

DRAFT

QPC(M)13/02
Minutes: 21 - 39

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Quality and Performance Committee at 9.00 am
on Tuesday, 19 March 2013 in the
Board Room, J B Russell House
Gartnavel Royal Hospital, 1055 Great Western Road,
Glasgow, G12 0XH**

P R E S E N T

Mr I Lee (Convener)

Dr C Benton MBE
Ms M Brown (from Minute 26)
Mr I Fraser

Cllr A Lafferty
Ms R Micklem
Cllr J McIlwee

Mr D Sime

O T H E R B O A R D M E M B E R S I N A T T E N D A N C E

Dr J Armstrong
Mr R Calderwood

Mr R Finnie
Mr P James

Mr A O Robertson OBE

I N A T T E N D A N C E

Ms J Gibson	..	Head of Performance and Corporate Reporting (to Minute 25)
Mrs J Grant	..	Chief Operating Officer
Mr J C Hamilton	..	Head of Board Administration
Mrs A Hawkins	..	Director, Glasgow CHP
Mr A McIntyre	..	Director, Facilities (for Minute 32)
Mr A McLaws	..	Director, Corporate Communications
Mr B Moore	..	Director, Inverclyde CHCP (for Minute 31)
Mr I Reid	..	Director of Human Resources
Ms C Renfrew	..	Director of Corporate Planning & Policy
Mr D Ross	..	Director, Currie & Brown UK Limited (for Minute No 26)
Ms H Russell	..	Audit Scotland
Mr A Seabourne	..	Director, New South Glasgow Hospitals Project (for Minute No 26)
Mr R Wright	..	Director, Health Information & Technology

21. APOLOGIES

Apologies for absence were intimated on behalf of Mr P Daniels OBE, Cllr M Kerr, Mrs P Spencer BEM, Mr B Williamson and Mr K Winter.

22. DECLARATIONS OF INTEREST

No declarations of interest were raised in relation to the agenda items to be discussed.

23. MINUTES OF PREVIOUS MEETING

On the motion of Ms R Micklem and seconded by Mr D Sime, the Minutes of the Quality and Performance Committee Meeting held on 15 January 2013 [QPC(M)13/01] were approved as a correct record, subject to the following correction:-

Minute 19 – “New South Side Glasgow Hospitals: Progress”, 3rd paragraph; 1st line – delete “112 week” and insert “205 week”.

NOTED

24. MATTERS ARISING

(a) Rolling Action List

(i) Local Delivery Plan : 2013/14

Ms Renfrew confirmed that the final Local Delivery Plan: 2013/14 would be submitted to the Scottish Government Health Directorate (SGHD) by the end of this week and a copy sent to NHS Board Members for information.

**Director of
Corporate
Planning and
Policy**

NOTED

(b) Clinical Risk Management: Surveillance of Adverse Clinical Incidents

In relation to Minute 13 – Clinical Risk Management: Surveillance of Clinical Incidents - Mr Finnie asked about the recent reports of a higher mortality rate at the Royal Alexandra Hospital. It was explained that this was in relation to a recent SGHD Freedom of Information response about Healthcare Improvement Scotland actions in relation to Scottish Standardised Mortality Rates (SMR) for 2010. The Medical Director would cover this issue in her report on Scottish Patient Safety Programme later on in the agenda.

NOTED

(c) Inverclyde NHS Partnership Beds and Local Authority Residential Beds - Update

In relation to Minute 4 (c) - Inverclyde Council Commissioned Services for Specialist Nursing Care, Older People’s Dementia and Adult Mental Health Intensive Supported Living Services – Mrs Hawkins advised that the SGHD Capital Investment Group had considered the submission to procure NHS mental health Continuing Care beds at the Inverclyde Royal Hospital Site at its meeting on 26 February 2013. The formal decision was awaited with the expectation that it may be announced by the end of this week. If approved there then would be a short period of time to agree the bridging requirements with Inverclyde Council.

Inverclyde Council had approved the commissioning of the older people mental health/dementia beds and adult mental health beds at its meeting on 28 February 2013.

