NHSGG&C(M)13/02
Minutes: 21 - 39

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 April 2013 at 9:30a.m.**

PRESENT

Mr I Lee (in the Chair)

Dr J Armstrong	Dr M Kapasi MBE
Dr C Benton MBE	Councillor A Lafferty
Mr R Calderwood	Councillor M Macmillan
Mr G Carson	Councillor J McIlwee
Ms R Crocket	Ms R Micklem
Mr P Daniels OBE	Councillor M O'Donnell
Prof A Dominiczak	Dr R Reid
Mr R Finnie	Councillor M Rooney
Mr I Fraser	Mr D Sime
Mr P James (to Minute No 27)	Mr K Winter

Mr B Williamson

IN ATTENDANCE

Dr S Ahmed	Consultant, Public Health Medicine (For Min No 30)
Ms S Gordon	Secretariat Manager
Ms J Grant	Chief Operating Officer, Acute Services Division
Mr J C Hamilton	Head of Board Administration
Ms S Laughlin	Head of Inequalities and Corporate Planning (for Min No 31)
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

21. APOLOGIES AND WELCOME

Mr Lee reported that the NHS Board Chair, Mr Robertson, had had a cycling accident on Sunday 14 April 2013. Mr Lee (Vice Chair, NHS Board), on behalf of the NHS Board, wished Mr Robertson well in his recovery.

Mr Lee sought and received NHS Board approval to change the running order of the agenda items to allow Item Number 12 "Financial Monitoring Report for the 11 Month Period to 28 February 2013" to be considered after "Matters Arising from the Minutes" to allow Mr P James to attend a meeting in Edinburgh.

Apologies for absence were intimated on behalf of Ms M Brown, Dr L de Caestecker, Councillor M Kerr, Mr A Robertson, Rev Dr N Shanks and Mrs P Spencer.

NOTED

22. 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

23. CHAIR'S REPORT

(i) On 22 February 2013, Mr Lee, along with other NHS Board non-executive members, visited the Vale of Leven Hospital. Members visited a rehabilitation ward and saw progress being made with the building of the new Alexandria Health and Care Centre.

(ii) Dr R Reid, as Chair of the NHS Board's Organ Donation Committee, provided an overview of organ donation activities both NHS Scotland-wide and, more locally, throughout NHSGGC. He highlighted the massive amount of work ongoing across the NHS Board's area to maximise organ donation and thanked all staff involved paying particular tribute to his predecessor, Mr R Cleland. He outlined the "Respect My Dying Wish" campaign undertaken by the NHS Board to highlight the importance in telling family and friends about the intention and wish to donate so that opportunities were not lost. As such, he made a plea to all NHS Board Members to consider entering their details on the Organ Donation Register and to take the opportunity to discuss this with their families. He concluded by thanking all those families who had agreed to proceed with organ donation, often in difficult/or tragic circumstances.

In response to a question from Dr Kapasi, Dr Reid agreed that if someone died at home it was often difficult to get an organ donation team there in time to retrieve "live" organs. He confirmed, however, that heart valves, corneas and bones could still be donated some time after a person's death so there was still the opportunity to donate.

(iii) Mr Lee asked the NHS Board to note receipt of the following petitions:-

Petition to save the Glasgow Homeopathic Hospital - "Please don't withdraw funding from the Glasgow Homoeopathic Hospital at a time when homeopathy is becoming more popular than ever. Patients want to continue using these homeopathic services and the hospital is part of our great British homeopathic heritage. The Glasgow Homoeopathic Hospital is the last homeopathic hospital in Europe to offer in-patient beds. Homeopathy represents excellent value for money and helps lift the burden of the overstretched services of the NHS". Signed by 4,400 people**.**

RAH Parking Petition - Corsebar and District Residents Association (CADRA) – "We, the undersigned, request the Greater Glasgow and Clyde NHS Board restore safety and the loss of amenity to our community, caused by their car parking policy using our streets as an overspill car park, by expanding the on-site parking capacity at the Royal Alexandra Hospital by an additional 300 spaces". 303 signatures.

(iv) Mr Lee recorded that Councillor J Handibode had resigned from the NHS Board. He acknowledged his appreciation of (and the valuable contribution made by) Councillor Handibode throughout his twelve year tenure.

