

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, 24 June 2014 at 9:30a.m.**

PRESENT

Mr A O Robertson OBE (in the Chair)

Dr C Benton MBE	Councillor A Lafferty
Ms M Brown	Mr I Lee
Mr R Calderwood	Councillor M Macmillan
Dr H Cameron	Councillor J McIlwee
Mr G Carson	Ms R Micklem
Ms R Crocket MBE	Councillor M O'Donnell
Councillor M Cunning	Dr R Reid
Dr L de Caestecker	Councillor M Rooney
Mr R Finnie	Mr D Sime
Mr P James	Mr K Winter

IN ATTENDANCE

Mr G Archibald	Lead Director, Acute Services Division
Mr A Crawford	Head of Clinical Governance (For Minute No 42)
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Mr A McLaws	Director of Corporate Communications
Mr I Reid	Director of Human Resources
Ms C Renfrew	Director of Corporate Planning and Policy
Mr T Walsh	Infection Control Manager (For Minute No 43)

ACTION BY

36. APOLOGIES

Apologies for absence were intimated on behalf of Dr J Armstrong, Mr P Daniels OBE, Councillor M Devlin, Professor A Dominiczak, Mr I Fraser, Dr M Kapasi MBE, Rev Dr N Shanks and Mr B Williamson.

NOTED

37. DECLARATION(S) OF INTEREST(S)

Declarations of interest were raised by two NHS Board Members in relation to the following agenda items:-

- Mr R Finnie – Agenda Item No: 10 – NHSGGC: Food Retail Policy – Mr Finnie was a Trustee with the charity League of Hospital Friends, Inverclyde.

- Councillor M Macmillan – Agenda Item No: 13 – Capital Plan 2014/15 to 2016-17 – Councillor Macmillan was the Leader of Renfrewshire Council.

NOTED**38. CHAIR'S REPORT**

- (i) Mr Robertson recorded that this would have been the last NHS Board Meeting for Mr B Williamson and Dr M Kapasi. Unfortunately, they had intimated their apologies but he took the opportunity to pay tribute to them and their contribution to the NHS Board since taking up membership in 2006. Both had had long and distinguished professional careers and that insight had allowed them to bring considerable and invaluable medical contributions to NHS Board deliberations. Mr Williamson had chaired Renfrewshire Community Health Partnership (CHP) and had been instrumental in building relationships with colleagues from Renfrewshire Council. Similarly, Dr Kapasi had been Vice-Convenor of Inverclyde Community Health and Care Partnership (CHCP) and had made an excellent contribution to joint working there.

Mr Robertson also reported that this would be the last meeting for Mr P James, Director of Finance, who was moving to pastures new after a three year period with NHSGGC. He recorded his appreciation, on behalf of the NHS Board, for his contribution in ensuring the NHS Board's met its various financial targets over this period.

- (ii) Mr Robertson sought and received approval to re-order the agenda items so that Item No 12 would be discussed prior to Item No 11. In doing so, he reported that, in order to consider Item No 12, the NHS Board meeting would be adjourned and members reconvened as NHSGGC Endowment Trustees to approve the Statement of Accounts 2013/14. Thereafter, the NHS Board meeting would be re-convened to consider Item No 11 onwards.
- (iii) Mr Robertson reported that he had been continuing to meet all Non-Executive NHS Board Members to conduct their annual appraisals. This had resulted in some excellent conversations, with only a few NHS Board Members still to be seen.
- (iv) Mr Robertson and Mr Calderwood attended the official opening of the Wolfson Wohl Cancer Research Centre on 1 May 2014. The Centre was opened by Harpal Kumar, Chief Executive, Cancer Research UK.
- (v) On 13 May 2014, Mr Robertson met with the Chairs and Principals of the three new Glasgow colleges and the West College, Scotland to discuss strategic engagement on future skills and training for the NHS workforce.
- (vi) On 6 June 2014, Mr Robertson attended the NHSGGC, Glasgow City Council and Glasgow Clyde College graduation ceremony of students who had completed year one of Project SEARCH. This was an international employability programme which offered work experience to students with learning disabilities in order to improve their chances of employment.
- (vii) On 11 June 2014 and 12 June 2014, Mr Robertson had begun visiting last year's Chairman's Award winners in their own work areas. His visits so far included the Royal Alexandra Hospital Diabetes Centre and the Royal Alexandra Hospital Facilities Team.

