NHSGG&C(M)12/05
Minutes: 78 - 95

NHS GREATER GLASGOW AND CLYDE

**Minutes of a Meeting of the
NHS Greater Glasgow and Clyde Board
held in the Board Room, Corporate Headquarters, J B Russell House,
Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH
on Tuesday, 16 October 2012 at 9:30 a.m.**

PRESENT

Mr A O Robertson OBE (Chair)

Ms M Brown	Mr I Lee
Mr R Calderwood	Ms R Micklem
Dr L de Caestecker	Councillor J McIlwee
Mr R Finnie	Councillor M O'Donnell
Mr I Fraser	Dr R Reid
Mr P James	Councillor M Rooney
Dr M Kapasi MBE	Mr D Sime
Councillor A Lafferty	Mr B Williamson

Mr K Winter

IN ATTENDANCE

Dr S Ahmed	Consultant in Public Health Medicine (for Minute 86)
Mr J Crombie	Director of Surgery & Anaesthetics
Dr J Dickson	Associate Medical Director
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Mrs A Hawkins	Director, Glasgow City CHP
Mr A McLaws	Director of Corporate Communications

ACTION BY

78. APOLOGIES

Apologies for absence were intimated on behalf of Dr J Armstrong, Dr C Benton MBE, Mr G Carson, Ms R Crocket, Mr P Daniels OBE, Prof A Dominiczak, Councillor J Handibode, Councillor M Kerr, Councillor M Macmillan, Rev Dr N Shanks and Mrs P Spencer.

NOTED

79. DECLARATION(S) OF INTEREST(S)

A declaration of interest was raised in relation to the following agenda item to be discussed:-

Item 10 – "Scotland's Health Commitment to the Armed Forces, their Families and Veterans" – Councillor M Rooney.

NOTED

80. CHAIR'S REPORT

(i) On 23 August 2012, Mr Robertson visited clinicians in NHS Lanarkshire who provided a "virtual" hospital service to older people who stayed in the community. This service comprised acute, primary care and social work services staff working in a hub arrangement. The service provided was exactly the same as a patient could expect to receive in a hospital but was provided in their own home. The newly appointed Cabinet Secretary for Health & Wellbeing had also recently visited this service and had been most impressed that it met patients' needs through a new model of service delivery.

(ii) On 12 September 2012, Mr Robertson visited the new Health and Social Care Centre in Alexandria. He commended the futuristic design of the Centre and the services to be provided therein which were greatly welcomed by the local community.

(iii) On 13 September 2012, accompanied by Mr R Finnie, Mr Robertson visited the Inverclyde Super Kitchen. Both had been most impressed with services and Mr Robertson reaffirmed that all food now served in NHSGGC's hospitals was prepared within the NHS Board's area.

(iv) On 18 September 2012, Mr Robertson attended the MacMillan Cancer Information and Support Service launch at the Mitchell Theatre. This launch was undertaken by the Cabinet Secretary for Health & Wellbeing and was an excellent service (forming part of the NHS Library Service) which provided points of reference for cancer sufferers and their families/carers. Councillor Rooney commended the support services provided by the MacMillan Cancer Network and referred, in particular, to the good relationship which currently existed with this Network within West Dunbartonshire. He wondered, however, if there was a presence in the Vale of Leven Hospital. Mrs Hawkins confirmed that the MacMillan Cancer Support Service was visible in many of the NHS Board's hospitals but that this particular project targeted local communities. She agreed to pick this point up with the MacMillan Service to see if there was any intention to have a presence in the Vale of Leven Hospital. **Director, Glasgow City CHP**

(v) On 21 September 2012, Mr Robertson attended the 40th birthday of the League of Hospital Friends at Inverclyde Hospital.

(vi) On 25 September 2012, Mr Robertson was involved in an event looking at arts in NHSGGC and, in particular, an arts strategy for the new southside hospital. This would look at the design of facilities and the provision of art and involved a wide range of community organisations.

(vii) On 2 October 2012, Mr Robertson, along with six other non-executive NHS Board members, visited the Decontamination Unit at Cowlairs. They received an excellent tour and briefing of the Unit and met staff who worked there.

(viii) On 11 October 2012, Mr Robertson and Mr Calderwood met with the Principal of the University of Glasgow to discuss the new clinical research facility planned for the new southside hospital.

