

NHSGG&C(M)14/06

Minutes: 91 - 110

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, 16 December 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	Councillor M Macmillan
Mr R Calderwood	Councillor J McIlwee
Dr H Cameron	Ms R Micklem
Ms R Crocket MBE	Councillor M O'Donnell
Dr L de Caestecker	Councillor M Rooney
Mr R Finnie	Mr D Sime
Mr I Fraser	Mr K Winter

IN ATTENDANCE

Mr A Curran	Head of Capital Planning & Procurement
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Ms A Harkness	Director, Emergency Care & Medical Services
Mr J Hobson	Interim Director of Finance
Ms K Murray	Interim Chief Officer, East Dunbartonshire CHP
Mr A McLaws	Director of Corporate Communications
Ms C Renfrew	Director of Corporate Planning and Policy

ACTION BY

91. APOLOGIES

Apologies for absence were intimated on behalf of Mr J Brown CBE, Councillor M Cuning, Mr P Daniels OBE, Councillor M Devlin, Professor A Dominiczak, Councillor A Lafferty, Mrs T McAuley, Dr R Reid, Rev Dr N Shanks.

NOTED

92. 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

93. CHAIR'S REPORT

- (i) Mr Robertson notified the NHS Board that it was likely there would be the need to hold an additional NHS Board meeting on 20 January 2015 to finalise and approve the re-structure of the new Health and Social Care Partnership Joint Integrated Boards. He anticipated a short NHS Board meeting to do this followed by the pre-arranged Quality and Performance Committee meeting.
- (ii) On 23 October 2014, Mr Robertson attended the official opening of the Clinical Research Facility at the Dental Hospital and School.
- (iii) On 24 October 2014, Mr Robertson met with partners involved in the greening of the Gartnavel Campus which had been officially opened by the then Cabinet Secretary for Health and Wellbeing, Mr A Neil MSP.
- (iv) On 14 November 2014, Mr Robertson attended the Inverclyde League of Friends AGM in Greenock.
- (v) On 17 November 2014, Mr Robertson attended the Chairman's Celebratory Awards Dinner with around 300 members of staff in attendance. Mr Sime commended this event which had been well received by nominees, winners and their peers. Feedback from the ceremony had been excellent.
- (vi) On 24 November 2014, the Right Honourable Lord MacLean issued the final report of the Vale of Leven Hospital Inquiry – this would be discussed in further detail at Item Number 10 of the Board Agenda.
- (vii) On 28 November 2014, Mr Robertson and the Chief Executive toured the new South Glasgow University Hospitals with Ms H Puttick and Mr M Llewellyn, both from the Herald newspaper.
- (viii) On 3 December 2014, Mr Robertson with Mr Hamilton attended the NHS Retirement Fellowship lunch.
- (ix) On 8 and 9 December 2014, Mr Robertson along with other NHS Board Members, attended the NHS Board's Offsite Strategy Event.
- (x) On 15 December 2014, Mr Robertson hosted a visit from the Cabinet Secretary for Health and Wellbeing, Ms S Robison MSP. This provided an opportunity for her to visit Ward 65 at Glasgow Royal Infirmary and to discuss the recent Healthcare Environment Inspectorate (HEI) report with staff.
- (xi) On the evening of 15 December 2014, Mr Robertson attended the University of Glasgow Academic Awards ceremony which recognised the contribution of NHSGGC's medical staff to medical education.

NOTED

94. CHIEF EXECUTIVE'S UPDATE

- (i) On 25 October 2014, Mr Calderwood attended the 50th Anniversary Dinner of the Walton Foundation to celebrate their support to medical education and research.

