

NHSGG&C(M)13/06
Minutes: 100 - 121

NHS GREATER GLASGOW AND CLYDE

**Minutes of a Meeting of the
NHS Greater Glasgow and Clyde Board
held in the Board Room, Corporate Headquarters, J B Russell House,
Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH
on Tuesday, 17 December 2013 at 9:30a.m.**

PRESENT

Mr A O Robertson OBE (in the Chair)

Dr J Armstrong	Mr I Fraser
Dr C Benton MBE	Mr P James
Ms M Brown	Dr M Kapasi MBE
Mr R Calderwood	Councillor A Lafferty
Dr H Cameron	Mr I Lee
Mr G Carson	Councillor M Macmillan
Ms R Crocket	Councillor J McIlwee
Mr P Daniels OBE	Ms R Micklem
Dr L De Caestecker	Councillor M Rooney
Councillor M Devlin	Rev Dr N Shanks
Prof A Dominiczak	Mr D Sime
Mr R Finnie	Mr K Winter

IN ATTENDANCE

Mr G Archibald	Lead Director, Acute Services Division
Mr A Finlayson	Head of IT Infrastructure
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Mrs A Hawkins	Director, Glasgow City CHP
Mr D Loudon	Project Director/Director of Facilities and Capital Planning – Designate
Mr M McAllister	Community Engagement Manager
Mr A McLaws	Director of Corporate Communications
Ms C Renfrew	Director of Corporate Planning and Policy
Mr I Reid	Director of Human Resources

ACTION BY

100. APOLOGIES

Apologies for absence were intimated on behalf of Councillor M Cunning, Councillor M O'Donnell, Dr R Reid and Mr B Williamson.

NOTED

101. 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

102. CHAIR'S REPORT

- (i) Mr Robertson commended the response from NHSGGC staff to the emergency that occurred on Friday 29 November 2013 following the Glasgow helicopter crash, in particular, the response from the Emergency Team on site and those at the Victoria Infirmary, Glasgow Royal Infirmary and Western Infirmary where casualties were received. Deputy First Minister Nicola Sturgeon and HRH Prince Charles visited Glasgow Royal Infirmary and met with staff and patients to extend their appreciation of the well rehearsed emergency response procedures that had worked well over that distressing weekend. In response to a question from Councillor Rooney, Mr Calderwood acknowledged that the chain of events had resulted in a knock-on effect of routine work being redirected to other NHSGGC sites and commended all staff who had kept the NHS Board's business-as-usual ongoing as well as dealing with the specific requirements of the incident.
- (ii) On 23 October 2013, Mr Robertson attended the opening of the Applefield Gardening Site on the Gartnavel Hospitals Campus. This was a raised bed area where Gartnavel Royal Hospital patients and staff would grow fruit, vegetables and herbs and the project would bring real benefits to patients, staff and the surrounding community given the therapeutic qualities of gardening and its mood-lifting powers for health and wellbeing.
- (iii) On 24 October 2013, Mr Robertson met with the South East Asian Anticipatory Care Project, a project delivering culturally and linguistically sensitive primary prevention health review for South Asians and supporting individuals to access a range of community health improvement services. The project was delivered by bilingual specialist pharmacists and community outreach workers working closely with GP practice teams and high concentrations of South Asian patients registered within their practices.
- (iv) On 30 October 2013, Mr Robertson attended the Excellence in Education Awards in conjunction with the University of Glasgow. Professor Dominiczak presented awards to University staff and Mr Robertson did likewise for NHSGGC clinical staff to commend their contribution to teaching.
- (v) On 11 and 19 November 2013, Mr Robertson met with the Principal of the University of Glasgow, Professor A Muscatelli, to discuss the development of the Gilmorehill Campus.
- (vi) On 25 November 2013, Mr Robertson met with Henry McLeish, Chair of the City of Glasgow College, to discuss areas of mutual interest.
- (vii) On 27 November 2013, Mr Robertson attended the formal opening of the Vale Centre for Health and Care. This new centre was officially opened by the Cabinet Secretary for Health, Alex Neil, and was one of the most modern health centres in Scotland, bringing together a variety of services delivering modern health care within a new state-of-the-art facility.
- (viii) On 6 December 2013, Mr Robertson attended the first Off-Site session where discussion surrounded the Clinical Services Review and Health and Social Care Partnership integration.

- (ix) On 13 December 2013, Mr Robertson met with PricewaterhouseCoopers (the NHS Board's internal auditor) to discuss the Board Effectiveness and Self Assessment Questionnaire. That afternoon, he also visited some wards at Glasgow Royal Infirmary that had recently been renovated.

