

NHSGG&C(M)15/02  
Minutes: 05 - 20

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, 17 February 2015 at 9:30a.m.**

**PRESENT**

Mr A O Robertson OBE (in the Chair)

Dr J Armstrong (To Minute No: 15)	Mr I Fraser
Dr C Benton MBE	Councillor A Lafferty
Mr J Brown CBE	Mr I Lee
Ms M Brown	Dr D Lyons
Mr R Calderwood	Mrs T McAuley OBE
Dr H Cameron	Councillor M Macmillan
Ms R Crocket MBE	Councillor J McIlwee
Councillor M Cunning (To Minute No: 16)	Ms R Micklem
Mr P Daniels OBE	Councillor M O'Donnell
Dr L de Caestecker (To Minute No: 16)	Dr R Reid (To Minute No: 16)
Councillor M Devlin	Councillor M Rooney (To Minute No: 17)
Professor A Dominiczak (To Minute No: 16)	Rev Dr N Shanks (To Minute No: 15)
Mr R Finnie	Mr D Sime
	Mr K Winter

**IN ATTENDANCE**

Mr J Best	Sector Director – North Sector (Acute Services Division)
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Mr J Hobson	Interim Director of Finance
Dr I Kennedy	Consultant in Public Health Medicine (For Minute No: 13)
Mr D Leese	Chief Officer Designate, Renfrewshire IJB
Ms S McCorry-Rice	Director, North-West Glasgow Sector – Glasgow CHP
Mr A McLaws	Director of Corporate Communications
Ms K Murray	Chief Officer Designate, East Dunbartonshire IJB (To Minute No: 16)
Ms C Renfrew	Director of Corporate Planning and Policy

**ACTION BY**

**05. WELCOME AND APOLOGIES**

Mr Robertson welcomed Mr J Brown CBE to his first NHS Board meeting.

No apologies for absence were intimated.

NOTED

**06. 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

**07. CHAIR'S REPORT**

- (i) Mr Robertson had acknowledged receipt of a petition prior to the NHS Board meeting from the Royal College of Nursing (RCN). The petition, signed by 7,000 people, stated:-

*“The new South Glasgow Hospitals site is the largest in the country and a great asset for Glasgow. However, if staff cannot get to or park at the site, then patient care may be affected. Read more about the problems staff will face getting to and from work on time and safely at the new site on the RCN website.*

*I ask that Glasgow City Council and NHS Greater Glasgow and Clyde resolve significant car parking and travel problems so I and my colleagues can get to work at the new South Glasgow Hospitals”.*

The Chief Executive would comment on that issue in his update to the NHS Board.

- (ii) On 16 December 2014, the Cabinet Secretary for Health and Wellbeing visited staff at Glasgow Royal Infirmary to follow up on recommendations made in a recent Healthcare Environment Inspectorate (HEI) unannounced inspection. This provided an opportunity for good interaction with staff and the chance to outline the various follow up actions being made.
- (iii) Also on 16 December 2014, Mr Robertson attended the Excellence in Education awards ceremony and with Professor A Dominiczak, presented awards to NHSGGC's senior medical colleagues who contributed to the education of NHSGGC's clinicians.
- (iv) On 12 January 2015, the interviews for the Chief Officer post at Renfrewshire Health and Social Care Partnership took place. Mr Robertson confirmed that the successful candidate was Mr D Leese.
- (v) Between 15 January 2015 and 16 February 2015, Mr Calderwood and Mr Robertson had had several meetings with the Cabinet Secretary for Health and Wellbeing and Scottish Government officials to discuss the 2020 Vision and the operational practicalities to achieve that at local NHS Board level.
- (vi) On 21 January 2015, Mr Robertson hosted a visit from Mr J Swinney, Deputy First Minister, at the South Glasgow University Hospitals campus.
- (vii) On 22 January 2015, Mr Robertson attended a meeting of the NHSGGC Primary Care Deprivation Group to discuss, amongst other things, the high level of satisfaction they had with the flexibility afforded in the 17c contracts.
- (viii) On 23 January 2015, the interviews for the Director of Finance post were held and Mr M White had been appointed.

