

NHSGG&C(M)13/01  
Minutes: 01 - 20

NHS GREATER GLASGOW AND CLYDE

**Minutes of a Meeting of the  
NHS Greater Glasgow and Clyde Board  
held in the Board Room, Corporate Headquarters, J B Russell House,  
Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH  
on Tuesday, 19 February 2013 at 9:30a.m.**

**PRESENT**

Mr A O Robertson OBE (Chair)

Dr J Armstrong	Dr M Kapasi MBE
Dr C Benton MBE	Councillor A Lafferty
Ms M Brown	Mr I Lee
Dr L de Caestecker	Councillor M Macmillan
Mr R Calderwood	Councillor J McIlwee
Mr G Carson	Ms R Micklem
Ms R Crocket	Councillor M O'Donnell
Mr P Daniels OBE	Dr R Reid
Mr R Finnie	Councillor M Rooney
Mr I Fraser	Rev Dr N Shanks
Councillor J Handibode	Mr D Sime
Mr P James	Mr B Williamson

Mr K Winter

**IN ATTENDANCE**

Dr S Ahmed	Consultant, Public Health Medicine (For Min No 09)
Dr E Crighton	Consultant, Public Health Medicine (For Min No 10)
Ms S Gordon	Secretariat Manager
Ms 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
Dr A Stanley	Consultant Gastroenterologist, Acute Services Division (For Min No 01)
Mr A Tough	NHS Board Archivist (For Min No 01)
Mr M White	PriceWaterhouseCoopers (For Min No 11)
Mr N Wilson	Paediatric Orthopaedic Surgeon, Acute Services Division (For Min No 01)

**ACTION BY**

**01. APOLOGIES AND WELCOME**

Apologies for absence were intimated on behalf of Prof A Dominiczak, Councillor M Kerr and Mrs P Spencer BME.

Mr Robertson welcomed Mr Tough, Dr Stanley and Mr Wilson, in attendance to present him with a gavel in celebration of the bi-centenary of the birth of David Livingstone, who trained as a doctor in Glasgow.

Mr Tough outlined the history of the gavel which was fashioned from the wood of a tree under which David Livingstone's heart was buried near Chitambo's Village, Malawi in 1873. Dr Stanley outlined the support given to Malawi from the NHS at large but, in particular, from NHSGGC. Mr Wilson, who was also David Livingstone's great great grandson, summarised the Livingstone family history and was delighted to present the gavel to Mr Robertson for display at the NHS Board's Headquarters, J B Russell House. Mr Robertson thanked him for the very kind gesture.

NOTED

## **02. 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

## **03. CHAIR'S REPORT**

- (i) On 17 and 18 January 2013, NHS Board members attended a Board time-out event to review service and financial performance for 2012; to present progress on planning for 2013/2014; and to begin to consider the planning context and challenges for 2014/15 and beyond.
- (ii) On 28 January 2013, Mr Robertson, with other NHS Board non executive members, visited the Renfrew Health and Social Care Centre which was now well established with staff settled in. Evident very early on were the advantages of the co-location of health and social care services.
- (iii) On 1 February 2013, Mr Robertson had hosted a visit from the Chief Executive and Vice Chair of NHS Dumfries and Galloway at the new Southern General Hospital development. This was a visit for them to see progress particularly as they were currently putting together a business case for the redevelopment of Dumfries Royal Infirmary.
- (iv) On 18 February 2013, Mr Robertson attended the cutting of the first sod at a special ceremony conducted by Cabinet Secretary, Alex Neil, to celebrate the construction of the new £10M Possilpark Primary and Community Health Centre. This new modern, state of the art health and care centre for the people of Possilpark would incorporate many services offering local people access to additional services including primary care, mental health services and money advice.

NOTED

## **04. CHIEF EXECUTIVE'S UPDATE**

- (i) On 22 January 2013, Mr Calderwood and Dr L de Caestecker met with the Commonwealth Games Organisation Committee to discuss progress, in particular, with the planned polyclinic. He would keep the NHS Board up-to-date with developments going forward with the Commonwealth Games' arrangements.