NOTED

103. CHIEF EXECUTIVE'S UPDATE

- (i) On 21 October 2013, Mr Calderwood, alongside Mr Robertson, met with Duncan McNeill MSP to discuss ongoing NHS developments in Inverclyde.
- (ii) On 22 October 2013, Mr Calderwood attended the Lord Lieutenant Certificate Presentations held in Glasgow City Chambers to formally recognise the service of members of the Volunteer Reserve Forces (VRF) and to also thank and recognise the support which employers gave to their employees who were members of the VRF.
- (iii) On 4 November 2013, Mr Calderwood attended his first meeting of the Health Technologies at Strathclyde (HTAS) International Advisory Panel. This brought together an extensive portfolio of health research and aligned the multi-disciplinary approach to partnership research in drug discovery, medical devices, diagnostics and interventions with the needs of industry, health care providers and society.
- (iv) On 8 November 2013, Mr Calderwood met with Jackson Carlaw MSP to discuss a range of issues regarding Eastwood and East Renfrewshire.

NOTED

104. MINUTES

On the motion of Councillor M Devlin, seconded by Dr M Kapasi, the Minutes of the NHS Board meeting held on Tuesday, 15 October 2013 [NHSGG&C(M)13/05] were approved as an accurate record and signed by the Chair.

NOTED

105. MATTERS ARISING FROM THE MINUTES

- (i) The rolling action list of matters arising was noted.
- (ii) Councillor Rooney asked about staff uptake rates for the flu vaccination. Dr de Caestecker reported, rather disappointingly, that rates were not as high as hoped and, in fact, had dropped slightly from last year. The uptake rate sat at around 37% and it would be key to improve performance for next year. In response to a follow up question from Councillor Rooney, Dr de Caestecker confirmed that this low uptake did not result in any wastage of the vaccinations.

NOTED

106. SCOTTISH PATIENT SAFETY PROGRAMME

A report of the NHS Board's Medical Director [Board Paper No 13/52] 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. Having previously advised the NHS Board of a significant shift in the strategic approach to developing the Acute Adult Care programme within SPSP (one major change being the implementation of patient safety essentials), she provided an update on work to ensure initial evaluation of needs was completed and the subsequent development plans were put into action. A number of key themes had emerged in a series of strategic discussions considering an effective model of programme management. There was clear benefit in continuing the designated corporate leadership model so there was appropriate oversight and support to service implementation, however, in addition, many of the issues potentially affecting patients had been observed arising in cross-system pathways of care. Identifying organisational leads who would maintain operational oversight and leadership of each priority (and would retain a specific responsibility to ensure cross-system issues were suitably integrated into improvement plans) were, therefore, being identified. There had also been further consideration of the role of local medical leads in developing engagement and supporting local testing. Building on the experience of other NHS Boards, NHSGGC was looking to find models of protected time for medical leads and would test the value of this concept in the implementation work for deteriorating patients.

Dr Armstrong reported that, although each priority had its rationale for inclusion in the programme, local discussions had framed a specific need to prioritise work in relation to deteriorating patients. Given this, she led the NHS Board through a draft driver diagram to guide this work which addressed the aim of reducing inappropriate interventions alongside the primary and secondary drivers which would build on the existing successful work on patient observation, early warning scores and escalation of concerns that had been progressed in the first phase of the SPSP programme. She highlighted, however, that this driver diagram (as published by Healthcare Improvement Scotland) represented a significant expansion of requirements and did not include all the areas NHSGGC thought may be required in the programme. This had also increased the complexity in ensuring both the reliability of the clinical process and the coordination of inputs to ensure these were efficiently and effectively aligned to maximise the difference being made for patients and families. As such, a further scoping session was planned after which a more detailed plan could be developed.

Dr Armstrong reported that a medicines reconciliation oversight group was being established (with representation from patients, doctors, nurses and pharmacists) to oversee medicines reconciliation quality improvement activity and this would augment existing improvement activity in the Acute Services Division with a cross-system focus and improve the overall governance of SPSP implementation.

With regard to sepsis, Dr Armstrong explained that implementation of the Sepsis 6 was a key focus for its success with many teams working on this.

Ms Micklem questioned the reporting of Venous Thromboembolism (VTE) and Dr Armstrong explained that although none of the teams had yet reached reliability with all five elements for VTE (as outlined in the SPSP programme), a number could show reliability for each of the six elements in the pre-existing programme.

NOTED

107. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No 13/53] 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. This target was extended once again, and NHS Boards were required to achieve a rate of 26 cases per 100,000 Acute Occupied Bed Days (AOBDs) by April 2013. For the last available reporting quarter (April to June 2013), NHSGGC reported 27.4 cases per 100,000 AOBDs. NHS Scotland reported 29.5 cases per 100,000 AOBDs. NHSGGC, therefore, failed to achieve the national 26 cases per 100,000 AOBDs target for 2013, however, reached its lowest ever AOBDRate to date, and fourth lowest in total patient numbers. The revised national HEAT target required all NHS Boards in Scotland to now achieve a rate of 24 cases per 100,000 AOBDs or lower by 31 March 2015.