NOTED

24. CHIEF EXECUTIVE'S UPDATE

(i) In acknowledging receipt of a petition noted earlier in the Chair's Report, Mr Calderwood explained that a number of NHS Boards in Scotland had started a consultation exercise to stop making referrals to the Homeopathic Hospital. He reminded the NHS Board that, in 2005, it made a decision to maintain the Homeopathic Hospital. NHSGGC's position, therefore, was that no further consultation would be undertaken at this time. He acknowledged, however, that if other NHS Boards ceased to refer patients to the Homeopathic Hospital, then the consequence was that funding would decrease and a decision may have to be made, at that time, whether NHSGGC could increase its funding contribution to continue to ensure the Homeopathic Hospital was viable. In response to a question, Mr Calderwood confirmed that the NHS Boards consulting on this, at the moment, were NHS Lanarkshire, NHS Lothian and NHS Highland. NHSGGC would await the outcome of these consultations prior to debating this matter any further.

(ii) On 21 February 2013, Mr Calderwood and senior colleagues met with the Scottish Public Services Ombudsman, Mr J Martin. This provided an opportunity for the Ombudsman to outline some of the findings from his Department in relation to the handling of complaints across NHSGGC. It was also hoped that there would be an opportunity in the future for shared learning between staff at the Ombudsman's office and staff handling complaints in NHSGGC.

(iii) On 13 March 2013, Mr Calderwood and Ms Grant attended to provide evidence at the Public Audit Committee to discuss the use of Social Unavailability Codes and the general management of waiting lists. That afternoon, the NHS Board held its annual corporate event and received a thought-provoking presentation from counterparts in NHS England which allowed the reflection and context-setting for NHS Scotland. Also discussed was the Health and Social Care integration and recommendations from the Francis Report.

(iv) On 18 March 2013, Mr Calderwood and senior colleagues, alongside the NHS Board Chair, attended a meeting with Jackie Baillie MSP and colleagues to discuss the Clinical Services Review and its impact on the Vale of Leven Hospital. This provided an opportunity for Mr Calderwood to reaffirm the NHS Board's support to the vision for the Vale of Leven and to talk through the impact on the Vale of Leven Hospital as the Clinical Services Review progressed. There was a concern expressed at the meeting that there was a "gap" for those who resided in the North West in terms of access to A&E Departments. Mr Calderwood confirmed that this matter would be considered and emphasised that, as the Clinical Services Review was still in its planning stages, no final decisions had been made. He reported, however, that the Cabinet Secretary for Health and Wellbeing had encouraged NHSGGC not to be inhibited by existing boundaries when considering proposals.

(v) On 19 March 2013, Mr Calderwood hosted a Commonwealth visit on behalf of Common Purpose UK. The participant group was fascinated to learn about NHSGGC and it provided an opportunity to compare this with healthcare in their own countries.

(vi) Mr D Loudon had been appointed to the post of Project Director South Glasgow Hospitals Development – Director of Facilities and Capital Planning – Designate. Mr Loudon would replace Mr A Seaborne, the current Project Director, who was due to retire in July 2013. Later on in the year, Mr Loudon would then also take on the role of Director of Facilities and Capital Planning – Designate, replacing Mr A McIntyre, the current Director who was also retiring.

(vii) On 27 March 2013, Mr Calderwood was a guest at the official opening of the Gleniffer Outreach Building within the grounds of the Royal Alexandra Hospital. This development would offer advice and support to patients and their families dealing with a life-limiting illness and was officially opened by the Cabinet Secretary for Health and Wellbeing, Mr A Neil MSP.

(viii) On 5 April 2013, Mr Calderwood met with Corsebar and District Residents Association (CADRA) to discuss their concerns about on-road car parking outwith the Royal Alexandra Hospital grounds. Mr Calderwood sympathised with residents who lived in close proximity to the Royal Alexandra Hospital and who were experiencing overspill onto their roads. CADRA's suggestion had been made to build a 300-space multi-storey car park on site but Mr Calderwood acknowledged the significant investment this would require on the part of the NHS Board. The NHS Board did not retain spare funding and its Capital Programme was currently fully committed. The NHS Board's budget was allocated to support quality patient care and to pursue such a suggestion might mean taking money away from alternative projects deemed to be a higher priority. Mr Calderwood reaffirmed that it was the NHS Board's intention to continue to monitor the situation on a regular basis and to work with the local Council to attempt to resolve the situation.