(ix) Mr Robertson reported that Mr I Fraser had agreed to chair the East Dunbartonshire Community Health Partnership (CHP) and Mrs M Brown would co-chair the NHS Board's Staff Governance Committee alongside Mr D Sime.

NOTED

81. CHIEF EXECUTIVE'S UPDATE

(i) On 31 August 2012, Mr Calderwood attended a joint meeting between NHSGGC and local Labour MSPs. At this meeting, a range of issues were discussed and a similar meeting had been set up for 19 November 2012 with local SNP MSPs. These meetings would now be arranged quarterly.

(ii) On 10 September 2012, Mr Calderwood sat on the interview panel for the NHSGGC Director for Health Information and Technology post. He reported that Mr R Wright had been appointed from NHS Lanarkshire where he was currently General Manager for ehealth/Information Technology and would take up post on 3 December 2012.

(iii) On 14 September 2012, Mr Calderwood had attended his first meeting of the Executive of the NHS Staff Council following his nomination as NHS Scotland's employer representative. This meeting had focussed on a discussion on Agenda For Change, the National Recruitment & Retention Review and Terms and Conditions. The next meeting was arranged for 9 November 2012.

NOTED

82. MINUTES

On the motion of Dr M Kapasi MBE, seconded by Mr K Winter, the Minutes of the NHS Board meeting held on Tuesday 21 August 2012 [NHSGG&C(M)12/04] were approved as a correct record and signed by the Chair pending the following amendment:-

- Page 7, Item 69 "Integrated Prevention for Long Term Conditions", 6th paragraph, second line, delete "life choices and lifestyles" and insert "life circumstances".

NOTED

83. MATTERS ARISING FROM THE MINUTES

(i) The rolling action list of matters arising was noted.

(ii) In respect of Minute Number 67 - "Scottish Patient Safety Programme Update" - Dr Dickson reported that work was moving forward to look at the provision of more information on Surgical Site Infection (SSI) rates for all procedure categories. He was hopeful that the new IT system would be in place to help analyse this data by March 2013 and this would provide greater reassurance of infection rates in all surgical procedures. Mr Williamson welcomed this inclusion and looked forward to receiving the information from mid-2013 onwards.

NOTED

84. SCOTTISH PATIENT SAFETY PROGRAMME UPDATE

A report of the NHS Board's Medical Director and Head of Clinical Governance [Board Paper No 12/41] 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 reported that the NHS Board's aim statement was currently being revised to take account of recent changes in the aims of the national programme. Many of the national aims were being reviewed in light of experience as well as new areas of development.

Dr Dickson reported that the scope of the overall programme continued to be extended and he outlined the main clinical improvement themes in terms of the following programmes:-

- Acute Core Adult
- Acute Paediatric
- Primary Care
- Mental Health
- Specialist (such as heart failure, sepsis and venous thromoembolism)
- Maternity Care

Dr Dickson led the NHS Board through the scale of activities associated with these programmes and described the challenge in capacity and support to sustain the SPSP in NHS Greater Glasgow and Clyde. He described the SPSP mental health work which was a four year programme with the overall aim of systematically reducing harm experienced by people using mental health services in Scotland, by supporting frontline staff to test, gather real time data and reliably implement interventions, before spreading these across their Board area. It started with a focus on adult psychiatric inpatient units, including admission and discharge processes. The work had two key phases and, so far, in NHSGGC, mental health services had agreed to participate in Phase 1 of the voluntary programme and had selected to undertake work on reliable implementation of risk assessment and safety planning. As such, a Steering Group, chaired by the Lead Associate Medical Director for Mental Health, had been established to co-ordinate and support this programme.

Dr Dickson also alluded to a two day launch programme for SPSP in Maternal Health Care which had been attended by NHSGGC staff on 26 and 27 September 2012. The Women's and Children's Directorate had identified local Midwifery Safety Champions and Obstetric Leads on each of the main sites to support local implementation and national collaborative development of the Safety Programme.