- (ix) On 3 February 2015, Mr Robertson and Ms Crocket visited dementia services at Lightburn Hospital.
- (x) On 5 February 2015, Mr Robertson and Mr Calderwood were guests at the Scottish Enterprise Life Sciences dinner. NHSGGC, the University of Glasgow and partners, ThermoFisher and Aridhia, were awarded with a major life sciences award in the “innovative collaboration” category.
- (xi) On 9 February 2015, Mr Robertson spoke at an event in the City Chambers called “Improving the Cancer Journey”, which brought together the NHS, the Council and third sector organisations led by Macmillan Cancer Care.
- (xii) On 16 February 2015, the shortlisting for the post of Director of Human Resources took place.
- (xiii) Mr Robertson referred to the imminent retiral on 31 March 2015, of two NHS Board Members, Dr C Benton MBE and Mr P Daniels OBE. Both had served an eight year period on the NHS Board and he referred to their tremendous contribution and insightful comments, not only at NHS Board meetings but at CH(C)P meetings and Pharmacy Practices Committee meetings. Both brought knowledge and clarity to many aspects of the work of the NHS Board and he recorded his appreciation and many thanks.

NOTED

**08. CHIEF EXECUTIVE’S UPDATE**

- (i) Mr Calderwood referred to the petition received by Mr Robertson prior to the NHS Board meeting and advised that the new South Glasgow University Hospitals site and surrounding area was already serviced by 50 buses on an hourly basis. This information had been relayed to staff in a number of ways including transport roadshows, ongoing internal communications and orientation packs for staff working at the new hospitals. Through consultation with staff, shift patterns of staff due to work at the hospitals had been tailored to maximise access to transport options.

More than 10,000 staff would work on the new South Glasgow University Hospitals site when it was fully operational. The car parking capacity, however, must not exceed 3,500 parking spaces, a figure determined by Glasgow City Council as part of the Town and Country planning process. When the hospital buildings were operational, there would be 2,500 spaces available, with a further 1,000 spaces to be opened by the summer of 2016 on completion of a third multi-storey car park. NHSGGC was in continued dialogue with planners to look at whether there was any scope to increase the number of spaces from 3,500 to 4,000 as part of the final master planning of the site.

The NHS Board’s Car Parking Policy was designed to ensure there was a balance in parking provision to meet patient and visitor parking requirements as well as staff. Permits were only issued to staff who worked across sites or performed a specialist role. The Car Parking Policy operated from Monday to Friday between 8am and 5pm, meaning that staff working at night and at the weekend could continue to park on site, as was the case at the moment.

The number of spaces NHSGGC could provide was regulated nationally by the Campus Carbon Sustainability Plan and the Green Travel Plan (all part of the planning application process). NHSGGC was investing £5.2m as part of the detailed Travel Plan which would improve accessibility to the new South

Glasgow University Hospitals campus. Improved public transport routes, traffic controls in the surrounding area and upgrading works to the local road network were all being implemented. The NHS Board was continuing to work closely in partnership with Strathclyde Partnership for Transport and Glasgow City Council to ensure that the investment was targeted at communities where there was currently insufficient public transport. The Scottish Government was also investing £40m in a new Fastlink scheme which, for the first time, would see direct transport from three main sites in the City Centre (Buchanan Street Bus Station, Queen Street and Central Stations) to the new South Glasgow University Hospitals campus. In addition, NHSGGC had submitted a further planning application with the City Council to increase the car parking capacity by a further temporary circa 600 spaces. Mr Calderwood hoped that this would be considered shortly, and, if approved, would assist with the provision of car parking for staff with permits.

- (ii) On 29 December 2014, the First Minister and Cabinet Secretary for Health and Wellbeing visited staff and survivors of the bin lorry tragedy at Glasgow Royal Infirmary.
- (iii) On 15 January 2015, Mr Calderwood was a guest at the launch of the University of Strathclyde's International Public Policy Institute.
- (iv) Throughout January 2015, Mr Calderwood had visited all of NHSGGC's Accident & Emergency sites given the significant pressures identified there. He had debated with clinicians and Directors how to align resources and maximise care and safety for patients.

In response to a question from Councillor Rooney, Mr Calderwood reported that the bed model for 2015/16, alongside the NHS Board's Acute Services Strategy, saw a reduction in elective beds but an increase in unscheduled care beds.

The NHS Board asked Mr Calderwood to clarify the role of the Support Team (appointed by the Scottish Government) to work with the Royal Alexandra Hospital (RAH), Paisley, to help improve performance in Accident & Emergency (A&E). Mr Calderwood explained that, from 16 February 2015, unscheduled care managers from the Scottish Government would be working with the hospital to identify immediate measures and key actions to support improvements. NHS Scotland Chief Executive, Mr P Gray, had recognised the challenging winter for A&E departments across Scotland and apologised to patients who had waited longer than they should to have been seen and treated. He recognised that all staff had been working extremely hard to ensure patients got the best possible care, however, he was concerned that performance was not recovering as quickly as it should at the Royal Alexandra Hospital. Through performance monitoring and management, he had, therefore, provided support to the NHS Board to help ensure patients were seen and treated in A&E within the appropriate timescale. As such, he had provided specialist support to work with NHSGGC to deal with the current level of demand. This action would help identify issues where they existed and prioritise actions that could be taken to improve A&E performance.