Councillor MacMillan welcomed the NHS Board's commitment to work with the Council to alleviate the concerns of local residents. Mr Calderwood also gave a commitment to reinforce the message to staff to be respectful of residential areas across hospital sites. Mr Williamson added that over-and-above this particular issue, there may be safety issues for staff having to park further away from their work base site and with day care treatments increasing, it was likely that this would have a resultant impact on demand for car parking for staff, patients and visitors. Given the overall interest in car parking in general, it was agreed that this form a future discussion item for members where it could be discussed in further detail.

Director of Corporate Planning and Performance

NOTED

25. MINUTES

On the motion of Dr M Kapasi, seconded by Dr R Reid, the Minutes of the NHS Board meeting held on Tuesday, 19 February 2013 [NHSGG&C(M)13/01] were approved as an accurate record and signed by the Vice Chair.

NOTED

26. MATTERS ARISING FROM THE MINUTES

The rolling action list of matters arising was noted.

Councillor Rooney asked about the NHS Board's plans to support the Commonwealth Games in 2014. Mr Calderwood confirmed that the NHS Board was in regular dialogue with the Commonwealth Games Medical Advisory Group and colleagues had been to London to get a debrief on the Olympics arrangements. The priority for NHSGGC would be to retain "business as usual services". Mr Calderwood reported that at the present time it appeared approximately 300 members of staff had volunteered to assist with the Commonwealth Games and the NHS Board was waiting to hear if they had been successful and, following that, to identify any associated risks of strain on the service.

Mr Calderwood suggested that Dr de Caestecker brief the NHS Board more fully on the business continuity plans for the Commonwealth Games 2014 later in the autumn. This suggestion was welcomed. **Director of Public Health**

NOTED

27. FINANCIAL MONITORING REPORT FOR 11 MONTH PERIOD TO 28 FEBRUARY 2013

A report of the Director of Finance [Board Paper No 13/16] asked the NHS Board to note the financial performance for the first eleven months of the year.

Mr James explained that the NHS Board was currently reporting an expenditure out-turn £0.5m below its budget for the first eleven months of the year. At this stage, therefore, 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 28 February 2013, the NHS Board was running around £2.2m behind its year-to-date cost savings target against original plans 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 had been one of the key factors in determining whether the NHS Board would achieve a break-even out-turn for the year.

In response to a question from Councillor Rooney, Mr James confirmed that, as reported to the February 2013 NHS Board, cover had been made for the £1.9m cost savings target shortage by offsetting additional non-recurring savings against other budgets. Councillor Rooney asked whether, in the NHS Board's final report for the financial year, it would be possible to see all the movements throughout the year in respect of over and under-budgeted allocations and the associated impact of these. Mr James alluded to the discussion that had taken place at a recent NHS Board Seminar around this but agreed that it could be provided for the next Financial Monitoring Report. **Director of Finance**

NOTED

28. SCOTTISH PATIENT SAFETY PROGRAMME UPDATE

A report of the NHS Board's Medical Director and Head of Clinical Governance [Board Paper No 13/11] 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 explained that the intention was to build outcome-based measures that would indicate the progress in improving the safety of the NHS in Scotland. She alluded to the family of programmes, each expected to make a contribution to creating a safer NHS. The Acute Care Programme was the initial focus of SPSP and the mainstay of reporting to the NHS Board over the last year. The various Board Leads were not receptive to the idea that there would be Acute Care 2, recognising that any new work should be seen as a continuation of the existing programme rather than branded distinctly.

Dr Armstrong explained that the latest member of the family was the Maternal Care Quality Improvement Collaborative, known as McQIC. It was an umbrella term that contained the established paediatric programme, neonatal programme and a recently established maternal care programme. Dr Armstrong led the NHS Board through details of the recent National Learning Session and update on the approach to Programme

Implementation and Progress, highlighting the aims and focus of work for the maternity stream of the collaborative. She summarised the current position and explained that the Clinical Governance Support Unit was working with the Women and Children's Directorate to develop an implementation plan to outline the arrangements to support delivery of the Change Package and aims across the three sites. This would detail the roles of the Maternity Champions, links the Clinical Governance Support Unit Team and reporting requirements both internally in NHSGGC and nationally.