In response to a question from Mrs Micklem, Dr Dickson reported there had been over 300 Patients Safety Leadership Walkrounds in the Acute Services Division from the start of SPSP (fours years ago) to September 2012. In terms of the 567 completed safety concerns raised by clinical teams, he agreed to obtain the actual figure of safety concerns raised (but not yet completed) and include this in future reports. **Medical Director**

Councillor Rooney sought further information in relation to the SPSP Mental Health Programme particularly in terms of safeguarding around current legislation. Dr Dickson reported there was an awareness of this and Phase 1 of the programme, which included initial scoping into the subject area, revealed a lack of evidence about those interventions demonstrating a reduction in harm in mental health services. The programme would, therefore, start with an initial one year phase focused on testing interventions to reduce harm experienced by individuals in receipt of care from mental health services. An analysis of this would inform much of the Phase 2 work expected to be undertaken from May 2013 onwards.

Mrs Hawkins agreed that challenges with this programme would present themselves and she hoped much of this would link in with the suicide reduction programme in that all interventions and discharge planning should be joined up.

NOTED

85. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No 12/42] 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 Dickson explained that the report represented data on the performance of NHS Greater Glasgow and Clyde on a range of key HAI indicators at national and individual hospital site level.

In 2007, the SGHD issued a Local Delivery Plan (LDP) HEAT target 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. For the last available reporting quarter (April to June 2012), NHSGGC reported 0.312 cases per 1000 acute occupied bed days (AOBDs). NHS Scotland reported 0.302 per 1000 AOBDs. The revised national HEAT required all NHS Boards in Scotland to achieve a rate of 0.26 cases per 1000 (AOBDs) or lower by 31 March 2013.

The national report published in October 2012 (April to June 2012) showed the rate of C.difficile within NHSGGC as 0.25 per 1000 occupied bed days in over 65s. This clearly placed the NHS Board below the national mean (0.31 per 1000 OBDs in over 65s) and also below the revised HEAT target for patients aged 65 and over, to be attained by 31 March 2013 of 0.39 cases per 1000 total occupied bed days.

Surgical Site Infection (SSI) rates for all procedure categories, apart from reduction of long bone fracture, remained below the national average.

The Cleanliness Champions Programme was part of the Scottish Government's Action Plan to combat HAI within NHS Scotland. To date, NHSGGC had supported 2,767 members of staff who were now registered as Cleanliness Champions.

Dr Dickson took members through the rest of the report focussing on hand hygiene, cleaning and the healthcare environment, outbreaks and other HAI related activity.

In response to a question, Dr Dickson reported a current figure of 96% hand hygiene compliance in NHSGGC as reported in the Health Protection Scotland (HPS) September 2012 report. He confirmed that hand hygiene compliance audits were carried out on a monthly basis in the majority of wards and departments in NHSGGC. This information was used at local level to tackle issues that may affect staff practice. Results were fed back through directorate based reporting mechanisms which allowed management to review the progress of individual wards. In terms of hand hygiene compliance in visitors, Dr Dickson updated that local hand hygiene co-ordinators had a plan to commence this work (and the marketing of this) and would begin with an audit of current compliance throughout the NHS Board's area.

Dr Kapasi asked about the ramifications of the closure of hospital wards should the existence of norovirus be confirmed. Dr Dickson explained the bed managing process that took place when this situation arose. Local bed managers (of which there was one in each hospital) and their teams worked to fill any gaps.

Mr Crombie added that the NHS Board's process had matured in that multi disciplinary teams worked, on these occasions, to meet service needs/demands.

NOTED

86. CHILDHOOD IMMUNISATION AND STAFF FLU VACCINATION PROGRAMMES

A report of the Director of Public Health [Board Paper No. 12/43] asked the NHS Board to receive and note an update of the Childhood Immunisation and Staff Flu Vaccination Programmes.

Dr de Caestecker introduced Dr S Ahmed, Consultant in Public Health, in attendance to deliver a presentation on the Programmes.