NHSGGC successfully achieved the 2013 Clodistrium Difficile HEAT target of less than 39 cases per 100,000 AOBDs in the over-65s age group. The new target for future attainment included cases in ages 15 and over and this was subsequently revised in 2013 by the Scottish Government following a change in the calculation of bed day data and now required NHS Boards to achieve a rate of 32 cases or less per 100,000 AOBDs to be attained by 31 March 2015. For the last available reporting quarter, April to June 2013, NHSGGC reported 33.5 cases per 100,000 AOBDs, combined rate for all ages. This placed the NHS Board slightly below the national average of 33.6 per 100,000 AOBDs.

For the last available quarter (April to June 2013), the surgical site infection (SSI) rate for all four orthopaedic procedure categories were below the national average, however, the rate for caesarean sections was above the national average although remained within the 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 2,991 members of staff who were now registered as Cleanliness Champions.

In respect of hand hygiene, the national campaign issued its last bi-monthly report in September 2013. Future audit schedules and the requirement to put in place a quality assurance programme had been passed to the NHS Board for action. Dr Armstrong confirmed NHSGGC had submitted its quality assurance plan to the Scottish Government and initial testing of this had commenced. This process would provide reassurance that local audits carried out by wards and departments were consistent with the methodology utilised previously.

Ms Crocket outlined the requirements and recommendations made following the Healthcare Environment Inspectorate (HEI) unannounced inspections at the Victoria Infirmary (23 and 24 July 2013) and the Western Infirmary (5 August 2013).

In response to a question from Councillor Rooney concerning one of the recommendations made from the Victoria Infirmary inspection regarding the cleaning of patient equipment, Ms Crocket reported that she had visited the ward in question to

ensure staff were conversant with NHSGGC and departmental standard operating procedures in relation to the cleaning of near patient equipment. Furthermore, leadership had changed and increased in-house unannounced inspections were now being undertaken to ensure that the requirements and recommendations from the HEI inspections were discussed at departmental meetings to facilitate local learning and implementation.

Councillor Rooney asked about the outbreak/exception reporting in October 2013 concerning ward 15 at the Vale of Leven Hospital and its increased incidence of C-Difficile. Dr Armstrong described the situation in further detail particularly regarding the four cases (three of which were hospital associated infections, two were linked while one was not, and one community). Given this, ward 15 was closed to admissions and transfers on 25 October 2013 to isolate and test the cases. The ward was reopened to admissions on Monday 4 November 2013. All patients had been isolated and recovered and no further cases had since been reported.

Dr Benton asked about the contaminated blood cultures that accounted for 13 reported SABs in quarters two and three. Dr Armstrong confirmed that these specimens were still included in national reporting figures and accounted for almost 6% of reported episodes.

NOTED

108. BUILDING MOMENTUM FOR CHANGE: BIENNIAL REPORT ON POPULATION HEALTH IN NHSGGC 2013-2015

A report of the Director of Public Health [Board Paper No 13/54] asked the NHS Board to receive the report of the Director of Public Health on population health in NHSGGC 2013-15 and to endorse the central importance of poverty and disadvantage in shaping the health of the population across the life course, supporting the recommendations for action to reduce the adverse health impact of poverty and disadvantage.

Dr de Caestecker explained that this was the fourth biennial report of the Director of Public Health. Covering the period 2013-2015, it highlighted the pivotal importance of poverty and disadvantage in shaping health at three key life stages (early years, adolescence and mature adults) and in two priority groups (looked after and accommodated young people and prisoners). The report also included a description of progress made since the previous report "With Health in Mind".

Dr de Caestecker recorded that the report would be formally launched that afternoon at an event at which Sir Harry Burns, Scotland's Chief Medical Officer, would respond. She extended an invitation to all NHS Board members to this launch event, explaining that the intended audiences for the report included, in addition to NHSGGC, wider public agencies and community planning partners who were urged to reflect carefully about potential impact on population health on all decisions about services and priorities in a time of constrained public sector budgets. Furthermore, she would present the report to a range of local events, CH(C)Ps and local authority staff and to a wide range of community groups, particularly as it was vital that the priority actions identified translated systematically and coherently into action on the ground.

Accordingly, the Public Health Directorate would use its existing inputs into the relevant internal and joint planning groups to oversee implementation of these actions with progress on implementation of the recommendations being reported at the December 2014 Board meeting.

