

NHSGG&C(M)14/05
Minutes: 73 - 90

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, 21 October 2014 at 9:30a.m.**

PRESENT

Mr A O Robertson OBE (in the Chair)

Dr J Armstrong	Mr I Lee
Dr C Benton MBE	Dr D Lyons
Ms M Brown	Mrs T McAuley
Mr R Calderwood	Councillor M Macmillan (To Minute No 85)
Dr H Cameron	Councillor J McIlwee
Ms R Crocket MBE	Ms R Micklem
Mr P Daniels OBE (To Minute No 84)	Councillor M O'Donnell
Dr L de Caestecker	Dr R Reid (To Minute No 83)
Professor A Dominicczak	Councillor M Rooney
Mr R Finnie	Rev Dr N Shanks
Mr I Fraser (To Minute No 88)	Mr D Sime
	Mr K Winter

IN ATTENDANCE

Mr G Archibald	Chief Officer, Acute Services Division
Mr R Garscadden	Interim Director of Corporate Affairs
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Mr J Hobson	Interim Director of Finance
Mr A MacKenzie	Interim Director, Glasgow City CHP
Mr A McLaws	Director of Corporate Communications
Mr G O'Hare	Clinical Nurse Specialist (For Minute No 84)
Ms C Renfrew	Director of Corporate Planning and Policy
Ms G Woolman	Audit Scotland

ACTION BY

73. APOLOGIES AND INTRODUCTORY REMARKS

Apologies for absence were intimated on behalf of Mr G Carson, Councillor M Cuning, Councillor M Devlin and Councillor A Lafferty.

In recording Mr Carson's apologies, Mr Robertson acknowledged that this would have been his last NHS Board meeting as his term of office was due to expire on 30 November 2014. Mr Carson had served eight years and had been the NHS Board's disability champion, bringing particular expertise from an independent living background. He would be greatly missed and, on behalf of the NHS Board, Mr Robertson extended his thanks and appreciation for his contributions to the business of the NHS Board and wished him well for the future.

Mr Robertson invited Mr Archibald to update on the UK-wide industrial action that had taken place on 20 October 2014 by the Society of Radiographers.

Mr Archibald reported that, following a recent ballot by the Society of Radiographers, industrial action was held on 20 October 2014 between 9:00am and 1:00pm and work to rule from Tuesday 21 October to Friday 24 October 2014. The action had some impact on services within NHSGGC, however, colleagues had worked hard with the Society of Radiographers to ensure that all essential and emergency services were covered. In other areas, public holiday cover would be provided. Other trade unions and professional associations were not participating in the action. NHSGGC was doing its utmost to ensure patients were seen in a timely manner during this period and he alluded to 93 patient tests and four elective appointments being postponed in advance as a result of the action and reassured that these would be rescheduled as soon as possible. The Society of Radiographers had picket activity on some sites but he reassured the NHS Board that essential health services would continue to be provided and he was hopeful that the impact for other staff and patients would be minimised.

NOTED

74. 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

75. CHAIR'S REPORT

- (i) Mr Robertson extended his congratulations to Mr G Archibald on his appointment to the position of Chief Operating Officer (Acute Services Division). Following a competitive interview process, Mr Archibald had taken up post immediately to lead the Acute Division through one of the most exciting and challenging periods in NHSGGC's history. This was a time for strong leadership and effective team working as the NHS Board moved to deliver organisational and service change on a significant scale.
- (ii) Mr Robertson alluded to the NHS Board's Annual Review held on 19 August 2014. This year had been a Non-Ministerial Review and a positive follow up letter had been received from the Cabinet Secretary for Health and Wellbeing.
- (iii) On 29 August 2014, Mr Robertson visited Ardgowan Hospice where members of staff were keen to build and develop a positive relationship with NHSGGC particularly around taking forward the NHS Board's Clinical Services Review.
- (iv) On 1 September 2014, Mr Robertson had attended one of a number of meetings, with other NHS Board Chief Executives and Chairs concerning preparation for the Integrated Joint Boards ((IJBs) from 1 April 2015 onwards. This was very useful in ensuring there was full awareness of all the issues and responsibilities for IJBs.
- (v) On 2 September 2014, Mr Robertson met with the judging panel for the Chairman's Awards, where the panel judged over 160 nominations. A celebratory dinner was arranged for 17 November 2014 when the awards would be presented – all NHS Board Members were invited to this event.