NOTED

25. INTEGRATED QUALITY AND PERFORMANCE REPORT

There was submitted a paper [Paper No. 13/20] from the Head of Performance and Corporate Reporting setting out the integrated overview of NHS Greater Glasgow and Clyde's performance.

Of the 41 measures which had been assigned a performance status based on their variance from trajectory and/or targets, 25 were assessed as green; eight as amber (performance within 10% of trajectory) and eight as red (performance 10% outwith meeting the trajectory). The areas of key performance change since the last report included:-

- Child and adolescence mental health services had moved from red to amber;
- Freedom of information requests had moved from red to amber;
- Bed days lost to delayed discharges for adults with incapacity had moved from red to amber;
- Access to psychological therapy had moved from amber to red;
- Admissions to stroke unit had moved from amber to red;
- Accident and emergency waits; maximum four hours had moved from amber to red
- New out-patients; maximum 12 weeks wait had moved from green to red;
- Delayed discharges over 28 days had moved from green to red;
- Overtime usage (whole time equivalent) had moved from green to amber;
- New out-patient did not attends had moved from amber to red; and
- Sickness absence had moved from amber to red.

Ms Gibson, Head of Performance and Corporate Reporting advised that it had been agreed that those performance measures which were reported on an annual basis would be reported as and when the data became available. To assist Members, this report had included a three year breakdown of the percentage of new outpatient did not attends by age, sex and deprivation.

Councillor Lafferty thanked officers for the report and whilst there had been an increase in the number of measures assessed as red, he had taken some comfort that the Committee's intervention had led to faster access to specialist child and adolescent mental health services.

Ms Micklem had been disappointed in the did not attend figures and had expressed an interest in the equalities impact assessment for the Access Policy in terms of ensuring accessibility to all those seeking treatment within NHSGG&C. Ms Renfrew made reference to the new GP referrals direct to hospital services and sought Members' agreement that a more detailed report be submitted to the next meeting of the Committee picking up on the issues highlighted from the equalities impact assessment report including the new GP referrals initiative. This was agreed.

**Director of
Corporate
Planning &
Policy**

Ms Benton enquired about the delayed discharges within Glasgow City CHP and Mrs Hawkins agreed that while stringent efforts were being made to reduce delayed discharges and in particular bed days lost, there was still much work to do to try and meet the target set.

Mr Lee referred to the recent Board Members' visit to the Vale of Leven Hospital and one of the problems highlighted by staff there was that the discharge of dementia patients could be held up by a lack of arrangements around guardianship and/or Power of Attorney. He wondered if there was more which could be done to promote and encourage people to consider this at an earlier stage. Mrs Hawkins indicated that action was already being taken in Glasgow to raise the profile of this matter and she envisaged that the anticipatory care work which will be part of the GMS contract in the coming year would give an opportunity for Power of Attorney to be actively discussed with patients. The role of GPs was particularly helpful when discussing these issues with patients.

Ms Micklem enquired about the increase in pressures to services across NHSGG&C and the impact it was having on an increased number of measures being categorised as red. Mr Calderwood recognised the impact of the relentless pressures over the winter period and whilst acknowledging the shift in the categorisation of specific performances was pleased that a high quality of services continued to be delivered to the vast majority of patients who attended services within NHSGG&C.

Mr Lee enquired about the psychological therapy services where performance has moved from amber to red and Mrs Hawkins advised that this was currently a preparatory target while data was gathered and different methodologies to assist in setting a realistic target for the future were reviewed.

NOTED

26. NEW SOUTH SIDE GLASGOW HOSPITALS – PROGRESS UPDATE – STAGES 2 & 3

There was submitted a paper [Paper No. 13/19] from the Project Director of the Glasgow Hospitals Laboratory Project setting out the progress against Stage 2 (design development of the new hospitals) and Stage 3 (construction of the adult and children's hospitals).

In relation to Stage 2 Mr Seabourne advised that progress continued to be made in reviewing and agreeing the design of layouts and systems for the two hospitals. The current focus of the design and review process was on specialist areas such as the Department of Child Psychiatry, Audiology, Dental and Major Imaging Equipment.