In leading the NHS Board through the report and its 20 priorities covering:-

- supporting our most disadvantaged families
- the transitions of adolescence
- promoting healthy ageing
- getting it right for looked-after and accommodated children and young people
- developing mechanisms for sharing information
- improving health in NHSGGC's prison settings

Dr de Caestecker sought a collective movement for change based on the many recommendations and aspirations in the report and made the case for a coherent response across public systems. She also alluded to the achievements being celebrated and showcased within the report and hoped this would inspire others to get involved in the change to mitigate some of the health effects of poverty and disadvantage.

Rev Dr Shanks commended the report and the writing style used which made it hugely readable and impressive. He wondered, however, what happened next in taking forward the 20 priorities. Dr de Caestecker explained that NHSGGC had an exceptionally strong track record of developing new initiatives for improving services to patients and the wider population. The report described just a fraction of the innovation which had taken place since her last report, however, some of this innovation was fragmented, localised and risked "withering on the vine" if not understood, supported and embedded in the wider organisation. In this respect, a key priority would be to coordinate what was being done best at the moment and accelerate evidence-based redesign of services to identify what worked best for the local health system. She described how a lot of evidence was now available but needed better coordination to utilise it. She also alluded to the work underway in redesigning the future clinical services strategy which provided an important opportunity to deliver transformational change by integrating evidence-based prevention into all of the NHS Board's clinical systems in ways that reflected the experience, capacity and learning of people in NHSGGC's communities and those at the front line of service delivery.

Ms Brown referred to the impact of welfare reforms not only to individuals but to whole communities. Dr de Caestecker acknowledged this and explained that the NHS Board continued to have a duty to assess the health needs of population groups and communities who were adversely affected by welfare changes, lack of employment opportunities and in-work poverty, in order to advocate for changes in national policy, local responses and social attitudes. She hoped that much of this work would be driven by the NHS Board's Health Improvement Teams within CH(C)Ps.

Ms Micklem welcomed the report and, in particular, the breakdown of the 20 priorities which were very clear and highlighted the work needed to achieve each one. She commented that it would be useful when the NHS Board was looking at its priorities alongside financial plans that options were clearly highlighted so that NHS Board members could identify the opportunity costs and ramifications of the tough decisions they were making.

DECIDED

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|--|----------------------------------|
| • That the draft report of the Director of Public Health on population health in NHSGGC 2013-2015 be received. | Director of Public Health |
| • That the central importance of poverty and disadvantage in shaping the health of the NHSGGC population across the life course be endorsed. | Director of Public Health |
| • That the recommendations for action by NHSGGC to reduce the adverse health impact of poverty and disadvantage be supported. | Director of Public Health |

109. ESTABLISHING SHADOW HEALTH AND SOCIAL CARE PARTNERSHIPS (HSCPs): EAST RENFREWSHIRE, INVERCLYDE AND WEST DUMBERTON

A report of the Director of Corporate Planning and Policy [Board Paper No 13/55] asked the NHS Board to note the ongoing progress in establishing the three shadow health and social care partnerships, namely, East Renfrewshire, Inverclyde and West Dumbarton.

Ms Renfrew described the ongoing progress made since the NHS Board last had an update on the proposals in August 2013. She confirmed the continued intention to leave flexibility within the shadow arrangements to ensure they could accommodate any reshaping of the Bill and related regulation and guidance as national policy continued to develop. She outlined the proposed series of changes to the existing CH(C)P Schemes of Establishment which the NHS Board Chief Executive and Chief Executives of East Renfrewshire, Inverclyde and West Dumbartonshire Councils had concluded was the appropriate approach to deliver the objective of beginning the transition from CH(C)Ps to the new bodies while retaining sustainability. She confirmed that the amended Schemes of Establishment would not constitute the full integration plans that needed to be developed and submitted to the Scottish Government because that process would not be in place until the legislative process was complete.

Ms Renfrew led the NHS Board through the proposed changes, confirming that these had, or would be, considered by the three CH(C)P Committees and Councils in the period between November 2013 and January 2014, enabling due process to be completed to establish shadow HSCPs from April 2014. In addition to these changes to the Schemes of Establishment, the job descriptions for the three CH(C)P Directors had been revised by the NHS and Council Chief Executives to reflect the move into the new integration arrangements.

Councillors Lafferty, McIlwee and Rooney confirmed their respective Councils' support of the proposals and, like NHSGGC, reported that each Council awaited the final national policy to be issued.

NOTED

110. NEW SOUTH GLASGOW HOSPITALS DEVELOPMENT: UPDATE**A) RE-PROVISIONING OF OFFICE ACCOMMODATION – APPROVAL OF FULL BUSINESS CASE**

A report of the Project Director/Director of Facilities and Capital Planning – Designate [Board Paper No 13/56] asked the NHS Board to approve the content of the Full Business Case (FBC) with a recommendation to proceed with the new office accommodation option and subsequent submission to the Capital Investment Committee, Scottish Government on 20 December 2013 for formal approval in January 2014.