- (ii) On 30 October 2014, Mr Calderwood attended the hub West of Scotland Annual Shareholders' Dinner.
- (iii) On 3 November 2014, Mr Calderwood attended the Golden Jubilee National Hospital for a lecture on the five steps to achieve high quality healthcare in uncertain times given by Derek Feeley, former Director General of NHS Scotland.
- (iv) On 5 November 2014, Mr Calderwood met with Miss S Cardle and Ms K Sinclair to discuss further the fundraising campaign for the Yorkhill Children's Charity and how this would continue when the new hospital was complete on the South Glasgow University Hospitals campus.
- (v) On 14 November 2014, Mr Calderwood attended the NHS Staff Council in London.
- (vi) On 21 November 2014, Mr Calderwood, attended the IHM Northern Ireland conference and delivered a presentation on "Delivering Safe, Efficient Quality Care – a Scottish Perspective".
- (vii) On 27 and 28 November 2014, Sir Peter Housden hosted the annual Scottish Leadership Forum at the Beardmore Hotel.
- (viii) On 4 December 2014, Mr Calderwood met with Councillor J Coleman, Glasgow City Council, to discuss further the provision of bus services by SPT to the new South Glasgow University Hospitals.
- (ix) On 10 December 2014, Mr Calderwood met with Councillor A Watson and Mr B Devlin from Glasgow City Council to discuss further car parking at the new South Glasgow University Hospitals. They had agreed to arrange a tripartite meeting in the New Year with the three partners (the NHS Board, Glasgow City Council and SPT) going forward.
- (x) On 11 December 2014, Mr Calderwood attended the retiral of Mr G Black (Chief Executive, Glasgow City Council) held at the City Chambers.

Councillor Rooney asked for some further information regarding the work being undertaken to address the transport issues to the new South Glasgow University Hospitals. Mr Calderwood highlighted that discussions would focus on a number of aspects to form a programme of work going forward, especially in the North and South corridors of Glasgow. He described that the priority would be to look at connectivity (rail, underground, bus and fastlink) and work would be set in motion to look at routes and timetables alongside interchange opportunities for these modes of transport.

Councillor Rooney also took the opportunity to commend the senior NHS Board team for their conduct on the release of the Vale of Leven Inquiry report. It was clear that the NHS Board immediately apologised and took responsibility for what had occurred in the hospital in 2007/8 and this had been received very positively and gratefully by the affected families.

NOTED

95. MINUTES

On the motion of Councillor J McIlwee, seconded by Councillor M Macmillan, the Minutes of the NHS Board meeting held on Tuesday, 21 October 2014

[NHSGGC(M)14/05] were approved as an accurate record and signed by the Chair.

NOTED

96. MATTERS ARISING FROM THE MINUTES

The rolling action list of matters arising was noted.

NOTED

97. SCOTTISH PATIENT SAFETY PROGRAMME UPDATE

A report of the NHS Board's Medical Director [Board Paper No 14/61] asked the NHS Board to note an update on the Scottish Patient Safety Programme (SPSP) for medicines reconciliation and venous thromboembolism (VTE).

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

- Medicines Reconciliation Workstream – Dr Armstrong explained that, although there was complementary improvement work underway within Primary Care and Mental Health programmes, her update focused specifically on Medicines Reconciliation in Acute Directorates. Medicines Reconciliation was the process of ensuring that patients were prescribed the correct medicines, in the correct doses appropriate to their current clinical presentation and that avoidable harm from medicines was reduced. Accurate, timely medicines reconciliation on admission to (and discharge from) hospital was an integral part of clinical care. Dr Armstrong outlined the goals and measures used for both Medicines Reconciliation on admission and discharge from hospital.

With regard to admission to hospital, the Medicines Reconciliation process started in clinical areas where patients were directly admitted to hospital, so that had been the focus of the programme to date. Target wards had been identified across all Acute Directorates. As part of the spread plan, the Directorates had identified sets of priority wards, usually with larger numbers of patient admissions. Those wards had been supported by the programme manager and clinical pharmacy to use the model for improvement to test and modify their Medicines Reconciliation process.

With regard to Medicines Reconciliation at discharge from hospital, the ability to perform this effectively relied on it being done well on admission. The programme was, therefore, focused on improving Medicines Reconciliation on admission before formalising to target discharge. In preparation for this work, however, the Department of Medicine for the Elderly wards at Glasgow Royal Infirmary had been doing some testing and measuring in this area.