- (vi) On 10 September 2014, Mr Robertson attended a celebratory event commemorating the first year of Modern Apprenticeships in NHSGGC. In attendance were the first 50 who had successfully come through the programme. On a similar theme, on 11 September 2014, Mr Robertson awarded staff with SVQ Certificates. He congratulated all those who had been successful in upgrading their training and undertaking further education. The event had been attended by family members and staff supervisors who had supported those staff members through their studies.
- (vii) On 22 September 2014, Mr Robertson attended the first meeting of the Shadow Board of Glasgow Health and Social Care Partnership, chaired by Mr P Daniels.
- (viii) On 9 and 10 October 2014, Mr Robertson attended the IHM Conference on “Building Effective Relationships” which had been excellent in sharing views about the challenges faced by NHS Scotland.
- (ix) On 15 October 2014, Mr Robertson visited the Scottish Veteran Residents’ House, Bellrock House, in Cranhill. This was a hugely impressive facility for Scottish Veterans and had been an encouraging event.

NOTED

76. CHIEF EXECUTIVE’S UPDATE

- (i) On 8 September 2014, Mr Calderwood had the opportunity to return to the workplace. He visited the Royal Alexandra Hospital (Intensive Care Unit and Ward 24) alongside Dr J Armstrong and Ms R Crocket as part of the NHS Board’s commitment to the Patient Safety Programme.
- (ii) On 11 September 2014, Mr Calderwood attended the Inspiring City Awards at the Chamber of Commerce, Glasgow.
- (iii) On 25 September 2014, Mr Calderwood hosted a visit from the Institute of Healthcare Optimisation, Boston. Delegates had a particular interest in patient flow and had visited Glasgow Royal Infirmary. Their remit was to look at ways patients could get access to relevant treatments more speedily and effectively. Currently, they were in their data gathering stage but would return in January 2015.
- (iv) On 13 October 2014, Mr Calderwood was a guest of Sir John Arbuthnott’s Presidential Address at the Royal Society of Edinburgh to celebrate his term as President.

NOTED

77. MINUTES

On the motion of Rev Dr N Shanks, seconded by Dr R Reid, the Minutes of the NHS Board meeting held on Tuesday, 19 August 2014 [NHSGGC(M)14/04] were approved as an accurate record and signed by the Chair, subject to the following amendment:-

- Page 8, third Paragraph, fourth line: the word “exciting” be deleted and replaced with the word “existing”.

NOTED

78. MATTERS ARISING FROM THE MINUTES

- (i) The rolling action list of matters arising was noted.
- (ii) In response to a question from Ms McAuley regarding Minute No 59 (ii), Ms Brown confirmed that the ongoing outcomes from the “Release Potential Campaign – Staff Engagement Event” were considered by the Staff Governance Committee, in particular to address the points raised by disabled staff about their experiences and suggestions on areas for improvement to ensure that managers understood the benefits of a workplace which supported disabled people.
- (iii) In response to a question from Ms McAuley regarding Minute No 69, Mr Hamilton confirmed that the NHS Board’s FOI Steering Group was considering further how to make the Freedom of Information legislation more accessible to ethnic minority and other groups in respect of any requests they wished to make.

NOTED

79. SCOTTISH PATIENT SAFETY PROGRAMME UPDATE

A report of the NHS Board’s Nurse Director [Board Paper No 14/51] asked the NHS Board to note an update on the Scottish Patient Safety Programme (SPSP) for mental health and primary care services.

Dr Armstrong led the NHS Board through a summary of progress to date in both areas as follows:-

- Mental Health Services – the SPSP Programme aimed to systematically reduce harm experienced by people receiving care from mental health services in Scotland by supporting clinical staff to test, gather real-time data and reliably implement interventions before spreading across the NHS Board area. The work was being delivered through a four year programme running from September 2012 to September 2016. The programme excluded inpatient units caring for people with dementia and also excluded older adult functional illness units. In NHSGGC, two wards were involved at the beginning and this had now extended to 14 wards with more wards showing interest in becoming involved. Five national workstreams had been identified and Dr Armstrong summarised the work taking place in the five areas which were:-
 - Risk assessment and safety planning;
 - Safe and effective person-centred communication at key transition;
 - Safe and effective medicines management;
 - Restraint and seclusion;
 - Leadership and culture.

In addition to the work taking place in NHSGGC, many staff had played key roles in the development of the programme at a national level and a national measurement plan had been developed that involved all participating wards collecting monthly outcome and balancing measures that were submitted to Health Improvement Scotland (HIS). Retrospective data was also collected and Dr Armstrong summarised the eight mental health outcome measures, reporting that challenges around definitions, sources and collection tools had been experienced throughout the programme. As such, Clinical Governance Support Unit staff were working with clinical leads and ward staff to ensure

the data collected was robust and able to be used to identify local and NHS Board-wide improvements and identify issues.