- (viii) On 16 June 2014, Mr Robertson attended the Lanarkshire Beatson ground breaking Ceremony at Monklands Hospital.
- (ix) On 19 June 2014, Mr Robertson attended the Big Noise Govanhill and met with the Chairman of Sistema to celebrate the achievements and the first birthday of Big Noise Govanhill. He reported that Sistema Scotland was working regularly with 700 children in this community, 60 of whom attended the Big Noise Govanhill after-school programme and had formed the Big Noise Govanhill Orchestra.
- (x) On 20 June 2014, Mr Robertson, along with Mr Calderwood, conducted interviews for the Director of Glasgow City Health and Social Care Partnership (HSCP). Mr D Williams, who was currently Glasgow City Council's Executive Director of Social Work, had been appointed.

NOTED

39. CHIEF EXECUTIVE'S UPDATE

- (i) On 29 April 2014, Mr Calderwood met with Glasgow Rotary Club to deliver a presentation on the New South Glasgow Hospitals project.
- (ii) On 15 May 2014, Mr Calderwood, accompanied by Dr Carol Clugston (University of Glasgow Medical School), presented to the Representatives of UKU Hospital and Medical Schools' Chief Executives and Deans on the creation of world class clinical facilities incorporating leading edge clinical research and teaching excellence in Glasgow.
- (iii) On 21 and 22 May 2014, NHSGGC hosted a visit from the Federation of Norwegian Enterprises (Virke), many of whose member companies were private not-for-profit healthcare providers. A cohort of membership Chief Executive Officers visited various facilities in NHSGGC and their feedback had been exceptionally positive and enlightening.
- (iv) On 23 May 2014, accompanied by Mr I Reid and Mr D Sime, Mr Calderwood met with representatives of a Scottish Government Task Force looking at Employee Relations and Engagement, the "Working Together Review" to share our experience of Partnership Working with Trade Unions in NHSGGC.
- (v) On 5 June 2014, NHSGGC received a visit from the Dental Pay Review body.
- (vi) On 10 June 2014, accompanied by Mr G Black, Chief Executive of Glasgow City Council, Mr Calderwood attended the National Community Planning Group at the Scottish Parliament.

NOTED

40. MINUTES

On the motion of Councillor J McIlwee, seconded by Mr K Winter, the Minutes of the NHS Board meeting held on Tuesday, 15 April [NHSGGC(M)14/02] were approved as an accurate record and signed by the Chair.

NOTED**41. MATTERS ARISING FROM THE MINUTES**

- (i) The rolling action list of matters arising was noted.
- (ii) In relation to Minute 25 - East Dunbartonshire Health and Social Care Partnership – the timescale date should read “April 2015” and not April 2016.
- (iii) In respect of Minute 31 – Review of Financial Governance – Mr James confirmed that this had been duly reissued to NHS Board Members in June 2014.
- (iv) In respect of Minute 9 – Public Health Screening Programme: Annual Report 2012/13 – Dr de Caestecker confirmed that she would follow up Ms Brown’s request for further information regarding interval cancers.
- (v) Minute 23 – Healthcare Associated Infection Report – In response to Dr Benton’s question, Mr Walsh confirmed that the closure of ward 2 (Leverdale Hospital) due to influenza, had had no link with staff members.

**Head of Board
Administration****Director of
Public Health**NOTED**42. SCOTTISH PATIENT SAFETY PROGRAMME UPDATE**

A report of the NHS Board’s Medical Director [Board Paper No 14/34] asked the NHS Board to note an update on the Scottish Patient Safety Programme (SPSP) and the work being progressed in NHSGGC.

Mr Crawford led the NHS Board through a summary of the following:-

- Safety Essentials – these were ten safety essentials deemed to be evidence based processes that had achieved a level of spread and reliability across Acute Hospitals in Scotland since the launch of SPSP in 2008. Over recent months, the Acute Services Division had confirmed that the level of spread in the reliable care processes across its clinical teams was of sufficient magnitude to translate into routine operational delivery mechanisms. Mr Crawford provided a brief update on ongoing plans for the transfer of reporting responsibilities for around the ten patient safety essentials.
- Points of Care Workstreams – there were nine Points of Care Priorities deemed safety critical for patients but known to require further rigorous testing, spread and reliable implementation using the quality improvement methodology familiar to those involved with the safety programme. Four of the nine were already a focus of work within the programme with the Acute Services Division recognising these as an opportunity to reinvigorate the current approach and priorities. The other five were acknowledged patient safety needs and the NHS Board already had dedicated structures to reduce the frequency and consequence of infections, falls and pressure ulcers. Mr Crawford reported that NHSGGC had clarified training and support needs in the Quality and Improvement methodology for staff linked to those structures and he outlined current activity, key areas of progress and key issues to note for each of the Points of Care workstreams.

