenge, requiring action from multiple agencies, both locally and nationally. Within Glasgow, suicide appeared to be one of the complex issues that contributed to the "Glasgow Effect" of excess mortality. Scottish suicide figures were released in August of each year, providing data for the previous calendar year and, standard practice was to analyse three-year rolling averages, given the degree of fluctuation year on year. NHSGGC had seen a significant, but modest, reduction in suicide rates over the last decade. Despite significant concerted effort, the decline in rates in NHSGGC had been more modest than the decline in rates for Scotland as a whole.

Mrs Hawkins emphasised that responding to suicide could not be seen as an isolated challenge but required a multi-agency response as well as engagement with members of the public. NHSGGC was working closely with many partners to advance the suicide prevention agenda, embedding this in a wider body of work aimed at promoting mental health and well-being for the population. She described how this activity would be categorised into the following four interlocking areas:-

- Direct clinical service approaches to suicide prevention
- Dedicated suicide prevention activities in community settings
- Wider mental health improvement programmes
- Action on underlying determinants

Given that the decline in suicide rates in NHSGGC, over the past decade, had been modest, Mrs Hawkins explained that this highlighted a need to take stock of current approaches and evidence of their effectiveness to address any gaps in service responses or support and to increase the focus on priority groups. One area of further exploration would be the degree to which suicide should be considered as part of a cluster of issues linked closely to deprivation (also including impacts such as obesity, depression, low levels of exercise and addiction problems). In order to provide overall co-ordination of the suicide prevention efforts, the NHS Board was establishing a new Suicide Prevention Group which was due to commence its work on 27 April 2012. This Group would work in close partnership with the six Choose Life programmes operating in the NHS Board's area. Its functions would include collating and reviewing data on trends and risk factors, development of recommendations for priority action and for co-ordination across relevant services, overseeing a continued programme of training for front-line staff and disseminating good practice approaches.

The Group would develop proposals for a strengthened suicide prevention approach by November 2012 and present these back to the NHS Board.

In response to a question from Dr Benton, Mrs Hawkins confirmed that the circa 4,000 staff trained in NHSGGC in suicide prevention skills did not include GPs. She further confirmed that any prisoner suicide figures were included in the data.

Mrs Brown alluded to the stark inequalities visible from the suicide data, with NHSGGC performing significantly worse on practically all 41 indicators of mental health, with particularly high rates of depression in women and anxiety in men. She referred to the pattern of suicides, at a Scottish level, which showed that most of the progress in Scotland, in terms of reduced suicide rates, had been amongst the least deprived categories of the population. With this in mind, she considered it paramount to develop approaches to tackling suicide working alongside voluntary sector organisations looking at projects currently in existence making sure they were accessible to all local communities. A priority should be promoting a social strategy to those in greater need. Mrs Hawkins agreed to feed these comments to the newly established Suicide Prevention Group. **Director, Glasgow City CHP**

Councillor Yates commended the report especially the next steps to be taken. He was disappointed that progress was not as good as hoped but, with the workstrands being taken forward by the new Suicide Prevention Group, he hoped this would provide a more co-ordinated approach. Mr Williamson agreed and referred to the national HEAT target. He considered it an essential starting point to collate all information available from the various organisations/agencies on suicide rates/prevention strategies to see how best improvements could be made. Mrs Hawkins agreed that this approach would avoid duplicating efforts made elsewhere and streamline activities in the right areas. She would feed back this to the Suicide Prevention Group. **Director, Glasgow City CHP**

DECIDED:

- That the suicide prevention update paper be noted.
- That the formation of a new NHSGGC Suicide Prevention Group to review progress and develop recommendations to strengthen the overall approach, in conjunction with the contributions of wider partners, be noted.
- That the proposals developed by the Group for a strengthened suicide prevention approach be presented back to the NHS Board after November 2012. **Director of Public Health**

31. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer (Acute Services Division) [Board Paper No. 12/15] asked the NHS Board to note progress against the national targets as at the end of February 2012.

Mrs Grant 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 (RTT), 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 on the date of receipt of a referral to a consultant led service.

Mrs Grant 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 90.9% performance against an agreed trajectory of 90%.

- Linked pathways – this was a measure of the percentage of patients where the total pathway was being linked at present. The NHS Board achieved 87.5% against an agreed trajectory of 80%.