In relation to Stage 3, as at 3 March 2013, 101 weeks of the 205 contract had been completed and the project remained within timescale and budget. Mr Seabourne provided Members with further images highlighting the progress of both hospitals and the shape of both the Adult and Children's Hospitals could now clearly be seen.

Mr Lee read a note from Mr Winter, who was unable to attend today's meeting, indicating that he had recently visited the hospital site and he endorsed the positive view presented in this progress report.

Councillor Lafferty commented on the impressive nature of the building work and how visible it had all become in the recent months. He asked about the type of gases under the site and the what the cladding panels were made of. Mr Seabourne advised

that it was natural gas which was under the site and the cladding panels were made of glass and therefore an ongoing cleaning programme would be required.

The Outline Business Case for the Teaching and Learning Centre had been approved by the SGHD Capital Investment Group and the Court of the University of Glasgow was to consider the Outline Business Case at its next meeting.

Mr Calderwood advised that the Scottish Medicines and Innovation Centre had secured a Scottish Funding Council grant of £5million to the University and a further application to another funding body was being considered. If approved, this would lead to a fourth floor on the Teaching and Learning Centre to be utilised by the University as part of its Strathclyde medicine initiative.

Ms Micklem was pleased to read about the improvements to walking and cycling access/egress and enquired about the possible enhancement of transport links to the new hospitals. Mr Seaborne advised that he and Mr Niall McGrogan, Head of Public Engagement and Transport, had been having a range of discussions with transport bodies around trying to ensure enhanced transport services to the new hospitals when they opened in 2015. In addition, through the Section 75 Agreement with Glasgow City Council the NHS Board have committed £2.25m to pump prime transport services. Mr Calderwood advised that the SGHD had sought to ensure that the fast link initiative also served the New South Side Hospitals development.

Mr Ross updated Members on the change control process and compensation events and Mr Calderwood advised that the additional wooden structures behind the hospital bed heads were to assist with a future development of patient entertainment systems; carrying out the works now would save major disruption to patients at a later date.

NOTED

27. SCOTTISH PATIENT SAFETY PROGRAMME – REPORT

There was submitted a paper [Paper No. 13/21] by the Medical Director providing an update on HSMR and the general ward workstream with specific notes on Early Warning Scoring systems (EWS). In addition, Dr Armstrong tabled a paper on HSMR which gave a description of what it was and how it was used to monitor progress on reducing hospital mortality over time. HSMR was calculated for all acute in-patient and day case patients and was based on hospital discharge summaries to death registrations from the National Records of Scotland. The calculation took account of patients who died within 30 days from hospital admission, including deaths which occurred in the community (out of hospital deaths). The national model was developed to calculate the predicted probability of deaths within 30 days of admission which took account of the patient's primary diagnosis; specialty; age; gender; where they were admitted from; the number and severity of prior morbidities in the previous 1 – 5 years and the number of emergency admissions in the previous 12 months where admitted as an in-patient or day case. HSMR was a useful indicator when used effectively but should not be used in isolation. It can provide an indication of where a problem might exist and should be used as a trigger for investigation. If an HSMR value was less than one, this meant that the number of deaths was less than predicted; if it was greater than one, this meant the number of deaths was more than predicted.

Dr Armstrong took Members through the HSMR data for the Royal Alexandra Hospital from 2010. In 2010 the HSMR data highlighted that the number of deaths

within 30 days of discharge from the Royal Alexandra Hospital was more than predicted and therefore an approach was made by Healthcare Improvement Scotland to review the data and respond appropriately. One of the key issues was inappropriate coding and changes were introduced to improve the coding. Additional actions were also taken, including changes to the trainee cover within high dependency units to allow them to have their own trainee and access to intensive care input being simplified; medical physicians undertook a review of 50 non-surgical deaths and this led to the implementation of monthly morbidity and mortality meetings; a review was conducted of the assessment of deteriorating patients and the resuscitation response resulting in the RAH being a test site for the harmonised national Early Warning Scoring system. The Medical Director of Healthcare Improvement Scotland confirmed that they were satisfied with NHSGG&C's response and that no further action was required.

Members welcomed this detailed review and it was planned to have further discussions at the NHS Board meeting to cover these and other issues raised by the Leader of Renfrewshire Council in relation to the mortality rates at the Royal Alexandra Hospital.