**Chief  
Executive**

- (ii) On 6 February 2013, Mr Calderwood met with the University of the West of Scotland to refresh the memorandum of understanding between both organisations. This represented an excellent piece of work for both organisations.
- (iii) On 7 February 2013, Mr Calderwood attended the Scottish Enterprise Life Sciences Awards Ceremony in Edinburgh where he had been most impressed with many of the research and development initiatives.
- (iv) On 14 February 2013, Mr Calderwood and Mrs J Grant met with the new president of the Royal College of Physicians and Surgeons, Glasgow, Dr Frank Dunn, to discuss matters of mutual interest.
- (v) Mr Calderwood alluded to the Mid Staffordshire Report which had been published in early February 2013. He reported that the NHS Board's Medical Director and Nurse Director were taking forward a piece of work looking at the recommendations in this report. This would be pulled together for consideration by the NHS Board at a later date.

**Medical  
Director/  
Nurse  
Director**

NOTED

## **05. MINUTES**

On the motion of Mr I Fraser, seconded by Dr R Reid, the Minutes of the NHS Board meeting held on Tuesday, 18 December 2012 [NHSGG&C(M)12/06] were approved as an accurate record and signed by the Chair.

NOTED

## **06. MATTERS ARISING FROM THE MINUTES**

The rolling action list of matters arising was noted.

NOTED

## **07. SCOTTISH PATIENT SAFETY PROGRAMME UPDATE**

A report of the NHS Board's Medical Director and Head of Clinical Governance [Board Paper No 13/01] asked the NHS Board to review and comment on the ongoing progress achieved by NHS Greater Glasgow and Clyde in implementing the Scottish Patient Safety Programme (SPSP).

Dr Armstrong provided the NHS Board with an update of the Venous ThromboEmbolic (VTE) collaborative and sepsis collaborative. This was in anticipation of a national team visit taking place to NHSGGC on 25 March 2013 for both the sepsis and VTE workstreams.

Firstly, she described the aim of the VTE collaborative programme in that it looked at the assessment of patients and concurrent administration of interventions to prevent VTE in patients being admitted for acute in-patient care. The challenging aim was the reliable risk assessment and appropriate thromboprophylaxis administration of 95% of all adult admissions by December 2014. NHSGGC now had 10 pilot wards identified in 6 hospitals active in developing processes around this care bundle. Dr Armstrong reported that these had been spread into 5 other wards since the autumn which included 3 additional teams in the Regional Directorate and the commencement of 2 teams in the

Surgery and Anaesthetics Directorate. Physicians had recommended the spread of the VTE collaborative to medical receiving wards and this was now being progressed. The rationale for this was to support reliable risk assessment within 24 hours of admission.

Dr Armstrong explained that, in the pilot teams, staff were testing to identify what was the best practice to ensure reliable clinical practice and she summarised the ongoing testing developments against each bundle measure.

In terms of the sepsis programme, its aim was to improve the recognition and timely management of sepsis in acute hospitals in NHSGGC – the desired outcome being a reduction in mortality from sepsis of 10% in the pilot population by December 2014.

Dr Armstrong reported that work continued recruiting pilot teams across the Acute Services Division and noted that there was clinical enthusiasm within NHSGGC for applying the sepsis six rules set to improve care. She described how the new national early warning score system had the sepsis six bundle written into the action reference tool and this was being implemented in all acute hospitals by the end of March 2013. As part of implementation, nursing staff were receiving supplementary education on the bundle to underpin its effective use.

In response to a question, Dr Armstrong confirmed that some tools and practices within the teams were being identified for common use in taking forward the sepsis programme. Furthermore, the seriousness of the condition was well acknowledged as a medical emergency so some pilot areas were working on specific equipment for use with patients in sepsis cases.