Dr Armstrong illustrated the results so far, explaining that, at the last review of progress in the Acute Services Division, specific improvements were noted in medical, cardiology, neurosurgery and renal services as well as a few surgical wards such as orthopaedic trauma at Glasgow Royal Infirmary. She described some of the challenges and further areas for development which included a change in the way NHSGGC assessed completion of the Medicines Reconciliation form.

- Venous Thromboembolism (VTE) Workstream – Historically, the risk of VTE and the benefit of prevention had been well recognised and a range of preventative measures had been instituted in healthcare. There was variation in the conduct of formalised documented VTE risk assessment, which contributed to inappropriately prescribed thromboprophylaxis either through omission in high risk patients or unnecessary administration in those at low risk. It was difficult to quantify the risk and benefit but Dr Armstrong alluded to some estimations made in NHSGGC and described the risks of not assessing for thromboprophylaxis in hospitalised patients. This area of work was looking at the assessment of patients and concurrent administration of interventions to prevent VTE in all patients being admitted for Acute inpatient care. The current aim was that there would be a sustained improvement in delivery of venous thromboembolism risk assessment in 50% of applicable wards by December 2015.

Dr Armstrong led the NHS Board through the measures being undertaken and provided a summary of progress as well as the proposal that the roll-out plan would be taken forward in three phases. As with other NHS Boards, NHSGGC was challenged by the lack of a national outcome measure for VTE and, as such, NHSGGC was trying to resolve this locally and a new process had been implemented whereby radiologists and sonographers flagged all new pulmonary emboli and deep vein thrombosis on the radiology system with a V flag. Some of the key challenges were highlighted and Dr Armstrong confirmed that clinical teams continued to report that their capacity to engage with the VTE prevention collaborative was limited by the need to also support other programmes of improvement work.

Mr Sime asked how the work on Medicines Reconciliation fitted with the NHS Board's Use of Antibiotics policy. Dr Armstrong confirmed that high-risk antibiotics had strict guidelines and their use was monitored. This had led to a dramatic reduction in C-Diff locally.

Ms Micklem found the report helpful and its honesty, in terms of the complexity of the challenges, was useful. Given that there were no national targets around this work, she thought it would be useful if some aims and objectives could be put in place so that, when monitoring both workstreams, success (or otherwise) was easily identified. Dr Armstrong welcomed this idea and would give it some thought but reiterated that there were no national targets in place as the SPSP ethos was in identifying better ways for teams to work together.

Medical Director

Mrs Brown agreed with Ms Micklem's point and referred to the numerous strands within the SPSP – this meant it was difficult to keep up with how all were evolving and being rolled out. It would be important to try and be clear about how NHSGGC was ultimately going to reach all the SPSP goals in the long term and she suggested an NHS Board Seminar session looking at overall progress with all the workstreams and how they were pulling together. This suggestion was welcomed.

Medical Director

In response to a question from Dr Benton, Dr Armstrong cited some examples of junior doctors maintaining good practice in Medicines Reconciliation as they moved between specialties. There was recognition, however, that with the rotation of junior staff through many clinical areas, the supervision by seniors was seen as an important reinforcement. Clinical supervision of junior doctors' compliance with the Medicines Reconciliation process was more challenging in some areas, notably surgical wards, where there was a different model of consultant-led ward rounds than in medical settings.

NOTED

98. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No 14/62] 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 3,185 members of staff who were now registered as Cleanliness Champions.

Dr Armstrong also reported on local SAB surveillance status information available for quarter 3 (July to September 2014) which indicated that NHSGGC had had a total of 87 patient cases – only four of which were MRSA. This was the lowest ever reporting quarter for NHSGGC with the previous lowest being 96 cases in quarter 3 of 2012. Local estimation of occupied bed day data suggested a rate of 24 cases per 100,000 occupied bed days. Local C-Diff surveillance figures for July to September (quarter 3) 2014 indicated that NHSGGC had had a total of 112 patient cases. Although this was an increase from previous months, only a third of these cases were hospital-acquired and 25 positive samples were obtained from GP practices alone.