Mr Loudon reminded the NHS Board that the Scottish Government approved the Outline Business Case at its Capital Investment Group meeting held on 5 November 2013. Subsequently, the NHS Board was invited to prepare and submit a Full Business Case (FBC) in support of the new office accommodation building. That FBC had been completed in accordance with the guidelines set out in the Scottish Capital Investment Manual – Business Case Guide, published by the Scottish Government. In preparing it, the assumptions and options of the Outline Business Case has been reviewed resulting in a recommendation that a new build office accommodation option

was significantly preferable to the refurbishment of the retained estate.

Mr Loudon led the NHS Board through the results of the benefits analysis of both options, describing the benefit criteria, its weight and score. He also described the financial options appraisal which concluded that the development of the office was more economical in terms of capital investment and highlighted the following:-

- Capital investment in retained estate - £42.623m
- Capital investment in new office development - £20.764

He concluded by outlining the advantages of the new office accommodation in terms of what it was likely to deliver including a 21st century office to support staff in carrying out their duties efficiently and effectively.

Mr Winter agreed that the analysis and process for the preparation of the Full Business Case were in accordance with best practice and the results of the benefits analysis clearly preferred the option for the new office accommodation scheduled for completion in April 2015 which meant that the facility would be open to support staff migrating to the New South Glasgow Hospitals.

DECIDED

- That the content of the Full Business Case with a recommendation to proceed with the new office accommodation option and subsequent submission to the Capital Investment Committee, Scottish Government on 20 December 2013 for formal approval in January 2014 be approved.

**Project
Director/
Director of
Facilities &
Capital
Planning -
Designate**

B) COMMUNITY BENEFIT PROGRAMME

Mr M McAllister, Community Engagement Manager, delivered a presentation to the NHS Board focusing on the requirement to deliver community benefits as incorporated in the procurement process for the New South Glasgow Hospitals and subsequent progress. He described how the community benefit provisions within the procurement process focused on three key areas including targeted recruitment and training, small/medium enterprise supplier development and social enterprises development. A partnership was established to deliver the programme which included Brookfield Multiplex, Glasgow City Council, Community Enterprise in Scotland, Jobs and Business Glasgow and NHSGGC.

Mr McAllister outlined the targets set and the five indicators which were as follows:-

- New entrants
- Qualifications to be achieved by new entrants
- Apprentices
- Work experience places
- Lifelong learning opportunities

Through the partnership approach described, all targets had been exceeded and the project continued to maximise opportunities for communities. Mr McAllister outlined how people were engaged in the project and how partners worked together to realise training and recruitment opportunities. The project had been recognised for its success to date and had been awarded the Best Corporate Social Responsibility Project by Scottish Go Awards. Furthermore,

he commended the partnership working with local businesses engaged as part of the procurement activity which resulted in more than 65% of available sub-contracting opportunities let to small/medium enterprises.

In addition, there had been an ongoing commitment to learning and education, with students and school pupils engaged with the project for site visits, workshops and seminars. The project also aimed to engage with the wider community and Brookfield Multiplex and NHSGGC had established a Good Neighbour Agreement and actively participated in local events and grant schemes for local projects. As a result, 12,000 local people were engaged in the project via wider stakeholder activities.

Mr McAllister recorded that the project was now moving from a construction phase to a commissioning phase which would inform future delivery. In doing so, it was the intention to incorporate lessons learned into wider NHSGGC programmes and delivery supporting NHSGGC's employability.

It was hoped to maintain and develop working relationships with education and further education sectors linked to NHSGGC's future workforce skills as well as the sustainability of employment opportunities and support for the workforce.

Mr Sime commended the established number of mechanisms set up to deliver this aspirational project and regarded it inspirational particularly following the earlier presentation from Dr de Caestecker on her biennial public health report.

In response to a question from Ms Micklem and Mr Carson regarding the recruitment of young women and under-represented populations such as disabled and ethnic minorities, Mr McAllister did not have statistical information on the make-up of the workforce and agreed to look at this point in the future.

**Community
Engagement
Manager**

Professor Dominiczak recognised that construction was scheduled to finish shortly but was encouraged that many opportunities would continue and she asked that this presentation be shared with other Groups and Universities in order to maintain the longer term benefit of this initiative.

**Community
Engagement
Manager**

Mrs A Hawkins acknowledged the excellent progress being made in delivering the community benefit programme and suggested that the West HUB Territory Board would be interested in receiving the presentation. Mr McAllister confirmed he would be happy to do a presentation to the Board.

