

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, 15 April 2014 at 9:30a.m.**

PRESENT

Mr A O Robertson OBE (in the Chair)

Dr J Armstrong	Councillor A Lafferty
Dr C Benton MBE	Mr I Lee
Ms M Brown	Councillor M MacMillan
Dr H Cameron	Councillor J McIlwee
Ms R Crocket MBE	Ms R Micklem
Councillor M Cunning	Councillor M O'Donnell
Councillor M Devlin	Dr R Reid
Prof A Dominiczak	Councillor M Rooney
Mr R Finnie	Rev Dr N Shanks
Mr P James	Mr D Sime
Dr M Kapasi MBE	Mr B Williamson

Mr K Winter

IN ATTENDANCE

Mr J Best	Director, Regional Services
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Mr B Moore	Director, Inverclyde CHP (Representing Partnership Directors)
Mr A McLaws	Director of Corporate Communications
Dr G Penrice	Consultant in Public Health Medicine (For Minute No: 24)
Ms J Reid	Immunisation Programme Manger (For Minute No: 24)
Ms C Renfrew	Director of Corporate Planning and Policy
Dr A Stanley	Consultant in Gastroenterology (For Minute No: 16)

ACTION BY

16. PRESENTATION ON MALAWI

Before beginning the formal NHS Board meeting, Mr Robertson introduced Dr A Stanley, Consultant in Gastroenterology. Dr Stanley attended the NHS Board meeting on 19 February 2013 to outline the support given to Malawi from the NHS at large but, in particular, from NHSGGC. He thanked the NHS Board for the invitation to provide an update on developments since last year and outlined how endoscopic services were being developed and supported in three central hospital endoscopy units in Blantyre, Lilongwe and Mzuzu. Following the provision of some equipment from NHSGGC, the main aims were to teach local clinicians the necessary skills in band ligation and stent insertion and this was undertaken by onsite training visits and formal UK approved endoscopy training courses in Malawi and progressed with regular meetings with hospital directors.

Prior to his training visit in October 2013, Dr Stanley reported that three video endoscopes, monitors, cables, accessory equipment and computers were shipped out via Glasgow City Council. On his arrival, the computer was installed for electronic reporting and presentations and guidelines duly uploaded. In terms of going forward, Dr Stanley reported that further training was scheduled for April 2014 and October 2014 and he was hopeful that further equipment would be sourced for further development and training purposes. He thanked NHSGGC for donating the endoscopes and other equipment and Glasgow City Council for shipping this from Glasgow to Malawi.

Mr Williamson commended the project and acknowledged its benefits to local communities and the trainees who undertook the courses. In response to his question, Dr Stanley confirmed that four courses had been held, to date, and eight local Malawi clinicians had attended each course. He acknowledged that many endoscopy procedures were undertaken by nurses in western countries but reported that this was not the case yet in Malawi – the focus was on surgeons and clinical medical officers undertaking this role. He reported that some staff had come from Malawi to Glasgow, where funding had been obtained, to learn techniques with the intention of returning to Malawi and adapting their training to the facilities and services available there.

Professor Dominiczak highlighted that the University of Glasgow had joined the Malawi-Liverpool Welcome Trust and alluded to opportunities for future collaborative working. Furthermore, some education programmes were being undertaken by the University of Glasgow and Professor Dominiczak suggested that Dr Stanley make contact with relevant personnel.

Mr Robertson reiterated the importance of maximising the use of equipment that may become redundant in NHSGGC when the new South Glasgow Hospitals opened. Mr Best confirmed that NHSGGC's procurement team was cited on this.

Mr Robertson thanked Dr Stanley for the informative presentation and update.

NOTED

17. APOLOGIES

Apologies for absence were intimated on behalf of Mr R Calderwood, Mr G Carson, Mr P Daniels OBE, Dr L De Caestecker and Mr I Fraser.

NOTED

18. 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

19. CHAIR'S REPORT

- (i) On 20 February 2014, Mr Robertson met with the Committee of the Samaritan Society at the Western Infirmary. The Society originally provided financial support for patients and their families in need before the days of welfare

benefits. As they would shortly be winding up their services after over 30 years, Mr Robertson regarded it as important to give recognition to the work they had done throughout the years.