Mr Williamson was encouraged to see the SPSP get into hard core issues and asked whether the sepsis programme included emergency and elective patients. Dr Armstrong reported that although the programme had started off at the front door of acute hospitals, then moved into medical acute receiving units and surgical wards, it was the intention to move the programme into all medical and surgical elective patients. She agreed, however, that there were very different indicators for sepsis in emergency and elective patients and the programme took account of this.

In response to a question concerning the training programme for junior doctors, Dr Armstrong confirmed that discussions were ongoing with NHS Education for Scotland (NES) regarding the inclusion of a whole raft of patient safety issues including the sepsis six rules.

#### NOTED

### **08. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)**

A report of the NHS Board's Medical Director [Board Paper No 13/02] 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 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 (July to September 2012), NHSGGC reported 29.3 cases per 100,000 Acute Occupied Bed Days (AOBDs). NHS Scotland reported 29.3 cases per 100,000 AOBDs. The revised national HEAT target required all NHS Boards in Scotland to achieve a rate of 26 cases per 100,000 (AOBDs) or lower by 31 March 2013.

The national report published in January 2013 (July to September 2012) showed the rate of C.difficile within NHSGGC as 17.4 per 100,000 occupied bed days in over 65s. This clearly placed the NHS Board below the national mean (31.9 per 100,000 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 39 cases per 100,000 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 2,881 members of staff who were now registered as Cleanliness Champions.

Dr Armstrong alluded to two unannounced Healthcare Environment Inspectorate (HEI) inspections. On 4 September 2012, the HEI inspected the Royal Alexandra Hospital and on 8/9 November 2012, they inspected Glasgow Royal Infirmary. She summarised the Inspectorate's key findings and recommendations made from these visits.

Mr Fraser wondered about the language used by the Inspectorate and, in particular, the interpretation of the word "good" which had been used often within the Glasgow Royal Infirmary findings. Dr Armstrong reported that she was pleased with the term "good" and this represented a totally satisfactory outcome for those parts of the findings.

Councillor Lafferty thanked Dr Armstrong for the clear way that the report had been written particularly with the inclusion of the explanation boxes for medical terms used.

#### NOTED

### **09. REPORT OF THE DIRECTOR OF PUBLIC HEALTH: BLOOD BORNE VIRUSES IN NHS GREATER GLASGOW AND CLYDE**

The Director of Public Health [Board Paper No. 13/03] asked the NHS Board to receive and note the report on blood borne virus infections, the prevention interventions to limit the transmission of these infections and the treatment and care services currently available within the NHS Board.

Dr Ahmed, Consultant, Public Health Medicine, reported that blood borne viruses (BBV's) were those viruses that were transmitted from the blood of one person to the blood of another person. Many BBV's could also be transmitted by other means, including sexual contact and intravenous drug use. The most common BBV's in the UK (and of particular concern in Scotland and NHSGGC) were human immunodeficiency virus (HIV), hepatitis C virus (HCV) and hepatitis B virus (HBV).

He reported that, in August 2011, the Scottish Government published the Sexual Health and Blood Borne Virus Framework 2011-2015. This framework brought together the four policy areas of each HIV, HCV, HBV and sexual health for the first time in an overarching policy document. The framework aimed to focus delivery on realising five outcomes that were embedded in the Quality Strategy and the inequalities agenda.

In NHSGGC, the planning structure for sexual health and blood borne viruses was revised in 2011 to reflect and align with the national framework so that effective

communication was in place and constructive relationships were developed and maintained. Dr Ahmed led the NHS Board through an update of the HIV, HCV and HBV viruses as follows:-