Mr Calderwood added that the Scottish Government would be working closely with the NHS Board throughout this process to ensure that performance improvements were sustainable. There had been a lot of learning across Scotland in recent months about various different approaches to improving efficiency of patient flows in A&E departments and Mr Calderwood was hopeful that some of this learning may prove to be appropriate for the RAH to help local teams on the ground to deliver improved performance in the weeks and months ahead. He reiterated that the NHS Board and staff remained committed to

meeting the highest levels of service provision for patients and every opportunity to improve current challenged performance was welcomed.

Members remained concerned about how NHSGGC was informed about this decision and as to why a Support Team was being sent to the RAH in particular. Mr Calderwood confirmed that he had ensured that NHS Board Members became aware of the situation as soon as was possible. He added that the Support Team had met on 16 February 2015 and he had since received details of the members of the Team which would be circulated to the NHS Board. The Team was expected to produce a report by 2 March 2015 for the Cabinet Secretary of Health and Wellbeing and, as soon as this was available, he would also share this with the NHS Board.

**Chief  
Executive**

In the interim, Mr Calderwood explained he would be restructuring the senior management team for “Clyde” and would bring forward the Interim Hospital Director appointment in advance of a substantive appointment being made. He also explained that learning from the Support Team and their work at the RAH would be rolled out across NHSGGC.

The NHS Board agreed to await the publication of the Team’s report on 2 March 2015 (which would hopefully be received in time to be discussed at the NHS Board’s Away Day on 9 March 2015) and discuss further how to proceed with the Scottish Government in terms of the resultant sequence of events.

**Chairman**

Councillor Macmillan referred to the petition received earlier by Mr Robertson and extended these concerns to all hospitals not just the new South Glasgow University Hospitals. He highlighted the importance in continuing to engage with all staff in terms of parking provision at all hospital sites.

NOTED

**09. MINUTES**

- (a) On the motion of Mr D Sime, seconded by Dr D Lyons, the minutes of the NHS Board meeting held on Tuesday, 16 December 2014 [NHSGGC(M)14/06] were approved as an accurate record and signed by the Chair.
- (b) On the motion of Mr I Lee, seconded by Dr R Reid, the minutes of the NHS Board meeting held on Tuesday, 20 January 2015 [NHSGGC(M)15/01] were approved as an accurate record and signed by the Chair subject to the following amendments:-
  - Minute No 03(a), 2<sup>nd</sup> paragraph, *delete* last sentence “He also commended the work of the current NHS Chair of the Community Health Care Partnership (CH(C)P)”. *Insert*: “He also commended the joint collaborative approach he had experienced in working with the current NHS Vice Chair of the Community Health Care Partnership (CH(C)P)”.
  - Minute No 03(c), delete 3<sup>rd</sup> paragraph and insert the following new paragraph:-
 

“Mr Sime referred to Section 10 of the draft and reported that the Area Partnership Forum’s comments had largely been incorporated into the draft. However, in paragraph 10.2, the draft equated the NHS Board’s Staff Governance Committee to the Council’s Staff Representative Forum

when they were obviously not equivalent. It would be desirable to amend the draft appropriately in relation to Staff Governance and the linkages to the Area Partnership Forum on an equivalent basis to the Council's Staff Representative Forum".

**Director of  
Corporate  
Planning &  
Policy**

- Minute No 03(d), delete 3<sup>rd</sup> paragraph and insert the following new paragraph:-

"Mr Sime welcomed paragraphs 9.2 to 9.4 referencing workforce governance. However, like the Inverclyde Scheme, the draft contained the same issues of equivalence. It would, therefore, be desirable to amend the Glasgow City draft appropriately in relation to staff governance and the linkages to the Area Partnership Forum on an equal basis to the Council's Joint Consultative Forum".

**Director of  
Corporate  
Planning &  
Policy**

- Minute No 03(d), 4th paragraph, "Dr Benton asked about the future of "hosted services....." change to read "Dr Benton asked about the future of "hosted services *including learning disabilities.....*".

