NHSGG&C(M)14/04
Minutes: 57 - 72

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, 19 August 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	Mrs T McAuley
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
Mr P Daniels OBE	Dr R Reid
Dr L de Caestecker	Councillor M Rooney
Councillor M Devlin	Rev Dr N Shanks
Professor A Dominiczak	Mr D Sime
Mr R Finnie	Mr K Winter

IN ATTENDANCE

Mr G Archibald	Lead Director, Acute Services Division
Mr R Garscadden	Director of Corporate Affairs
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Ms A Harkness	Director of Emergency Care and Medical Services
Mr J Hobson	Interim Director of Finance
Mr K Redpath	Director Representative for Partnerships
Mr I Reid	Director of Human Resources
Mr D Walker	Director, Glasgow City CHP (South Sector)

ACTION BY

57. WELCOME AND APOLOGIES

Mr Robertson welcomed Mrs T McAuley to her first NHS Board meeting as a newly appointed Non-Executive Member. He also introduced Dr D Lyons who had also been appointed but who had submitted his apologies for this meeting. The Chair of National Services Scotland, Ms E Ireland, was in attendance to observe the proceedings of the NHS Board meeting and Mr Robertson extended a warm welcome to her.

Apologies for absence were intimated on behalf of Councillor M Cunning, Mr I Fraser and Dr D Lyons.

NOTED

58. 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

59. CHAIR'S REPORT

(i) On 25 June 2014, Mr Robertson attended the official opening of the new Lister Building at Glasgow Royal Infirmary. This was opened by the Cabinet Secretary for Health and Wellbeing and the £15m major refurbishment included three floors for NHSGGC Laboratory Services and two floors for the University of Glasgow and represented one of the most modern in the UK, providing first class, 21st century facilities from both.

(ii) On 26 June 2014, Mr Robertson attended the "Release Potential Campaign – Staff Engagement Event", the aim of which was to talk to disabled staff about their experiences and how things could be improved so that they felt able to tell their managers about their impairment and also so that managers understood the benefits of a workplace that supported disabled people. The event gave an insight into a range of experiences of staff with a disability and a report would be drawn up summarising the key themes raised.

(iii) Mr Robertson continued to visit last year's Chairman's Award winners in their own work areas which he was finding enlightening in terms of how lessons were being learned to improve services within local areas and, furthermore, being rolled out wider across NHSGGC.

(iv) On 24 July 2014, along with other NHS Board Members, Mr Robertson attended the Topping Out Ceremony (performed by the Cabinet Secretary for Health and Wellbeing) of the new Teaching and Learning Centre at the new Southside Hospital development. This Centre was developed jointly by NHSGGC and the University of Glasgow and was an investment of £27m to provide a training environment for the clinical years of the undergraduate medical degree, post graduate training facilities for medical staff and a large variety of NHS professionals. It would ensure that training of the next generation of doctors, scientists, clinical academics and support staff could be undertaken. The new Centre would replace facilities at the Western Infirmary, Victoria Infirmary, Southern General and the Royal Hospital for Sick Children which would all close following the transfer of clinical services to the new Southside Hospital site.

(v) On 31 July 2014, Mr Robertson attended the National Young Carers Festival at West Linton. This was an excellent event attended by around 700 young carers and provided an opportunity to share their good and bad experiences, highlighting where improvements could be made.

(vi) On 7 August 2014, Mr Robertson hosted a Thank You Afternoon Tea for volunteers and staff of the Royal Voluntary Service (RVS) as well as NHSGGC staff who had benefited from their "Gifting Fund" which included the gifts of a replacement private ambulance and a special garden designed at the Langlands Unit.

(vii) Councillor Rooney commended the NHS Board's preparation and contingency plans in light of the success of the Commonwealth Games. He took the opportunity to celebrate the achievement and praised staff for their excellent

planning and service delivery throughout the Queen's Baton Relay and the Commonwealth Games themselves. Dr Armstrong agreed and alluded to official feedback from the Organisation Committee of the Commonwealth Games Glasgow 2014, who had confirmed excellent support and input from NHS staff. Mr Robertson acknowledged this and suggested the full report of the Organisation Committee be considered at a future NHS Board meeting. **Director of Public Health**

NOTED

60. CHIEF EXECUTIVE'S UPDATE

(i) On 31 July 2014, Mr Calderwood addressed the Greater Glasgow and Clyde branch of Unite the Union. He outlined NHSGGC service provision from 2015 onwards and looked at services going forward in relation to Acute Services Implementation, Finance, Health and Social Care Integration, Clinical Services Review and Management Restructuring.