- HIV – HIV remained a significant challenge and the Scottish Government had provided leadership and commitment in the form of the Blood Borne Virus and Sexual Health Strategy. NHSGGC was committed to delivering the framework's ambitions and would continually review its preventative interventions to ensure that each component of the programme was clearly defined and re-evaluated against both changing research evidence and the local epidemiology. Dr Ahmed confirmed that people living with HIV in NHSGGC had access to excellent treatment and care services, however, the challenges remained around diagnosing the undiagnosed fraction and reducing the proportion diagnosed late. Progress had been made with community development initiatives among black African sub groups which had substantially improved access to HIV prevention for this sub population at risk from HIV infection. Furthermore, significant progress had been made in relation to testing rates amongst men who had sex with men (MSM) and the new evidence from the needs assessment would enable the NHS Board to enhance prevention efforts targeting interventions to those MSM's at highest risk of acquiring HIV. The success of the antenatal HIV screening programme was proof that prevention programmes could work.
- HCV – HCV was primarily associated with a history of injecting drug use. Primary prevention aims were met through the provision of sterile injecting equipment to those at risk and interventions designed to prevent initiation into, and cessation of, injecting drug use. Drug users across NHSGGC had access to information, support and sterile injecting equipment through a range of providers. The Managed Clinical Network (MCN) and Addictions Services were working closely to increase reach into affected communities. Recent years had seen a significant reduction in the number of undiagnosed infections. Diagnostic testing in addiction services accounted for much of this activity. There were opportunities to increase testing activity in primary care settings and prisons and the MCN was developing case finding initiatives to support this work. Dr Ahmed explained that the majority of people who had completed a course of anti-viral treatment could be cured of their infection. Treatment services across NHSGGC had been developed in line with the number of diagnosed cases. Outpatient and out reach models of care had been established to increase uptake at a range of settings. Local treatment outcomes compared favourably with those across Scotland.
- HBV – compared to HIV and HCV, there was a relatively low prevalence of HBV in NHSGGC, however, diagnosis continued to increase, primarily among people coming from countries of high prevalence. Arrangements were in place to support the diagnostic testing and vaccination of those most at risk and the management of close family/sexual contacts for those infected. Specialist care centres and primary care centres were working together to ensure effective and equitable provision of treatment where this was indicated.

In response to a question from Dr Kapasi, Dr Ahmed referred to significant work ongoing at an international level to reduce the spread of the HIV infection particularly amongst UK residents visiting countries where the prevalence of HIV was high.

Dr Kapasi asked whether those diagnosed positive with the HCV virus went on to become re-infected. Dr Ahmed acknowledged that although the treatment for HCV was expensive, it had significant side effects which tended to motivate patients to not become infected again.

Rev Dr Shanks was encouraged with the progress made locally particularly in relation to the HIV infection. He asked about the plans to normalise and increase HIV testing in a wider range of clinical settings as he noted that this was a priority.

Dr Ahmed explained that it was hoped, in the future, that HIV testing would be normalised, like that of any other chronic disease, and he hoped that it would eventually demystify and desensitise the issues currently surrounding HIV. Often, patients first presented with symptoms that could be a trigger for testing for HIV infection but such diagnosis of HIV was not made until a much later stage – testing earlier or picking up the symptoms of an earlier HIV positive diagnosis remained a challenge.

Mr Williamson alluded to the European Global comparisons and wondered whether, in governance terms, comparative data could be obtained separately for the immigrant population to that of infection rates amongst the resident population – that may help to tell how well prevention interventions were doing. Dr Ahmed reported that Scotland wide (and UK wide) comparisons could, at the moment, be undertaken and, in terms of NHSGGC's performance this was similar and/or better than other areas but European comparisons were not routinely undertaken due to data availability and compatibility.

In response to a question from Dr Benton, Dr Ahmed confirmed that NHSGGC worked closely with the Scottish Prison Service and all inmates were risk assessed and offered blood borne virus testing on arrival at a prison.

Councillor Lafferty asked if information was available regarding the prevalence amongst age groups. Dr Ahmed responded in the affirmative but added that there was no evidence to suggest an increased prevalence of HIV amongst adolescents in NHSGGC.

#### NOTED

#### **10. PUBLIC HEALTH SCREENING PROGRAMMES ANNUAL REPORT 1 APRIL 2011 TO 31 MARCH 2012**

A report of the Director of Public Health [Board Paper No. 13/04] asked the NHS Board to note the Public Health Screening Programme Annual Report from 1 April 2011 to 31 March 2012.