Councillor Rooney asked why the “falls” and “pressure ulcers” workstreams had no key areas of progress so far and sought clarity on whether these workstreams were only

Acute-based. Mr Crawford confirmed that, at the moment, both were Adult Acute-based workstreams but, as they were successfully implemented and training/coaching evolved, it would be the intention to provide support to roll learning and methodologies out into community settings. So far, reports on these workstreams were limited but this under-recognised the progress made. This was being addressed so that richer updates would be provided in the future reports.

**Medical
Director**

Ms Micklem congratulated Mr Crawford and his teams for the progress in moving the priorities forward but she asked about the continued difficulty with data collection and measurement. Mr Crawford agreed that this currently proved to be a local challenge and described the reporting processes for clinical teams. A priority would be to work with clinical teams to see how better and more reliable ways of reporting could be achieved. The second challenge was in the aggregation of the information from clinical teams and this had been raised at a national level.

NOTED

43. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No 14/35] 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.

Mr Walsh 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). 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 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 (January to March 2014), the surgical site infection (SSI) rates for all procedures were below the national average with the exception of the repair of neck femur procedure category which was slightly above 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 3,130 members of staff who were now registered as Cleanliness Champions.

Mr Walsh highlighted that all areas within NHSGGC scored green (which represented

>90%) in the most recent report in the national cleaning specification. He also alluded to an unannounced inspection by Healthcare Environment Inspectorate (HEI) at the Princess Royal Maternity on 30 April 2014. The inspection report was due to be published later in June 2014.

Dr Benton referred to the two new Standard Operating Procedures (SOPs) for Vascular Line Insertion in adult inpatients and noted that staff from Practice Development, the Directorate Clinical Nurse Educators and Infection Control and Prevention Team would visit each ward and clinical areas to highlight the availability of these. In response to her question, Mr Walsh outlined the four salient educational points which were being addressed and confirmed that, at the moment, these were predominantly “line” associated.

NOTED

44. KEEP WELL PROGRAMME

A report of the Director of Public Health [Board Paper No 14/36] asked the NHS Board to receive and note the update in respect of the Keep Well Programme.

Dr de Caestecker outlined the origins and national policy context of Keep Well which was originally launched in 2006 with the initial focus being to pilot anticipatory care on a large scale in disadvantaged areas across Scotland with a primary focus on cardiovascular disease. Its core element, the Keep Well Health Check, targeted individuals residing in Scotland’s most deprived areas by offering interventions.

The Keep Well Programme in NHSGGC had been extensively evaluated and, as a result of the findings, had explicitly sought to strengthen the functioning connections between primary care clinicians and wider stakeholders. Rather than an over-reliance on individualised health checks, the NHSGGC Keep Well Programme unequivocally placed emphasis on actions to systematically address health inequalities, in partnership with general practice, through sustained investment in planned systems for primary prevention.

Dr de Caestecker outlined to the NHS Board, the following NHSGGC priorities in delivering Keep Well:-

- The deployment of community outreach workers;
- The creation of a coherent system for health improvement in primary care;
- Customised approaches for defined population subgroups.

NHSGGC had planned for (and implemented) the mainstreaming of Keep Well on the basis of programme funding becoming part of the NHS Board’s general allocation from 2014. The Scottish Government, however, announced a phasing out of Keep Well funding which came at a time of other challenging financial pressures. In addition to recent boundary changes, recent announcements had also been made by the Scottish Government on discontinuation of other national ring-fenced allocations to further prevention programmes and the impact of this was a radically shrinking financial envelope for preventative public health services.

Dr de Caestecker expressed her disappointment at the Scottish Government’s announcement to discontinue funding for Keep Well, particularly when the programme offered a valuable learning opportunity in relation to the public health policy and programme development and implementation. She reported that the NHSGGC Keep

Well Management Group would continue to work closely with Partnership Directors to develop a financial disinvestment plan and agree appropriate mechanisms to mainstream key elements of programme learning in advance of funding cessation in 2017. It was imperative, however, that this took cognisance of the wider financial pressures to maximise leverage of NHSGGC's existing investments in health improvement and anticipatory care.