In relation to the stage of treatment position, all specialties continued to meet the NHS Greater Glasgow and Clyde target of 10 weeks for available new out-patients and eight weeks for available in-patients and day cases, with the exception of Orthopaedics. Orthopaedics remained within the waiting time of 12 weeks for both available out-patients and in-patient/day cases. Mrs Grant reported, however, that agreement had been reached with the SGHD to support additional activity to return the orthopaedic in-patient/day case maximum waiting time to 9 weeks by 31 March 2012. As such, she reported that the number of available patients waiting over 9 weeks for orthopaedics, as at February 2012, was 379 and that every effort was being made to return to 9 weeks although formal confirmation of the position at 31 March was awaited.

Mrs Grant led the NHS Board through the remaining waiting times including accident and emergency, cancer, chest pain, stroke and delayed discharges.

NOTED

32. FINANCIAL MONITORING REPORT FOR THE 11 MONTH PERIOD TO 29 FEBRUARY 2012

A report of the Director of Finance [Board Paper No. 12/16] asked the NHS Board to note the financial performance for the first 11 months of the financial year.

At the outset, Mr James reported an error in section 2 of the report where, in the table, the entry "Approved Funding for Expenditure Commitments Not Yet Underway" was listed as £50.2million annual budget. This should, in fact, read £51million annual budget.

Mr James explained that the NHS Board was currently reporting an expenditure out-turn of £0.3million in excess of its budget for the first 11 months of the year. At this stage, the NHS Board considered that a year end break-even position remained achievable. Mr James also alluded to details of expenditure to date against the NHS Board's 2011/12 capital allocation.

Mr Lee congratulated Mr James and his team for their efforts, given the challenges in managing the NHS Board's financial resources. In doing so, he also praised the work being undertaken by the Acute Services Division and Partnerships in ensuring that they managed services within their allocated budgets.

NOTED

33. QUARTERLY REPORT ON COMPLAINTS: 1 OCTOBER 2011 TO 31 DECEMBER 2011

A report of the Head of Board Administration, Chief Operating Officer (Acute Services Division) and Director, Glasgow City CHP asked the NHS Board to note the quarterly report on NHS complaints in Greater Glasgow and Clyde for the period 1 October – 31 December 2011. The NHS Board was also asked to note changes associated with complaints handling to be implemented in accordance with the Patients Rights (Scotland) Act 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.

Although no reports had been laid before the Scottish Parliament concerning any NHSGGC Ombudsman cases, 19 Decision Letters were issued. These letters were not published in the Scottish Public Services Ombudsman monthly commentary, however, within the Partnerships and Acute Services Division, they were dealt with as though they could contain recommendations. Of the 19 Decision Letters, there were 22 issues upheld and 22 issues not upheld. The 27 recommendations made from these Decision Letters would be submitted to the Quality and Performance Committee for monitoring purposes.

In looking at some of the various service improvements and ongoing developments as a result of complaints made, Mr Hamilton alluded to the Patients Rights (Scotland) Act 2011 which received Royal Assent on 31 March 2011. This focused on patients rights and responsibilities and, from 1 April 2012, the aim was to support the development of a culture that valued and listened to the views of patients, carers and service users to help inform and improve the development and delivery of person-centred quality healthcare. As such, the NHS Board's complaints handling policy, guidance, standard operational procedures and leaflets would be reviewed. The Act also introduced the Patient Advice and Support Service (PASS) which would replace the Independent Advice and Support Service (IASS) from 1 April 2012. This contract had been awarded to Citizens Advice Scotland for a period of three years.

Mr Hamilton concluded by summarising the Scottish Public Services Ombudsman's (SPSO) annual report 2010/11 and the Information Services Division (ISD) annual report 2010/11.

NOTED

34. 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. 12/18] 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 four 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**

35. AUDIT COMMITTEE MINUTES: 10 JANUARY 2012

The Minutes of the Audit Committee meeting held on 10 January 2012 [A(M) 12/01] were noted.

NOTED

36. AREA CLINICAL FORUM MINUTES: : 2 FEBRUARY 2012

The Minutes of the Area Clinical Forum meeting held on 2 February 2012 [ACF(M)12/01] were noted.

NOTED

The meeting ended at 12:45 p.m.