Dr Ahmed led the NHS Board through an update of both the Programmes as follows:-

- Childhood Immunisation Programmes – children in NHSGGC were protected through immunisation against many serious infectious diseases. Vaccination programmes aimed both to protect the individual and to prevent the spread of these illnesses throughout the population. As a public health measure, immunisations had been hugely effective in reducing the burden of disease. The immunisation schedule used in NHSGGC was the same as the schedule used in other parts of the UK and covered the recommended immunisations for children and young people aged 0 – 18 years. It comprised of the recommended universal routine immunisations which were offered to all children and young people at specified ages, as well as selective and non routine immunisations which were targeted to children at higher risks from certain diseases. The immunisation schedule was continually reviewed and updated based on advice from the scientific advisory committee, Joint Committee on Vaccinations and Immunisations (JCVI). Dr Ahmed reported that the JCVI had recently recommended that all children between the ages of 2 – 17 years should be given the flu vaccine on an annual basis and this recommendation had been accepted by all the UK administrations. As such, it was expected that this Programme would start in October 2014 when adequate supplies of the vaccine that was planned to be used was likely to be available. Other vaccines that were likely to be added to the childhood Programme, over the next few years, included a vaccine for the Meningococcal B strain of the Meningococcal Bacteria that caused around 100 cases of meningitis annually in Scotland. There was also likely to be some changes to the current Men C and pertussis vaccines schedule including additional doses of these vaccines for adolescent's programmes at school.

  In terms of childhood immunisation uptake in NHSGGC, Dr Ahmed reported very good local immunisation uptake rates for babies by 12 months of age. By the age of 24 months of age, the uptake rates were above the 95% target set by the Scottish Government and the World Health Organisation. Furthermore, there was significant improvement of the MMR uptake rate by five years of age following the decline of the MMR uptake rate due to the controversy about the MMR vaccine which linked the vaccine to inflammatory bowel disease and autism.

  With regard to the Human Papillomavirus (HPV) Immunisation Programme, introduced in September 2008, offering vaccinations to all girls aged between 12 – 13 years at secondary school (Year S2), Dr Ahmed reported a very good uptake rate in NHSGGC compared to the national rate. He also noted the significant differences in the uptake rate among girls who were targeted at

school and those who were targeted in the community. Data supported the concept that the best way to immunise school age children was to do a school based programme rather than intervention in the community.

- Staff Flu Vaccination Programme 2011/12 – Dr Ahmed reported that, historically, the uptake of flu vaccine among healthcare staff had been very low at less than 15%. As such, planning for the 2012/2013 Staff Flu Vaccination Programme commenced in March 2012 analysing what worked well in 2011/12 and what could be done better for 2012/13. The Directorate of Public Health now led the co-ordination and implementation of the annual staff vaccination programme with support from the occupational health service and local flu champions. Dr Ahmed explained the Programme objectives in that all 38,000 NHSGGC employees were included within the cohort of the staff flu vaccination programme. It was not, therefore, restricted or complicated by defining "frontline staff only" for NHS employees. As per the 2011/12 Programme, there would be four modes of vaccination delivery to staff in NHSGGC including peer immunisation, mass vaccination clinics, roving teams and appointments at occupational health departments. The flu season ran from 1 October to 31 March, however, the number of reported flu cases normally increased from the beginning of December, with the main season peak around mid January. Achieving protection of staff through immunisation by the end of November was, therefore, desirable. To this end, the mass vaccination clinic schedule would run until mid November and peer immunisation sessions commence early October to finish by December/early January at the very latest. Dr Ahmed alluded to a key aspect to the success of this Programme which was in raising awareness through a marketing strategy. This would include a new flu information GGC microsite, various internal communications, the identification of "Flu Champions" and email communications sent to all NHSGGC staff.

In response to a question from Mr Sime regarding a Tuberculosis (TB) vaccination, Dr Ahmed clarified that this was given to babies born in a family whose parents were born in high risk countries and was not cost effective (or required) for all babies and/or school children.

Mr Fraser commented on the disappointedly low uptake rate among staff for the flu vaccination. Dr Ahmed agreed but reported that this was widely seen across the western world and not just within NHSGGC. As such, it was paramount to educate healthcare staff. Mrs Brown wondered how best the NHS Board could improve this rate, which was, at the moment, unacceptable and worrying. Dr de Caestecker referred to the increase seen last year and, so far, this year through peer immunisation and hoped that lessons could be learned from the approach taken at Birmingham Children's Hospital where they reached an over 90% uptake rate. Furthermore, she referred to the "Mythbusters" marketing campaign to be undertaken by the Public Health Protection Unit which addressed many flu vaccination myths amongst staff. Mr McLaws also referred to the various communications targeted to reach staff including the use of Core Briefs, Team Briefs and Staff News. This all would hopefully reinforce the message of importance of the flu vaccination amongst healthcare workers and increase the uptake rate.