Dr Armstrong alluded to some of the challenges identified with the SPSP mental health programme such as data collection, scale, commitment, quality improvement capacity and capability as well as competing priorities for ward staff who reported many clinical demands and competing organisational priorities which could result in limited focus on this work in some areas. Despite these challenges, the SPSP mental health work continued to grow and develop within NHSGGC with a great deal of enthusiasm and hard work being invested by all concerned.

- Primary Care Services – This was launched 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 Boards and 95% of primary care clinical teams were tasked with developing a safety culture and achieving reliability in three high risk areas by 2016. Dr Armstrong reported that there were now 21 practices and nine district nursing teams working on the programme. In addition, an NHSGGC Polypharmacy Local Enhanced Service had been developed regarding polypharmacy and quality, safe and effective use of long-term medication. A medicines reconciliation component had been built into this using the bundle approach and measurement by reporting monthly compliance.

As part of negotiations for the GP contract 2014/15, all practices in Scotland were invited to take part in SPSP activity looking specifically at the Safety Climate Survey within clinical teams and using the trigger tool to identify previously undetected evidence of patient safety incidents and identify learning from them. Dr Armstrong summarised activity being undertaken in these areas and explained that, in addition, participating practices had been asked to identify one local safety concern of choice and must involve patients in the work to ensure that the person-centredness aspect was incorporated into the work of the programme. To date, data had been collected at NHS Board level and used for identifying improvements. A draft measurement plan had been developed by HIS to include safety culture measures, outcome measures, balancing measures and process measures. Despite excellent progress in taking this forward, there continued to be challenges in data collection, commitment, scale, competing priorities and interface.

In response to Councillor Rooney's questions, Dr Armstrong would clarify the scoring system used in the General Practice Safety Climate Survey. She also explained further the technicalities of undertaking an SPSP "pilot" in these areas in that the process of testing could take between six months to a year before evaluation and any rolling out wider across the NHS Board.

Medical Director

Dr Armstrong welcomed points raised by Dr Lyons concerning the restraint and seclusion bundle within the mental health SPSP and suggested she arrange a meeting for him with Dr M Smith, Lead Associate Medical Director for Mental Health. She also alluded to the role of the Mental Welfare Commission in looking at local NHS Board's processes and procedures in the provision of mental health services locally.

Ms Brown suggested that Non-Executive NHS Board Members be involved in the Leadership walkrounds in mental health services and Dr Armstrong agreed this would be useful and would arrange it for the future.

Medical Director

Ms Micklem referred to the links to other ongoing programmes and also the NICE prediction that effectively addressing malnutrition would be the fourth largest cost saving area for the NHS in the UK. She would welcome further detail around the research evidence demonstrating this and Dr Armstrong suggested that a fuller report be considered at a future Quality and Performance Committee meeting.

Medical Director

Councillor O'Donnell recognised that many of the challenges highlighted were an additional role/task for already very busy staff members. Dr Armstrong agreed but reported that the SPSP bundles often highlighted ways to change the way staff worked so that improvements could be made in undertaking some tasks more systematically. She also agreed that it was a priority to have software to support and extract relevant data which would ease much of the burden that staff had at the moment in doing much of the data gathering manually.

Rev Dr Shanks referred to the challenges identified in both programmes and was disappointed to see terms used such as “burden”, “challenges in managing the work” and “commitment” – he wondered about trying to change the tone of these to ensure that the focus and intention was all about patient safety.

Medical Director

NOTED

80. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No 14/52] 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 (April to June 2014), NHSGGC reported 29 cases per 100,000 AOBs. NHS Scotland reported 30.7 cases per 100,000 AOBs. The revised national HEAT target required all NHS Boards in Scotland to achieve a rate of 24 cases per 100,000 AOBs or lower by 31 March 2015.

NHSGGC successfully achieved the 2013 Clodistrium Difficile HEAT target of less than 39 cases per 100,000 AOBs 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 AOBs to be attained by 31 March 2015. For the last available reporting quarter, April to June 2014, NHSGGC reported 26.4 cases per 100,000 AOBs, combined rate for all ages. This placed the NHS Board below the national average of 33.4 per 100,000 AOBs.

For the last available quarter (April to June 2014), the surgical site infection (SSI) rates for caesarean section and knee arthroplasty procedure categories remained below the national average. SSI rates for hip arthroplasty and repair of neck of femur procedures, however, were both above the national average although remained within the 95% confidence intervals.