Councillor Rooney was disappointed to note the letter from the Chief Medical Officer dated 13 December 2013 advising of the disinvestment in Keep Well by 2017. He had not been aware of this and was particularly disappointed to note that there was no mention of any Equality Impact Assessment (EQIA) being undertaken to withdraw the programme, which was a requirement of the equality legislation. He also asked about the impact on staff, GPs, services and protected/vulnerable patient groups. Dr de Caestecker advised that the timetable for disinvestment had been discussed at NHS Board Development and Seminar sessions. She reported that those staff on temporary contracts would not have their contracts renewed and those with permanent contracts would be redeployed. It was anticipated that the learning would be mainstreamed into GP practice and other service areas. With regard to an EQIA being undertaken beforehand and/or any consultation with protected/vulnerable groups, she was not aware of this but would seek clarification from the Scottish Government. She would update the NHS Board at its next meeting scheduled for August 2014.

**Director of
Public Health**

In response to a question from Ms Brown regarding the timescale for disinvestment, Dr de Caestecker confirmed that those services affected would look at how best the programme could be wound down and whether there would be any opportunities for future reinvestment. She also alluded to the hope that much of the learning and lessons learned would be mainstreamed into current service provision.

Mr Carson was impressed by the work Keep Well had achieved and Dr de Caestecker agreed that it would be important for the NHS Board to partner with other agencies in taking some of the workstreams forward especially ones such as money advice and employability.

Ms Micklem sought clarity around where the evidence was that the programme had made a difference to health outcomes. Dr de Caestecker explained that there was variation in terms of how Keep Well was implemented across Scotland, therefore, it was difficult to see and/or evaluate the project, however, that was how funding was originally set up. On this point, Dr Reid wondered why the programme was not able to show any tangible benefit and Dr de Caestecker explained that many high-risk patients were being picked up already by their GPs and through Chronic Disease Management Programmes.

Given the level of interest in this, Mr Robertson suggested that Dr de Caestecker report on progress of the disinvestment programme to the Board in around 9/12 months time.

**Director of
Public Health**

NOTED

45. NHSGGC RETAIL FOOD POLICY

A report of the Director of Public Health [Board Paper No 14/37] asked the NHS Board to adopt a Retail Food Policy.

The NHS Board first endorsed a policy position on food, fluid and nutrition in 1993 and the extant Food, Fluid and Nutrition Policy was approved in 2008 with a subsequent review in 2011. The key objective of the policy was to increase availability of an acceptable and appropriate healthy diet for employees, visitors and outpatients within NHSGGC. NHSGGC operated dining, cafe and vending facilities and had

successfully achieved a high level of compliance with national and local healthy eating guidance. This included:-

- 12 Aroma Cafes/ten dining rooms with Health Living Award +
- One Aroma Cafe/two dining rooms with Healthy Living Awards
- 60 drink vending machines – 100% sugar free
- 34 snack vending machines with 50% healthier items
- 8 meal vending machines with Healthy Living Awards

The Aroma Cafe brand was a wholly owned NHS coffee bar brand piloted within NHSGGC and now extended to 16 outlets across NHS Scotland, all meeting the Health Living Award + status. The last four years had seen income generation reduce a NHSGGC retail catering deficit into a £73,000 surplus in 2013/14.

The Food Retail Policy proposed that NHSGGC adopted an exemplar position in the routine provision of healthy eating opportunities for patients, staff and visitors. The remaining vending machines, managed by external companies, were now moving towards compliance with the Food Retail Policy. In addition, on completion of the move to the New Southside Hospitals in 2015, new lease agreements with externally operated retail shops, cafes, tea rooms and trolleys were anticipated to be in operation.

Dr de Caestecker reported that the Retail Food Policy was approved by the NHS Board's Quality and Performance Committee at its May 2014 meeting.

In response to a question from Ms Micklem, Dr de Caestecker confirmed that the NHS Board did link with the sustainability agenda looking at local suppliers and locally grown produce and worked with the Soil Association to discuss how, as an organisation, NHSGGC could make improvements in this regard.

Dr Reid asked about the subjective terms used in relation to the inclusion of salt and sugar. Dr de Caestecker clarified that there were strict guidance levels that lay behind those policy statements.