Councillor Lafferty asked about the scope of the flu vaccination which included all NHS employees but staff employed by local government should approach their respective employers as they did not fall within the NHSGGC staff programme. Dr Ahmed reported that the Scottish Government policy was clear in that the flu vaccination programme was an employer's responsibility and as such local authorities should also be targeting their social care staff.

In response to a question from Dr Kapasi, concerning polio and smallpox vaccinations, Dr Ahmed confirmed that the polio vaccination was still available in the UK. In relation to smallpox, only 2 places in the world (America and Russia) held the organism that caused smallpox. He explained that there was an on-going debate on whether to destroy these viruses but there was some reluctance to destroy the organism altogether as it then could not be used for further investigation should the situation ever arise.

Mr Robertson thanked Dr Ahmed for the powerful and thought-provoking presentation.

NOTED

87. SCOTLAND'S HEALTH COMMITMENT TO THE ARMED FORCES, THEIR FAMILIES AND VETERANS

A report of the Director of Glasgow City CHP [Board Paper No. 12/44] asked the NHS Board to note progress being made to implement the Scottish Government's health commitment to the armed forces, their families and veterans.

Mrs Hawkins reported that, in May 2011, the Ministry of Defence (MOD) published the Armed Forces Covenant. The Covenant followed a number of earlier productions, including the 2008 service personnel command paper which set out a series of undertakings to be delivered by the UK Government on behalf of the armed forces community. She led the NHS Board through the Scottish Government's approach to delivering these undertakings and the actions taken in NHSGGC.

To ensure a co-ordinated and strategic approach to the planning and delivery of public services and support of the armed forces community, a Scottish minister had portfolio responsibility for ensuring their support and welfare needs were reflected in policy. The Director General (Learning and Justice) had the strategic lead for the devolved impact of all defence matters across the Scottish Government. Mrs Hawkins reported that the Scottish Government had also appointed an armed forces and veterans advocate and the Director General (Health and Social Care) currently had this role and was responsible for ensuring that policy development and implementation across the Scottish Government (which impacted on the armed forces and the veteran community) was coherent and co-ordinated. The Government had worked with the armed forces in Scotland and with representatives from the veteran's community, reservists and cadet organisations to develop the Firm Based Forum which was designed to discuss matters of policy and strategy about the delivery of the armed forces Covenant in Scotland. There was a series of functional groups for health, education and veterans and, working with the Firm Based Forum, the Scottish Government was encouraging the development of local community Covenants; the aim of which was to bring together local civilian communities, with the armed forces community, in an area to create mutual understanding and support. The Government's aim was that all local authorities would have a community Covenant by Autumn 2012.

Mrs Hawkins summarised future Government plans and outlined, in particular, activity within NHSGGC – in acute services, partnerships and in mental health. Given this, NHSGGC continued to work with all partners to deliver services for veterans, serving personnel and their families and was making steady progress in delivering the Scottish Government's objectives.

Mr Williamson referred to the Scottish minister's policy decision to provide priority health treatment for veterans with a service related condition. It was his view that all patients were entitled to the same referral arrangements based on clinical priority.

Councillor Rooney agreed that all patient groups deserved the same level of treatment and this should be undertaken on medical need. Mrs Hawkins agreed to mention this point at the next Champions meeting as she was one of three veterans Champions within NHSGGC. **Director, Glasgow City CHP**

Councillor McIlwee commended the work being taken forward since the introduction of the Covenants and reported that, in March 2012, Inverclyde Council signed its armed forces community Covenant. Following on from that, a proposal was developed locally to create a helpdesk function for veterans as part of the Council's customer service centre. This would then be linked in to key support agencies and, currently, the customer services centre manager was working with veterans' charities to develop the pre-set question algorhythms so that customer care staff would be able to talk through an initial assessment with veterans and/or service families and then make an appropriate referral.

In response to Mr Williamson earlier point, Mr Sime recognised that services should be provided according to need but considered that the evidence-base used by the Scottish Government was the introduction of the armed forces Covenant and that ensured veterans were provided with priority treatment.