- (ii) On 14 and 21 March 2014, Mr Robertson, along with other Non-Executive NHS Board members, visited the New South Glasgow Hospitals. He had been hugely impressed with the progress made and reported that many parts of the buildings were complete and now awaiting delivery of equipment. The handover date would be the end of January 2015 and the project remained within budget. Attention was now being focussed on the development of migration plans for the Victoria Infirmary, Western Infirmary, Royal Hospital for Sick Children, Mansionhouse Unit and older parts of the Southern General Hospital. This was a huge undertaking and the contractor, Brookfield Multiplex, had recently handed over a comparable hospital in Western Australia. Mr Calderwood and an operational team were currently with Brookfield Multiplex visiting Western Australia Health Authorities to discuss their handover arrangements and technical details and this was proving very useful.
- (iii) On 20 March 2014, Mr Robertson met with COSLA in Edinburgh where discussion focused on the governance and delivery of the new Health and Social Care Partnerships. Although in NHSGGC, energies were being spent on getting the six new Partnerships up and running, it was important to also be able to contribute to central policy discussions.
- (iv) On 24 March 2014, Mr Robertson attended Glasgow City Chambers for the Addiction graduation ceremony. This celebrated SVQ awards and other certificates given to individuals supported by addictions teams and was an excellent event for them and their families.
- (v) On 29 and 31 March 2014, Mr Robertson attended events in St Andrews Cathedral, the City Chambers and Kelvingrove Art Gallery and Museum to commemorate those who had lost their lives (and others who survived) in the Clutha Helicopter Tragedy. The events also highlighted the appreciation of the combined efforts of all the emergency services and the NHS was well represented and given a real sense of appreciation.

NOTED

20. MINUTES

On the motion of Mr D Sime, seconded by Professor A Dominczak, the Minutes of the NHS Board meeting held on Tuesday, 18 February 2014 [NHSGG&C(M)14/01] were approved as an accurate record and signed by the Chair pending the following addition:-

- Page 7, Item 09 “Public Health Screening Programmes Annual Report – 1 April 2012 to 31 March 2013”, 5th bullet point, add “Mrs Brown asked if there was any significance in the comparatively lower incidence rates (but higher death rates) in NHSGGC and Dr De Caestecker confirmed there was no known significance”.

NOTED

21. MATTERS ARISING FROM THE MINUTES

- (i) The rolling action list of matters arising was noted.
- (ii) Councillor Rooney questioned why none of the actions in relation to Minute No: 09 (Public Health Screening Programmes Annual Report – 1 April 2012 to 31 March 2013) were noted in the Rolling Action List to ensure actions were taken to improve performance. Mr Hamilton reported that this was an omission and would be duly added to the Rolling Action List.
- (iii) In respect of the handling of endowments funds as discussed at the 18 February 2014 NHS Board Meeting, under Minute No: 3 (Chair's Report), Mr Robertson reported that a strategy was being compiled and would be complete in July 2014 – the NHS Board would, thereafter, receive this for consideration.

**Head of Board
Administration****Director of
Finance**NOTED**22. SCOTTISH PATIENT SAFETY PROGRAMME**

A report of the NHS Board's Medical Director [Board Paper No 14/08] asked the NHS Board to note an update on the Scottish Patient Safety Programme (SPSP) for primary care and the work being progressed in NHSGGC.

Dr Armstrong reminded the NHS Board that the Scottish Government formally launched the SPSP Primary Care programme in April 2013 with the overall aim "to reduce the number of patient safety incidents to people from healthcare delivered in any Primary Care setting. All NHS territorial Boards and 95% of Primary Care clinical teams would be developing their safety culture and achieving reliability in three high risk areas by 2016".

She reported that NHSGGC commenced, in 2011, with a locally established programme involving eleven general practices and six district nursing teams testing on the following clinical processes:-

- Medicines reconciliation;
- Disease modifying anti-rheumatic drugs (DMARDs);
- Prevention of pressure ulcers in the community (district nurses).

The local initiative had now evolved into the National Programme and had been extended to include 21 practices and eight district nursing teams. An additional district nursing team had been identified to take forward improvement aims relating to nutritional screening and falls prevention. In addition, an NHSGGC polypharmacy local enhanced service had been developed addressing polypharmacy and the quality, safe and effective use of long-term medication. A medicines reconciliation component had been built into this local enhanced service and 252 practices participated, so far, in NHSGGC.