(ii) On 5 August 2014, Mr Calderwood met with Dr F G Dunn, President, Royal College of Physicians and Surgeons of Glasgow, to discuss the difficulties of delivering the PACES examination within the NHSGGC area. The challenges had been in identifying sufficient examiners and the requisite space within the NHSGGC area. Mr Calderwood agreed to work with Dr Dunn to try to accommodate dedicated clinical skills areas at the Southside Hospital and Glasgow Royal Infirmary.

(iii) On 14 August 2014, Mr Calderwood delivered a presentation to the Holyrood Summer School held at Stirling University on "Delivering World-Class Healthcare and the Challenges of the Next Five Years". The interaction with the participants had been insightful.

NOTED

61. MINUTES

On the motion of Dr R Reid, seconded by Mr D Sime, the Minutes of the NHS Board meeting held on Tuesday, 24 June [NHSGGC(M)14/03] were approved as an accurate record and signed by the Chair.

NOTED

62. MATTERS ARISING FROM THE MINUTES

(i) The rolling action list of matters arising was noted.

(ii) In response to a question from Councillor Rooney concerning Minute No 44 (Keep Well Programme), Dr de Caestecker reported that an EQIA had not been carried out in relation to Keep Well nationally but that this had been looked at locally.

(iii) In response to a question from Councillor Rooney concerning Minute No 48 (Capital Plan: 2014/15 to 2016/17), Mr Calderwood confirmed that £1.1m remained unallocated at that time. All unallocated funds were reviewed every 2/3 months to review progress and consider proposals for their reallocation.

NOTED

63. SCOTTISH PATIENT SAFETY PROGRAMME UPDATE

A report of the NHS Board's Nurse Director [Board Paper No 14/44] asked the NHS Board to note the high level overview report on the Maternity and Children Quality Improvement Collaborative (MCQIC) which encompassed the clinical improvement activity of the Scottish Patient Safety Programme's (SPSP) maternity, neonatal and paediatric strands. Its overall aim was to improve outcomes and reduce inequalities in outcomes by providing a safe, high quality care experience for all women, babies and families in Scotland. It was launched in March 2013 and would run until December 2015.

Ms Crocket led the NHS Board firstly through an update on the maternity workstream and secondly the paediatric and neonatal workstream. She explained that there were three major obstetric care sites within NHSGGC. All three had been well engaged and were demonstrating good levels of progress in implementing the National Programme aims of the maternity workstream which aimed to support clinical teams to improve the quality and safety of maternity healthcare. She provided a snapshot of the measurement activity from each of the sites and cited examples and challenges that demonstrated a broad scope of activity generated in the first year including:-

- Person-centred care;
- Leadership and culture;
- Teamwork, communication and collaboration;
- Safe, effective and reliable care;
- Key outcome measures.

In going forward, Ms Crocket reported that each team had a local plan for further development.

In terms of the paediatric and neonatal workstream, there were currently 20 teams supported across paediatric and neonatal services. She highlighted the areas of particular success and reported that neonatal teams had agreed the use of the national toolkit in order to submit their data to the local data team for monthly collation and reporting.

Mr Sime asked if there was a mechanism in place to standardise the SPSP for the Maternity and Children Quality Improvement Collaborative. Ms Crocket confirmed that NHSGGC was working with other NHS Boards who had a paediatric hospital to look at how this could be coordinated nationally.

Ms Micklem found the report helpful but sought further information about the two workstreams in terms of baseline information and how NHSGGC was performing when compared to other NHS Scotland Boards (and the wider UK). Ms Crocket agreed to provide Ms Micklem with this information. **Nurse Director**

NOTED

64. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No 14/45] 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). For the last available reporting quarter (January to March 2014), NHSGGC reported 26.3 cases per 100,000 AOBDs. NHS Scotland reported 28.4 cases per 100,000 AOBDs. These were the lowest SAB rates achieved to date. 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, January to March 2014, NHSGGC reported 24.1 cases per 100,000 AOBDs, combined rate for all ages. This placed the NHS Board below the national average of 28.7 per 100,000 AOBDs. This was the lowest rate to date.

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 3,158 members of staff who were now registered as Cleanliness Champions.

Dr Armstrong summarised the requirements and actions from an unannounced Healthcare Environment Inspectorate (HEI) inspection at the Princess Royal Maternity Hospital on 30 April 2014. She also alluded to norovirus activity which saw one ward closed (in one hospital) throughout May and June 2014.