Dr Crighton presented information about the following screening programmes offered to residents across NHSGGC for the period 2011/12:-

- Cervical screening
- Breast screening
- Bowel screening
- Pregnancy screening:-
  - Communicable diseases in pregnancy
  - Haemoglobin apothics in screening
  - Downs syndrome and other congenital anomalies
- New born screening:-
  - New born blood spot
  - Universal new born hearing
- Diabetic retinopathy screening
- Preschool vision screening

She also described the plans for implementing abdominal aortic aneurysm screening in February 2013 that would be offered to all men aged 65 who were residents in NHSGGC.

Dr Crighton explained that screening was a public health service offered to specific population groups to detect potential health conditions before symptoms appeared. Screening had the potential to save lives and improve quality of life through early diagnosis of serious conditions.

In NHSGGC, the co-ordination of all screening programmes was the responsibility of the Public Health Screening Unit led by a consultant in public health medicine. Multi disciplinary steering groups for the programmes were in place and the remit was to monitor performance, uptake and quality assurance.

Dr Crighton highlighted that, as the screening programmes stretched across the whole organisation, successful delivery relied on a large number of individuals working in a co-ordinated manner towards common goals in a quality assured environment. It was essential that good information management systems were in place to monitor and evaluate each component and the overall performance of every screening programme offered to NHSGGC residents. All the screening programmes, with the exception of pre school vision screening, had clinical standards set by Health Improvement Scotland.

NHSGGC's Public Health Screening Unit was committed to working in partnership with voluntary and statutory services to identify innovative ways to tackle inequalities in health and encourage uptake of screening programmes. Encouragingly, for the first year, the report included analysis on uptake among people with learning disabilities but did not, as yet provide screening activity by ethnicity as this data was not available.

Dr de Caestecker commended the efficiency of the screening programmes and reiterated that they could prevent disease. She and Dr Crighton responded to a range of members' questions by confirming the following:-

- Mrs Brown had sought previously more information around interval times of breast cancer detection as such information would be helpful in looking at overall detection as the purpose of screening was not just to detect but to detect at an *earlier* stage. In clinical governance terms, therefore, she suggested it would be useful to measure and report on the interval/stage of the breast cancer detection. Dr Crighton agreed but reported that the new IT system had unfortunately not been available as hoped for this reporting year so the extraction of such information could not be easily analysed. She was hopeful, however, that this could be done in the future. Dr de Caestecker added that, although a lot of data was available in NHSGGC, breast cancer information, extrapolated as Mrs Brown suggested, could not be done separately for screen detections at the moment. She reassured the NHS Board, however, that cancer steering groups and MCNs looked at the governance of all screening programmes which were also governed at a national level.
- In response to a question from Mr Williamson concerning the cut off age of 74 years old for the bowel screening programme, Dr Crighton acknowledged that all tumours' prevalence increased with age. Originally, the bowel screening programme pilot stopped at age 70 but was increased, at the implementation stage to age 74. Anyone aged 75 or above could, however, self-refer to the programme.
- The introduction, from February 2013, of the abdominal aortic aneurysm (AAA) screening across NHSGGC was welcomed. It was recognised that such aneurysms were strongly linked to increasing age, hypertension, smoking, other vascular disease and a positive family history of AAA. Furthermore, studies had found that approximately 7% of men aged 65 were found to have an aneurysm and it was less common in men and women under age 65 years. When an aneurysm ruptured, less than half of patients would reach hospital alive and when an operation was possible, mortality was as high as 85%.

**Director of  
Public Health**



The aim of the AAA screening was, therefore, the early detection and elective repair of a symptomatic AAA in order to prevent spontaneous rupture. All men aged 65 years, resident in NHSGGC would be invited to attend for a single abdominal ultrasound scan.