NOTED

88. PATIENT RIGHTS ACT (SCOTLAND) 2011 – ACCESS POLICY FOR TREATMENT TIME GUARANTEE

A report of the Chief Operating Officer (Acute Services Division) [Board Paper No. 12/45] asked the NHS Board to approve the Access Policy for Treatment Time Guarantee.

Mr Crombie, Director of Surgery and Anaesthetics, explained that the Access Policy for Treatment Time Guarantee aimed at ensuring a consistency of approach in providing access to services and, as such, it supported the Patient Rights Act (Scotland) 2011.

He explained that the NHSGGC Access Policy had been developed to provide a common vision, direction and understanding of how the NHS Board would ensure equitable, safe, clinically effective and efficient access to services to patients. The Policy set out principles that would ensure that systems were in place to optimise the use of facilities and available capacity in order to deliver high quality and safe patient care, in a timely manner. It would ensure that NHSGGC had systems, processes and resources in place to deliver the responsibilities described in the national access policy and it was intended to support a maximum wait of 18 weeks from referral to first definitive treatment and a 12 week maximum wait from decision to treat until treatment (known as the treatment time guarantee).

Mr Williamson understood that, by following the key principles set out in the Policy (and defining responsibilities under those principles), NHSGGC would ensure equity of service and reduce variation. He cautioned, however, on occasions when GPs referred to specific clinical teams that may know a particular patient or have more experience in dealing with chronic conditions. Mr Crombie agreed that this had already been flagged as a relative point and clinicians were sensitive to this. The Acute Services Division had engaged widely particularly with sub-specialities to make sure that relevant clinical information was available to staff when treating individual patients.

Mrs Brown asked whether an Equality Impact Assessment (EQIA) had been carried out on this Policy and, in more general terms, what the sequencing of undertaking such an assessment was with any new Policy. Mr Crombie responded by confirming that an EQIA had commenced on the Policy. Mr Robertson agreed that the NHS Board consider the sequencing of undertaking an EQIA prior to consideration of a new Policy at NHS Board level.

Director of Corporate Planning and Policy

DECIDED

That the Patient Rights Act (Scotland) 2011 – Access Policy for Treatment Time Guarantee be approved.

Chief Operating Officer (Acute Services Division)

89. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer [Board Paper No 12/46] asked the NHS Board to note progress against the national targets as at the end of August 2012.

Mr Crombie led the NHS Board through the report highlighting the actions being taken to deliver the waiting times and access targets. This included general waiting times/18 week's referral to treatment (RRT) and the waiting times for various specific treatments including accident and emergency, cancer, chest pain and stroke. He also highlighted the delayed discharge figures across NHSGGC.

NOTED

90. FINANCIAL MONITORING REPORT FOR THE 5 MONTH PERIOD TO 31 AUGUST 2012

A report of the Director of Finance [Board Paper No. 12/47] 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 £0.7m in excess of its budget for the first five months of the year. At this stage, however, the NHS Board considered that a year end breakeven position remained achievable.

Mr James led the NHS Board through further information in relation to expenditure in acute services, NHS partnerships and corporate services. At this stage of the year, overall assessment was that, at 31 August 2012, the NHS Board was running £1m behind its original year to date cost savings plans. Within partnerships, a shortfall of £0.5m against the in year savings target was being managed by expenditure reductions in other areas that were not included within the savings plan proposals. Within the Acute Services Division, a similar level of slippage was being experienced and the Division was actively reviewing potential substitute schemes and availability of non recurring funding to offset costs in the areas where there had been some delays to original start dates.

Given this, a comprehensive assessment of progress against savings targets was currently being undertaken as part of the NHS Board's midyear financial review which was due to be completed by mid October 2012. Mr James reported that this would identify whether alternative schemes or actions may be required to enable the NHS

Board to achieve a break even outturn for the year or whether the NHS Board had sufficient in-year flexibility to provide non recurring relief until savings plans could be fully implemented.

In response to a question from Councillor Rooney, Mr James confirmed that, for the year to date, overall prescribing expenditure continued to be reported as running in line with budget within primary care services.

NOTED

91. QUARTERLY REPORT ON COMPLAINTS – 1 APRIL – 30 JUNE 2012

A report of the Head of Board Administration, Chief Operating Officer and Director of Glasgow City CHP [Board Paper No 12/48] asked the NHS Board to note the quarterly report on NHS complaints received in NHS Greater Glasgow and Clyde for the period 1 April 2012 to 30 June 2012. Furthermore, the NHS Board was asked to note and agree changes to the Complaints Policy implemented in accordance with the Patient Rights (Scotland) Act 2011.