In response to a question from Mr Winter, Dr de Caestecker reported that, when the policy was in place, staff, patients and visitors would see a difference in terms of how sugary foods and sweets were displayed as they would not then be at eye level.

DECIDED

- That the Retail Food Policy be adopted.

**Director of
Public Health**

UNDER STANDING ORDER 12, THE NHS BOARD ACCEPTED A MOTION TO ADJOURN ITS MEETING TO ALLOW IT TO RECONVENE AS NHSGG&C's ENDOWMENT TRUSTEES FOR THE FOLLOWING ITEM:-

46. STATEMENT OF ACCOUNTS FOR 2013/14

A report of the Director of Finance asked the Trustees to adopt the Statement of Accounts for the financial year ended 31 March 2014 and authorise the Director of Finance to sign the Statement of Trustees Responsibilities and balance sheet.

Mr James presented an audited set of accounts for Trustees' approval following detailed scrutiny at the NHS Board's Audit Committee meeting on 17 June 2014. He explained that this year, for the first time, the accounts of NHS Greater Glasgow & Clyde Endowments Funds were TO BE consolidated with the NHSGGC Financial

Statements. HM Treasury had noted that the Trustees who controlled the Endowments Funds were all members of the NHS Board. In their view, therefore, this meant that the NHS Board controlled the Endowments Funds. He explained that the Endowments Funds accounts required to be adopted prior to the NHSGGC Consolidated Annual Accounts being approved by the NHS Board.

Mr James took the Trustees through the accounts, the Statement of Trustees Responsibilities and the Independent Auditors Report to the Trustees.

Mr Lee asked about the total unrestricted funds which included an amount of £11.4m (2013 was £10m) which had been allocated for the New South Glasgow Hospitals Fund. It was agreed that the sum designated to this project had been £10m and, therefore, this sum should appear in the Accounts.

Dr Benton highlighted a typographical error on page 130 of the NHS Board papers where one of the columns was dated 2012 instead of 2013. Mr James would have this amended.

**Director of
Finance**

Mr James thanked his finance teams for their work throughout the year and, in particular, for their endeavours in consolidating the Endowments Funds with the NHSGGC Financial Statements for the first time this year.

DECIDED

- That, the Statement of Accounts for the financial year ended 31 March 2014 be adopted.
- That, the Director of Finance sign the Statement of Trustees Responsibilities and Balance Sheet be authorised.

**Director of
Finance**

UNDER STANDING ORDER 12, THE NHS BOARD MEETING WAS RECONVENED TO COMPLETE THE BUSINESS TO BE TRANSACTED.

47. GOVERNANCE STATEMENT 2013-14

A report of the Convenor of the Audit Committee [Board Paper No 14/38] comprising a Statement of Assurance by the Audit Committee and a Governance Statement, which was part of the Annual Accounts for 2013/14, was submitted. Subject to approval of this report, the NHS Board was asked to authorise the Chief Executive to sign the Governance Statement as the Accountable Officer.

The Convenor of the Audit Committee, Mr K Winter, presented the report.

The Audit Committee, at its meeting on 3 June 2014, received a report which provided members with evidence to allow the Committee to review the NHS Board's system of internal control for 2013/14. Based on the review of internal control, the Audit Committee approved both the Statement of Assurance to the NHS Board on the system of internal control within NHS Greater Glasgow and Clyde and the Governance Statement for NHS Greater Glasgow and Clyde.

Mr Winter took the NHS Board through Appendix 1 – Statement of Assurance by the Audit Committee and Appendix 2 – Governance Statement. He reported that there were no significant matters relating to the system of internal control which required to be disclosed in the Governance Statement and that the Audit Committee recommended that the NHS Board approve the Governance Statement and that this be signed by the

Chief Executive as Accountable Officer.

DECIDED

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| 1. That the Statement of Assurance from the Audit Committee be accepted and noted. | Director of Finance |
| 2. That the Governance Statement be approved for signature by the Chief Executive. | Chief Executive |

Mr James referred to the Board Paper No 14/39 which asked the NHS Board to adopt and approve, for submission to the Scottish Government Health Directorate (SGHD), the Statement of Accounts for the financial year ended 31 March 2014.

Mr James introduced the accounts which had previously been considered in draft form by the Audit Committee. He advised that the Revenue Resource Limit and Capital Resource Limit had both been achieved.

The accounts were prepared, as required, to comply with the requirements of International Financial Reporting Standards (IFRS) and in a format required by the SGHD, so that these could be consolidated with the accounts of other NHS Board to form the accounts of NHS Scotland.