- Mr Fraser was disappointed to note the decrease, of 1.3%, in bowel screening between 2010/11 and 2011/12. Dr Crighton agreed and hoped that continued monitoring and audit of the performance of the programme, as well as vast health promotion activities to encourage uptake, would result in better rates to fully utilise the resources that NHSGGC had in place. Mr Finnie wondered if patients had difficulty in conducting the test itself and if that was a deterrent to uptake rates. Dr Crighton explained some of the development resources ongoing to help people better understand how to undertake the test and pictorial explanations were being drafted.
- Mr McLaws reported that the next edition of Health News was focusing on the NHS Board's screening programmes including more detail around how they were undertaken.

Mr Robertson, on behalf of the NHS Board, thanked Dr de Caestecker and Dr Crighton for their comprehensive summary of the annual report.

#### NOTED

### **11. INTERNAL AUDIT REPORT ON WAITING TIMES**

A report of the Chief Operating Officer (Acute Services Division) [Board Paper No. 13/05] asked the NHS Board to note the internal audit report on waiting times, including management actions.

Mrs Grant explained that the report had already been submitted to the December 2012 Audit Committee and the progress in meeting the actions identified within the report would be reviewed by them at their March 2013 meeting. She introduced Mr M White from the NHS Board's internal auditors, PriceWaterhouseCoopers (PWC), to lead the NHS Board through the report.

Mr White described the background to the Scottish Government's New Ways Guidance governing the 18 week Referral to Treatment standard issued in 2008. He outlined the interpretation and implementation of the New Ways Guidance across NHSGGC alluding to the commitment made by the then Cabinet Secretary that every NHS Board in Scotland would undertake "rigorous and specific detailed internal audit of local waiting times management and processes, including reporting mechanisms". In NHSGGC, this internal audit review was undertaken by PWC between the period 1 January 2012 until 30 June 2012.

Mr White reported that the PWC review considered a number of areas relating to waiting times arrangements and focused on three key areas noted in the Scottish Government's Terms of Reference. Within NHSGGC, data interrogation of the waiting times system was limited due to the limited architecture of particular systems such as iSoft (used for North Glasgow) and Meditech (used for the Southern General and Yorkhill Children's hospitals). The interrogation of both these systems by PWC was further complicated by the fact that both systems were due for imminent replacement by the new TRAKcare system as it rolled out across the NHS Board in the coming months. As such, support from the supplier of both systems was being wound down. Mr White highlighted that the limitations of these systems (and the related issues in extracting

data) did not affect NHSGGC's management and monitoring of their waiting times processes. Whilst the capabilities of TRAKcare were significantly greater, both iSoft and Meditech were capable of collating and producing sufficient information to manage the process. Indeed, it was the internal management reports produced by each of these systems that formed the basis of PWC's risk based audit approach. Despite the lack of a suite of information from the data interrogation exercise, the review involved interviews with staff, consideration of relevant waiting times reports and testing of patient records within iSoft and Meditech. There was no limitation to the interrogation of the information and testing PWC subsequently performed. So, despite not being able to take an overall systems download to inform PWC's audit, Mr White reported that PWC was still able to adopt a risk based audit approach, focusing its work and sample testing into particular specialities, at particular times and on particular issues.

Mr White concluded that the findings of the work had enabled PWC to make a number of observations on key areas around the waiting times process within NHSGGC. As such, a number of issues had been highlighted and identified in areas for improvement. Overall, however, the waiting times processes and procedures within NHSGGC were operating in a controlled manner with no material deficiencies identified. In addition, the sample testing did not identify any evidence of inappropriate amendments or contraventions of NHSGGC's waiting times policy.

Councillor Rooney commended the upfront approach taken in the report and was reassured that although the current information and data collection systems were not now fit for purpose, a solution was well on its way to implementation. Mrs Grant agreed and confirmed that TRAKcare was a tried and tested system which would be fully rolled out across NHSGGC by May/June this year. She confirmed that training would be given to all staff to ensure it was fully functional to meet the treatment times guarantee.

Given that this was a difficult piece of work to audit, Mr Fraser welcomed the fact that it reflected honesty and integrity of the waiting times management across NHSGGC.