**Medical
Director**

It was highlighted that whilst the HSMR rates for the RAH and Inverclyde Royal Hospital were under one, they still showed a trend of being higher than other hospitals within NHSGG&C. Whilst this would be reviewed further it was highlighted that palliative care patients were admitted to a surgical ward within the RAH and there was a need to ensure the accuracy of information contained within discharge letters. However this area was being kept under review. It was also expected that HIS may adapt the HSMR methodology and this was awaited.

In relation to the Acute Services core adult programme – general ward workstream, Ms Micklem acknowledged the challenging targets faced by the wards, however enquired as to whether the target teams for the Early Warning System of 165 were all the teams across the NHSGG&C. Dr Armstrong would review and confirm to Members the actual number of teams to be involved, recognising that this might change the percentage number of teams achieving the elemental aim within the identified timeline.

**Medical
Director**

NOTED

28. INFECTION CONTROL SERVICE – HAI REPORT; MARCH 2013

There was submitted a paper [Paper No. 13/22] by the Medical Director covering the Board-wide infection prevention control activity. The report was on an exception reporting basis only as the full report was submitted to each NHS Board meeting.

The NHS Board compliance with hand hygiene for the period 19 – 30 November 2012 was 94% against the Scottish average of 96%. Councillor Lafferty asked if these figures related solely to staff compliance and Dr Armstrong advised that this was indeed the case and monitoring of visitors did not take place routinely on the basis that there was little evidence of infections from visitors to patients. However the recent audit indicated that if the first visitor used the hand gel then others followed suit. The Infection Control Team as discussing ways to improve visitor compliance.

**Medical
Director**

Mr Lee enquired about possible improvements to the signage to encourage staff and visitors to use the hand gel on entering ward areas and also to wash their hands. Councillor Lafferty wondered if this and other measures could be considered to

ensure a higher level of compliance. Dr Armstrong advised that notices/posters were available within the ward areas and that the Associate Medical Director had written to all medical staff about the importance of this issue and between that and further discussions at Associate Medical/Clinical Directors' meetings and at Clinical Governance meetings there had been an increase of uptake from the medical staff. If a single member of staff was repeatedly noticed not to be complying with the hand hygiene requirement they would be spoken to by the Clinical Director. She had recognised that it had proven extremely difficult to achieve or get very close to the 100% compliance rate. She also advised that the SGHD were considering one of two models to monitor compliance and a decision was awaited on this in the fairly near future. However there would be further debate with the Acute Sector clinical leads about how to improve compliance.

Medical Director

In relation to the previous agenda item and the surgical site infections element of the report, Ms Brown made reference to the number of times the Royal Alexandra Hospital featured within these exception reports. Dr Armstrong acknowledged this was indeed the case at this time however the detailed investigations around the increases in surgical site infections had not highlighted any particular pattern or reason for a wider concern. In relation to the cases of C. Difficile, seven were associated with individual wards, with no ward having more than one case identified. In the case of Ward 1, where three cases had been highlighted, none of these cases were severe (two being confirmed as the same ribotype). Ward 1 did not take any new admissions for a week and a revised cleaning regime had been introduced, using chloride based detergents. Mr Lee asked if this was worth considering for all wards and Dr Armstrong agreed to follow this up and report the outcome at the next meeting. Dr Benton had enquired about those staff who were unable to utilise alcohol hand gel due to dermatological reasons and what steps had been put in place to ensure that they observed good hygiene standards. Dr Armstrong agreed to report back on this in the next report and also on Councillor McIlwee's comment that monitoring reports should take account of those staff who may have to adhere to a different regime, beyond just hand washing.

Medical Director

Medical Director

Lastly, Dr Armstrong highlighted the ongoing investigation into a perceived increase in surgical site infections within the Orthopaedic Surgical Unit at Gartnavel General Hospital. An analysis of cases had been extended to Glasgow Royal Infirmary in order to obtain comparable data and further analysis was being undertaken and follow-up meetings to be held with the orthopaedic consultants at Gartnavel General to review these findings when available. Dr Armstrong agreed to report back on this matter in the next report to the Committee.