Dr Armstrong led the NHS Board through detail of the actions being taken to progress all of the workstreams in the programme. She explained that the lack of a SPSP data system meant that a great deal of effort went into manual data collection and collating data from different systems. This continued to prove challenging, limiting further expansion of the programme and had repeatedly been highlighted to the National Support Team in Healthcare Improvement Scotland.

Ms Crocket highlighted some of the work being undertaken in Community Nursing with areas identified for improvement to patient safety which included falls, catheter acquired urinary tract infections, malnutrition universal screening tool and the continuation of the prevention of pressure ulcer work. Work had commenced with district nurses to develop each of these workstreams and test the prototypes to develop reliable models of care that could be spread across the system. To date, work had focused on pressure ulcers and the malnutrition universal screening tool.

Mr Williamson regarded the report to be very enlightening and commended the excellent developments in Primary Care. In terms of the work being undertaken by Community Nursing, he wondered how this was governed. Ms Crocket alluded to the support from Professional Nurse Advisors, GPs and Partnership Clinical Directors for the work being undertaken by District Nurses, which was fed into Partnerships' Clinical Governance Forums and Professional Nurse Groups.

Councillor Rooney regarded the uptake from NHSGGC's Primary Care practitioners to be very encouraging so far, and hoped this would continue to meet the target by 2016. He asked about the incidences of pressure ulcers in patients from residential care homes. Ms Crocket reported that any patient with a pressure ulcer could be tracked to identify exactly where it originated. On a monthly basis, information was fed back through Heads of Nursing and Partnerships to identify and prevent reoccurrence and this method of monitoring was proving really helpful for district nurses.

In response to a question from a member, Dr Armstrong confirmed that a support infrastructure needed to be built up and the current funding of clinical posts was from National QUEST monies. Ms Micklem followed this up by asking about progress being made by Healthcare Improvement Scotland to obtain a data collection system. Dr Armstrong reported that discussions were ongoing on how best to collect data nationally. At the moment, however, this was being collected manually and presented a challenge. Mr Wright (Director of Health Information and Technology, NHSGGC) was also involved in the discussion, looking at whether any use could be made of the Clinical Portal to help with this.

Councillor O'Donnell wondered whether, as integration developed, there was scope for Local Authority employees (particularly Social Work) to supplement/complement the work of district nursing. Ms Crocket thought there were huge opportunities for development and the roll-out of good practice as the Integrated Partnerships bedded in.

In response to a question from Dr Benton, Ms Crocket confirmed that the Tissue Viability Specialist Nursing Team worked with district nurses providing support and advice.

NOTED

23. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No 14/09] 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 (October to December 2013), NHSGGC reported 36.8 cases per 100,000 AOBDs. NHS Scotland reported 33.4 cases per 100,000 AOBDs. 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, October to December 2013, NHSGGC reported 31.9 cases per 100,000 AOBDs, combined rate for all ages. This placed the NHS Board below the national average of 32.9 per 100,000 AOBDs.

For the last available quarter (October to December 2013), caesarean section procedures were below the national average, hip anthroplasty procedures matched the national average of 0.7% while the surgical site infection (SSI) rate for knee anthroplasty and repair of neck femur procedures rose above the national average although both 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 3,041 members of staff who were now registered as Cleanliness Champions.

Dr Armstrong alluded to some of the actions being taken by NHSGGC's clinical and infection control teams to achieve the SAB HEAT target of 24 cases or less per 100,000 AOBDs by 31 March 2015 and referred, in particular, to monitoring which included each Acute Directorate having illustrative reductions updated each quarter to monitor progress towards this target.

Ms Crocket alluded to the two Healthcare Environment Inspectorate (HEI) unannounced inspections at the Victoria Infirmary (on 27 November 2013) and the Vale of Leven Hospital (on 16 January 2014). She led the NHS Board through the requirements and recommendations made as a result of these two inspections.