#### NOTED

## **12. WAITING TIMES AND ACCESS TARGETS**

A report of the Chief Operating Officer [Board Paper No 13/06] asked the NHS Board to note progress against the national targets as at the end of December 2012.

Ms Grant 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 weeks referral to treatment (RRT) and the waiting times for various specific treatments including accident and emergency, cancer, chest pain and stroke. She also highlighted the delayed discharge figures across NHSGGC

In response to a question from Councillor Rooney concerning the information for accident and emergency waiting times at the Vale of Leven hospital, Mrs Grant reported that although there was no accident and emergency department at the Vale of Leven hospital, the figures included waiting times at all units receiving patients including minor injury units.

In relation to the number of patients waiting discharge from hospital, Mrs Hawkins explained that variations across the Partnerships occurred due to different process issues, local hospital issues, social work practice and social work staffing within each

Partnership area. As such, there was no one solution that would fit all the Partnerships but she reassured the NHS Board that joint work was going on with local social work teams, the Acute Services Division and the Partnerships to identify the best local solutions for this very complex area. Ms Renfrew, however, alluded to the reduction in bed days occupied by patients over 65 awaiting discharge which was certainly a step in the right direction. Given this, and the ongoing work to find solutions for future practice and individual patients, Dr Reid paid tribute to all staff involved in this difficult and complex area.

In response to a question from Mr Lee concerning the demand pressures for winter planning, Mr Calderwood reported that demand had exceeded winter planning this year. Additional resources had, therefore, been invested and, in going forward, work would be carried out to look at trends and increases in demand from 2009/10, 2011/12 and 2012/13. This would be scrutinised alongside the ongoing Clinical Services Review work to ensure a whole systems review of winter planning and the acute services strategy. Mr Calderwood alluded to two sites; that of the Victoria Infirmary and the Western Infirmary, both of which were scheduled to close in 2015 so did not benefit from any recent capital investment. By way of reassurance, he commented that, if following the analysis, some interim service measure redesign had to be put in place, he would keep the NHS Board duly informed through the regular winter planning reports.

**Chief  
Operating  
Officer**

NOTED

**13. FINANCIAL MONITORING REPORT FOR THE 9 MONTH PERIOD TO DECEMBER 2012**

A report of the Director of Finance [Board Paper No 13/07] asked the NHS Board to note the financial performance for the first nine months of the financial year.

Mr James explained that the NHS Board was currently reporting an expenditure outturn of £0.2m in excess of its budget for the first nine months of the year. At this stage, however, the NHS Board considered that a year end break even 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 December 2012, the NHS Board was running around £1.9m behind its year to date cost savings target although this was currently being offset by additional non recurring savings against other budgets. Achieving the NHS Board's overall savings target of £59m for 2012/13 remained one of the key factors in determining whether the NHS Board would achieve a breakeven outturn for the year.

In response to a question from Councillor Rooney regarding the £11.9m expenditure listed as "unallocated funds", Mr James clarified that this money was not surplus because, although it was not yet allocated, it was earmarked for allocation. He also confirmed that, in respect of the £1.9m cost savings target shortage, cover had been made for this by offsetting additional non recurring savings against other budgets.

In response to a question concerning the additional underspend arisen due to off patent price reductions in respect of the NHS Board's prescribing cost savings target of £16.5m, Mr James confirmed that these reductions were greater than anticipated in the financial plan. As such, these budgets had been reallocated and, as a result, for the year to date, overall prescribing expenditure now continued to be reported as running in line with budget. In terms of the allocation of this underspend, Mr James referred to the

detailed discussion that had taken place at the NHS Board seminar where it was confirmed that 60% of the underspend had been allocated for non recurring projects and 40% for operational expenditure. Dr Kapasi added that this underspend was a fortuitous saving for the NHS Board. Mr James agreed.