The Cleanliness Champions Programme was part of the Scottish Government's Action Plan to combat HAI within NHS Scotland. To date, NHSGGC had supported 3,182 members of staff who were now registered as Cleanliness Champions.

In response to a question from Dr Reid, Dr Armstrong confirmed that contaminated blood cultures would now also be reported as hospital acquired or healthcare associated cases. Continued best practice and adherence with aseptic technique must be undertaken by clinicians when obtaining blood specimens for culture in order to minimise the risk of contamination from the environment, clinician or patients' skin flora.

Mrs McAuley recognised the excellent work ongoing in improving performance and welcomed the continued local monitoring of GPs and their community antimicrobial prescribing practice in terms of analysing recurring C-Diff infections and relapse/reinfection cases.

Councillor Rooney referred to the Healthcare Associated Infection report cards for each acute hospital and key community hospitals and wondered why the rates for MSSA were higher than those for MRSA. Dr Armstrong advised that one third of the population carried MSSA, usually on their nose or on their skin, and patients often entered hospital with it. It was, therefore, more prevalent in society than MRSA which was viewed as more of a hospital acquired infection.

He also referred to the reported C-Diff cases that were not acquired within an NHSGGC hospital and Dr Armstrong confirmed that work was undertaken with the voluntary sector and care homes to look at risk management and often, in particular, pressure ulcer management.

NOTED

81. CLINICAL SERVICES FIT FOR THE FUTURE – REVIEW PAPER

A report of the Medical Director [Board Paper No 14/53] asked the NHS Board to note progress on the Renfrewshire Development Programme.

Dr Armstrong outlined the origin of the Renfrewshire Development Programme. She explained that its purpose was to test the whole-system approach and effectiveness of the interface service models to support more detailed planning to develop the confidence that the model could deliver the future position and to allow costing of the approach to ensure that it was affordable and deliverable.

Dr Armstrong explained that the Development Programme brought together a range of components from the emerging service models to further develop and assess their cumulative impact. It built upon relevant service developments being progressed through other initiatives and also considered the underpinning requirements and ways of working which would be important to support the effective delivery of the programme.

The Programme Team was now established and, along with service managers and frontline staff, it was developing ways to improve the provision and accessibility of Community Health and Social Care services, ensuring that:-

- Only people who needed to attend A&E did so;
- Unnecessary hospital admission was prevented;
- The time patients had to spend in hospital was reduced.

A comprehensive review of the population needed to be undertaken. The needs assessment was a systematic approach which aimed to ensure that resources were used in the most efficient way to improve the health of the population.

A range of information had been collected locally as well as aggregated census information. This work would create a multi-variate report on the population which would form the basis of the future monitoring and evaluation of the programme.

Dr Armstrong summarised the four key projects underway as part of the programme to cover gap areas identified to support the test of the model as follows:-

- Anticipatory care planning;
- Access to comprehensive geriatric assessment;
- New chest pain unit;
- Out of hours community in-reach services.

These projects were due to be in place by the end of October 2014 following recruitment and preparatory work. The Programme Team was also continuing to evolve the work programme including developing smaller scale redesign projects and other areas currently being progressed including:-

- Developing ambulatory care models to increase the proportion of patients who could be managed without admission at the front door;
- Day of care audit;
- Discharge planning;
- Further pharmacy input to the programme;
- IT systems and how to maximise the systems and information currently held to improve communications and information sharing;
- Working with the PPF to consider patient/public engagement on how the public use services.

The Programme Team would continue to develop this work and to fully implement the monitoring and evaluation programme to allow review of the projects which were now being established. As new components of the programme were developed, these would be built into the evaluation process.

Ms Micklem reported that she and Dr Lyons, as part of a recent Board Members visit, had been in departments at the RAH where staff were indeed talking about the programme in a very positive way. She asked whether the evaluation would have external input? Dr Armstrong reported that this was being considered at the moment. Professor Dominiczak suggested the input of the Institute of Health and Wellbeing at the University of Glasgow who may be able to assist and Dr Armstrong welcomed this offer and would make contact with them.

Medical Director

In response to a question from members concerning the timeframe for the programme, as well as that for the broader Clinical Services Review, Dr Armstrong considered that the programme needed to be in place for at least a year to be able to see how the model functioned. It was also important that it built upon any service developments being progressed through other initiatives such as “On the Move”, the Unscheduled Care Programme and the Change Fund Initiatives. Mr Calderwood confirmed that the Clinical Services Review proposals would be considered shortly at an NHS Board meeting prior to any public consultation taking place.