Medical Director

NOTED

29. CLINICAL RISK MANAGEMENT REPORT – SURVEILLANCE OF ADVERSE CLINICAL INCIDENTS

There was submitted a paper [Paper No.13/23] by the Medical Director on adverse clinical incidents. The report of adverse clinical incidents had been displayed on two separate charts in order to highlight the position within acute services and separately within Partnerships.

Dr Armstrong provided Members with a summary of an ongoing investigation in relation to a fatality which had occurred at the Victoria Infirmary. Recognising this was an ongoing investigation Dr Armstrong answered Members' questions in relation to principles and policies operating within NHS GG&C and not on the specifics of the particular case.

It was also reported that the NHS Board has submitted its comments to the national consultation undertaken by Healthcare Improvement Scotland on building a national approach to learning from adverse events through reporting and review. The internal consultation on the Significant Clinical Incident Policy was underway and already had led to identified additions which were currently under development:-

- Guidance for staff – what to expect if I'm involved in a Significant Clinical Incident;
- Guidance for managers – supporting staff through a Significant Clinical Incident;
- Recommendations - guidance implementing recommendations from reviews
- Templates to support patient/relative communications;
- Information for patients/relatives on processes and what to expect;
- Reflective practice template/tips.

Dr Armstrong provided an update on the recently completed and ongoing Fatal Accident Inquiries and made particular reference to the recent Sheriff Determination issued in relation to the death of Mrs L which had been widely reported within the media. She answered Members' questions about elements of the detail of the case and the involvement of clinical staff at different stages of this distressing case. A significant factor had been the failure to follow up care when Mrs L had been boarded out to a different ward and the Sheriff's Determination was being considered within the clinical governance structures and with the staff involved.

NOTED

**30. BOARD CLINICAL GOVERNANCE FORUM MINUTES –
18 FEBRUARY 2013**

There was submitted a paper [Paper No. 13/24] in relation to the Board Clinical Governance Forum meeting held on 18 February 2013. The minutes highlighted the up-to-date position with regard to the Castlemilk Group Practice and a discussion ensued on the actions taken by NHS Board Officers to ensure a satisfactory outcome for staff and patients, particularly vulnerable children.

NOTED

31. INVERCLYDE CHCP PERFORMANCE REPORT

There was submitted a paper [Paper No. 12/28] from the Director, Inverclyde CHCP, providing information on the establishment and responsibilities of the Inverclyde CHCP. Mr B Moore, Director, Inverclyde CHCP, had been invited to attend to provide Members with a presentation on the range of services provided by the CHCP; its performance against set targets and its challenges in the years ahead. Mr Moore provided a full and informative presentation to Members and the following comments/questions were raised:-

- Councillor Lafferty thanked Mr Moore for a good report and positive presentation and felt he had given a very distinctive local perspective to the issues and challenges within Inverclyde and this was welcomed.
- In relation to Mr Moore's council-wide responsibility for information governance, he answered Members' questions in relation to the policies, procedures and arrangements in place to handle client/patient confidential

information and the need to comply with the data protection legislation. He advised that data protection audits would take place within public authorities from next year and Ms Brown highlighted the challenges that would bring for integrated organisations and the need to ensure stricter protocols around patient-sensitive information.

- In relation to the Change Fund Mr Moore advised that Inverclyde would continue to build on established procedures and new developments were underway to utilise these funds in as an innovative way as possible. He emphasised the ownership of targets between his staff and those within acute services and a need to continue to deliver improvements for patients.
- In relation to the Care Inspector's Report and the section, which had no comments, Mr Moore indicated these areas had not been identified for any particular action and there were no underlying historical difficulties in relation to any areas of performance. He advised that Inverclyde had been selected as a pilot site for the joint inspection between Healthcare Improvement Scotland and the Care Inspectorate.
- In relation to a point by Ms Micklem, Mr Moore acknowledged the integrated approach possibly leading to a more strategic solution to shared areas however he believed that the community planning framework set out a more robust way to have such matters considered and discussed. Audit Scotland would be issuing a report on 20 March about community planning arrangements.
- Mr James highlighted the progress being made within Inverclyde CHCP in terms of the significant reduction in relation to prescribing although it was acknowledged that more work was still required going forward.

