

NHSGG&C(M)13/04

Minutes: 63 - 80

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, 20 August 2013 at 9:30a.m.**

PRESENT

Mr A O Robertson (in the Chair)

Dr J Armstrong	Councillor A Lafferty
Dr C Benton MBE	Mr I Lee
Ms M Brown (To Minute No71)	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
Councillor M Devlin	Councillor M Rooney
Prof A Dominiczak	Rev Dr N Shanks
Mr P James	Mr D Sime
Dr M Kapasi MBE	Mr B Williamson (To Minute No 76)

Mr K Winter

IN ATTENDANCE

Mr G Archibald	Director, Surgery and Anaesthetics, Acute Services Division
Dr H Cameron	Chair, Area Clinical Forum
Dr E Crichton	Consultant in Public Health
Ms S Gordon	Secretariat Manager
Mrs A Hawkins	Director, Glasgow City CHP
Mr A McLaws	Director of Corporate Communications
Mr I Reid	Director of Human Resources

ACTION BY

63. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Dr L De Caestecker, Mr R Finnie, Mr I Fraser and Councillor M Kerr.

NOTED

64. 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

65. CHAIR'S REPORT

- (i) On 4 July 2013, Mr Robertson visited the last of 2012's Chairman's Award Winners. This was the triage nurses from the Women's and Children's Directorate based at the Southern General Hospital. Mr Robertson was hugely impressed with the nurses' enthusiasm and commitment to both their patients and NHSGGC.
- (ii) On 25 July 2013, Mr Robertson visited the new Vale of Leven Centre for Health and Care. This was a state-of-the-art centre which ensured a clear focus on the provision of excellent and continuously improving health and care services in the Vale of Leven area.
- (iii) On 26 July 2013, Mr Robertson and Mr Calderwood attended the funeral of Sir Thomas Thompson who had been the Chairman of Greater Glasgow Health Board from 1987 to 1993.
- (iv) On 5 August 2013, Mr Robertson reviewed over 160 nominations for the 2013 Chairman's Awards. The nominations were of a very high calibre and it was proving difficult to narrow them down to winners. All were to be congratulated on their excellent contribution to their work / teams locally but also to the wider NHSGGC.
- (v) On 15 August 2013, Mr Robertson visited the Royal Alexandra Hospital (RAH) to gain a fuller understanding of their pathway for medical receiving. On the afternoon of 15 August 2013, Mr Robertson and other non-executive NHS Board members visited the Sandyford Sexual Health and Genitourinary Service which had proved to be a very informative visit and greatly appreciated by staff there.
- (vi) Mr Robertson formally launched the Code of Conduct and Whistleblowing arrangements which not only committed the NHS Board to openness and transparency but also offered protection, encouragement and reassurance to staff that their concerns would be treated seriously at the highest level. Mr Robertson reported that the revised Code of Conduct for Staff was now available on Staffnet and covered fraud, bribery, register of interests for staff and the revised whistleblowing arrangements. He explained that whistleblowers played a crucial role in holding the NHS to account through raising concerns about conduct by colleagues which they believed to be malpractice or illegal. These included suspicions that patient care had been compromised or that a colleague was involved in theft, bribery or a conflict of interest. The Code would be conveyed to all staff via various communication links. Mr Sime welcomed the launch of the revised Code of Conduct which had been discussed at the Area Partnership Forum and met best practice.

NOTED

66. CHIEF EXECUTIVE'S UPDATE

Mr Calderwood reported that, since the last NHS Board meeting, he continued to be involved with a series of meetings with the Scottish Government Health Directorate (SGHD) and the Local Authorities to progress the Integration of Health and Social Care agenda. Although the Bill remained in draft form, much work was ongoing to establish the new Health and Social Care Partnerships.

NOTED

67. MINUTES

On the motion of Dr R Reid, seconded by Mr D Sime, the Minutes of the NHS Board meeting held on Tuesday, 25 June 2013 [NHSGG&C(M)13/03] were approved as an accurate record and signed by the Chair.

NOTED

68. MATTERS ARISING FROM THE MINUTES

- (i) The rolling action list of matters arising was noted.
- (ii) In response to a question from Councillor Rooney regarding auto enrolment, Mr James confirmed that, originally, the NHS Board had forecast 24% automatic enrolment of staff to the superannuation scheme. As such, a provision of £5.9m had been made in the financial plan. Mr James reported that it was likely the NHS Board would now have to make additional provision for auto enrolment as more staff than expected remained within the superannuation scheme.
- (iii) In response to a question from Councillor O'Donnell regarding the SGHD's announcement to revise Health Board boundaries to create consistent co-terminosity between NHS Boards and Local Authorities from April 2014, Ms Renfrew reported that a Steering Group had been established with NHS Lanarkshire. She explained that a detailed report of the Steering Group would be presented to the October 2013 NHS Board meeting.