In response to a question from Councillor Rooney, Dr Armstrong confirmed that the evaluation would only include the population of Paisley, therefore, any attendees at the RAH from outwith Paisley would not be included in the analysis but still treated.

Councillor Macmillan reported that Renfrewshire Council was committed to the programme and working with health colleagues to test the service models.

NOTED

82. COMMONWEALTH GAMES

A report of the Director of Public Health [Board Paper No 14/54] asked the NHS Board to note the lessons learned following the Commonwealth Games, support the recommendations for action by NHSGGC and acknowledge that the planning from all areas contributed to a successful event.

Dr de Caestecker explained that the Commonwealth Games could have had a major impact on NHSGGC's service delivery due to the additional pressure caused by an increase in demand for health services linked to the Games and celebrations. There was also an increased likelihood of a major incident occurring as large crowds gathered to watch the Games and participate in the parallel events that were planned. In order to ensure that NHSGGC was resilient and responsive to the additional and unique challenges the Games brought, and to provide continuity of service and quality of care to the resident population, a Civil Contingencies Strategic Group was formed. This had overall responsibility for the Commonwealth Games planning, providing leadership and direction for the Health Protection and Health Services workstreams.

Dr de Caestecker reported that services were largely unaffected due to the significant amount of planning that took place prior to the start of the Games, however, a norovirus outbreak was identified amongst members of the security workforce within the Athletes' Village. Health Protection staff worked with Environmental Health colleagues and the Glasgow 2014 Team at the Village to control the outbreak.

A structured debrief was held to highlight any key issues which were in need of development or that were considered not to have been successful. It was conducted using a recognised methodology and Dr de Caestecker led the NHS Board through the positive and negative comments as well as the debrief's recommendations.

In response to a question from Councillor O'Donnell, Dr de Caestecker reported that there had been no obvious increase in NHSGGC activity during the Games period. This had meant there had been no significant impact on NHSGGC's services.

Mr Finnie congratulated NHSGGC's contribution to the success of the Games which had been a major achievement. In response to his question about food available at the venues, Dr de Caestecker reported that, although the food supplied to the athletes in the Village won an award, there were public health messages to be learned in terms of that provided at the venues and she was taking this forward with the relevant stakeholders.

NOTED

83. SCOTTISH PATIENT SAFETY PROGRAMME UPDATE – IMPLEMENTATION OF FALLS AND PRESSURE ULCERS

A report of the Nurse Director [Board Paper No 14/55] asked the NHS Board to note an update of the progress in improving the clinical response to falls and pressure ulcers and in implementing the related SPSP workstreams.

Ms Crocket summarised activities in both the workstreams as follows:-

- SPSP Implementation of Falls workstream – the existing approach to falls prevention was based on clinical standards which were complemented with standardised general safety precautions to minimise falls risks in clinical settings which may include monitors, observation and/or lowering bed height.

To facilitate implementation of these standards, there was an established governance structure for falls reduction and specialist posts, Falls Coordinators, to advise clinical teams. More recently the Cannard assessment had been incorporated within the new nursing admission and assessment documentation to ensure patients were risk assessed on admission and minimising falls risk had been incorporated into the new Active Care documentation. There had been had a positive impact of this work shown in the reduction of falls.

Ms Crocket outlined the structured application of improvement techniques expected to augment the existing organisational approach. This was being developed in an initial cohort of nine clinical teams piloting the four national care bundles. Teams were working in different areas across the four bundles and had observed success in nearly completing the tested development of a new risk assessment process and supporting documentation and good initial progress in the tested development of post-falls review. Ms Crocket explained that measurement was a key aspect of the quality improvement process and NHSGGC was working with 19 wards, testing revisions to a visual monitoring tool for ward staff showing when and where falls occurred and allowing wards to monitor the incidence of falls. She highlighted the challenges and that a new risk assessment had been recommended through SPSP and was being developed in pilot teams but it was different from the current tool, the Cannard assessment. It was much shorter and quicker for nursing staff to administer, but Cannard was well established and was currently included in the nursing assessment document as a mandatory field. This meant that wards were required to do both assessments to ensure completeness of recording during the early testing phase. The falls rate was part of the national measurement plan linked to the SPSP indicator. NHSGGC was, therefore, recommended to aggregate falls rates in line with national descriptors and this required development of DATIX used to record falls.