In response to a question from Councillor O'Donnell concerning caesarean section births, Dr Armstrong reported that it was not yet clear if there would be an aim linked to reducing elective caesarean sections but she agreed that taking account of women's choice was pertinent hence the focus on patient experience and explicit aim to reflect this.

For future reports, Ms Micklem asked that a glossary be added explaining technical and/or medical terms. **Medical Director**

Mr Williamson commended the SPSP outcomes and the fact that it was now extending into other areas such as maternity care. At CH(C)P level, much discussion surrounded high-risk babies being born to high-risk mothers. Dr Armstrong acknowledged that deprivation had a significant impact on outcomes. The implications of this would be taken into consideration when developing the programmes.

NOTED

29. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No 13/12] 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 (October to December 2012), NHSGGC reported 27.6 cases per 100,000 Acute Occupied Bed Days (AOBDs). NHS Scotland reported 29.9 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 April 2013 (October to December 2012) showed the rate of C.difficile within NHSGGC as 17.8 per 100,000 occupied bed days in over 65s. This clearly placed the NHS Board below the national mean (26.7 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.

For the last available quarter (October to December 2012), there were no inpatient surgical site infections (SSI) detected for knee anthroplasty and reduction of long bone fracture procedures, however, the SSI rate for hip anthroplasty, repair of neck of femur

and caesarean section procedures were above the national average although remained within 95% confidence intervals.

The Cleanliness Champions Programme was part of the Scottish Government's Action Plan to combat HAI within NHS Scotland. To date, NHSGGC had supported 2,900 members of staff who were now registered as Cleanliness Champions.

Dr Armstrong alluded to one unannounced Healthcare Environment Inspectorate (HEI) inspection. On 17 December 2012, the HEI inspected Inverclyde Royal Hospital. She summarised the Inspectorate's key findings and recommendations made from this visit.

NOTED

30. MAJOR DEVELOPMENT TO IMMUNISATIONS PROGRAMMES IN SCOTLAND – IMPLICATIONS FOR NHSGGC

A report of the Director of Public Health [Board Paper No. 13/13] asked the NHS Board to receive and note major developments to immunisation programmes in Scotland and their associated implications for NHSGGC.

Dr Ahmed explained that immunisation policy in the UK was determined by the UK Health Ministers and devolved administrations with advice from the Independent Expert Advisory Group, the Joint Committee on Vaccination and Immunisation (JVCI). Over the last few years, there had been a number of recommendations from the JVCI to extend the childhood, adolescent and adult immunisation programmes in the UK. In December 2012, the Scottish Government, along with other UK administrations, announced that there would be a major development to immunisation programmes in the UK starting from July 2013. Dr Ahmed summarised these as follows:-

- Adding Rotavirus vaccination to the Universal Childhood Vaccination Programme from July 2013.

- Offering Meningococcal C-Vaccine to adolescents with a concomitant decrease in the number of doses offered to infants from two to one. This also included a catch-up programme for 4/5 years for those young people entering higher education who would otherwise miss out on the programme.

- Introducing Herpes Zoster (shingles) vaccine for all those aged 70 years with a catch-up for 70-79 years. The routine programme would start in September 2013 but the catch-up would be completed over a 4-5 year period (to be decided) starting from September 2013.

- Extending the Seasonal Flu Immunisation Programme to all children and young people aged 2-16 years.

Dr Ahmed reported that these developments would have wide-ranging implications for the NHS in Scotland as well as locally within NHSGGC. The number of people being offered a vaccination each year would double in Scotland from approximately one million to approximately two million once these new programmes were fully implemented. Dr Ahmed led the NHS Board through a summary and timescale for introduction of each of the four vaccinations, explaining the rationale for the programmes and expected benefits to public health.