**Director of
Corporate
Planning &
Policy**

NOTED

69. SCOTTISH PATIENT SAFETY PROGRAMME

A report of the NHS Board's Medical Director and Head of Clinical Governance [Board Paper No 13/34] 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 led the NHS Board through a summary of recent activities in respect of the SPSP. She summarised the commitment made by the Scottish Government in April 2013 when it formally launched the SPSP Primary Care Programme. As part of negotiations for 2013/14, it had been agreed that all GP practices in Scotland would be invited to take part in SPSP activity. This took the form of 11 Quality and Outcome Frameworks (QOF) looking specifically at a safety climate survey within clinical teams and using the trigger tool to identify previously undetected evidence of patient safety incidents and identifying learning from them. In addition to this, the NHS Board planned to continue testing during 2013/14 and had sought expressions of interest from GPs to undertake work in the following areas:-

- DMARD (disease-modifying anti-rheumatic drugs);
- Outpatient communication;
- Records handling;
- Medicines reconciliation.

In addition, participating practices had been asked to identify one local safety concern of choice and must involve patients in the work to ensure that the person-centredness aspect was incorporated into the work of the programme, linking with the Person-

Centred Health and Care Programme Manager. A Service Level Agreement had been drafted and would be completed by participating practices. To date, Dr Armstrong reported that 18 practices had expressed an interest in the core programme with a closing date of 16 August 2013.

Dr Armstrong highlighted the various training that had been conducted with GPs and their staff to take forward the commitments of SPSP. She also reported that a site visit from Health Improvement Scotland (HIS) was scheduled to take place on 3 September 2013 to engage with the NHS Board around the work being progressed to date and to offer support in areas which had been identified as a challenge.

Dr Armstrong also summarised work continuing in the Acute Services Division in respect of the SPSP, highlighting the following:-

- Reliable care process for patients at risk of sepsis – the implementation of the NHSGGC Early Warning System was now complete as of July 2013. This standardised tool was key to consistent identification of patients with possible sepsis. The Acute Medical Unit had developed the first reliable process for sepsis 6 and this was now being spread to other clinical areas.
- Reliable care process for patients at risk of venous thromboembolism – this workstream was still at the testing stage and, as yet, there was no reliable process design for broader implementation.
- Developing improvement capability – the National SPSP Programme for Acute Adults was holding another learning session on 28 and 29 August. NHSGGC was currently identifying staff who could benefit or contribute to the learning collaborative to represent the NHS Board at this event, including a small group who were leading workshops.

Mr Robertson alluded to his visit to the RAH, mentioned earlier, when he had met two physicians who were SPSP Fellows. Both had given a tremendous sense of the effectiveness of the programme and how the annual recruitment to the SPSP Fellowship helped other clinicians with techniques and peer support. Dr Armstrong was pleased to report that six clinical staff from NHSGGC had been supported in applying for this important development opportunity in 2013/14.

NOTED

70. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No 13/35] 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 (January to March 2013), NHSGGC reported 26.8 cases per 100,000 Acute Occupied Bed Days (AOBDs). NHS Scotland reported 30.1 cases per 100,000 AOBDs. The revised national HEAT target required all NHS Boards in Scotland to achieve a rate of 24 cases per 100,000 AOBDs or lower by 31 March

2015. NHSGGC, therefore, failed to achieve the national 26 cases per 100,000 AOBDS target for 2013. This was extremely close, however, and Dr Armstrong confirmed that the NHS Board was only four patient cases over. This was the NHS Board's lowest AOBDS rate to date and fourth lowest in total patient numbers.

The national report published in July 2013 (January to March 2013) showed the rate of *C.difficile* within NHSGGC as 21.6 per 100,000 AOBDS in over 65s. This clearly placed the NHS Board below the national mean (24.2 per 100,000 AOBDS in over 65s). The revised HEAT target required Boards to achieve a rate of 25 cases per 100,000 AOBDS in **all** patients (previously, the target *only* included patients 65 years and over) to be attained by 31 March 2015.