Ms Crocket led the NHS Board through the Healthcare Environment Inspectorate (HEI) Glasgow Royal Infirmary report and outlined the findings from their first day of the inspection in the emergency department. She described the action plan put in place following the visit, including an audit of all the emergency departments in NHSGGC as well as the provision of additional training for staff at GRI. All staff working in all emergency departments had since signed a statement indicating that they were aware of their responsibilities and the action plan would be shared with all emergency

departments to ensure that the learning from this inspection could be shared across the piece. As well as the concerns raised about cleanliness of patient equipment, infection control precautions and the care of PVC devices, the inspectors identified a number of staff in breach of the NHSGGC Uniform and Dress Code Policy. This had been addressed.

Ms Crocket referred to Mr Robertson's earlier comment that the Cabinet Secretary for Health and Wellbeing, Ms S Robison MSP, had visited the GRI on 15 December 2014 to discuss this report with staff. She also confirmed that she had met with all lead nurses to reflect on the outcomes of the HEI report and a similar session would be arranged for January 2015 with all senior charge nurses. She reported that staff were disappointed themselves with the findings from the inspection and were anxious to make all necessary improvements.

In response to a question from Councillor Rooney regarding the HEI announced and unannounced inspections, Ms Crocket confirmed that all NHSGGC staff had a responsibility to the NHS Board (as their employer) and to their regulatory bodies. She specified the mandatory requirements in respect of staff training which were intrinsic to their roles. She added that the NHS Board had fully accepted the report and had already undertaken a number of actions for improvement which included:-

- The infection control precautions audit tool would be embedded in the new infection prevention and control audit tool.
- The IPC education strategy had been updated to include infection control precautions as a mandatory element of staff development not only at induction but also as a three-yearly update.

Ms Micklem referred to the 342 reported cases of C-Diff from 1 January to 31 October 2014 in NHSGGC and the fact that local analysis of recurring infections indicated a recurrence of C-Diff in 15% of patient cases. Dr Armstrong reported that, of these 342 patients, in only one case, the patient "caught" it from another patient. Furthermore, a re-infection *was* counted as a new case. In response to a further question, Ms Crocket confirmed that, locally, inspections were carried out in wards and the last GRI emergency department inspection was undertaken in September 2015. She agreed that, when feedback from wards was 95-96% compliance (and, therefore, scored green) it was important to look at the 4-5% reasons for not meeting 100% compliance. Ms Crocket agreed to consider how best this could be reported in future to the NHS Board in a meaningful way.

Nurse Director

Ms Brown wondered whether NHSGGC needed to review its sanctions for those not meeting compliance in respect of the Uniform Policy. Ms Crocket agreed and reported that a Core Brief had gone out to remind staff of the Uniform Policy and that, from now on, the nurse in charge of each shift would carry out a staff inspection. This would be monitored on an ongoing basis.

NOTED

99. UPDATE ON BIENNIAL DIRECTOR OF PUBLIC HEALTH REPORT ON POPULATION HEALTH IN NHSGGC 2013-2015

A report of the Director of Public Health [Board Paper No 14/63] asked the NHS Board to note progress on the priorities for action identified in the Director of Public Health's report "Building Momentum for Change", published in 2013.

Dr de Caestecker reminded the NHS Board that "Building Momentum for Change" covered the period 2013 to 2015. It highlighted the pivotal importance of poverty and

disadvantage in shaping health at three key life stages (early years, adolescence and mature adults) and in two priority groups (looked-after and accommodated young people and prisoners).

She led the NHS Board through an update on progress made against the priorities for action, explaining that most of the work was still in progress so the report included only examples of activity in key areas identified for action. She described innovative models of financial inclusion for families, work with authorities on tackling poverty, mental health promotion for young people, the legacy of Keep Well, information on the needs of looked-after children and young people, and health improvement of offenders. She cited some examples of the work in progress as follows:-

- Supporting NHSGGC’s most disadvantaged families – looking at ways to better support frontline staff, strengthen involvement in advocacy and develop innovative new schemes to help people maximise their incomes by putting patients in touch with a team of money advice workers known as income maximisers.
- The transition of adolescence.
- Promoting healthy ageing.
- “Getting it Right for Looked-after Children and Young People”.
- Improving health in NHSGGC’s Prison Service.