**Community
Engagement
Manager**

Councillor Macmillan echoed the views made already and, in response to his question, Mr McAllister confirmed that he would be happy to also share his presentation with Local Authorities. Mr James added that the Glasgow Community Planning Partnership had already seen the presentation and had been equally supportive and appreciative of its success. On this point, Mr Winter took the opportunity to thank Mr McAllister for his dedication and commitment to the success of the project – Mr McAllister thanked Mr Winter for his kind comments.

NOTED

111. CLINICAL SERVICES FIT FOR THE FUTURE: CLINICAL SERVICES REVIEW UPDATE PAPER

A report of the Medical Director [Board Paper No 13/57] asked the NHS Board to

consider the Clinical Services Update paper and approve the development programme proposal.

Dr Armstrong reminded the NHS Board that, following agreement for the direction of travel set out in the Service Models paper presented in August 2013, the Clinical Services programme had continued to progress the work to determine the strategy for NHSGGC to 2020. She provided an update on the work being progressed and set out the proposal for the development programme as follows:-

- Update on the implications of the service models – all of the Groups were continuing work to determine the implications of the service models and this focussed on considering the short to medium term where there was strong clinical evidence/consensus about service change to improve quality of care and patient outcomes such as consolidation of low volume/high complexity care. Further information on the work of these groups would be considered by the NHS Board in early 2014.
- Development programme – aimed at bringing together a range of components of the emerging clinical service models to further develop and assess their cumulative impact. Dr Armstrong described the core elements of the model and reported that the initial focus would be adult services and would focus on developing the interface services further particularly on areas with greatest impact on patient care. The programme would test out both the service developments and the underpinning ways of working which were set out in the service models and would build upon any relevant service developments being progressed through other initiatives. It would not seek to replicate activity underway or planned but rather take stock of the position and level of implementation to understand the baseline and components of the model already established or being established. Given this, the Clinical Services Review Steering Group had agreed what the programme arrangements should encompass and a high level process was undertaken to review the areas across NHSGGC to determine the location for the programme with the Paisley locality being identified as the proposed site.

Dr Armstrong highlighted the profile of the area explaining that it predominantly linked to the Royal Alexandra Hospital which would give a large enough population to be able to develop the clinical models and assess impact on improving patient care. To date, discussions with clinical directors and Primary and Secondary Care had identified support and willingness to proceed, with strong interest to progress with the programme.

Similarly, Renfrewshire Council had expressed interest in working with NHSGGC to undertake the development programme and emphasis for this work would be between health and social care to implement some of the core components of the programme as well as developing a more collaborative approach to addressing problems for patients with multi-morbidity and frailty across health and social care.

Dr Armstrong led the NHS Board through the proposed programme structure and costs and explained that a robust evaluation plan for the work was in place to allow the impact to be assessed fully and ensure that progress was monitored effectively to allow adoption of the learning across the system.

Mr Fraser regarded the programme as a good model for change management and leadership. In response to his question, Dr Armstrong agreed that it was a significant change and needed to be carefully thought out and clinically led. Ms Renfrew added that, following a meeting with GPs, they had been very supportive of the concept as

had Renfrewshire Council and, in particular, the social work department. She agreed that some radical changes lay ahead but cautioned that some ways of working were likely to remain the same albeit done in a more consistent way.

Rev Dr Shanks asked about timescales and Dr Armstrong confirmed that it was a priority to have clinical leads in place and ready to start in March 2014. She anticipated reasonably quick feedback and results but reported that the actual monitoring and evaluation of the programme had deliberately been left open-ended to see the evolving impact of the changes. This would allow the programme team to innovate as it progressed. With this in mind, however, she anticipated a likely evaluation within a year. In terms of who would carry this out, this had not yet been decided but discussions were taking place with local universities as well as with one of the NHS Board's own health economics teams. Professor Dominiczak agreed that this evaluation would be hugely significant in rolling out any likely lessons learned from the programme.

Ms Brown referred to the initial assessment of costs for the programme infrastructure which she noted were dominated by health/clinical leadership. Dr Armstrong confirmed that all costs would be tracked and the NHS Board would see a full record of this at its February 2014 meeting when looking at costs in general. The costs alluded to in the NHS Board paper related more to upfront costs and she agreed that it was important for the NHS Board to see a full illustration of costs to balance this against benefits delivered.

DECIDED

- That the Clinical Services Review update paper be noted.
- That the development programme proposal be approved.

**Medical
Director**
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112. POST INCIDENT REPORT ON RECENT ICT SYSTEMS FAILURE

A report of the Director of Health, Information and Technology [Board Paper No 13/58] asked the NHS Board to note the findings of the post-incident review into the recent ICT systems disruption. The report and recommendations had previously been discussed and noted at the November 2013 meeting of the NHS Board's Quality and Performance Committee.