Nationally, a number of working groups had been set up to plan and implement these new programmes in Scotland with a number of staff from NHSGGC representing Public Health and School Health. Furthermore, CH(C)P management attended these National

Groups. In NHSGGC, planning to implement these programmes was coordinated by the Directorate of Public Health with support from colleagues in CH(C)Ps and other services. A number of issues and workstreams had been identified and these were currently being addressed, both locally and nationally with colleagues within the NHS and Local Authorities.

Dr Ahmed highlighted that the Scottish Government had intimated that costs for all new vaccines would be funded and procured centrally by the Government for the new programmes. It had further intimated that all other costs related to the delivery of the programmes including remuneration of GP Practices, would need to be funded by NHS Boards from their existing general allocations. The detailed delivery costs for these programmes in NHSGGC were currently being worked on and finalised by the various Service Delivery Planning Groups set up locally.

Given the current measles outbreak in Swansea, Wales, Dr Ahmed summarised measles incidence and uptake of the MMR Vaccination in all four countries in the United Kingdom. Scotland performed well in its MMR uptake rate and Dr Ahmed explained that a local media campaign in Swansea discouraged the uptake of the MMR Vaccination and Swansea saw a significant dip in its uptake.

In response to a question from Councillor Lafferty regarding a vaccination for chickenpox, Dr Ahmed confirmed that one did exist but, given the other vaccinations given to children and their prioritisation, it had not been introduced in the UK. Furthermore, chickenpox was not regarded life-threatening for children.

Dr Benton asked about the shingles vaccination available to those aged 70 years plus. Dr Ahmed confirmed that anyone could get the shingles vaccination (particularly if considered to have a condition that depressed the immune system either due to disease and/or treatment) but that, given that increasing incidence with age was thought to be associated with age-related waning of immunity, this group had been targeted. Dr Kapasi wondered if 70 year olds who had already had shingles would also be eligible for the vaccination. Dr Ahmed responded in the affirmative.

Ms Micklem wondered about the use of "live" vaccinations. Dr Ahmed acknowledged that a priority with this was in getting the communications message across confidently. He reiterated that no "live" vaccination could cause the infection itself. In response to a further question from Ms Micklem concerning the flu vaccination, Dr Ahmed explained that the pilot and partial implementation was due to start in October 2013 with full implementation by October 2015. To date, the Scottish Government had not finalised arrangements regarding the policy so it had not yet been fully costed.

In response to a question from Mr Williamson, Dr Ahmed agreed that a clinician could prescribe a vaccination to anyone who may benefit – the vaccinations being described in the paper were those relating to the Public Health Programme.

In response to a concern about the financial implications for NHSGGC, Ms Renfrew reported that this would be covered in the Financial Plan Paper to be considered at the May 2013 Board Seminar alongside the other policy decisions. Mr Finnie welcomed this and, given that it was NHS Scotland Policy, recognised that the NHS Board needed to budget for these programmes from existing resources.

NOTED

31. EQUALITY LEGISLATION

A report of the Head of Inequalities and Corporate Planning [Board Paper No. 13/14] asked the NHS Board to approve the Equality Scheme 2010-2013, Final Monitoring

Report and approve the content of "A Fairer NHSGGC: Meeting the Requirements of Equality Legislation 2013-16".

Ms Laughlin explained that NHSGGC was bound by the general public sector Equality Duty introduced as part of the Equality Act 2010. In addition, secondary legislation, the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 was introduced conferring specific duties on public bodies.

Ms Laughlin led the NHS Board through the strands of equalities work, explaining that, once approved, the report would be published by 30 April 2013 on the NHSGGC website and, in limited numbers, in hard copy in order to comply with the timescales set out under the specific duties. Ms Laughlin summarised the activities of both strands as follows:-

- Equality Scheme 2010-13 Final Monitoring Report – In line with previous monitoring reports, the Final Monitoring Report was constructed in two parts. Firstly it considered progress in integrating and understanding of the general duty into mainstream organisational activity such as planning, performance, service management and service redesign. As part of this, it highlighted exemplar work that was being carried out across NHSGGC, progress on the introduction of Inequalities Sensitive Practice and progress towards a more diverse workforce which was supported and trained to respond effectively to inequalities and discrimination. Secondly, Ms Laughlin described how the report noted progress against the Action Plan, using a pre-agreed set of yearly milestones as the marker. Overall the report indicated that the response by NHSGGC to the Equality Act 2010 remained proportionate and relevant to the size and nature of the organisation and that there had been further incremental progress over the course of the previous year. Most of the identified milestones had been reached and it was possible to see that progress was being translated into tangible outcomes for NHSGGC's population.