The Convener thanked Mr Moore for his helpful and informative presentation and for answering Members' questions so openly.

NOTED

32. CENTRAL DECONTAMINATION UNIT (CDU)

Following the recent press coverage of concerns expressed by orthopaedic consultants at Gartnavel General Hospital about aspects of the central decontamination unit, Mr A McIntyre, Director of Facilities, attended to provide Members with a summary and background of the central decontamination unit and the steps taken to try and address the concerns raised.

Mr McIntyre advised that the CDU was the biggest in Europe and opened in 2005. It dealt with the cleaning of 7,700 trays of clinical instruments each week and this amounted to 250,000 individual instruments per week. Concerns had surfaced in September 2012 by orthopaedic consultants at Gartnavel General Hospital in relation to surgical site infections. Health Protection Scotland and Health Facilities Scotland were asked to review the day-to-day processes and procedures and provided a report in October 2012. It, together with the internal audit report, had been generally positive but had identified a number of areas for further review, including some additional cleaning processes for particular instruments, transportation and theatre storage. An action plan had therefore been drafted to address these areas which included additional investment in shelving and instruments.

The theatre lists at Gartnavel were more intensive on Wednesdays and Thursdays and this has led to greater use of the fast-track system of turning around clean instruments within eight hours rather than the usual 24 hours. This had led to the fast-track system moving from 10% of cases to 25 – 29% and had resulted in five

whole-time members of staff moving to night shift to cope with this additional workload.

Other issues which had been highlighted in discussions with the orthopaedic consultants had been the issues of tears within the wrapping of the instruments (instruments arrived at theatres double wrapped). Additional investment had recently been made in enhanced wrapping for the trays and bases. It had been highlighted that instruments had been missing from trays and this had been an issue which had been ongoing for some time. Additional instrumentation had been ordered and while the delivery time was between 6 - 13 weeks, 85% of the new instrumentation had been received. The biggest concern related to contaminated trays/instruments and specific instrumentation was now subject to a brush through process to ensure the cleanliness of the instrumentation. To try and ensure a greater confidence in the service, the cleaning of the theatre instrumentation had been moved to the unit in Inverclyde however this was leading to additional work pressures within that CDU. In addition there was now a backlog of 2,000 trays requiring to be cleaned at the CDU and agency staff had been brought in over the last fortnight and this had made an impact on the turnaround time. No specific concerns had been raised by other clinical services across NHSGG&C in relation to infection rates however it was recognised that it was important to ensure a detailed analysis of surgical site infection rates at Gartnavel General Hospital has been completed and a comparison was undertaken with Glasgow Royal Infirmary, although it was important to note that infection control colleagues had not identified any direct link with the instrumentation issue. The concerns had related specifically to knee infections as a higher number of infections than had been expected were being experienced.

Mrs Grant and Mr McIntyre answered a range of questions from Members around patient safety and quality control measures. Members were grateful for the briefing and detail provided in relation to this ongoing issue. The discussion touched on the staffing, management of the services (Mr McIntyre advised that an additional General Manager had been seconded for a period of time to deal with ongoing issues), confidence levels of the clinical staff at Gartnavel in the service, identification of any issues lying outwith the CDU, the concerns at the significant increase in the use of the fast-track system for Gartnavel, the need for more robust measures around issues included within the risk registers and the need to try and ensure an early resolution.

Mrs Grant advised that just over 200 patients had to be rescheduled and to date half that number had been treated and she expected that within a week the remaining available patients would have a revised date for their elective procedures.

The Convener thanked Mrs Grant and Mr McIntyre for updating the Committee on this issue.

NOTED

33. TERMS AND REMIT OF GROUP TO REVIEW RECOMMENDATIONS OF THE MID STAFFS (FRANCIS) REPORT

There was submitted a paper [Paper No. 13/25] from the Medical Director setting out the process, timescale and terms of reference of the group set up to review the 290 recommendations contained within the Mid Staffs (Francis) Report and their possible impact within NHSGG&C.