Mr Finlayson described the incident that resulted in the failure of a significant number of ICT systems during 1 and 2 October 2013 and how, following the incident, the NHS Board and Scottish Government jointly commissioned an independent review of the technical environment that was in place when the failure occurred and the response to the incident by ICT staff in recovering services.

The review followed a commitment by the Cabinet Secretary for Health and Wellbeing to ascertain the “root cause” of the problem and to ensure that lessons learned in NHSGGC were available to be shared with other NHS Boards.

Mr Finlayson led the NHS Board through the independent review undertaken by industry experts and summarised the review team's findings and recommendations. Whilst the technical environment was assessed to be in accordance with industry standard best practice, the review team set out a number of areas that would provide additional security to the NHS Board in the event of a similar service failure in future. As such, a second phase review and assessment, covering all NHS Boards, had been undertaken and the report from that would be published at the end of December 2013. This was conducted by the National Computing Centre on behalf of the Scottish Government and concentrated on the resilience shown in NHSGGC (95% of activity

continued to be delivered) and was set up to assess whether further improvements were necessary in NHSGGC contingency planning and whether other NHS Boards were equipped to operate to a similar level in the event of a failure.

In respect of the two recommendations noted to be “under consideration”, Mr Finlayson responded to Mr Daniels by confirming that the NHS Board was looking at additional security and forensic software and it may be that a recommendation for the purchase of this met the requirements of these two recommendations. On this point, Ms Brown asked about the NHS Board’s current contractual arrangements with Microsoft and Mr Finlayson reported that Microsoft had stated that the NHSGGC configuration was consistent with a standard active directory deployment of its size.

NOTED

113. MANAGEMENT OF NHS WAITING TIMES

A report of the Lead Director, Acute Services Division [Board Paper No 13/59] asked the NHS Board to note the assurance provided to the Scottish Government on 13 December 2013 in relation to the Audit Scotland report “The Management of Patients on NHS Waiting Lists” which was published in February 2013.

Mr Archibald explained that, in February 2013, Audit Scotland published a report on “The Management of Patients on NHS Waiting Lists”, which contained a number of actions to be addressed by NHS Boards. At that time, the NHS Board provided an interim assurance statement in April 2013 which was signed off by Mr Winter as Chair of the Audit Committee. This was followed up by a report from the Scottish Parliament Public Audit Committee in May 2013 and the latest assurance update was in response to a further request from the Scottish Government following their letter to all NHS Boards on 4 October 2013 seeking an update on all audit action points by 13 December 2013.

Mr Archibald explained that the NHS Board’s assurance statement had been provided by the Director, PricewaterhouseCoopers (PWC) who undertook an internal audit review to assess the NHS Board’s progress in implementing the recommendations from the nationwide assessments undertaken in 2013.

The review focussed on PWC’s recommendations from an internal audit review (November 2012), the Audit Scotland recommendations (February 2013) and the Public Audit Committee (May 2013).

Mr Finnie sought clarity around the process adopted and Mr Calderwood explained that, as requested by the Scottish Government, PWC undertook the audit as the NHS Board’s internal auditors. As such, it was their template that had been submitted to the Scottish Government to provide the necessary assurance.

DECIDED

- That, following review of the Waiting Times Follow-up Report by the internal auditors, the NHS Board agreed to sign off the report for submission to the SGHD as the assurance that the recommendations of the Audit Scotland – The Management of Patients on NHS Waiting Lists had been, or were being implemented.

**Lead Director,
Acute Services
Division**

114. WAITING TIMES AND ACCESS TARGETS

A report of the Lead Director, Acute Services Division [Board Paper No 13/60] asked the NHS Board to note progress against the national targets as at the end of October 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 number of patients awaiting discharge from hospital beds across NHSGCC.

In response to a question from Mr Lee regarding the Accident & Emergency Waiting Times, particularly at the Western Infirmary, Mr Archibald agreed that their disappointing performance stood out and explained that redesign work was ongoing to address the physical limitations at the Western Infirmary and to look at out-of-hours provision from that site. This included ongoing liaison with the Scottish Ambulance Service and identifying capacity, resource and physical changes to ensure a consistent flow of patients to attempt to improve the length of time from arrival at A&E to admission, discharge or transfer for patients.

Ms Brown referred to the earlier paper discussed and, in particular, recommendation number seven from the PWC report which stated that NHS Board non-executive directors should ensure they had the full range of information available to scrutinise how their Board was applying waiting list codes and planning and managing capacity to meet the waiting time targets. She wondered whether the NHS Board paper on waiting times included enough information to ensure that the NHS Board could scrutinise how waiting list codes were being applied and the planning and managing of capacity to meet waiting time targets. Mr Archibald replied by confirming that the Waiting Times and Access Targets report to the NHS Board was designed to show performance against all waiting times guarantees; the total inpatient, day case and outpatient waiting lists and, therefore, the identification of available and unavailable waiting lists. This allowed the NHS Board to scrutinise how waiting list codes were being applied.