Dr de Caestecker was delighted that progress had been made in all of the priorities for action and reported that further updates would be provided in the 2015 Director of Public Health report.

**Director of
Public Health**

Dr Lyons welcomed the report and the associated actions. He raised two points which fitted in with the broad themes and where, he considered, further action was required, firstly, young people entering working age and, secondly, healthy ageing and the need to have a healthy older population. He also cited the obesity and alcohol consumption problems faced by the NHS. Dr de Caestecker agreed and confirmed that obesity and alcohol consumption were issues discussed within the chronic disease management protocols. There were a number of programmes available within NHSGGC to target both and she referred also to wider societal changes that needed to take place to target these areas such as the pricing of healthier food options and the pricing and availability of alcohol. Both were being discussed at a national level and she also referred to work she did locally with licensing boards.

Councillor Macmillan recorded his thanks and appreciation to Dr de Caestecker for her contribution to tackling poverty in Renfrewshire.

Councillor Rooney asked about the concept of “income maximisers” and Dr de Caestecker explained that they provided advice and help to families on how to get the most out of their income with the aim of improving their long-term health. They also provided advice on reducing debt payments or helped to change service tariffs. What was initially a project aimed at pregnant women and families with young children, “Healthier, Wealthier Children”, had now expanded to provide the same support to people affected by a number of health issues. In terms of access to these income maximisers, that depended on the setting but she encouraged people to attend, in the first instance, local financial inclusion projects for referral.

In response to a question from Mr Robertson, Dr de Caestecker confirmed that, with the introduction of Health and Social Care Partnerships in 2015, it was her intention to provide her future DPH report in a different format. There would be a chapter looking

at the whole of NHSGGC and, thereafter, a chapter for each Health and Social Care Partnership.

**Director of
Public Health**

NOTED

100. RESPONSE TO THE VALE OF LEVEN HOSPITAL INQUIRY REPORT – IMPLEMENTATION OF RECOMMENDATIONS

A report of the Chief Executive [Board Paper No 14/64] asked the NHS Board to approve the process to submit, to the Scottish Government Health Directorate by 19 January 2015, the progress made in implementing the 65 NHS Board recommendations from the Vale of Leven Hospital Inquiry report.

At the outset, Mr Calderwood recorded his personal apology in respect of the shortcomings identified in the Vale of Leven Hospital Inquiry report. He acknowledged that there had been a failure at the hospital which he profoundly regretted and provided assurances that, as a result of the lessons learned, could not happen again. The NHS Board had approached the families who had submitted legal claims and had made a formal offer to settle the outstanding claims, and negotiations with the families' solicitors were ongoing.

The Chairman had asked the Chief Executive and appropriate directors to review the statements made by Lord MacLean in relation to individual members of staff and to also consider all subsequent steps taken since 2008 in relation to the actions of staff at that time. That review was now currently underway and would have Non-Executive Director involvement in the process and outcome.

Mr Calderwood explained that the Scottish Government Health Directorate had set up a process to monitor each NHS Board's assessment and implementation against the 65 recommendations identified for NHS Boards. He led the NHS Board through the guidance note and template that had been provided and explained that he would be required to describe the current position/progress towards implementing the recommendations and, where relevant, provide supporting evidence and examples of good practice.

He was then required to sign and return NHSGGC's template to the Scottish Government Health Directorate by 19 January 2015. Given this, it was recommended that a final draft be submitted to NHS Board Members by email on 13 January 2015 for comment. Once completed, it would be submitted to the Scottish Government Health Directorate by 19 January 2015 and the finalised template would then be submitted to the Quality and Performance Committee at its meeting on 20 January 2015 for endorsement.

In response to a question from Councillor Rooney, Mr Calderwood reported that, over and above the recommendations made in the Vale of Leven Hospital Inquiry report, the previous Cairns Smith report had highlighted recommendations which had been implemented. Cairns Smith had also met with the families as had the previous and current Cabinet Secretaries for Health and Wellbeing.