- SPSP Implementation of Pressure Ulcers workstream – the existing approach to pressure ulcer prevention was based on clinical standards and these were complemented with standardised general safety precautions to minimise the risk of pressure damage for patients. NHSGGC had developed and implemented the “Top 10 Tools” for pressure ulcer prevention and management alongside promotion of a zero tolerance approach to avoidable pressure ulcer development. These tools were consistent with the Scottish Patient Safety Change Package so for wards there was no change to current practice in terms of risk assessment tools. The success of this current approach was illustrated, showing a gradual, but downward trajectory throughout 2014. Ms Crocket explained that the structured application of improvement techniques was expected to augment the existing organisational approach. This was being developed in an initial cohort of nine clinical teams with two key areas of focus. There were currently nine wards testing the measurement plan for the Pressure Ulcer Change Package. The major change in implementing the pressure ulcer bundles was in ensuring that implementation was reliable and sustained within a whole team approach to prevention and management. Tissue viability nurses had been provided with basic training in improvement techniques and were now working within pilot teams to coach on tested development as a means to create a reliable care process. Given the long-standing improvement work within NHSGGC, a key area was measurement to ensure there was an understanding where outcomes and

process reliability could be improved. Work was currently being undertaken to implement the national measurement plan within the test wards.

Significantly, a model had been developed that allowed staff to determine whether a hospital acquired pressure ulcer was avoidable or unavoidable and this provided the basis for analysis which could target the tests of change in improving the clinical processes. Ms Crocket alluded to the challenges in the two electronic systems used for collecting quality indicators data (Lanqips and DATIX). Having to record the same information twice into two different systems was time consuming for front-line staff and was known to reduce data quality, therefore, a single integrated data collection process needed to be developed.

Mr Winter referred to the increased need for record keeping in both workstreams and referred to the regular Healthcare Environment Inspectorate (HEI) inspections that regularly criticised record keeping and wondered how this would be done. Ms Crocket referred to work being undertaken over the last two years looking at nursing time spent on documentation and entries in records. She recognised the challenges this presented and reported that the workstream may identify how documentation could be reduced in a way to mainstream activity within existing processes.

In response to a question from Dr Benton regarding falls, Ms Crocket reported that the highest incidence of falls occurred when a patient got up rather than them falling out of bed. She also added that a significant amount of work was being undertaken with the new South Glasgow University Hospital to ensure maximum observation for staff and discussion around where patients with vulnerabilities would be situated on a ward.

Ms Brown referred to incidents currently recorded on DATIX and the over reliance on recording “other” in fields which made analysis difficult. Dr Armstrong was leading on work to review the use of DATIX in NHSGGC and how it was utilised by staff.

In response to a question from Councillor O’Donnell, Ms Crocket confirmed that falls and pressure ulcers could be tracked back in order to establish their origin, be this in an acute setting, mental health setting, care home setting or within the remit of district nursing.

Councillor Rooney referred to the number of acquired pressure ulcers as illustrated in the graph and asked if there was any measurement undertaken in terms of those which were avoidable or unavoidable. Ms Crocket replied in the affirmative and reiterated work that was being undertaken with Tissue Viability nurses to help in improvement techniques and risk identification/assessment.

In response to a question from Dr Lyons, Ms Crocket apologised that Figure 2 stopped at May 2014 data but reported that from May to September 2014, a reduction in falls in one ward after the introduction of the Falls Safety Cross continued. She would provide an up-to-date graph.

Nurse Director

Mrs Crocket agreed with Dr Lyons that risk assessments were essential and that although the NHS Board had a zero tolerance approach to falls, she agreed that restraint should be avoided.

NOTED

84. THE DEVELOPMENT OF CANCER NURSE TEACHING INITIATIVES BETWEEN GLASGOW AND PALESTINE

A report of the Nurse Director [Board Paper No 14/56] asked the NHS Board to note the background to the development of cancer nurse teaching initiatives between NHSGGC and Bethlehem University and agreed to the continued support for the development of the first accredited postgraduate cancer training diploma in Palestine and the annual clinical placements of two Palestine nursing students to the Beatson West of Scotland Cancer Centre.

Ms Crocket described the background to the development of a proposal for a postgraduate diploma in cancer nursing to be provided by Bethlehem University. The course content would encompass the epidemiology and science of cancer, including every aspect of the patient's journey from diagnosis, treatment options, management of symptoms and psychological support. It was proposed that particular emphasis would be placed on the most common cancers that were prevalent in Palestine. The diploma would integrate oncology and palliative care, ensuring that participating nurses, on completion of the course, would be better prepared to recognise and respond to the difficult challenges that cancer patients posed, from diagnosis to end of life care.