Councillor Rooney commended the good progress made in meeting the targets in Healthcare Associated Infections since 2007/08. He also asked about the healthcare associated infection report cards that provided information for each acute hospital and key community hospital within NHSGGC. Dr Armstrong explained that it was important to understand the source of infections either from hospitals and/or community sources so that there was a geographical focus, if and when, any infections increased. It also helped in looking at prescribing patterns and the use of antibiotics within geographical communities.

Dr Benton asked about continuous improvement measures in place. Dr Armstrong summarised ongoing learning and training undertaken in respect of central vascular catheters (CVC) and peripheral vascular catheters (PVC) and how/when they were inserted/removed. This was achieved by ensuring staff were aware and adhered to best practice and completed the accompanying care bundle documentation to ensure the risk

of infection to patients was minimised.

In response to a question from Councillor Rooney concerning the public inquiry into the Vale of Leven Hospital, Mr Calderwood reported that, in accordance with the Vale of Leven Hospital Inquiry website, its Chairman (the Right Honourable Lord MacLean) had now considered each of the responses to the warning letters issued. As the responses received were both lengthy and detailed, this process had taken some time and that had now been concluded with any necessary amendments being made to the report. Once the amendments had been made, the whole report would then be reviewed in preparation for submission to the publishers.

NOTED

65. UNSCHEDULED CARE

A report of the Director of Emergency Care and Medical Services, Acute Services Division [Board Paper No 14/46] asked the NHS Board to note developments with the Local Unscheduled Care Plan, ongoing service redesign work between NHS services and its partners, and approve the allocation of £1.1m additional investment required in 2014/15.

Ms Harkness reported that, in 2013, the Scottish Government announced a three year National Unscheduled Care Programme designed to ensure that patients were admitted or discharged from emergency departments as soon as possible with a view to ensuring that 95% of patients were treated in accordance with the standard by September 2014 and 98% by April 2015. NHSGGC prepared a Local Unscheduled Care Action Plan and this was approved by a National Evaluation Panel on 31 July 2014.

Ms Harkness recorded that NHS Board performance had been at 90% for recent months with most patients waiting in an Emergency Department for an inpatient bed to be made available. A review of activity had been undertaken and illustrated that, while the number of patients attending Emergency Departments and Minor Injuries Units remained static in 2013/14, the number of people admitted following an Emergency Department attendance had risen by 2.4% compared with the previous year. By the end of June 2014, attendances were 2.6% higher than the first quarter last year.

Ms Harkness led the NHS Board through some service improvement initiatives undertaken including the following:-

- Working with partner agencies was key to ensuring that people received the right care, in the right place at the right time.

- Work across NHS services (acute and community services) to ensure that people could be cared for at home or in a homely setting for a long as possible and were discharged as soon as they were ready for this to take place.

- Work within Acute Services looking at local processes to ensure that discharge decisions were implemented as soon as possible.

Ms Harkness explained that, whilst service redesign and joint work continued to make progress, the results could take some time to deliver sustained improvement. There was, therefore, a need to take a number of immediate actions in order to ensure that patients could be admitted from NHSGGC's Emergency Departments.

Inpatient beds were a rapid solution to the issue and could be closed equally rapidly when the impact of other initiatives was felt – it was proposed to open additional beds on three hospital sites.

Furthermore, a review by a senior decision maker was required to ensure that patients had been promptly assessed, treatment initiated, and a care plan agreed. It was proposed to appoint a medical nurse practitioner to work at Inverclyde Royal Hospital – all other sites currently had this resource, however, it was also proposed to increase emergency nurse practitioner hours in the Emergency Department at the Royal Alexandra Hospital and to appoint four additional consultant physicians. A surgical assessment area would also be established at the Royal Alexandra Hospital to allow patients to move more quickly from the Emergency Department to specialist care.

A number of other initiatives would also be taken forward by local services and this would require additional investment of £1.1m by the NHS Board (in addition to the Local Unscheduled Care Action Plan allocation). The impact of these actions would be evaluated and, should they deliver the planned levels of improvement, they would be recommended for consideration for ongoing investment in 2015/16.

Mr Walker summarised the core elements of a report prepared by Glasgow City Social Work Services, Glasgow CHP and the Acute Services Division setting out the wider context within which a shifting of care for older people could be achieved over the course of the next four years and, at the same time, outlined the actions that were proposed to improve hospital discharge arrangements in 2014/15. He led the NHS Board through the key issues including the plan to reconfigure the balance of community-based health and social care for older people and the core elements of the proposed change programme including the potential impact on hospital delays this financial year. He outlined how the development would be funded on a recurring basis from 2015/16 and identified the need for transitional resource this year to address the reduced levels of care home funding and ease the anticipated pressures whilst the planned programme of change was implemented.