Mr Hamilton advised that the report provided a commentary with statistics on complaints handling within NHSGGC for the period 1 April 2012 to 30 June 2012. It looked at complaints received and handled at the local resolution stage and by the Scottish Public Services Ombudsman and identified areas of service improvements and ongoing developments.

Mr Hamilton led the NHS Board through the number of complaints received and completed in the quarter. In terms of performance, 76% of all complaints had been responded to within 20 working days.

Mr Hamilton reflected that an important part of the Patient Rights (Scotland) Act 2011 was to ensure that patient's feedback, comments, concerns and complaints were more actively monitored and used to improve services. This had led to additional reporting requirements which would, in future, include more detailed reporting about complaints including those made about primary care contractors. This report was the first report where changes had been introduced to the style of reporting and included the presentation of more detailed information on where complaints had been raised and what improvements had been brought about to services as a result of complaints. Future complaint reports would have further refinements and members comments would be welcomed on the future presentation on new information to ensure it met their needs.

Mr Hamilton summarised the Patient Advice and Support Service (PASS) findings for NHSGGC for the period and led the NHS Board through the three Ombudsman reports laid before Parliament as well as the Ombudsman's Annual Letter 2011/12 on complaints received about NHSGGC.

In terms of the NHS Board's revised Complaints Handling Policy, Mr Hamilton explained that various amendments had been made reflecting the introduction of the Patient Rights (Scotland) Act 2011. He also highlighted that it was recommended that the NHS Board accept that the Nurse Director fulfil the role identified in the Statutory Instrument as Feedback and Complaints Manager.

Mrs Micklem was impressed with the new style of reporting this information, particularly the Appendix outlining service improvements as the result of complaints

completed. In recognition, however, that the majority of complaints were about staff communication/attitude and behaviour, she wondered how best generic issues such as this could be followed up. Mr Calderwood outlined the appraisal process for senior clinical staff which included looking at complaints received. He also alluded to internal NHS Board processes that were followed if complaints were raised about personnel but cautioned that this had to be balanced with the Facing the Future Together (FTFT) principles of working towards a culture of learning and staff development. Mrs Hawkins added that much of the FTFT materials recently launched were on team development and much learning could be made from that as there were various materials and practical cases for use.

Mr Finnie was concerned to note the high level of upheld and premature complaints received by the Ombudsman about the health sector which rose from 45 to 56% from the previous year. Mr Finnie's concern was that those complaints had been looked at, in depth, by NHS Boards prior to the Ombudsman's involvement and yet, in more than half the cases, fault was being found by the Ombudsman. He asked whether there was something in local complaint procedures that was not picking up complaints that were then being picked up at Ombudsman level. Mr Calderwood responded by agreeing that the statistic was disappointing but referred to numerous aspects of Ombudsman decisions. He alluded to ongoing improvements required in local record-keeping and a raft of issues that was underlying the information. Nonetheless, he agreed this had to improve locally.

DECIDED

- That the quarterly report on complaints in Greater Glasgow & Clyde for the period 1 April 2012 to 30 June 2012 be noted.

- That the changes to the complaints policy implemented in accordance with the Patient Rights (Scotland) Act 2011 be agreed. **Head of Board Administration**

92. 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. 12/49] 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 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**

93. AREA CLINICAL FORUM MINUTES: 2 AUGUST 2012

The Minutes of the Area Clinical Forum meeting held on 2 August 2012 [ACF(M)12/04] were noted.

NOTED

94. PHARMACY PRACTICES COMMITTEE MINUTES: 31 AUGUST 2012 AND 20 SEPTEMBER 2012

The Minutes of the Pharmacy Practices Committee meetings held on 31 August 2012 [PPC(M)12/03] and 20 September 2012 [PPC(M)12/04] were noted.

NOTED

95. QUALITY AND PERFORMANCE COMMITTEE MINUTES: 18 SEPTEMBER 2012

The Minutes of the Quality and Performance Committee meeting held on 18 September 2012 [QPC(M)12/05] were noted.

NOTED

The meeting ended at 12 noon