In response to a question from Councillor Rooney regarding the SAB performance, Dr Armstrong explained that although the October to December 2013 performance was 36.8 cases per 100,000 AOBDs, she had been informed that the January to March 2014 performance was 26.7 – she was confident, therefore, that NHSGGC would be able to achieve the rate of 24 cases by March 2015. With regard to the calculation of bed days used for the C.Diff infection in patients aged 65 and over, she responded by reporting that this had now been corrected nationally as the original calculation had been set incorrectly.

Dr Benton referred to the exception report regarding Ward 2, Leverndale Hospital, which had been closed to admissions and transfers on 7 February 2014 due to five confirmed cases of influenza A. She wondered if there was any link with staff in relation to these cases and whether or not staff in the Ward had been immunised. Dr Armstrong agreed to obtain more details about this and let Dr Benton know.

**Medical
Director**

NOTED

24. REVIEW OF STAFF FLU VACCINATION PROGRAMME 2013/14 IN NHSGGC

A report of the Director of Public Health [Board Paper No 14/10] asked the NHS Board to note the Review of Staff Flu Vaccination Programme 2013/14 in NHSGGC.

Dr Penrice reported that the Staff Flu Vaccination Programme had been running for several years in Scotland and in NHSGGC. Historically, the uptake of the vaccine had been very low, varying from 15% to 20%. Since 2010/11 therefore, the Public Health Protection Unit had worked closely with NHSGGC's Occupational Health Service and other key stakeholders to deliver the Annual Staff Flu Vaccination Programme. In 2010/11, the uptake among NHSGGC staff was approximately 24%, improving to 36% in 2012/13. Uptake for 2013/14 was 32% and this had, as per previous years, included four modes of vaccination delivery to NHSGGC staff including peer immunisation, mass staff vaccination clinics, roving teams and appointments at the Occupational Health Department. Furthermore, a communication strategy was used to raise awareness amongst staff of how to access the flu vaccination and challenged the myths surrounding it.

Given the disappointing uptake, NHSGGC's Multidisciplinary Planning Group had been reconvened to learn lessons from 2013/14 and begin planning for 2014/15. The Planning Group had, to date, identified a number of priority areas to consider including:-

- Representation from the Acute Services Division on the Planning Group to facilitate more effective engagement and targeting of clinical/medical staff;
- Consult with staff regarding motivations for, and barriers to, flu vaccination using Survey Monkey questionnaires;
- Review and refresh the communications strategy including weekly "myth-busting";
- Evaluate and strengthen the role of Flu Champions;
- Ensure data was recorded consistently each year to enhance applicability of analysis and reduce time screening data including location of peer immunisation sessions;
- Further promote peer immunisation as an accessible method for NHSGGC's clinical/medical staff to receive the vaccine and encourage return of forms;
- Investigate potential learning from NHS Boards with higher uptakes.

Mr Sime agreed that staff needed to be encouraged more to get the flu vaccination however, cautioned that not all 39,000 members of staff were in patient-facing roles so the result may not be as bad as it appeared.

Mr Winter agreed, however, thought it would be useful to identify staff who had (and had not) had the vaccination so that a more persuasive approach could be taken with those who had not.

Mr Finnie supported the idea of obtaining staff views but wondered if there was a more rigorous undertaking that could be carried out rather than consulting them via a questionnaire concerning their motivations for/against having the vaccination. Mrs Brown agreed that staff had a right to choose but also considered that staff had a responsibility to their job and the patients they treated and, given this, the results were particularly disappointing despite all the work that had been done to encourage staff to have the vaccination. She also asked if Appendix 1 which showed the uptake of the flu vaccination at various locations throughout NHSGGC, week on week, could have an additional column added to be able to compare like for like performance across the sites – Dr Penrice acknowledged that this could be added in future reports.

**Director of
Public Health**

Dr Reid asked why staff having the flu vaccination was voluntary rather than mandatory and wondered if this was because the evidence was not strong enough to make it mandatory? Dr Penrice responded that it was national policy. Mr Williamson agreed and suggested that, given the strength of feeling amongst NHS Board Members regarding the disappointing results, this form further discussion with Dr de Caestecker at a future NHS Board Seminar. Mr Robertson welcomed this suggestion and agreed that it would be factored into the Seminar Rolling Programme.