- A Fairer NHSGGC: Meeting the Requirements of Equality Legislation, 2013-16 – The purpose of this report was to meet the requirements of the specific duties, specifically to report on progress towards mainstreaming of equality into core business, to present a set of agreed Equality Outcomes, to provide an Equal Pay statement and to highlight the diverse composition of the workforce. Ms Laughlin highlighted that the overview of progress in mainstreaming reflected the changes that had been delivered within NHSGGC as the result of the two previous equality schemes. The equality outcomes had been identified on the basis of internal and external evidence which indicated further explicit activity needed to be taken forward to address the needs of certain protected characteristics and also to strengthen compliance with the three general duties.

Ms Micklem commended the report but referred to the volume of evidence that suggested there were still major issues and work to be done to address inequality and discrimination. She reiterated that the documents sent a strong message that NHSGGC staff would challenge and remove discrimination in its services to ensure they were transparently fair and equitable for everyone. In accepting that this was no easy task, Ms Micklem wondered if it would be possible to publish, in greater detail, the data associated with the measures used to track progress on equality. Ms Laughlin agreed to consider how this data might be made more visible.

Head of Inequalities and Corporate Planning

In response to a question concerning the Equality Impact Assessments (EQIA) undertaken locally in NHSGGC, Ms Laughlin described the number of phases undertaken during the process of implementing the EQIA programme. She was

confident that these had made a difference to policy and services across NHSGGC. A more refined system now ensured that each EQIA was followed up after six months of completion to identify progress against agreed actions. This information would be available on the NHS Board's equality website. The latest phase of the EQIA programme was designed to ensure that strategic developments and subsequent service redesigns were subject to EQIA.

Dr Benton referred to the demographic profile of the workforce of NHSGGC and, in particular, those employees who disclosed a disability. At 0.5%, she wondered if this was a true reflection. Ms Laughlin referred to the limitations in the way this data was obtained and that scrutiny of other data such as that held by Occupational Health was providing a more comprehensive picture. In terms of going forward, NHSGGC was about to launch a Disability Awareness Campaign with its focus on staff to stimulate debate and discussion and to give managers confidence to deal with staff who may have a disability. Furthermore, NHSGGC recently retained its 2 Ticks accreditation.

Mr Lee thanked Ms Laughlin and noted her imminent retiral from the NHS. He thanked her for her enthusiasm and commitment in taking forward the equalities agenda throughout NHSGGC.

NOTED

32. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer [Board Paper No 13/15] asked the NHS Board to note progress against the national targets as at the end of February 2013.

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

Councillor Rooney asked if it would be possible to report on a full year's results as well as the monthly waiting times and access targets in order to identify any dips in performance. Ms Grant confirmed that this was indeed possible and she would include in future reports. **Chief Operating Officer**

In respect of the bed days occupied by patients over 65 awaiting discharge in East Renfrewshire, Ms Grant reflected on the statistics as presented and agreed there was an error. She would ensure this was rectified. **Chief Operating Officer**

Mr Daniels was concerned to note the disappointing performance in relation to the four hour target for Accident and Emergency patients. Ms Grant outlined the reasons for this reduced performance but reassured the NHS Board that those patients who breached a 12 hour wait in A&E had been actively treated by A&E staff but had not reached their final destination. Although Mr Daniels was comforted that these patients were under the care of a clinical team, he sought a full analysis of the issues. Ms Grant confirmed that Key Indicators were multi-factorial and these would be addressed by the Division. Mr Williamson added that, especially during winter months, capacity in A&E was so difficult to predict.

NOTED

33. QUARTERLY REPORT ON COMPLAINTS – 1 OCTOBER TO 31 DECEMBER 2012

A report of the Nurse Director [Board Paper No 13/17] asked the NHS Board to note the quarterly report on complaints in Greater Glasgow and Clyde for the period 01 October to 31 December 2012 and note extracts from the Information Services Division (ISD) Annual Report 2011/12.