For the last available quarter (January to March 2013), the surgical site infection (SSI) rate for caesarean sections and reduction of long bone fracture procedures were below the national average, however, the rate for hip arthroplasty, knee arthroplasty and repair of neck femur procedures were above the national average although all remained within 95% confidence intervals. Surveillance continued and there were no orthopaedic SSIs in April 2013.

The Cleanliness Champions Programme was part of the Scottish Government's Action Plan to combat HAI within NHS Scotland. To date, NHSGGC had supported 2,948 members of staff who were now registered as Cleanliness Champions.

In respect of hand hygiene, the latest information available, as at July 2013, recorded a figure of 93% compliance in NHSGGC. The Cabinet Secretary, however, had agreed to a change to utilising existing local hand hygiene data collection and reporting processes to include "opportunity taken", "correct technique" and identification of staff groups. That local data would also be reported via the HAIRT. As such, the National HAI Policy Unit was currently in the process of determining timescales for local reporting and issues such as local governance and local quality assurance processes and aimed to formally announce proposals to NHS Boards shortly.

Dr Armstrong highlighted some key findings from the Healthcare Environment Inspectorate (HEI) announced inspection at the Southern General Hospital on 15 and 16 May 2013 and led the NHS Board through some of the actions that would now be taken in respect of the recommendations made.

Councillor Lafferty commended the report and the work going on at local level to produce such excellent outcomes. He asked if there were any resource implications for the NHS Board to meet the further improvements demanded nationally. Dr Armstrong described existing work undertaken by the Infection Control teams particularly in educating ward staff to follow safety measures and in taking forward the "nuts and bolts" of the SPSP. As such, there were not many direct resource implications required for further improvement and/or to meet the new targets as ongoing monitoring and reviewing resulted in the policies and procedures being regularly updated.

Dr Benton referred to the eight cases of *C.difficile* recorded in June 2013 at Glasgow Royal Infirmary. Dr Armstrong reported that all cases were reviewed and, apart from the two patients in the same ward who were both previous cases and had been identified as having different ribotypes, the cases of *C.difficile* were spread throughout the hospital with no links in time or place. All infection control precautions were put in place and all patients were isolated. All cases were monitored by the Infection Prevention and Control Team and none were diagnosed as being severe cases. Facilities were asked to use chlorine-based detergent for all routine cleaning for a week and this was carried out. At the moment, microbiology were reviewing the case-notes for all the patients and the results of these were awaited.

Councillor Rooney asked how challenging it would be to meet the new SGHD targets. Dr Armstrong reported that pilots were undertaken before implementation and roll-out and she was confident, in particular areas, that improvements could be further made by looking at changes in working practice. She agreed that it would be a challenge but not an impossibility.

In response to a further question from Councillor Rooney concerning “confidence intervals”, Dr Armstrong explained that these were set by NHSGGC in order to benchmark against the national dataset and as a way of tracking performance. She confirmed that these confidence intervals had been agreed with Health Improvement Scotland (HIS).

NOTED

71. CLINICAL SERVICES FIT FOR THE FUTURE – SERVICE MODELS

A report of the Medical Director [Board Paper No 13/36] asked the NHS Board to approve the direction of travel as set out as the basis for future planning of clinical services across NHSGGC and to agree the next steps of the Clinical Services Fit for the Future programme.

Dr Armstrong led the NHS Board through the proposed service models which had emerged from the Clinical Services Fit for the Future programme and described the approach and process taken to develop these. She described how this would be used as the basis to develop detailed future plans for clinical service delivery across NHSGGC returning to the NHS Board for approval in due course.

The service models had been developed through the work of seven clinically-led groups, namely, emergency care and trauma, planned care, child and maternal health, older people’s services, chronic disease management, cancer and mental health. The clinical working groups involved patient representatives and had been supported by wider patient reference groups, involving patients, carers and voluntary groups. The output from these groups was shared at an event in April 2013 involving 180 representatives from across NHSGGC and partner organisations. Following that session, a discussion paper was produced which brought together all of the material for further engagement. The discussion paper set out the following sections which Dr Armstrong summarised for the NHS Board as follows:-

- The case for change;
- Developing the service models;
- Delivering improvements for patients;
- Service models overview;
- Service model – chronic disease and frail elderly;
- Service model – emergency and trauma;
- Service model – mental health;
- Service model – planned care;
- Service model – cancer;
- Service model – children’s services;
- Service model – maternity;
- Next steps.