Mr Robertson advised that Non-Executive Member involvement in this group and attendance at its Away Day on 11 April 2013 had been secured via Ms Ros Micklem agreeing to join the group together with Mr D Sime and Mrs P Spencer who were already members of the group. The membership section would be revised to take account of Ms Micklem's involvement.

**Medical
Director**

NOTED

34. PROGRESS REPORT ON TRANSFER OF PRISON HEALTH SERVICES

Mrs Hawkins advised that it was her intention to bring a written report to the next meeting of the Committee and she sought Members' agreement that it covered the following issues – staffing issues, GP staffing, skill mix, dental services, consideration of specific services for women prisoners now held at Greenock, addiction services, learning disability services, the outcome of the health needs assessment, clinical governance issues including handling of complaints and preparation for the new women's prison within the Greenock area. Members agreed that these issues would be helpful in discussing the first 18 months of managing prison health services.

**Directors
Glasgow City
CHP**

NOTED

35. SCOTTISH PUBLIC SERVICE OMBUDSMAN – QUARTERLY REPORT

There was submitted a paper [Paper No. 13/26] from the Head of Board Administration in relation to the actions taken in connection with the recommendations of the full investigation reports and decision letters of the Scottish Public Service Ombudsman. It was highlighted that there had been four full reports in the quarter from October to December 2012 and 15 Decision letters in addition to reporting on the two outstanding actions from the previous quarter in relation to recommendations affecting a GP practice and dental practice.

Mr Fraser expressed his ongoing concern at the number of issues the SPSO upheld and he was concerned that the local resolution stage of the NHS Complaints Procedure was not being conducted robustly enough to ensure a lower level of upheld findings by the Ombudsman. Mr Calderwood agreed that this remained a challenge for the organisation when dealing with complaints under local resolution within the 20 working days target. Proper recording of information in patient records was not always robust enough and the Ombudsman would find fault where administrative processes or the handling of a complaint had not fully followed the Board's own NHS Complaints Policy. Mrs Hawkins indicated that meetings with patients did prove helpful on a number of occasions but it was not always possible to do this successfully or within a reasonable timeframe. Ms Brown raised her concerns in one case highlighted within the report where it was clear basic care was not even offered to the patient in question. She wanted assurances that the clinical governance quality processes and reviews ensured not just learning within the area of the complaint but that learning applied across the NHS Board. Mrs Grant recognised the failures in this case and indicated that the action plan developed for the upheld aspects of this case were shared wider within the clinical governance structures to ensure staff were reminded of the importance of providing dignity and respect when dealing with all patients. The Chief Executive and senior Directors had met with the Scottish Public Services Ombudsman last month to discuss a range of issues and he had been positive about Complaint handling within NHSGGC. However he had encouraged the NHS Board to close down some cases at an earlier stage when it was

clear a resolution could not be found.

NOTED

36. QUALITY POLICY DEVELOPMENT GROUP MINUTES – 18 DECEMBER 2012

There was submitted a paper [Paper No. 13/27] enclosing the minutes of the Quality Policy Development Group meeting of 18 December 2012.

NOTED

37. MEDIA COVERAGE – JANUARY/FEBRUARY 2013

There was submitted a paper [Paper No. 13/29] from the Director of Corporate Communications highlighting the outcomes of media activity for the January/February 2013 period. The report supplemented the weekly media round-up which was provided to NHS Board Members every Friday afternoon and summarised media activity over the last few days and provided an alert for some issues which may be reported in the immediate future.

Mr McLaws highlighted the increase in the number of negative reports about NHS GG&C during the period of winter pressures on Accident and Emergency together with the Audit Scotland's report on waiting times.

NOTED

38. FINANCIAL MONITORING REPORT TO JANUARY 2013

There was submitted a paper [Paper No. 13/30] providing the financial report for the 10 month period to 31 January 2013. The report showed an expenditure out-turn of £0.3million under budget for the first 10 months of the year and it was considered that a year-end break-even position remained achievable.

NOTED

39. DATE OF NEXT MEETING

9.00am on Tuesday 21 May 2013 in the Board Room, J B Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow G12 OXH

The meeting ended at 12.40pm