NOTED

## 10. MATTERS ARISING FROM THE MINUTES

The Rolling Action List of matters arising was noted.

NOTED

## 11. SCOTTISH PATIENT SAFETY PROGRAMME (SPSP) UPDATE

A report of the NHS Board's Nurse Director [Board Paper No 15/03] asked the NHS Board to note an update on the Maternity and Children Quality Improvement Collaborative (MCQIC) which encompassed the clinical improvement activity of the SPSP's Maternity, Neonatal and Paediatric strands. Its overall aim was to improve outcomes and reduce inequalities in outcomes by providing a safe, high quality care experience for all women, babies and families in Scotland.

Ms Crocket reported that MCQIC was launched formally as a collaborative in March 2013 (a paediatric workstream had been active prior to that) and was a programme of quality improvement that would run until December 2015.

Ms Crocket described some of the key MCQIC events that had taken place and led the NHS Board through an update on the maternity workstream and the paediatric and neonatal workstream as follows:-

- Maternity Workstream – The maternity care strand aimed to support clinical teams in NHSGGC to improve the quality and safety of maternity healthcare. There were three major obstetric care sites in NHSGGC and they continued to make good progress in implementing the programme. The MCQIC Midwifery Champion roles were nationally funded and this funding ended in July 2015. A review of the support arrangements to consider the post-champion model was underway. The Directorate was also undergoing a revision of its governance structures within obstetrics and the role of MCQIC was a key feature of this. Ms Crocket highlighted some examples of the progress against each individual measure for the Southern General Hospital, Royal Alexandra Hospital and Princess Royal Maternity Unit.

- Paediatric and Neonatal Workstream – Its aim was to achieve a 30% reduction in adverse events that contributed to avoidable harm in neonatal and paediatric services by December 2015. There were currently 20 teams supported across paediatric and neonatal services.

In response to a question from Mr Robertson concerning the main aim of the paediatric and neonatal workstream, Ms Crocket acknowledged that to achieve a 30% reduction was a challenge. Given progress so far, however, she was hopeful this would be achieved.

Dr Lyons asked about tables 2 and 3 and, in particular, the use of Situation, Background, Assessment and Recommendation (SBAR). Ms Crocket reported that SBAR was a way of transferring critical information about patients. The tables reflected where teams currently were, and the Clinical Governance Unit Support Team was linking with the neonatal and paediatric service to consider how best to implement SBAR and align it to the current frontline team methods for data collection and reporting. It had been agreed that a monitoring group would review and sign off the quarterly SBAR reports prior to submission.

Ms Micklem commended the collaborative approach taken with both these workstreams but wondered how the inequalities element would be measured. Ms Crocket agreed that both workstreams were process and clinically driven so it was difficult to measure inequalities particularly when the aims were to provide a safe, high quality care experience for *all* women, babies and families across maternity care settings in Scotland – that was regardless of whether someone was in one of the protected characteristic groups or not. She agreed with Ms Micklem that the measurement of this particular aspect of the aim had to be considered further.

**Nurse Director**

In response to a question from Dr Reid regarding one of the aims to “reduce the incidence of non-medically indicated elective deliveries prior to 39 weeks gestation by 30%”, Ms Crocket reported that in NHSGGC, most elective deliveries related to the woman’s and/or child’s health. In order to meet this aim, she agreed that it would be useful to look at comparative data with other NHS Boards.

**Nurse Director**

#### NOTED

## **12. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)**

A report of the NHS Board’s Medical Director [Board Paper No 15/04] 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 (July to September 2014), NHSGGC reported 24.1 cases per 100,000 AOBs. NHS Scotland reported 32.3 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 AOBDS in the over-65s age group. The new target for future attainment included cases in ages 15 and over and this was subsequently revised in 2013 by the Scottish Government following a change in the calculation of bed day data and now required NHS Boards to achieve a rate of 32 cases or less per 100,000 AOBDS to be attained by 31 March 2015. For the last available reporting quarter, July to September 2014, NHSGGC reported 33.8 cases per 100,000 AOBDS, combined rate for all ages. This placed the NHS Board below the national average of 39.7 per 100,000 AOBDS.

The Cleanliness Champions Programme was part of the Scottish Government's Action Plan to combat HAI within NHS Scotland. To date, NHSGGC had supported 3,214 members of staff who were now registered as Cleanliness Champions.

Ms Crocket led the NHS Board through the progress made following the Healthcare Environment Inspectorate (HEI) unannounced inspections at Glasgow Royal Infirmary in October 2014. She summarised the eight requirements and one recommendation resulting from these inspections.