Dr Armstrong reported that an integrated impact assessment considering equalities, health and human rights was carried out on the draft service models paper. It made a series of recommendations for revisions to the final paper which had been incorporated and also flagged up a range of potential benefits and risks which needed to be taken into account for the next stages of development and implementation.

Furthermore, the Scottish Health Council had been involved in the process from the start, attending the ongoing engagement events with the patient reference groups and the third sector as well as attending the event in April 2013 when the emerging service models work was shared with the wider clinical group. In addition, their officers had met with NHS Board officers to discuss the programme and to share thinking on the approach taken, feedback on their observations and to support planning for ongoing engagement. As the next stage of the programme progressed, this close engagement would be continued to ensure the approach taken was in line with Scottish Health Council guidance in relation to engagement, pre-consultation and consultation. Dr Armstrong alluded to the Scottish Health Council's commentary on patient and public engagement so far which was attached to the NHS Board paper.

There had also been extensive engagement on the service models discussion paper throughout June, July and August with general feedback being very supportive and welcoming the approach being taken to involve the whole system. A number of parts of the organisation had formally written about the proposed service models, offering comments on the direction of travel as well as giving suggestions on what it required to take this approach forward, including examples of how services could be changed and developed to support the models. These comments had been incorporated into the final version of the service models paper and into the approach described in relation to the next steps to develop the more detailed position in relation to service delivery and overall clinical strategy.

Dr Shanks commended the work undertaken so far to reach the stage of service modelling. He particularly welcomed the use of case studies which illustrated some practical patient examples of attendances/treatments received now compared with what their treatment plan would look like in the future – these were most helpful. He recognised the challenges which lay ahead regarding the practicability of implementing new proposals especially in terms of resource implications and acceptability from members of the public, political influences and staff.

Dr Kapasi agreed that the proposals were laudable but had reservations around their implementation, particularly in terms of resource implications. Many of the proposals suggested the central point as being that of the GP and/or community teams and this needed huge changes to bring all these facets together to successfully effect this type of care in a unified manner. He also erred on the side of caution when drawing comparisons with other health structures particularly in Europe as society and local structures were so different to that of Scotland.

Mr Calderwood accepted the points raised by Dr Shanks and Dr Kapasi and agreed that, fundamentally, the service models captured the distillation of current services. They also aspired to provide the best health and social care possible but, in doing so, there had to be trade-offs. As such, he agreed that there was much debate ahead with patients/public, political parties and staff. The proposals, however, represented clinical excellence and, in taking forward the integration of health and social care, all public sector resources were being brought to bear. He agreed that patient stories were a good format which highlighted likely future pathways. He commented on the Scottish Health Council's desire to engage with members of the public before a solution had been determined but cautioned that this was difficult if the future consultation was not giving people a choice. This would be for the NHS Board to debate all aspects of clinical opinion prior to the formal consultation being launched.

Mr Williamson echoed the views already made and agreed that the clinical evidence base was incontestable in that changes had to be made to deliver services in the future. The discussion paper represented an excellent starting point but he wondered whether it should include a section articulating the impact of the reduction in the NHS Board's budget, highlighting the ramifications in future services if status quo remained. He also

considered it paramount that, in taking forward these difficult discussions in the near future, professional groups work in sync with managers if they were to be successful.

Councillor Lafferty recognised the challenge that lay ahead and was supportive of the proposals, however he considered that, in the future, anticipatory care was key and services should be increasingly available on a prevention basis before people fell ill.

Dr Reid strongly supported the proposals as did Professor Dominiczak. Both recognised that it would not happen overnight and agreed that the professional workforce had to be on board quickly to take it forward and make it a success. Professor Dominiczak added that Glasgow was a great place for academic medicine and that sector also needed to be engaged early on.

Dr Crichton recognised that the main aim of the proposals was to maximise the health of the NHS Board's population. Given this, she suggested that, collectively, NHSGGC could make it happen and solutions could be found locally if staff and patients truly believed in the principles.

Councillor O'Donnell recognised that primary care services were essential in moving the review forward. Mr Robertson agreed and was hugely encouraged by the NHS Board's discussion today and delighted that NHS Board members considered the review to be a goal worth striving for.