Mr O'Hare, Clinical Nurse Specialist, explained that he had established links with the Dean of the Nursing Department at Bethlehem University resulting in Bethlehem University hosting a cancer conference in March 2012.

He described how teaching resources for the diploma would require input from clinicians and academics from Palestine with some input being provided by clinicians from Scotland, including NHSGGC, who had expressed an interest in providing support. Mr O'Hare had committed to return to Palestine annually to contribute to the delivery of the diploma and staff who had expressed an interest in supporting the diploma would do so in their own time, however, it was anticipated that travel and accommodation costs would be provided through a UK based charity called Medical Aid to Palestine (MAP).

Mr O'Hare added that, as the city of Glasgow had been twinned with Bethlehem since 2007, Glasgow City Council had supported successful projects in art, culture and education, and the current Lord Provost was keen to expand this to the area of health through the provision of annual funding to support two Palestine nurses to undertake a two week clinical placement within the West of Scotland Cancer Centre. A programme for the clinical placement, together with learning outcomes, would be agreed with Bethlehem University and the Cancer Centre.

Mr Sime considered the paper heartening, which would, in the longer term, help communities and people to help themselves. He referred back to a previous arrangement NHSGGC had to provide Malawi with IT equipment and wondered if a central register was held for such initiatives. Mr Calderwood confirmed that a register could be collated.

It was also suggested that future Chairman's Awards could include an award that had an international dimension so that initiative such as this could be recognised.

**Head of
Procurement**

**Director of
Corporate
Communications**

DECIDED

- That, the background to the development of cancer nurse teaching initiatives between NHSGGC and Bethlehem University be noted.

- That, the continued support for the development of the first accredited postgraduate cancer training diploma in Palestine be agreed.
- That, the annual clinical placements of two Palestine nursing students to the Beatson West of Scotland Cancer Centre be agreed.

Nurse Director

Nurse Director

85. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Officer, Acute Services Division [Board Paper No 14/57] asked the NHS Board to note progress against the national targets as at the end of August 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 Grant alluded to nine patients who had breached the national inpatient treatment time guarantee of 12 weeks from decision to treat (seven patients in July and two in August). All nine patients had now attended for their treatment and, in respect of the two that were due to administrative errors, administrative processes in each speciality had since been reviewed to ensure this did not recur.

In respect of outpatients, there were 72 ophthalmology and 20 neurology patients waiting over 12 weeks at the end of July 2014. At the end of August 2014, there were 26 ophthalmology and 106 Neurology patients waiting over 12 weeks. As previously explained, Mr Archibald highlighted the significant demand and capacity pressures in both of these specialties and explained that this was a national issue and not limited to NHSGGC.

Mr Archibald highlighted a number of steps taken to provide additional facilities to alleviate the pressure in meeting the Accident & Emergency waiting times to ensure that the maximum length of time from arrival to A&E to admission, discharge or transfer was four hours for 98% of A&E patients. He explained that additional clinical staff were being appointed in the emergency departments and in medicine.

In response to a question from Mr Finnie concerning the term “breachers”, Mr Archibald advised this was a nationally recognised term and was used in management reports but he agreed it was not a term to be used in frontline services and would ensure that future reports, to the NHS Board, described missing treatment time targets in a more appropriate way.

Chief Officer,
ASD

Dr Benton asked about the fact that many NHS Boards were strictly interpreting the access provision and returning patients to the care of their GPs if they had declined two reasonable offers. Mr Archibald reported that this practice had not been adopted in NHSGGC and that patients continued to be provided with access to their nearest hospital, if possible. This had the effect of increasing patient unavailability. He agreed to establish what practice other NHS Boards adopted to tackle unavailability.

Chief Officer,
ASD

Mrs Brown asked about the breast cancer waiting times and Mr Archibald confirmed that this remained an area of concern. Weekly meetings were in place between surgical teams and diagnostic imaging teams to ensure that all available local slots were fully utilised. Furthermore, the fortnightly cancer performance improvement meeting

remained in place as did the weekly reporting of cancer waiting times to Acute Division Directors and the Scottish Government Health Directorate Cancer Performance Support Team as well as the monthly Detect Cancer Early meetings.

Mrs McAuley thanked Mr Archibald for such an honest assessment and explanations of the waiting times situation in NHSGGC and commended the areas where waiting times were being met and/or exceeded.

NOTED

86. FINANCIAL MONITORING REPORT FOR THE 5 MONTH PERIOD TO 31 AUGUST 2014

A report of the Interim Director of Finance [Board Paper No 14/58] asked the NHS Board to note the financial performance for the first five months of the financial year.