In response to a question from Councillor Lafferty regarding the Accident & Emergency waiting times for the Victoria Infirmary, Mr Archibald clarified that this included the Accident & Emergency *and* Minor Injuries Unit waiting times. At Councillor Lafferty's request, Mr Archibald agreed to split these in future so that both could be monitored.

**Lead Director,
Acute Services
Division**

Ms Micklem commended the good work contained within the report and especially the improvement made between June and September to meet the stroke target. She also welcomed the NHS Board's approach to the access policy which was flexible in how it was applied which demonstrated an excellent person-centred approach.

NOTED

115. FINANCIAL MONITORING REPORT FOR THE 7 MONTH PERIOD TO 31 OCTOBER 2013

A report of the Director of Finance [Board Paper No 13/61] asked the NHS Board to note the financial performance for the first seven months of the financial year.

Mr James explained that the NHS Board was currently reporting an expenditure out-turn £3.1m less than its budget for the first seven months of the year. At this stage, however, the NHS Board forecast that a year-end surplus of £8m 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 Plan.

Addressing a point raised at the last NHS Board meeting concerning resource transfer to Local Authorities as noted in the NHS Partnerships chapter of the paper, Mr James confirmed that this would look different in future reports.

**Director of
Finance**

Mr Finnie queried the jump in period 7 (from £14m to £62m for Corporate and Other Budgets as noted as chapter 5 of the NHS Board paper). Mr James agreed to clarify this point and report back to Mr Finnie.

**Director of
Finance**

NOTED

116. QUARTERLY REPORT ON COMPLAINTS: 1 JULY – 30 SEPTEMBER 2013

A report of the Nurse Director [Board Paper No 13/62] asked the NHS Board to note the quarterly report on complaints in NHS GGC for the period 1 July to 30 September 2013 and note extracts from the ISD and SPSO Annual Reports 2012/13.

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 64% of complaints responded to within 20 working days had been achieved. Although disappointingly below the target of 70%, this was attributable to a significant rise in prisoner complaints. It was hoped that with the introduction of patient information leaflets in prisons, tighter prescribing guidelines and evidence-based assessment tools, fewer complaints around medication from prisoners would be received in the future.

Mr Crocket alluded to the format of the report which now provided much greater detail on completed complaints by Acute Directorate (then broken down further into hospital location) and, in respect of CH(C)Ps, disaggregated to service areas. Furthermore, for the first time, statistics and service improvements were recorded from Family Health Service practitioners (doctors, dentists, community pharmacists and opticians).

As a result of consideration of a number of improvements to the current complaints-handling processes, a GAP analysis undertaken of the Francis Report and the identified need to improve the quality of local resolution responses, Ms Crocket highlighted several of the initial actions that had been undertaken and confirmed that further discussion would take place to identify how complaints-handling could continue to improve – this approach was welcomed.

NOTED

117. CHANGES TO HEALTH BOARD BOUNDARY

A report of the Director of Corporate Planning and Policy [Board Paper No 13/63] asked the NHS Board to note changes to the Health Board boundary and work in progress on the financial issues.

Ms Renfrew updated the NHS Board on the progress being made to manage the changes to NHS GGC's boundary with NHS Lanarkshire; the changes of which came

into effect on 1 April 2014. She reported that the transition process was being overseen by a joint steering group with NHS Lanarkshire and a joint project with a number of key workstreams underway to plan and manage the change process.

NHSGGC needed to ensure that the combination of a reduction in its costs (because it no longer provided services to this population) and additional cross-boundary flow income matched the sum of £117.8m as confirmed by the Scottish Government as the share of resources that would transfer with the shift in population.

Ms Renfrew confirmed that a full communications plan had been developed for the project to ensure all key stakeholders, including independent contractors, patients, locally elected members and MSPs, were kept fully up to date.

NOTED

118. 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. 13/64] 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**

119. AUDIT COMMITTEE MINUTES: 8 OCTOBER 2013

The Minutes of the Audit Committee meeting held on 8 October 2013 [A(M)13/06] were noted.

NOTED

120. AREA CLINICAL FORUM MINUTES: 3 OCTOBER 2013

The Minutes of the Area Clinical Forum meeting held on 3 October 2013 [ACF(M)13/05] were noted.

NOTED

121. QUALITY AND PERFORMANCE COMMITTEE MINUTES: 19 NOVEMBER 2013

The Minutes of the Quality and Performance Committee meeting held on 19 November 2013 [QPC(M)13/06] were noted.

NOTED

The meeting ended at 12.30pm