Mr Calderwood thanked the NHS Board for the useful debate and confirmed that clinical engagement was being finalised at the moment to ensure all counter arguments were included in the consultation. Modified patient pathways would, thereafter, be outlined and various workstreams formed to debate the quality-driven issues, aspirational issues, prevention/health promotion issues as well as the application of scarce resources. Discussions would continue until the end of 2013 with a series of options presented in early 2014. The challenge, thereafter, would be to move from the consultation phase to the pilot phase to full implementation from 2020 onwards.

DECIDED

- That the direction of travel set out in the emerging service models paper, as the basis for future planning of clinical services across NHSGGC, be approved.
- That the next steps of the Clinical Services: Fit for the Future programme be agreed.

**Medical
Director**

**Medical
Director**

72. TRANSITION FROM COMMUNITY HEALTH AND SOCIAL CARE AND COMMUNITY HEALTH PARTNERSHIPS

A report of the Director of Corporate Planning and Policy [Board Paper No 13/37] asked the NHS Board to approve the approach to developing proposals for Health and Social Care Partnerships (HSCPs) outlined. Ms Renfrew described the process the NHS Board had taken with the three Local Authorities with whom fully integrated CHCPs already existed, and with the three community health partnerships (CHPs). In addition to ongoing work with the six local authorities and the respective partnerships, the NHS Board had in place an Integration Development Group involving directors from across NHSGGC. This Group was responsible for developing the approach to the emerging issues around integration including planning, finance, governance and acute services. Ms Renfrew explained that, most importantly, the Group would also lead the development of the NHS Board's approach to communication, staff engagement and cultural and organisational development as the process of shifting to HSCPs gathered momentum.

The NHS Board also continued to aim to influence the development of national policy through a number of different routes and Ms Renfrew emphasised that much of the direction and guidance which would shape the new HSCPs was still in draft or being developed, including the overall approach to governance.

Mr Sime confirmed that the Area Partnership Forum (APF) had considered the approach to developing the proposals but had been concerned to note engagement after the proposals had been put together. The APF would have welcomed the opportunity to influence the proposals in a partnership way of working. Ms Renfrew noted staff side were represented on the Integration Development Group but agreed that more detailed engagement with the APF needed to be arranged while reiterating that many outstanding issues still had to be resolved at a national level. It was due to this that there appeared to be a lack of clarity at the moment.

In response to a question from Councillor Rooney, Mr Calderwood confirmed that membership of the partnership Committees (and the exact number of members) was likely to be stipulated when the Bill was revised, particularly given concerns raised by COSLA and the NHS. The NHS Board's intention was, however, to leave flexibility within the shadow arrangements to ensure NHSGGC could accommodate any reshaping of the Bill and related regulation and guidance. Councillor O'Donnell accepted this point but considered that the NHS Board should support the principle that membership of the partnerships be determined locally. Mr Calderwood reported that he was happy that NHSGGC enter into local decisions to arrive at integration plans and governance arrangements unique to each area. This would then be submitted to the Scottish Government Health Directorate who would respond either positively or negatively thereafter. This principle was agreed with the caveat that if the Bill stipulated a different view, then the NHS Board would have to respond accordingly.

DECIDED

- That the approach to developing proposals for health and social care partnerships (HSCPs) outlined be approved.

**Director of
Corporate
Planning and
Policy**

73. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer [Board Paper No 13/38] asked the NHS Board to note progress against the national targets as at the end of June 2013.

Mr Archibald 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. He also highlighted the delayed discharge figures across NHSGGC.

In response to a question, Mr Archibald confirmed some teething problems with the Trakcare Electronic Information System as departments adapted to new ways of working. Additional staff had been put in place during the early weeks and on-site IT support provided. These issues had been addressed and recent data showed that the performance had further improved. He was confident that, going forward, these teething issues would be ironed out.

In response to a question from Councillor Macmillan, Mr Archibald confirmed that the target for patients awaiting discharge from April 2013 was four weeks.

To clarify a point raised by Ms Micklem, Mr Calderwood reported that the target for stroke was that 90% of patients admitted with a diagnosis of stroke would be admitted to a stroke unit on the day of admission or on the day following presentation. Any stratification of this target was not captured but improvement action plans were in place at each site to reinforce the stroke pathway and improve the flow of patients through stroke units. In addition, each hospital was undertaking daily and weekly monitoring of admissions and analysis of patients who breached the national target in order that all possible actions were taken to meet the national target on each site.

In response to a question from Dr Reid, Mr Archibald outlined five issues that were being progressed in an attempt to understand what key improvement measures would make the greatest impact on cancer waiting times and, in particular, the 62 day urgent referral to treatment target (which included screened positive patients and all patients referred urgently with a suspicion of cancer).