Mr Hobson reported that the NHS Board currently had an overspend of £1.4m for the five month period to 31 August 2014. At this stage, however, the NHS Board forecast that a year end break even outturn would be achieved.

He led the NHS Board through expenditure for the period as it related to Acute Services, NHS Partnerships, Corporate Services and other budgets and Capital. He confirmed that, at this stage, the NHS Board was close to its year to date cost savings target against plan.

Mr Fraser noted that expenditure on Acute Services was £1.2m over budget as at 31 August 2014 and thought it would be helpful for future reports to include a paragraph outlining how, given an overspend, the NHS Board intended to achieve break even. Mr Hobson agreed to include such information in future reports. Mrs McAuley asked a follow up question in connection with the NHS Board reaching a balanced position and Mr Hobson reassured the NHS Board that, given the pressures and challenges on finances, a look-back/look-forward approach was taken to assess the likely year end position.

**Interim Director
of Finance**

Councillor Rooney referred to the decision made at the August 2014 NHS Board meeting to allocate £1.1m additional investment for unscheduled care and Mr Calderwood confirmed that this was not included in the five month period report but would be included in the financial monitoring report for the six month period (due to be considered at the December 2014 NHS Board meeting).

**Interim Director
of Finance**

NOTED

87. QUARTERLY REPORT ON COMPLAINTS: 1 APRIL TO 30 JUNE 2014

A report of the Nurse Director [Board Paper No 14/59] asked the NHS Board to note the quarterly report on complaints in NHSGGC for the period 1 April to 30 June 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 81% 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, staff attitude/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 Brown asked about the PASS feedback which listed Renfrewshire CHP as being the most frequently recorded CHP in terms of the PASS service. Mr Hamilton agreed to make contact with the PASS service to understand better what lay beneath this.

**Head of Board
Administration**

Mrs McAuley welcomed the identification of service improvements made as a result of complaints. She was disappointed, however, to note that only 45% of dental practices responded to the survey asking about their local complaints data. Mr Hamilton agreed that this was disappointing and that this had been raised with the General Dental Practitioner Sub-Committee and the Local Dental Committee who had agreed to put out a regular reminder to general dental practices in the Local Dental Committee newsletter timed to coincide with the scheduled opening of each quarter's survey to see if that would improve the return rate.

In response to a question from Dr Lyons, Ms Crocket confirmed that learning was shared in terms of lessons learned across Partnerships as information was shared with the Quality and Performance Committee and Board Clinical Governance Forum.

NOTED

88. AUDIT SCOTLAND'S ANNUAL REPORT ON THE 2013/14 AUDIT

A report of the Interim Director of Finance [Board Paper No 14/60] asked the NHS Board to note the report by the external auditors, Audit Scotland, on the 2013/14 Audit of NHSGGC. The report had already been reviewed by the Interim Director of Finance and scrutinised by the Audit Committee.

Ms Woolman summarised the key findings to emerge from Audit Scotland's 2013/14 audit. During the course of the year, Audit Scotland assessed the strategic and financial risks which NHSGGC faced, they audited the financial statements and reviewed the use of resources and aspects of performance management and governance. Ms Woolman set out Audit Scotland's key findings as they were presented to the Audit Committee at its meeting held on 12 August 2014 and summarised these as follows:-

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

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

Mr Finnie repeated an issue he had raised at the Audit Committee on 12 August 2014 in relation to the possible inference that the NHS Board was only made aware of risks as a result of Audit Scotland's report and this was clearly not the case. Ms Woolman advised that her response to the Audit Committee, and now, was that that was not the intention and she would review next year's report with these comments in mind.

In response to a question from Rev Dr Shanks in connection with a review of the arrangements for Glasgow Community Planning Partnership, Mr Calderwood agreed to clarify the intention and discuss this with the Chief Executive of Glasgow City Council.

Chief Executive

In response to a question from Councillor O'Donnell concerning the future audit arrangements for the newly formed Health and Social Care Partnerships, Ms Woolman confirmed that the respective Councils' appointed auditors would also be the auditors for the Health and Social Care Partnerships.

NOTED

89. AREA CLINICAL FORUM MINUTES: 7 AUGUST 2014

The Minutes of the Area Clinical Forum meeting held on 7 August 2014 [ACF(M)14/04] were noted.

NOTED

90. AUDIT COMMITTEE MINUTES: 12 AUGUST 2014

The Minutes of the Audit Committee meeting held on 12 August 2014 [A(M)14/04] were noted.

NOTED

The meeting ended at 12:45pm