Ms Crocket led the NHS Board through the detail presented on complaints received and completed in the quarter, confirming that an overall NHSGGC Complaints Handling Performance of 72% of complaints responded to within 20 working days had been achieved. She alluded to the format of the report which now provided a breakdown of completed complaints by Directorate, CH(C)P, Acute Hospital Location and CH(C)P Service Areas. Further refinements would continue so that more detail was provided showing complaints per speciality/ward area together with any requirement for exception reporting to explain any anomalies or actions undertaken as a result of highlighting where specific problems may have arisen. This approach was welcomed.

In reviewing some of the service improvements as a result of complaints completed in the quarter, Ms Crocket described how this illustrated frontline actions taken to prevent a recurrence of complaint issues.

NOTED

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

A report of the Head of Board Administration [Board Paper No. 13/18] asked the NHS Board to approve, note and agree any revisions to the governance arrangements in place within NHS Greater Glasgow and Clyde.

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

In response to the launch of the Quality Strategy and the need to embed its requirements within corporate reporting and governance structures, the NHS Board had considered an integrated approach to performance reporting and established the Quality and Performance Committee from July 2011 to carry out these functions.

Mr Hamilton reported that this year's review had not included the outcome of the review of Standing Financial Instructions (SFIs). The Director of Finance was carrying out a fundamental review of the SFIs and schemes of delegation and intended that his final report and recommendations be submitted to an NHS Board meeting later in the calendar year for consideration.

Mr Hamilton led the NHS Board through the changes which provided a solid governance framework for the NHS Board properly to discharge its responsibilities and statutory functions. The Audit Committee, at its meeting on 26 March 2013, reviewed the paperwork associated with the Annual Review of Corporate Governance and was

content with the changes submitted and endorsed the arrangements for the NHS Board's consideration. It did ask that the Fraud Policy be included as part of the documents to be considered as part of the Annual Review. It was agreed, however, that the revised Fraud Policy be discussed with the Area Partnership Forum in the first instance and, thereafter, be submitted to the NHS Board for approval at the end of that process. **Director of Finance**

DECIDED

(i) That the Standing Orders for the Proceedings and Business of the NHS Board and the Decisions Reserved for the NHS Board [Appendix 1] be approved. **Head of Board Administration**

(ii) That the remits of the Standing Committees – Quality and Performance Committee [Appendix 2], Audit Committee [Appendix 3], Pharmacy Practices Committee [Appendix 4] and Area Clinical Forum [Appendix 5] be approved. **Head of Board Administration**

(iii) That the memberships of the Standing and Subcommittees [Appendix 6] be approved. **Head of Board Administration**

(iv) That the membership of the Adults with Incapacity Supervisory Body [Appendix 7] be approved. **Head of Board Administration**

(v) That the list of Authorised Officers to sign Healthcare Agreements and related contracts [Appendix 8] be approved. **Head of Board Administration**

35. MENTAL HEALTH (CARE AND TR EATMENT) (SCOTLAND) ACT 2003: LIST OF SECTION 22 APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No. 13/19] 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 five 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**

36. AREA CLINICAL FORUM MINUTES: 7 FEBRUARY 2013

The Minutes of the Area Clinical Forum meeting held on 7 February 2013 [ACF(M)13/01] were noted.

NOTED

37. PHARMACY PRACTICES COMMITTEE MINUTES: 14 MARCH 2013

The Minutes of the Pharmacy Practices Committee meeting held on 14 March 2013 [PPC(M)13/01] were noted.

Mr Daniels alluded to concerns with advice given from the National Appeals Panel concerning how the NHS Board's Pharmacy Practices Committee conducted its business. Advice was being sought from the Central Legal Office.

NOTED

38. QUALITY AND PERFORMANCE COMMITTEE MINUTES: 19 MARCH 2013

The Minutes of the Quality and Performance Committee meeting held on 19 March 2013 [QPC(M)13/02] were noted.

NOTED

39. AUDIT COMMITTEE MINUTES: 26 MARCH 2013

The Minutes of the Audit Committee meeting held on 26 March 2013 [A(M) 13/02] were noted.

NOTED

The meeting ended at 12.15pm