Mr Walker summarised the projected shift in the balance of care in financial terms and projected numbers of people supported over what would be a very challenging four years. He confirmed the projected shift in available resources away from long-term care to intermediate care, reablement, day care, telecare and community-based healthcare including rehabilitation. He explained that the continued risk remained the mismatch between available supply and demand for care home placements, particularly where the hospital system experienced unexplained surges in demand.

Mr Walker went on to describe the in-year actions required to improve discharge performance and the continuing gap between the available care home budget and demand for placements. The impact of this gap was that if no action was taken by the end of this financial year there could be approximately 160 further patients delayed in hospital awaiting funding. He set out the capacity gains and financial costs associated with meeting this pressure, at the centre of which was a redesign/improvement plan to significantly increase the levels of intermediate care capacity in the city from the present 37 to 115 places. The hypothesis underpinning the redesign was that, by facilitating discharge from the acute care system at (or close to) the "fit for discharge" date, followed by comprehensive assessment, with access to intensive rehabilitation and other appropriate care that a proportion of people could be returned to their own homes rather than be placed permanently in a care home.

In response to a question from the Chairman, Mr Walker confirmed that the Council was currently considering the provision of additional in-year financial support.

In response to a question from Rev Dr Shanks, Mr Walker indicated that successful implementation of the improvement plan should deliver significant improvements in terms of a sharp reduction in the number of patients awaiting discharge coupled with better outcomes for patients particularly if more could be returned to their own homes. In terms of whether accommodation was immediately available for intermediate care,

Mr Walker indicated that this would likely come from a combination of the private care home sector and the Council's new residential care programme which would see five new care homes opening in Glasgow in the space of the next 12 months. In terms of the assessment of patients, the aim under the plan would be to discharge suitable patients from hospital as soon as possible so that assessments were not undertaken in a hospital environment. Mr Walker conceded that work still had to be undertaken to iron out issues of consent and who had to be involved in that process.

In relation to the financial framework, Mr Calderwood confirmed that the full year cost of the improvement plan, totalling £3.764m, would be a first call on the Integrated Care Fund received by Glasgow in 2015/16 and, thereafter, funded from within the residential/nursing budget to be managed by the new HSCP. However, in the current year, there remained a significant financial shortfall to meet the gap between the available care home budget and demand for placements and, at the same time, the need to initiate the improvement plan.

Councillor Rooney also alluded to the £1.2m deficit being reported, as at 30 June 2014, by the NHS Board and wondered how, in light of this, an additional £1.1m could be found for this purpose. Mr Hobson recognised this additional pressure on the budget but it was considered that it would be containable within exciting resources. In addition, there would need to be an assessment undertaken to establish if the proposed model was working and whether having patients return to their home (either unsupported or in a supported care package) did reduce the spend in acute beds.

In response to a question about the Change Fund, Mr Calderwood agreed that there was concern regarding this future funding source and clarity was awaited. All NHS Boards and Local Authorities faced major choices in the future if there were changes made to the Change Fund.

Mr Carson referred to a lack of accessible housing for people with disabilities and encouraged NHSGGC to work with partners to address this. Mr Walker agreed and reported that Glasgow City had over 60 housing associations and that the Partnership would continue to work with them in the future as part of the wider Reshaping Care arrangements.

In response to Councillor O'Donnell's point regarding future available funds, Mr Calderwood commented that all public partners were considering and assessing spending. In the NHS in particular, all parts of the system were seeing a rise in demand so the redesign of services had to be undertaken around static resources and this was a huge challenge going forward.

In response to further questions, Mr Calderwood emphasised that, fundamentally, NHSGGC was working to achieve the discharge of suitable assessed patients after an acute intervention and this proposal was a non-recurring package for 2014/15. A number of initiatives may prove to be successful so it may be that these were considered for mainstreamed funding from 2015/16 onwards.

Dr Reid supported the proposals as did Mr Finnie, following Mr Calderwood's clarification particularly in looking at the expenditure elements. There was appreciation of the difficulty in looking objectively at planning patient care going forward against the challenge of meeting financial obligations.