Mrs McAuley asked about the C.Diff incidence rates and Dr Armstrong expected that, each quarter, these would fluctuate. She highlighted, however, that NHSGGC's rates were lower than the average rate for the rest of NHS Scotland. Every case of C.Diff was reviewed thoroughly to understand any local linkages with other cases and to explore further GP prescribing patterns.

With regard to the community hospitals report card, Dr Lyons referred to the MRSA, MSSA and C.Diff numbers and asked whether these had presented at one particular community hospital. Dr Armstrong described the upper and lower control limits that existed within each hospital (including community hospitals) and reported that the rates would not be specific to one hospital. She agreed to share the actual figures with Dr Lyons.

**Medical  
Director**

In response to a question from Dr Benton regarding dress code and staff uniform compliance, Ms Crocket reported that Senior Charge Nurses had a responsibility on every shift to check and record compliance. This included junior doctors and she agreed it was paramount to keep reinforcing the message locally.

NOTED

**13. EBOLA – UPDATE ON CONTINUING PREPAREDNESS ACTIVITIES AND HANDLING OF A CONFIRMED EBOLA CASE**

A report of the Director of Public Health [Board Paper No 15/05] asked the NHS Board to note the Ebola preparedness activities undertaken by the NHS Board over the past six months and support ongoing activities which would further enhance this as well as public safety in the extremely low likelihood of further confirmed cases.

Dr de Caestecker described the background to the current Ebola crisis and the major international effort to control the outbreak, including nearly 2,000 personnel from the UK, which had resulted in first slowing, and more recently, a decrease in new cases.

She led the NHS Board through NHSGGC's preparedness plans to deal with any outbreak or individual who presented with an infectious disease. These plans were well-rehearsed in 2014 in preparation for the Commonwealth Games. She also summarised NHSGGC's response to an Ebola positive case in Glasgow in late

December 2014.

In summarising ongoing activity in NHSGGC, Dr de Caestecker reported that, given the trends and incidence and the commencement of Phase 2 clinical trials of Ebola vaccines in West Africa, it was becoming increasingly likely that the outbreak would be brought under control during 2015. Given that, it was anticipated that the activity required within NHSGGC to ensure preparedness would begin to taper off over the next 3-6 months. Many of the Ebola preparedness activities applied to other potential risks. In summary, over the past six months, significant work had been done to ensure NHSGGC was prepared for Ebola. The handling of the confirmed Ebola case demonstrated the success of that work though opportunities for further improving the response had been identified. These activities had improved the preparedness and resilience of NHSGGC, not just for Ebola, but more generally.

Mr Sime recorded his appreciation to all staff who had been, or had requested, to be deployed to help tackle Ebola and to the teams from across NHSGGC, particularly the Brownlee Unit, for the handling of the confirmed Ebola case. He reported that Dr Kennedy had attended the Area Partnership Forum meeting in December 2014 to provide an update on ongoing activities.

In response to questions from Dr Benton, Dr Kennedy confirmed that it was difficult to compare statistical information on Ebola as some countries reported cases as being “probable” whilst others reported “confirmed” only. He added that engagement with local communities was a priority and that a vaccine was not yet commercially available.

#### DECIDED

- That thanks to the teams from across the NHS Board, particularly the Brownlee Unit, for the handling of the confirmed Ebola case, be recorded. **Director of Public Health**
- That the Ebola preparedness activities undertaken by the NHS Board over the past six months be noted. **Director of Public Health**
- That the ongoing activities which would further Ebola preparedness and public safety, in the extremely low likelihood of a further confirmed case, be supported. **Director of Public Health**

#### **14. APPROVAL OF SCHEMES OF INTEGRATION – INTRODUCTORY PAPER**

A report of the Director of Corporate Planning and Policy [Board Paper No 15/06] asked the NHS Board to approve the Integration Schemes for Renfrewshire and East Dunbartonshire to provide a basis to move the two draft Integration Schemes into the next phase of process which was submission to the two respective Councils and then to Scottish Ministers for their approval. Once that approval was granted, Integrated Joint Boards (IJBs) could be established by Order of Scottish Ministers.

Ms Renfrew also sought to agree an approach to resolve the role for the IJB in oversight of local NHS Children’s Services within the East Dunbartonshire Council area.

Ms Renfrew led the NHS Board through the introductory paper which set the context for the draft Integration Schemes which were the formal step required by legislation to establish the new IJBs. These had been developed in a process led by each Chief Officer and an important point of that context was that, for the NHS Board, the planning and service responsibilities which would be discharged by IJBs remained part of a whole NHS system for NHSGGC.