NOTED**14. PATIENTS' PRIVATE FUNDS – ANNUAL ACCOUNTS 2011/12**

A report of the Director of Finance [Board Paper No. 13/08] asked the NHS Board to adopt and approve for submission to the Scottish Government Health Directorates the 2011/12 Patients Private Funds Annual Accounts for NHS Greater Glasgow and Clyde.

Mr James advised that the NHS Board held the private funds of many of its patients, especially those who were in long term residence and who would have no ready alternative for the safe-keeping and management of their funds. Each of the Board's hospitals had arrangements in place to receive and hold and, where appropriate, manage the funds of any patients requiring this service. Any funds that were not required for immediate use were invested to generate interest which was then distributed to the patients' accounts based on each individual's balance of funds held

NHS Boards were required to submit audited annual accounts for these funds in the form of an Abstract of Receipts and Payments to the Scottish Government Health Directorates. The funds had been audited and now required NHS Board approval prior to the auditors then signing their report, which had no qualifications.

In terms of process, Mr Finnie suggested that these funds, in future, be approved by the NHS Board's Audit Committee rather than being considered by the NHS Board. This was agreed

**Director of Finance**DECIDED

1. That the Patients' Private Funds Annual Accounts for 2011/12 be adopted and approved for submission to the Scottish Government Health Directorates.
2. That the Director of Finance and Chief Executive be authorised to sign the Abstracts of Receipts and Payments for 2011/12.
3. That the Chair and Director of Finance be authorised to sign the Statements of Board Members' Responsibilities for 2011/12
4. That the Chief Executive be authorised to sign the Letter of Representation to KPMG LLP on behalf of the NHS Board.

**Director of Finance****Director of Finance/Chief Executive****Chair/Director of Finance****Chief Executive****15. 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. 13/09] 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 one Medical Practitioner 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**

**16. INDEPENDENT CONTRACTORS – ESTABLISHING POWERS TO CREATE PANEL HEARINGS**

A report of the Head of Board Administration [Board Paper No. 13/10] asked the NHS Board to establish panels to act on its behalf in terms of the powers to consider any cases for the suspension of independent practitioners on the NHS Board's lists.

Mr Hamilton summarised the regulations governing independent practitioners which determined the arrangements for the provision of general medical, dental and optometric services and the management of their respective NHS Board lists. The NHS Board was required to agree an appointment process for a panel to act on its behalf to carry out the functions defined in the relevant regulations.

DECIDED

- That the NHS Board, under the relevant regulations governing independent contractors, establish panels to act on its behalf in terms of the powers to consider any cases for the suspension of independent practitioners on NHS Board lists (general medical practitioners, general dental practitioners and opticians).
- That the NHS Board delegate to the chair of the NHS Board, authority to appoint three non executive members of the NHS Board who have had experience in disciplinary and grievance appeal hearings, to form a panel to consider any case to suspend an independent practitioner under the relevant regulations.

**Head of  
Board  
Administration**

**Chair**

**17. AREA CLINICAL FORUM MINUTES: 6 DECEMBER 2012**

The Minutes of the Area Clinical Forum meeting held on 6 December 2012 [ACF(M)12/06] were noted.

NOTED

**18. PHARMACY PRACTICES COMMITTEE MINUTES: 28 NOVEMBER 2012 AND 11 DECEMBER 2012**

The Minutes of the Pharmacy Practices Committee meetings held on 28 November 2012 [PPC(M) 12/06] 11 December 2012 [PPC(M)12/07] were noted

NOTED

**19. QUALITY AND PERFORMANCE COMMITTEE MINUTES: 15 JANUARY 2013**

The Minutes of the Quality and Performance Committee meeting held on 15 January 2013 [QPC(M)13/01] were noted.

NOTED

**20. AUDIT COMMITTEE MINUTES: 4 DECEMBER 2012 AND 22 JANUARY 2013**

The Minutes of the Audit Committee meetings held on 4 December 2012 [A(M) 12/06] and 22 January 2013[A(M)13/01] were noted.

NOTED

The meeting ended at 12.20pm