Mr Finnie expressed his disappointment at comments made in the editorial section of the Herald newspaper when the report was launched. He was keen to ensure a full response was given to each recommendation contained within the report. Mr Calderwood explained the approach taken by the NHS Board in that it issued a statement immediately to ensure that members of the public understood that NHSGGC's hospitals were a safe environment. In terms of assessment and implementation against the 65 recommendations, Mr Calderwood highlighted that many had already been implemented since September 2008 and, in responding to

others, he recognised that some would require a generic approach and some more governance-led.

DECIDED

- That, the process to submit to the Scottish Government Health Directorate by 19 January 2014 the progress made in implementing the 65 NHS Board recommendations from the Vale of Leven Hospital Inquiry report be approved.

**Chief
Executive**

101. DONATION OF SURPLUS EQUIPMENT

A report of the Interim Director of Finance [Board Paper No 14/65] asked the NHS Board to consider requests to donate surplus equipment to charitable organisations and, if so, note the proposed governance process for this.

Mr Hobson explained that, when services migrated to the new South Glasgow University Hospitals in 2015, existing equipment would be transferred where appropriate. Equipment not transferring would be redeployed to alternative sites or services where possible. Any remaining equipment may be declared surplus and disposed of. The NHS Board had received a number of requests from charitable organisations to donate NHS assets which had been identified as surplus to requirements. NHSGGC had previously received a formal submission from the Malawi Initiative, had considered this and supported it as an agreed strategy. This allowed the Malawi Initiative first call on such equipment and for the NHS Board to sanction any loss of potential income as a charitable donation. Subsequent requests had been received to donate equipment to Kenya, Syria and Zambia.

Mr Hobson outlined how the disposal of surplus assets was governed by the NHS Board's Standing Financial Instructions. These stipulated that, where an asset had been declared surplus to requirements, it must be disposed of for the maximum possible disposal proceeds or alternatively, the cost of disposal should be minimised. In order to maintain appropriate governance arrangements over the disposal of surplus assets to charitable organisations, he outlined the proposed process. This would not apply to surplus IT equipment for reasons of information governance. Any other device or equipment that had data storage or information processing capability must have all data removed prior to disposal. Data removal would be recorded by Medical Physics in the equipment record.

DECIDED

- That, surplus assets should be made available to charitable organisations which were registered with the Office of the Scottish Charity Regulator (OSCR) or an equivalent organisation be approved.
- That, the proposed governance processes be noted.

**Interim
Director of
Finance**

102. BOARD PROPERTY TO BE DECLARED SURPLUS

A report of the Head of Capital Planning and Procurement [Board Paper No 14/66] asked the NHS Board to note the progress towards the disposal of four sites and that marketing arrangements for these properties would be progressed.

Mr Curran reported that, following a meeting of the Property Committee on 26 November 2014, as part of the NHS Board's continuing programme of rationalisation of its estates, four premises were to be declared surplus to requirements as follows:-

- Whittinghame Gardens Day Hospital, Great Western Road, Glasgow;
- Eastwood Resource Centre, 38 Seres Road, Clarkston;
- Maryhill Health Centre, 41 Shawpark Street, Glasgow;
- Clarkston Clinic, 56 Busby Road.

He reported that the first stage in the disposal process was to declare the properties surplus to requirements. Such a declaration would permit the property to be trawled in line with the NHS Property Transactions Handbook and ready the sites for marketing for sale.

NOTED

103. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Officer, Acute Services Division [Board Paper No 14/67] asked the NHS Board to note progress against the national targets as at the end of October 2014.

Ms Harkness 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. She also highlighted the number of patients awaiting discharge from hospital beds across NHSGGC.

Ms Harkness alluded to fourteen ophthalmology and 243 neurology patients waiting over 12 weeks at the end of September 2014. At the end of October 2014, there were two ophthalmology, two dermatology and 110 neurology patients waiting over 12 weeks. She summarised various actions being taken over recent months to improve performance in these areas, highlighting the significant demand and capacity pressures in these specialties – she added that this was a national issue and not limited to NHSGGC.