The Audit Committee had scrutinised the Director of Finance's report at its meeting on 3 June 2014 and the final draft set of accounts at its meeting on 17 June 2014. As a consequence, the Audit Committee could confirm to the NHS Board meeting that it recommended that the NHS Board adopt the accounts for the year to 31 March 2014.

Mr James advised that, at its meeting on 17 June 2014, the Audit Committee received confirmation from Audit Scotland of its intention to issue an unqualified opinion in respect of the financial statements, the regularity of financial transactions undertaken by the NHS Board, and on other prescribed matters.

Mr James confirmed that the NHS Board's Financial Statements disclosed that the NHS Board had met its financial targets. He took members through the key elements of the accounts including the Operating Cost Statement, Balance Sheet and Cash Flow Statement to the year ended 31 March 2014. Mr James summarised the main issues arising from his report and confirmed that Audit Scotland's opinion was that the financial statements gave a true and fair view of the accounts.

Ms Brown referred to the Staff Governance Committee membership on page 145 of the NHS Board papers and highlighted that three members were missing. Mr James agreed to have this updated.

Director of Finance

DECIDED

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| 1. That the Statement of Accounts for the financial year ended 31 March 2014 be adopted and approved for submission to the Scottish Government Health Directorate. | Director of Finance |
| 2. That the Chief Executive be authorised to sign the Director of Finance's report, the remuneration report, the Statement of the Chief Executive's responsibilities as the Accountable Officer of the NHS Board and the Governance Statement. | Chief Executive |
| 3. That the Chair and the Director of Finance be authorised to sign the Statement of NHS Board Members Responsibilities in respect of the Accounts. | Chair and Director of Finance |

4. That the Chief Executive and the Director of Finance be authorised to sign the Balance Sheet.

**Chief
Executive and
Director of
Finance**

48. CAPITAL PLAN 2014/15 TO 2016/17

A report of the Director of Finance [Board Paper No 14/40] asked the NHS Board to approve the proposed allocation of funds for 2014/15, note the current indicative allocations for 2015/16 and 2016/17, and delegate to the Quality and Performance Committee and Joint Capital Planning and Property Group, the authority to allocate any additional available funds against the 2014/15 Capital Plan throughout the year.

Mr James advised that a balanced capital position for 2014/15 with planned expenditure of £179.520m was matched by an equivalent level of funding. Following the Scottish Parliament's approval of the 2014/15 Budget Bill in February 2014, an initial capital resource allocation of £169.4m was announced for NHSGGC. Since that time, further allocations had been confirmed by the SGHD in respect of NHSGGC's Capital Programme and brokerage of £7m from 2013/14 to 2014/15 was also agreed. These adjustments resulted in revised capital resources for 2014/15 of £179.520m.

Mr James led the NHS Board through the proposed Capital Plan, incorporating proposed capital schemes across Acute Services, Board and Partnerships including Mental and Oral Health. Expenditure on all capital schemes would be monitored throughout the year and reported to the Joint Capital Planning and Property Group to ensure that a balanced capital position was maintained for 2014/15.

Councillor Rooney asked where proposed capital projects such as that for Clydebank Health Centre were included. Mr James explained that there were a number of plans for such projects but that these were not part of the NHS Board's Capital Plan as they were subject to HUB funding. All six CH(C)Ps were required to bid to the Scottish Government for such funding streams. Mr Calderwood emphasised that if the schemes were not funded through HUB, there was no prospect of them being currently progressed from within the NHS Board's Capital Plan.

Mr Carson congratulated the NHS Board for developing the New South Glasgow Hospitals on budget and ahead of schedule.

Following up on Councillor Rooney's earlier point, Mr Finnie queried the format of the Capital Plan and asked how capital allocation for projects such as health centres were decided – and asked in particular, if there was any clinical/medical criteria. Mr Calderwood explained that directorates and CH(C)Ps considered their own local priorities and challenges with clinical staff and submitted for further consideration the schemes they believed merited capital funds. With restricted access to capital funds, many schemes were prioritised to meet the Board's legal obligations in respect of health and safety, fire and disability discrimination regulations. All proposed capital projects over £1.5m were thereafter submitted to the NHS Board's Quality and Performance Committee for approval.

DECIDED

1. That the proposed allocation of funds for 2014/15 be approved.
2. That the current indicative allocations for 2015/16 and 2016/17 be noted.