Ms Renfrew described NHSGGC's approach to operational delivery, the essence of which was that the Chief Officer would carry that responsibility with oversight and direction provided by the IJB. The Service Delivery Framework attached to the NHS Board paper had been drafted to ensure a clear basis for delegation and assurance about the lines of sight back to the NHS Board's statutory responsibilities for governance across clinical quality and safety, staff and employment, equalities and finance. That Framework had been finalised following further discussion with Directors and Chief Officers.

Ms Renfrew reported that Renfrewshire and East Dunbartonshire Councils had both not included Children's and Criminal Justice Services which were included in NHSGGC's other four Schemes but were discretionary under the legislation. The NHS Board had proposed including planning and delivery of local NHS Children's Services within its proposals for the Chief Officer role and IJB oversight. In the case of East Dunbartonshire Council, there had not been agreement that the IJB would fulfil the functions of oversight and direction for these responsibilities. From the health perspective, there were clear benefits to integrated local oversight for local Children's Services and it was not clear what alternative arrangements the NHS Board could establish. To try to reach agreement, NHSGGC proposed promoting a discussion at the shadow IJB to inform a formal proposal to put to the Council and potentially for discussion with the IJB when established. The Scheme could be submitted with wording which enabled this issue to move forward in this way and commit neither party to the outcome.

The NHS Board discussed the circumstances of East Dunbartonshire Council's Children's Services and Criminal Justice Services. It was agreed that Ms Renfrew reword the Scheme to reflect the opportunity for these services to be added at a later date if this be agreed by both East Dunbartonshire Council and NHSGGC. This would allow Ministerial sign-off at this stage, but also afforded the opportunity for the services to be added developmentally in the future. Discussion would not be with the Shadow IJB but through a proposal put to the Council.

**Director of  
Corporate  
Planning &  
Policy**

The paper set out possible arrangements in the likely event that the Integration Schemes had not passed due process by 1 April 2015 at which point, the legislation which established CH(C)Ps was rescinded. The current CH(C)P Committees would be migrated to oversight Subcommittees of the NHS Board with the aim to try and find an approach which enabled Councillors who were part of the IJBs to be part of these arrangements.

Mr Robertson invited each Chief Officer Designate to lead the NHS Board through their draft Scheme of Integration as follows:-

- (a) Renfrewshire
- (b) East Dunbartonshire

**(a) Renfrewshire Scheme of Delegation**

Mr Leese, Chief Officer Designate, Renfrewshire Integrated Joint Board, led the NHS Board through the detail of Renfrewshire's draft Integration Scheme. He summarised activities that had taken place during the consultation phase between 19 January and 3 February 2015. He thanked NHS and Council colleagues for the significant amount of effort to reach this stage.

**(b) East Dunbartonshire Scheme of Delegation**

Mrs Murray, Interim Chief Officer, East Dunbartonshire Integrated Joint Board, led the NHS Board through the draft Integration Scheme and reported that a Council meeting of East Dunbartonshire was arranged for 5 March 2015 to similarly consider the draft Scheme. She summarised the formal public consultation undertaken in relation to the Scheme and outlined the IJB’s Strategic Priorities.

DECIDED

- That, the Integration Schemes for East Dunbartonshire and Renfrewshire be approved:-
  - With authorisation to the Interim Chief Officers and Director of Corporate Planning and Policy to work together with Council colleagues to revise Schemes based on the NHS Board discussion and to engage with the Scottish Government to progress the Schemes’ approval;
  - Should that approval process raise issues which could not be resolved, to report back to the NHS Board for further direction;
  - Endorse the final framework for Service Delivery;
  - A proposal be made by the NHS Board to East Dunbartonshire Council with regard to arrangements for children’s services.
  - Confirm the direction of the proposed arrangements should IJBs not be in place from 1 April 2015.

**Director of Corporate Planning & Policy**

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**15. DRAFT STRATEGIC DIRECTION AND LOCAL DEVELOPMENT PLAN 2015/16**

A report of the Director of Corporate Planning and Policy [Board Paper No 15/07] asked the NHS Board to discuss work in progress to finalise the Strategic Direction and Local development Plan 2015/16 for submission to the Scottish Government by the end of March 2015.