Councillor Rooney asked about the cost of NHSGGC's unavailability policy whereby it continued to seek to provide patients with access to their nearest hospital, where at all possible, and accepted patient requests to wait to be treated at their choice of hospital/by their choice of consultant. Mr Calderwood explained that this had the effect of removing these patients from the waiting times guarantee and that, with access to nine acute hospital sites, NHSGGC patients were often eligible to be treated at a range of sites, thus making patient choice an option that may not be available in other Boards. He conceded that, going forward, it would be more difficult for NHSGGC to sustain that "choice factor" for patients. In response to his follow-up question concerning the Change Fund ceasing from April 2015, it was reported that it would be replaced by integration funds which would initially be for one year and this would assist with plans to continue to reduce bed days lost.

Dr Lyons welcomed the improvement on breast cancer performance due to improvement initiatives during the course of quarter 3 including the rapid improvement event for breast oncology. He referred to a recent English judgement concerning adults with incapacity which would result in implications for social work departments. He wondered if any horizon scanning was taking place in Scotland in light of this? Ms Harkness confirmed that she was aware of the judgement and that, in Scotland, guidance had been issued in terms of its likely impact.

Mrs Brown noted the information regarding patients awaiting discharge and was

concerned to see the increase in South Lanarkshire. Ms Renfrew agreed that this was disappointing and confirmed that attempts were being made to discuss this with NHS Lanarkshire as well as escalating it to the Scottish Government Health Directorate.

NOTED

104. FINANCIAL MONITORING REPORT FOR THE 7 MONTH PERIOD TO 31 OCTOBER 2014

A report of the Interim Director of Finance [Board Paper No 14/68] asked the NHS Board to note the financial performance for the first seven months of the financial year.

Mr Hobson reported that the NHS Board currently had an overspend of £1.3m for the seven month period to 31 October 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.

Councillor Rooney referred to the decision made at the August 2014 NHS Board meeting to allocate £1.1m additional investment for unscheduled care – Mr Hobson confirmed that this was included in the report.

NOTED

105. QUARTERLY REPORT ON COMPLAINTS: 1 JULY TO 30 SEPTEMBER 2014

A report of the Nurse Director [Board Paper No 14/69] asked the NHS Board to note the quarterly report on complaints in NHSGGC for the period 1 July to 30 September 2014 and note extracts from the ISD and SPSO Annual Reports 2013/14.

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 82% of complaints responded to within 20 working days had been achieved.

Ms Crocket advised that a recording error had occurred in the Acute Services Division relating to the number of received and completed complaints. In correcting the method of validation, therefore, it had been necessary to amend the previous quarter's figures to reflect the accurate recording method. Apologies were given for this error which had now been rectified and, going forward, one single officer would complete the NHS Board quarterly returns and those submitted to ISD.

Ms Micklem welcomed the helpful and informative nature of the report. She referred to the online patient feedback system and asked about the proposed marketing campaign for this. Mr McLaws confirmed that a marketing campaign was planned for 2015 when the totality of ways which patients could provide feedback would be launched.

This was considered a more proactive and wider approach than marketing the online patient feedback system in isolation.

NOTED

106. QUALITY AND PERFORMANCE COMMITTEE MINUTES: 16 SEPTEMBER 2014

The Minutes of the Quality and Performance Committee meeting held on 16 September 2014 [QPC(M)14/05] were noted.

NOTED

107. AREA CLINICAL FORUM MINUTES: 2 OCTOBER 2014

The Minutes of the Area Clinical Forum meeting held on 2 October 2014 [ACF(M)14/05] were noted.

NOTED

108. PHARMACY PRACTICES COMMITTEE MINUTES: 1 OCTOBER 2014 AND 10 OCTOBER 2014

The Minutes of the Pharmacy Practices Committee meetings held on 1 October 2014 [PPC(M)14/05] and 10 October 2014 [PPC(M)14/06] were noted.

NOTED

109. AUDIT COMMITTEE MINUTES: 25 NOVEMBER 2014

The Minutes of the Audit Committee meeting held on 25 November 2014 [A(M)14/05] were noted.

NOTED

110. CLOSING REMARKS

The Chairman wished all members and those in attendance a very merry Christmas and best wishes for 2015.

The meeting ended at 12:10pm