**Director of
Finance**

3. That the Quality and Performance Committee and Joint Capital Planning and Property Group be delegated the authority to allocate any additional available funds against the 2014/15 Capital Plan throughout the year.

**Director of
Finance**

49. 2014/15 FINANCIAL PLAN

A report of the Director of Finance [Board Paper No 14/41] was submitted providing an overview to the NHS Board of the major elements within the Financial Plan, highlighting key assumptions and risks and explaining how it was proposed to address the cost savings challenge which the NHS Board faced in order to achieve a balanced financial outturn in 2014/15.

Mr James provided an overview of the process used to develop the Plan; an explanation of the funding uplift that the NHS Board would receive in 2014/15; the most recent projection of the scale of financial challenge which the NHS Board would need to address if it was to succeed in managing its Revenue Resource Limit for 2014/15 and the cost savings plan for 2014/15 that would enable the NHS Board to address that financial challenge and deliver a break even financial outturn for the year.

Mr James took the NHS Board through the most salient points of the Financial Plan. The SGHD had confirmed a headline funding uplift for 2014/15 of £53.6m or 2.7%.

Mr James referred to the proposals for funding following discussions with Directors which had led to pressures and possible investments being captured and agreed. The 2014/15 Financial Plan assumed that the pressures and investments would be funded but Mr James erred that it might be prudent to increase the challenge in order to address additional pressures that may emerge and an update on this would be provided to the NHS Board during the year as appropriate.

**Director of
Finance**

In response to a question, Mr James alluded to some of the costs and pressures including pay cost growth, prescribing and energy cost growth. In terms of the development of a cost savings plan for 2014/15, proposals had been produced that totalled £32.9m of cash releasing savings and although recurring savings proposals had been produced, it had been difficult for divisions to suggest adequate in-year savings to address the full financial challenges faced. Recurring savings proposals were largely in line with the £32.9m target but it was likely that the “current year” impact in 2014/15 of savings proposed would only be £24.2m – creating an in-year gap of £8.7m which would be funded non-recurringly. £4.4m of the £8.7m gap related to capital charges that would not be needed until the beginning of 2015/16, leaving a figure of £4.3m to be funded. It was, therefore, proposed to provide non-recurring funding of £4.3m in order to bridge the gap.

Mr James reported that the plan also allowed the NHS Board to retain its recurring contingency of £5m. As Divisions produced further proposals that met their overall 2014/15 targets, there would be a favourable impact on the plans for 2015/16. These further proposals would be considered by the Quality and Performance Committee when available. This would give the NHS Board a start towards the further significant challenge it faced in 2015/16 and beyond.

Mr James confirmed that the Financial Plan had been prepared using the most up-to-date information, however, it was recognised that circumstances can (and do) change during the year.

As such, he highlighted some of the main risks including boundary changes, medicines, savings schemes and winter pressures.

In response to a question from Dr Benton concerning the £3m earmarked for Hepatitis C, Mr James reported that this remained the case and that the wording in the NHS Board paper was an error.

Councillor O'Donnell asked about the term "medium" as it related to the NHS Board's financial strategy. Mr James explained that he regarded medium term to be around 2/3 years.

DECIDED

- That, the Financial Plan for 2014/15 be approved.

**Director of
Finance**

50. WAITING TIMES AND ACCESS TARGETS

A report of the Interim Lead Director, Acute Services Division [Board Paper No 14/42] asked the NHS Board to note progress against the national targets as at the end of April 2014.

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 (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 NHSGGC.

Mr Archibald reported that two patients breached the national treatment time guarantee of 12 weeks from decision to treat and explained that, in both instances, the patients were not added to the waiting list at the correct time due to administrative errors. As such, processes had since been reviewed to ensure that this did not occur in future.

In respect of Accident & Emergency waiting times, 19 patients waited over 12 hours to the conclusion of treatment and NHSGGC performance for the quarter overall was 89.1% (the national target was 98%). This had been disappointing.

Although not within the reporting quarter, Mr Archibald alluded to events on Monday 2 June into Tuesday 3 June during which the Acute Services Division experienced an unprecedented 25% surge in attendances and a 24% increase in admissions at the Victoria Infirmary Accident & Emergency Department. Increases in activity were also experienced elsewhere in the city and led to a number of unacceptable lengths of stay for some patients. Mr Archibald outlined the measures taken to deal with this peak in demand, highlighting that clinical teams worked hard to care for all patients during this period of exceptional demand. Furthermore, a number of actions had been identified to ensure that NHSGGC's ability to admit patients from Emergency Departments was improved.