Councillor Macmillan also welcomed the paper and summarised work being carried out in Renfrewshire CHP (alongside the Council's Social Work department). He also agreed that there was a huge pressure on NHS Boards and Local Authorities in terms of amendments to the Change Fund but appreciated that this was likely to be discussed in the future.

Ms Brown considered that the paper should have made reference to community health services, nurses, GPs and palliative care in the community to provide a whole system approach for "hospital to home". She appreciated that the documents being considered was a summary, but would like to see the full strategy outlining the proposals for the four years going forward. Ms Harkness described the huge amount of work going on and indicated that this aspect had been referred to in her paper. Mr Walker agreed to circulate the strategy document to Members. Dr Cameron agreed that this would be useful, particularly in seeking reassurance around future workforce planning.

Director, Glasgow City CHP (South Sector)

DECIDED

- That, the Local Unscheduled Care Plan had been approved by the Government with an associated allocation of £1,766,457m be noted.
- That, the Government had funded an additional £1,100,000m to facilitate the discharge of Glasgow City Council residents from hospital be noted.
- That, the ongoing Service Redesign work in NHS services and with partners be noted.
- That, the allocation of £1,100,000m additional investment required in 2014/15 be approved.
- That, the elements of this would require to be considered as part of the Board's financial plan for 2015/16 and beyond be noted.

Director, Emergency Care & Medical Services

66. NEW SOUTHSIDE HOSPITALS - NAMING

A report of the Chief Executive [Board Paper No 14/47] asked the NHS Board to agree that the new Adult Hospital be named the South Glasgow University Hospital and that the new Children's Hospital be named the Royal Hospital for Sick Children.

Mr Calderwood explained that the stage had been reached where the next step was to begin to order the hospital signage for the neighbouring streets around the hospitals and internally within the hospital campus. It was important to recognise that the new Adult Hospital brought together three hospitals into one site (Southern General Hospital, Western Infirmary and Victoria Infirmary). In addition, the new hospital campus would have a major university presence particularly in relation to the Teaching and Learning Centre, Centre for Stratified Medicine and the Clinical Research Facilities on site. To give full and proper recognition to the amalgamation of the three hospitals on the new Southside campus, its location and the significant partnership work with the University of Glasgow, it was proposed to name the new Adult Hospital the South Glasgow University Hospital.

As with the Adult Hospital, signage also needed to be ordered for the new Children's Hospital. Mr Calderwood explained that it was not considered necessary to change the name of the Children's Hospital from its current name as the Royal Hospital for Sick Children. It had a proud and long history of providing care and treatment to children from all over Scotland for many decades and it was not bringing different hospitals together onto one site.

It was, therefore, recommended that the name of the new Children's Hospital on the South Glasgow campus be the Royal Sick Hospital for Sick Children.

Mr Calderwood acknowledged that requests had been made to give recognition to

some historical and significant names within the hospitals involved in the migration. This would be fully discussed with the interested parties and due recognition would be given to the requests received, where considered appropriate, recognising that this was a new hospital and naming of the wards had been planned in order to assist the movement and flow of patients around these two new complexes.

Professor Dominiczak welcomed both names and considered that it represented the excellent partnership work between NHSGGC and the University of Glasgow.

Some members enquired why the word "South" was being retained particularly given that the new hospital had a much wider catchment than South Glasgow. The consensus was, however, support for the proposed name.

DECIDED

- That, the new Adult Hospital be named the South Glasgow University Hospital. **Chief Executive**

- That, the new Children's Hospital be named the Royal Hospital for Sick Children. **Chief Executive**

67. WAITING TIMES AND ACCESS TARGETS

A report of the Interim Lead Director, Acute Services Division [Board Paper No 14/48] asked the NHS Board to note progress against the national targets as at the end of June 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 inpatients had 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 outpatients, 77 ophthalmology and 6 neurology patients waited over 12 weeks and Mr Archibald reported significant demand and capacity pressures in both of these specialties which was a national issue and not limited to NHSGGC. He led the NHS Board through further background information and details of the specific planned actions taken by both services.

In respect of Accident & Emergency waiting times, 42 patients waited over 12 hours to the conclusion of treatment and NHSGGC's performance for the quarter overall was 90.1% (the national target was 98%).