Ms Renfrew explained that the NHS Board submitted a Local Development Plan (LDP) each year to outline how it would deliver against the Annual Planning Guidance issued by the Scottish Government. NHSGGC’s approach was to develop the LDP as an integral part of finalising its strategic direction for 2015/16. She led the NHS Board through progress in developing this work in relation to the following:-

- The draft Strategic Direction and LDP;
- A draft of the current Financial Plan which had been submitted to the Scottish Government.

Ms Renfrew explained that this was still work in progress and summarised the work still required and the areas of activity needed to drive the decisions which would be necessary to deliver a balanced financial plan.

Ms Renfrew described the implications for the LDP process given that Integrated Joint

Boards (IJBs) would be in place from early in the new financial year with their new responsibilities for strategic planning of local services and substantial elements of unscheduled care. She also alluded to specific LDP requirements and provided a brief indication of NHSGGC's position in the following areas:-

- Health inequalities and prevention;
- Antenatal and early years;
- Person-centred care;
- Safe care;
- Primary care;
- Integration;
- Workforce;
- Community planning and partnership contribution.

At headline level, a major issue was the NHS Board's ability to deliver the targets and standards set within available resources and the NHS Board would need to assess, in financial planning, whether all of these targets could be delivered.

Mr Sime referred to the current appraisal of the financial position which showed a gap between NHSGGC's 2015/16 income and known costs of £48m. Mr Calderwood explained that, across Acute, Partnerships and Corporate Services, NHSGGC had, so far, identified around £32m of savings, establishing a gap of around £16m. Work was underway to identify further cost savings for 2015/16 and there may also be further cost pressures to cover, for example, additional costs for new drugs and for out-of-hours services.

Ms Brown referred to a proposal to assess, from the Paisley Development Programme, whether there were self-financing changes which could be made in Primary Care and the NHS Board's commitment to continue the development of the 17c programme with new practices joining in 2015/16. She did not think the NHS Board should restrict itself to looking at only self-financing changes and hoped that the NHS Board would work with IJBs to set out prioritised local actions that were being pursued to increase capacity in Primary Care and the resources identified to achieve this. Ms Micklem agreed and recognised the difficult decisions that had to be made looking at resource allocations in line with Scottish Government policy.

**Director of  
Corporate  
Planning &  
Policy**

Mr Winter acknowledged that the NHS Board faced a very challenging year and noted the savings that had to be made. Mr Calderwood described factors that would be explored, in greater detail, to release costs and confirmed that the NHS Board would continue to look at opportunities as well as redesign work and different service delivery models. Proposals were currently being worked up and they would be shared with the NHS Board.

**Chief  
Executive**

In response to a question from Ms Micklem regarding the financial gap, Mr Calderwood reported that he and colleagues continued to have dialogue with the Scottish Government, on a daily basis, and that all options would be explored. He reiterated that government policy determined the NHS Board's uplift and National Reserve Allocation Committee (NRAC) parity.

Dr Reid welcomed the inclusion in the Local Development Plan of how services would support positive care experiences delivered in accordance with the "five must-dos with me". This was an essential element of person-centred care and he looked forward to seeing how local action would be taken to transform the culture to support staff and the public to be open and confident in giving and receiving feedback.

DECIDED

- That, the work in progress to finalise the Strategic Direction and Local Development Plan 2015/16 be noted and submitted to the Scottish Government by the end of March 2015.

**Director of  
Corporate  
Planning &  
Policy**

**16. WAITING TIMES AND ACCESS TARGETS**

A report of the Chief Officer, Acute Services [Board Paper No 15/08] asked the NHS Board to note progress against the national targets as at the end of December 2014.

Mr Best 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 NHS GGC.

In response to a question from Dr Lyons regarding stroke performance at the Royal Alexandra Hospital (RAH), Mr Best reported that the RAH had an unusually high number of patients missing just one of their required targets and this explained the particularly low performance – he reassured the NHS Board that action was being taken particularly with stroke scanning at the RAH over weekends. This work was being taken forward by the Rehabilitation and Assessment Directorate.

Professor Dominiczak referred to the current national difficulty in filling consultant neurologist vacancies and suggested that the University of Glasgow may be able to offer assistance from an academic point of view. Mr Best welcomed this offer and would discuss this further with her.

**Chief Officer  
(Acute  
Services)**

Councillor Rooney referred to the Accident & Emergency waiting times and highlighted, in particular, the performance in December 2014 at the Western Infirmary (69%) and the Royal Alexandra Hospital (77%). He set this in the context of the Ministerial Support Team established to help at the RAH discussed earlier. Mr Calderwood took the opportunity to highlight that, as the Western Infirmary was scheduled to close in May 2015, there may be limited learning now from there. He recorded that staff were working well in the RAH and that there had been an issue with the flow of patients. He looked forward to working with the Support Team to have their insights into how performance could be improved.