**Director of
Corporate
Planning and
Policy**

Dr Kapasi suggested correlating staff sickness/absence from work due to the flu versus staff members who did not get the vaccination – this may be a useful way of highlighting the importance to staff of the flu vaccination.

Ms Reid explained that a staff questionnaire had been circulated to staff in an effort to find out what motivated staff to be vaccinated, what were barriers for others and what could be done to encourage more staff to take up the offer. Approximately 4,000 responses had been gathered. She went on to say that more targeted focus groups/semi-structured interviews were being planned for areas that had achieved a better uptake and those that had not performed as well. Ms Reid assured NHS Board members that planning for this year's staff flu vaccination programme would be informed by the findings.

NOTED

25. EAST DUNBARTONSHIRE HEALTH AND SOCIAL CARE SHADOW HEALTH AND SOCIAL CARE PARTNERSHIP AGREEMENT

A report of the Director of Corporate Planning and Policy and Interim Chief Officer, East Dunbartonshire CHP [Board Paper No 14/11] asked the NHS Board to approve the Partnership Agreement as the basis to establish a Shadow Integrated Joint Board (IJB) with East Dunbartonshire Council.

Ms Renfrew described the proposed local arrangements for the transition to a Shadow Health and Social Care Partnership for the East Dunbartonshire Council area in preparation for the enactment of the Public Bodies (Joint Working) (Scotland) Act 2014. She set out the arrangements for NHSGGC and the Council to work in partnership to establish a shadow IJB and then to a full IJB when the legislation required was fully in place. She described the first stage which was to establish a shadow IJB to lead, with the Interim Chief Officer, planning for the transition to the new Partnership. At this stage, the shadow IJB would operate alongside the current NHSGGC and Council governance arrangements operated by the CHP and Social Work Committee respectively.

Mr Sime welcomed the involvement of the Public Partnership Forum's input to take account of both health and social care service users. He also encouraged the development of mechanisms to achieve meaningful engagement with NHS and Local Authority Trade Unions and Professional Organisations, over the shadow period, in order to fully meet NHS Staff Governance standards and the Council's Partnership At Work arrangements.

In response to a question from Dr Reid, Ms Renfrew confirmed that, in accordance with the Act, the Chief Officer of the Shadow IJB was a non-voting member.

Councillor Lafferty asked about the chairing arrangements to be made for the IJBs and Ms Renfrew confirmed that these would be locally negotiated from 1 April 2015 onwards and confirmed that the role of Chair had the casting vote on the IJBs.

DECIDED

- That, the Partnership Agreement as the basis to establish a Shadow Integration Joint Board with East Dunbartonshire Council, be approved.

**Director of
Corporate
Planning and
Policy**

26. WAITING TIMES AND ACCESS TARGETS

A report of the Lead Director, Acute Services Division [Board Paper No 14/12] asked the NHS Board to note progress against the national targets as at the end of February 2014.

Mr Best 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 (RTT) 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 NHS GGC.

In response to a question from Dr Shanks concerning Accident & Emergency (A&E) waiting times performance at the Western Infirmary, Mr Best provided reassurance that actions were being taken to address this challenge including looking at patient flows and services to ensure that patients were discharged as soon as they were ready including ensuring prescriptions were written in advance and travel arrangements (including ongoing discussions with the Scottish Ambulance Service) were made. In response to a further question from Mr Sime concerning A&E waiting times, Mr Best reported that the SGHD looked at overall NHS GGC performance but also that of each hospital site.

With regard to patients awaiting discharge, Mr Best reported that, from April 2015, the national target for discharge would be two weeks. Given this, joint planning work continued with Local Authorities regarding older people and was supported by the additional "Change Funds" released to Partnerships. As at the end of February 2014, the areas with significant numbers of delays were Glasgow City (South Glasgow) and South Lanarkshire and funding was now being flagged as a barrier to discharge. Councillor Cunning noted that there had been local management difficulties in this regard which were hopefully now resolved and a paper was being presented for consideration by Glasgow City Executive Group to take this forward. Ms Renfrew outlined the actions being taken to address this including weekly meetings focusing on delays and issues with allocation as well as the increase in the use of "step down beds" with 35 places now available across the city with current occupancy at 80%.