Councillor O'Donnell referred to the term "breachers" when a patient had not been seen within a specific target period. Disappointingly, this term was now being used in frontline services and by staff which gave the perception of there being a problem with the patient. Mr Archibald agreed to consider a more suitable alternative phrase when reporting to the NHS Board. **Interim Lead Director (Acute Services)**

Councillor Rooney asked about patient "unavailability" and Mr Archibald explained that many NHS Boards were strictly interpreting the access provision and returning patients to the care of their GP if they had declined two reasonable offers. This practice had not been adopted in NHSGGC and the Acute Services Division continued to seek to provide patients with access to their nearest hospital, where at all possible. This had the effect of increasing patient unavailability. To draw any comparison, therefore, with other Boards was difficult as they applied the rules differently and NHSGGC chose to maximise access to its patients.

Mrs McAuley welcomed the overall focus on finding solutions that this report demonstrated. She referred, in particular, to the specific challenges at the Victoria Infirmary in meeting the stroke target. Mr Archibald explained that plans were in place to change the stroke admission pathway at the Victoria Infirmary so that all patients from that catchment area were being admitted consistently to the Southern General Hospital, replacing the current inconsistent pathway. This change would be implemented on 1 September 2014 and would be reflected in reporting information from that date onwards.

Mr Daniels asked about the seven patients awaiting spinal surgery whose care and treatment had not been provided within the treatment time guarantee. Mr Archibald reported that arrangements had been made for these patients to have their operations delivered by Ross Hall Hospital within the 12 week waiting time guarantee. The hospital had then been unable to provide the operations as required. This matter was being taken forward with Ross Hall (this arrangement was set up by the Scottish Government) and alternative arrangements had been made for the patients to have their operations.

NOTED

68. FINANCIAL MONITORING REPORT FOR THE 3 MONTH PERIOD TO 30 JUNE 2014

Mr Hobson reported that, as at 30 June 2014, the NHS Board was reporting expenditure levels of £1.2m over budget. This was close to the NHS Board's planned trajectory to achieve break-even by 31 March 2015. At this stage of the year, the NHS Board was also close to its year-to-date cost savings target against plan. In terms of capital expenditure, the first quarter amounted to £22.6m and it was anticipated that a balanced year-end position would be achieved.

In response to a question from Councillor Rooney, Mr Hobson confirmed that the £1.2m deficit did not take account of the decision made earlier on Unscheduled Care investment.

NOTED

69. FREEDOM OF INFORMATION MONITORING REPORT FOR THE PERIOD 1 APRIL 2013 TO 31 MARCH 2014

A report of the Head of Board Administration [Board Paper No 14/50] asked the NHS Board to note the Annual Monitoring Report on the operation of the Freedom of Information (FOI) (Scotland) Act 2002 and the Environmental Information (Scotland) Regulations (EIR) 2004 within NHSGGC for the period 1 April 2013 to 31 March 2014.

Mr Hamilton reported that the overall number of FOI / EIR requests received by NHSGGC during 2013/14 showed an increase of approximately 29% on 2012/13. The

distribution of FOIs varied from month to month with an average of 65 requests per month.

Mr Hamilton led the NHS Board through the report which detailed, amongst other issues, the source of requests, the type of information requested, performance monitoring and requests for review. He also indicated that Mrs Flynn, FOI Manager, had been successful in gaining the Practitioner Certificate in FOI (Scotland) with distinction.

In response to a question from Mrs McAuley, Mr Hamilton explained that all NHSGGC staff had access to an e-learning training module for both the Freedom of Information (Scotland) Act 2002 and the Environmental Information (Scotland) Regulations 2004. Their aim was to increase the knowledge and understanding within the organisation so that performance against legislative timescales continued to improve and the culture of FOI within the organisation developed. He agreed that NHSGGC also learned lessons from the outcomes of requests for review and decisions issued by the Scottish Information Commissioner. Use was made of the Act's provisions to provide advice and assistance to requesters where necessary, however, maybe more needed to be done to support those groups who did not make many requests.

Councillor Rooney asked if NHSGGC charged for providing a response in accordance with the Act. Mr Hamilton reported that NHSGGC did not charge for meeting requests.

NOTED

70. QUALITY AND PERFORMANCE COMMITTEE MINUTES: 1 JULY 2014

The Minutes of the Quality and Performance Committee meetings held on 1 July 2014 [QPC(M)14/03] were noted.

NOTED

71. AREA CLINICAL FORUM MINUTES: 5 JUNE 2014

The Minutes of the Area Clinical Forum meeting held on 5 June 2014 [ACF(M)14/03] were noted.

NOTED

72. AUDIT COMMITTEE MINUTES: 17 JUNE 2014

The Minutes of the Audit Committee meeting held on 17 June 2014 [A(M)14/03] were noted.

NOTED

The meeting ended at 11.30am