Ms Brown welcomed the progress being made with patients awaiting discharge. In response to her request, Mr Best confirmed that he would include a report on the processes adopted for rapid improvement events and design initiatives so that improvements could be identified. She also encouraged the inclusion of patient involvement in the Ministerial Support Team.

**Chief Officer  
(Acute  
Services)**

Dr Benton wondered if it would be possible to give a further breakdown of the reasons patients cite as being unavailable and, therefore, included in NHS GGC's unavailability rates. Mr Best confirmed that patient choice of consultant or hospital site was consistently the reason for approximately 50-70% of the total patient-advised unavailability. He agreed to add further information in future reports.

**Chief Officer  
(Acute  
Services)**

Mr Calderwood went on to explain that other NHS Scotland Boards were strictly

interpreting the access provision and returning patients to the care of their GP if they had declined two reasonable offers. In line with the NHSGGC Access Policy, this practice had not been adopted and patients' preferences of admission date/site were consistently accommodated.

In response to a question from Members, Mr Calderwood agreed to share with the NHS Board information that had been provided about the Support Team, its members and what it set out to do.

**Chief  
Executive**

NOTED

**17. FINANCIAL MONITORING REPORT FOR THE 9 MONTH PERIOD TO 31 DECEMBER 2014**

A report of the Interim Director of Finance [Board Paper No 15/09] asked the NHS Board to note the financial performance for the 9 month period to 31 December 2014.

Mr Hobson reported that the NHS Board currently had an overspend of £0.7m for the 9 month period to 31 December 2014. At this stage, 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, Partnerships, Corporate Services and other budgets and capital. He confirmed that, at this stage, the NHS Board was ahead of its year to-date cost savings target against plan.

Referring to discussions earlier around the challenges that the NHS Board faced now and in the future, Mr Finnie took the opportunity to thank Mr Hobson and his teams for managing the NHS Board's financial performance.

In response to a question from Councillor Rooney about the additional funding allocation of £3.6m the NHS Board received from the Scottish Government to offset drug cost pressures in 2014/15, Mr Hobson confirmed that this was non-recurring.

NOTED

**18. PATIENTS PRIVATE FUNDS – ANNUAL ACCOUNTS 2013/14**

A report of the Interim Director of Finance [Board Paper No 15/10] asked the NHS Board to adopt and approve, for submission to the Scottish Government Health Directorates, the 2013/14 Patients Private Funds Annual Accounts for NHS Greater Glasgow and Clyde.

Mr Hobson advised that the NHS Board held the private funds of many of its patients, especially those who were in long term residence and who would have no ready alternative for the safe-keeping and management of their funds. Each of the NHS Board's hospitals had arrangements in place to receive and hold and, where appropriate, manage the funds of any patients requiring this service. Any funds that were not required for immediate use were invested to generate interest which was then distributed to the patients' accounts based on each individual's balance of funds held.

NHS Boards were required to submit audited annual accounts for these funds in the form of an Abstract of Receipts and Payments to the Scottish Government Health

Directorates. The funds had been audited and now required NHS Board approval prior to the auditors then signing their report, which had no qualifications.

DECIDED

- |  |  |
|--|--|
| 1) That the Patients' Private Funds Annual Accounts for 2013/14 be adopted and approved for submission to the Scottish Government Health Directorates. | <b>Interim<br/>Director of<br/>Finance</b>       |
| 2) That the Director of Finance and Chief Executive be authorised to sign the Abstracts of Receipts and Payments for 2013/14.                          | “ ”  |
| 3) That the Chair and Director of Finance be authorised to sign the Statements of Board Members' Responsibilities for 2013/14.                         | <b>Chair/Interim<br/>Director of<br/>Finance</b> |
| 4) That the Chief Executive be authorised to sign the Letter of Representation to KPMG LLP on behalf of the NHS Board.                                 | <b>Chief<br/>Executive</b>                       |

**19. QUALITY AND PERFORMANCE COMMITTEE MINUTES: 18 NOVEMBER 2014**

The minutes of the Quality and Performance Committee meeting held on 18 November 2014 [QPC(M)14/06] were noted.

NOTED**20. AREA CLINICAL FORUM MINUTES: 4 DECEMBER 2014**

The minutes of the Area Clinical Forum meeting held on 4 December 2014 [ACF(M)14/06] were noted.

NOTED

The meeting ended at 12:40pm.