Mr Williamson noted cancer waiting times and, in particular, the three screened cancers (breast, cervical and colorectal). In response to his question about the

difference in performance between screened only and screened excluded for colorectal, Mr Best reported that a detailed action plan was in place that had a commitment to address this imbalance.

In response to a question from Dr Cameron, Mr Best confirmed that “linked pathways” referred only to consultant episodes.

NOTED

27. FINANCIAL MONITORING REPORT FOR THE 11 MONTH PERIOD TO 28 FEBRUARY 2014

A report of the Director of Finance [Board Paper No 14/13] asked the NHS Board to note the financial performance for the first eleven months of the financial year.

Mr James explained that the NHS Board was currently reporting a surplus of £9.7m for the first eleven months of the year. At this stage, therefore, the NHS Board was forecasting that a year-end surplus of £10m 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.

In response to a question from Councillor Rooney concerning the £10m surplus, Mr James confirmed that this was non-recurring money which had been reported to the NHS Board’s Quality and Performance Committee and would be used to assist with the transition costs of the move to the New South Glasgow Hospitals – he confirmed that this arrangement had been agreed with the SGHD. In response to a further question from Councillor Rooney regarding the brokerage agreement with the SGHD of £7m of Capital Funding which had been returned by the end of February 2014, Mr James explained the process for this in that the NHS Board would get this back in 2014/15.

Mrs Brown referred to the earlier discussion around the £10m surplus and understood the logic for this being used for the double-running costs as migration progressed to the New South Glasgow Hospitals. She asked whether there would be opportunities to use these monies for any other purpose and Mr James reported that a report would be presented to the May 2014 Quality and Performance Committee meeting scrutinising, in further detail, the savings plan for recurring and non-recurring expenditure and to identify exactly how it would be used.

NOTED

28. PATIENTS’ PRIVATE FUNDS – ANNUAL ACCOUNTS 2012/13

A report of the Director of Finance [Board Paper No 14/14] asked the NHS Board to adopt and approve, for submission to the Scottish Government Health Directorates, the 2012/13 Patients Private Funds Annual Accounts for NHS Greater Glasgow and Clyde.

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

distributed to the patients' accounts based on each individual's balance of funds held

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

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

Director of Finance

Councillor Cunning was interested in the governance of the arrangements surrounding the management of these funds and Mr James confirmed that this was covered in the legislation including the process to deposit/withdraw from accounts which was done at a cashier's office on each NHS hospital site. Nonetheless, he suggested further discussion at a future Board Seminar to go into more detail around how this was managed. Councillor Cunning welcomed this suggestion.

Director of Corporate Planning and Policy

DECIDED

1. That the Patients' Private Funds Annual Accounts for 2012/13 be adopted and approved for submission to the Scottish Government Health Directorates.
2. That the Director of Finance and Chief Executive be authorised to sign the Abstracts of Receipts and Payments for 2012/13.
3. That the Chair and Director of Finance be authorised to sign the Statements of Board Members' Responsibilities for 2012/13.
4. That the Chief Executive be authorised to sign the Letter of Representation to KPMG LLP on behalf of the NHS Board.

Director of Finance

Director of Finance/Chief Executive

Chair/Director of Finance

Chief Executive

29. QUARTERLY REPORT ON COMPLAINTS: 1 OCTOBER – 31 DECEMBER 2013

A report of the Nurse Director [Board Paper No 14/15] asked the NHS Board to note the quarterly report on complaints in NHSGGC for the period 1 October to 31 December 2013.

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 80% of complaints responded to within 20 working days had been achieved.

Ms Crocket alluded to the three issues attracting most complaints and highlighted that, across Partnerships and the Acute Division, these were disappointingly, the same, namely, clinical treatment, date for appointment and attitude/behaviour. These issues were consistent with previous quarters and she outlined some of the service improvements and actions being taken in an attempt to address this and improve complaints handling across NHSGGC.

In terms of investigation reports/decision letters published by the Scottish Public Services Ombudsman during the reporting quarter, Ms Crocket was pleased to report

that more issues had not been upheld than upheld and this represented an improvement. All upheld issues highlighted by the Scottish Public Services Ombudsman were scrutinised by the Quality and Performance Committee and operational directors to identify lessons learned to avoid a recurrence.