NOTED

74. FINANCIAL MONITORING REPORT FOR THE 3 MONTH PERIOD TO 30 JUNE 2013

A report of the Director of Finance [Board Paper No 13/39] asked the NHS Board to note the financial performance for the first three months of the year.

Mr James explained that the NHS Board was currently reporting an expenditure out-turn £0.9m in excess of its budget for the first three months of the year. At this, stage, however, the NHS Board considered that a year-end break-even position would be achieved. Mr James led the NHS Board through further information in relation to expenditure in Acute Services, NHS Partnerships and Corporate Services and included details of expenditure to date against the NHS Board's 2013/14 capital allocation.

Mr James answered members' questions in relation to auto-enrolment, explaining that the NHS Board had originally underestimated the uptake of this. As such, it needed to find a "top up" of £9m (£6m had already been set aside) from the fiscal planning for the NHS Board. The NHS Board would receive further information about this at the next Quality and Performance Committee meeting. On this point, Councillor Rooney reported that Local Authorities had also made estimates for staff auto-enrolment and these were being reviewed likewise.

**Director of
Finance**

NOTED

75. QUARTERLY REPORT ON COMPLAINTS – 1 APRIL TO 30 JUNE 2013

A report of the Nurse Director [Board Paper No 13/40] asked the NHS Board to note the quarterly report for the period 1 April to 30 June 2013 on complaints and their handling in Greater Glasgow and Clyde.

Ms Crocket led the NHS Board through the detail presented on complaints received and completed in the quarter, confirming that an overall complaints handling performance of 73% 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 Acute Directorate then broken down further into hospital location and, in respect of CH(C)Ps, disaggregated to 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. She alluded, in particular, to the organisational learning from a complaint regarding smokers outside the Beatson West of Scotland Cancer Centre and the resultant actions following issues raised in the complaint itself and advice from the Central Legal Office. This illustrated an example of a complaint having a direct and immediate impact on improving NHSGGC services to patients, carers and visitors.

Ms Crocket referred to the Complaints Seminar held on 14 August 2013, the purpose of which was to improve complaints handling at the Local Resolution stage, bring a focus to valuing complaints and being open and honest when responding to complaints, as well as promoting a more empathetic, compassionate and less defensive approach. The event was well attended and she would keep NHS Board members advised of the next steps in improving complaints handling in NHSGGC.

**Nurse
Director**

NOTED

76. AUDIT SCOTLAND'S ANNUAL REPORT ON THE 2012/13 AUDIT

A report of the Chair of the Audit Committee [Board Paper No. 13/41] asked the NHS Board to note the report by the external auditors, Audit Scotland, on the 2012/13 audit of NHSGGC. The report had already been reviewed by the Director of Finance and scrutinised by the Audit Committee.

Mr Winter summarised the key findings to emerge from Audit Scotland's 2012/13 audit. During the course of the year, Audit Scotland assessed the key strategic and financial risks which NHSGGC faced, they audited the financial statements and reviewed the use of resources and aspects of performance management and governance. Mr Winter set out Audit Scotland's key findings as they were presented to the Audit Committee at its meeting on 6 August 2013 and summarised these as follows:-

- The financial statements;
- The Board's financial position;
- Governance and accountability;
- Best value, use of resources and performance.

Mr Winter confirmed that the report showed the issues identified by Audit Scotland as having been considered by management and agreed actions to address them.

NOTED

77. PHARMACY PRACTICES COMMITTEE MINUTES: 3 JUNE 2013

The minutes of the Pharmacy Practices Committee meeting held on 3 June 2013 [PPC(M)13/03] were noted.

NOTED

78. AREA CLINICAL FORUM MINUTES: 6 JUNE 2013

The Minutes of the Area Clinical Forum meeting held on 6 June 2013 [ACF(M)13/03] were noted.

NOTED

79. AUDIT COMMITTEE MINUTES: 19 JUNE 2013 AND 6 AUGUST 2013

The minutes of the Audit Committee meetings held on 19 June 2013 [A(M)13/04] and 6 August 2013 [A(M)13/05] were noted.

NOTED

80. QUALITY AND PERFORMANCE COMMITTEE MINUTES: 2 JULY 2013

The Minutes of the Quality and Performance Committee meeting held on 2 July 2013 [QPC(M)13/04] were noted.

NOTED

The meeting ended at 12.20pm