95% of all eligible patients should wait no longer than 62 days (or 31 days) for treatment for cancer. Disappointingly, 94.5% was achieved in NHSGGC for the period and an action plan was produced for scrutiny by the SGHD who had since reported that they were reassured that NHSGGC was informed on the detail and underlying cause for this performance, and staff collectively were taking ownership and providing leadership to seek solutions. Mr Archibald added that a very detailed list of measures was being taken forward in each pathway which would improve performance.

Councillor Rooney asked about the "Change Funds" released to Partnerships for the joint planning between health and local authorities regarding older people. Mr Calderwood outlined the Change Fund allocations for 2014/15 but added that with the

withdrawal of Change Fund allocations, this would be challenging going forward from 2015/16. Guidance would be issued on Change Fund monies shortly and the NHS Board would liaise with SGHD at that time.

Mr Carson asked about any obligation on the NHS when it disposes of land for housing development to ensure that a quota of new-build housing was suitable for wheelchair use. Mr Calderwood explained that, at this time, there were no imposed restrictions to buyers when purchasing land from the NHS and the priority was to seek to maximise revenue. Mr Carson was disappointed and suggested that criteria in future would be useful to ensure social housing was built. He considered that future disposal strategies should encourage more engagement between the private and public sector in a collaborative way to meet the needs of the current (and future) population mix.

NOTED

51. FINANCIAL MONITORING REPORT FOR THE 2 MONTH PERIOD TO 31 MAY 2014

Mr James reported that, as at Month 2, the NHS Board was in £1m overspend and this was broken down to Partnerships having a £200,000 overspend with the Acute Services Division an £800,000 overspend (Corporate broke even). This was to be expected at this time in the financial year and full reports would be considered by the NHS Board from Month 3 going forward.

NOTED

52. QUARTERLY REPORT ON COMPLAINTS – 1 JANUARY TO 31 MARCH 2014

A report of the Nurse Director [Board Paper No 14/43] asked the NHS Board to note the quarterly report on NHS complaints in Greater Glasgow and Clyde for the period 1 January to 31 March 2014.

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 75.5% of complaints responded to within 20 working days had been achieved.

Ms Crocket alluded to the issues attracting most complaints and highlighted that, across Partnerships and the Acute Services Division, these were clinical treatment, date for appointment, attitude and behaviour and oral communication. She outlined some of the service improvements and actions being taken to address complaints both within the Acute Services Division and at Partnership level. She also noted the Scottish Public Services Ombudsman's reports and the recommendations contained therein which were submitted to the Quality and Performance Committee for monitoring purposes.

Ms Micklem asked about the feedback received from patients via the NHS Board's website, launched late in 2013. Mr McLaws confirmed that, to date, the figures had been fairly consistent and it was his intention to launch a marketing campaign to highlight its availability. In terms of patients providing feedback (both positive and negative) via this route, there had not been an initial target set.

Ms Brown asked about the PASS feedback which listed East Renfrewshire CH(C)P as being the most frequently recorded CH(C)P in terms of the PASS service. Councillor Lafferty reported that the East Renfrewshire CH(C)P Director would make contact

with the PASS service to understand better what lay beneath this.

NOTED

53. QUALITY AND PERFORMANCE COMMITTEE MINUTES: 18 MARCH 2014 AND 20 MAY 2014

The Minutes of the Quality and Performance Committee meetings held on 18 March 2014 [QPC(M)14/02] and 20 May 2014 [QPC(M)14/03] were noted.

NOTED

54. AREA CLINICAL FORUM MINUTES: 10 APRIL 2014

The Minutes of the Area Clinical Forum meeting held on 10 April 2014 [ACF(M)14/02] were noted.

NOTED

55. PHARMACY PRACTICES COMMITTEE MINUTES: 24 MARCH 2014 AND 21 MAY 2014

The Minutes of the Pharmacy Practices Committee meetings held on 24 March 2014 [PPC(M)2014/02] and 21 May 2014 [PPC(M)2014/03] were noted.

NOTED

56. AUDIT COMMITTEE MINUTES: 3 JUNE 2014

The Minutes of the Audit Committee meeting held on 3 June 2014 [A(M)14/02] were noted.

NOTED

The meeting ended at 12.25pm