In response to a question from Councillor O'Donnell, Ms Crocket confirmed that Glasgow City CHP "hosted" complaints handling for prisoners from HMP Barlinnie, Low Moss and Greenock. It had adopted a policy of seeking to resolve complaints at local level within three working days under the complaints procedure where a resolution could be mutually agreed with the patient. This had seen 35% of all complaints resolved locally between healthcare staff and patients. Councillor O'Donnell asked a follow up question about how prison complaints handling and performance fed into the Community Justice Authority. Ms Crocket responded by confirming that the prison health service monitored and would report this to prison governors to consider in accordance with their own governance processes.

NOTED

30. ANNUAL REVIEW OF GOVERNANCE ARRANGEMENTS – STANDING ORDERS, COMMITTEE REMITS AND MEMBERSHIPS AND OTHER ARRANGEMENTS

A report of the Head of Board Administration [Board Paper No 14/16a] 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 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 5 March 2014, 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.

A review of Standing Financial Instructions (SFIs) and Scheme of Delegation had been undertaken by the Director of Finance and his team. He intended to carry out a further and fundamental review of these once the arrangements for the Joint Integrated Boards were further developed and better understood.

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**

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| (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 |
| (vi) That the delegation to the Medical Director (or nominated representative during periods of leave) and Director of Public Health (or nominated representative during periods of leave) to approve medical practitioners under Section 22 of the Act to carry out the designated tasks described in Section G of this report with effect from 16 April 2014 be approved. | Medical Director/
Director of Public Health |

31. REVIEW OF FINANCIAL GOVERNANCE

A report of the Director of Finance [Board Paper No 14/16b] asked the NHS Board to approve the proposed Standing Financial Instructions and Scheme of Delegation.

Mr James reported that, following a review, it was identified that there were a number of areas in which the NHS Board's Standing Financial Instructions were out of date. It was also identified that a large number of changes would be needed in order to ensure that the SFIs were fit for purpose when the integration of health and social services was implemented in 2015. Given this, at a Corporate Management Team meeting in November 2013, it was agreed to amend the SFIs in two phases. The first phase would focus only on the changes needed in order to bring the SFIs up to date for 2013/14. That had been done and was reflected in the NHS Board paper. The second phase which would be developed over 2014 for subsequent NHS Board approval, would involve significant further change to accommodate the advent of the new Health and Social Care Partnerships.

Mr James led the NHS Board through the key changes proposed to bring the SFIs up to date and explained that these had been discussed by the Audit Committee at its meeting on 5 March 2014 when they were endorsed and agreed for presentation to the NHS Board for final approval. Since that time, however, there had been a meeting of the NHS Board's Quality and Performance Committee at which changes to its remit were discussed and agreed, some of which related to Capital Expenditure. The changes proposed for the Quality and Performance Committee prompted further discussions about the SFIs and, as a result, some further changes had since been incorporated which Mr James highlighted.

Mr Finnie drew attention to various inconsistencies in the document and Mr James agreed that a further update was necessary. Given this, Mr James suggested he update and amend the document and re-circulate it to all NHS Board Members for completeness.

Director of Finance

DECIDED

- That, the proposed Standing Financial Instructions and Scheme of Delegation

be approved pending the amendment of some inconsistencies by the Director of Finance.

Director of Finance

32. 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 14/17] 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 nine 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

33. AREA CLINICAL FORUM MINUTES: 6 FEBRUARY 2014

The minutes of the Area Clinical Forum meeting held on 6 February 2014 [ACF(M)14/01] were noted.

In response to a question from Dr Benton regarding the Staff Survey results, Ms Renfrew reported that a sub group of the Area Partnership Forum had been set up to scrutinise the detail of this and she agreed to share the details with her.

Director of Corporate Planning & Policy

NOTED

34. PHARMACY PRACTICES COMMITTEE MINUTES: 16 JANUARY 2014

The minutes of the Pharmacy Practices Committee meeting held on 16 January 2014 [PPC(M)14/01] were noted.

NOTED

35. AUDIT COMMITTEE MINUTES: 5 MARCH 2014

The minutes of the Audit Committee meeting held on 5 March 2014 [A(M)14/01] were noted.

NOTED

The meeting ended at 12.20pm