

NHSGG&C(M)15/03

Minutes: 12 - 30

NHS GREATER GLASGOW AND CLYDE

**Minutes of a Meeting of the  
NHS Greater Glasgow and Clyde Board  
held in the Board Room, Corporate Headquarters, J B Russell House,  
Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH  
on Tuesday, 21 April 2015 at 9:30a.m.**

**PRESENT**

Mr A O Robertson OBE (in the Chair)

Dr J Armstrong  
Mrs S Brimelow OBE  
Ms M Brown  
Mr R Calderwood  
Ms R Crocket MBE  
Councillor M Devlin  
Mr R Finnie  
Mr I Lee  
Dr D Lyons  
Mrs T McAuley OBE

Mr A Macleod  
Councillor M Macmillan (To Minute No 24)  
Councillor J McIlwee  
Ms R Micklem  
Councillor M O'Donnell  
Dr R Reid  
Councillor M Rooney  
Rev Dr N Shanks  
Mr D Sime  
Mr M White

Mr K Winter

**IN ATTENDANCE**

Mr G Archibald	Chief Officer, Acute Services Division
Dr E Crighton	Consultant in Public Health Medicine (For Minute No 20)
Ms J Erdman	Corporate Inequalities Manager (For Minute No 23)
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Mr A McLaws	Director of Corporate Communications
Ms C Renfrew	Director of Corporate Planning and Policy
Mr R Wright	Director, Health Information & Technology

**ACTION BY**

**12. WELCOME AND APOLOGIES**

Mr Robertson welcomed Mrs S Brimelow and Mr A Macleod to their first NHS Board meeting as Non-Executive Members from 1 April 2015. Similarly, he welcomed Mr M White to his first NHS Board meeting since being appointed Director of Finance on 1 April 2015.

Apologies for absence were intimated on behalf of Mr J Brown CBE, Dr H Cameron, Councillor M Cunning, Dr L de Caestecker, Professor A Dominiczak OBE, Mr I Fraser and Councillor A Lafferty.

NOTED

**13. DECLARATION OF INTEREST**

One declaration of interest was recorded as follows:-

- Dr D Lyons, in respect of Item No 12 - Meeting the Requirements of Equalities Legislation – A Fairer NHS GGC: Monitoring Report 2013-15 – Dr Lyons was a member of the Equality and Human Rights Commission – Scotland Committee.

NOTED

**14. CHAIR'S REPORT**

- (i) On 23 February 2015, the Cabinet Secretary for Health and Wellbeing, Shona Robison MSP, officially opened the new state-of-the-art Assisted Conception Service Centre at Glasgow Royal Infirmary. The Unit now provided a modern facility for assisted conception services for patients across NHS GGC, Ayrshire and Arran, Dumfries and Galloway, Lanarkshire and Highland Health Boards. On the same day, Ms Robison cut the first sod at a special ceremony to mark the construction of Eastwood Health and Care Centre in Clarkston. This new Health and Care Centre would serve the whole of the Eastwood area of East Renfrewshire and would house GP practices, district nursing, health visitors, social work, physiotherapy and podiatry services as well as mental health services. In addition, the Centre would be home to a Community Enterprise in the form of a cafe run as an employability project.
- (ii) On 9 March 2015, NHS Board Members had attended an off-site day focusing on the moves to the new South Glasgow University Hospitals and financial planning 2015/16.
- (iii) On 12 March 2015, Mr Robertson attended a volunteer thank you event at the Royal Alexandra Hospital in the form of a "Springtime Tea Party" to celebrate and thank all volunteers for their contribution.
- (iv) On 24 March 2015, Ms A MacPherson was appointed as the Director of Human Resources and Organisational Development for NHS GGC to replace Mr I Reid. Her appointment would take effect from 1 June 2015.
- (v) On 31 March 2015, Mr Robertson attended the 2015 Addiction Employability Graduation Ceremony held in the City Chambers.
- (vi) On 1 April 2015, the Cabinet Secretary for Health and Wellbeing officially opened the Possilpark Health and Care Centre.
- (vii) On 8 April 2015, Mr Robertson visited the 100 Flowers art collection in the new South Glasgow University Hospital. This recognised the benefit of having art work within the hospital areas and the collection could be seen in the Adult Hospital Cafe, Atrium, Interview Rooms and corridors.
- (viii) On 9 April 2015, Mr Robertson attended a conference at the Lighthouse Glasgow, on "Lateral Thinking – the Value of Collaboration between the Arts, Health and Environment".

NOTED

**15. CHIEF EXECUTIVE'S UPDATE**

- (i) Mr Calderwood updated on the organisational restructuring to the Senior Management Team as follows:-
- Director of Human Resources and Organisational Development – Anne MacPherson had been duly appointed and would start on 1 June 2015. She would work with the current Director of Human Resources, Mr I Reid, for a month prior to Ian's departure at the end of June 2015.
  - Director of Nursing – Rosslyn Crocket had intimated her intention to retire at the end of August 2015. This post would be advertised next week.
  - South Clyde Sector Director – Marie Farrell had been appointed and would be based at the Royal Alexandra Hospital.
  - Director of Regional Services – Gary Jenkins had been appointed.
  - The majority of General Manager appointments had now been made and steps would be taken to advertise the remaining General Manager posts.
  - Director of Research and Development – A joint post with the University of Glasgow. Regrettably, following interviews on 9 April 2015, an appointment was not made. Mr Calderwood and Dr J Armstrong would consider how best to proceed to fill this important post.
- (ii) On 9 April 2015, the NHS Board hosted a visit from representatives from the Danish Health Service who were on a fact-finding visit in relation to Acute Services Modernisation and Healthcare Premises. The cohort toured the new South Glasgow University Hospital and it provided an excellent opportunity to share knowledge with a different healthcare system.
- (iii) Mr Calderwood reported that Monday 28 April 2015 would see the existing Outpatients Department from the current Southern General Hospital move into the new South Glasgow University Hospital. Thereafter, a rolling programme was in place to move patients into the new hospitals.

NOTED

**16. MINUTES**

On the motion of Councillor M Devlin, seconded by Councillor J McIlwee, the minutes of the NHS Board meeting held on Tuesday, 17 February 2015 [NHSGGC(M)15/02] were approved as an accurate record and signed by the Chair.

NOTED

**17. MATTERS ARISING FROM THE MINUTES**

- (a) The Rolling Action List of matters arising was noted. Mr Macleod asked for an update on the NHS Board's Endowment Funds Strategy. Mr White summarised the work being taken forward to improve the NHS Board's degree of oversight and governance going forward to comply with the associated regulations. Dr R Reid would be the Chair of the Endowments Committee

going forward.

- (b) Mrs McAuley asked for an update on the Schemes of Delegation for Glasgow City (in relation to Forensic Services and Children's Services) and East Dunbartonshire (in relation to Children's Services). Ms Renfrew reported that a resolution had been reached with Glasgow City Council and this would be considered further at the May 2015 Quality and Performance Committee meeting to finalise the arrangements for Forensic and Children's Services going forward. In relation to Children's Services in East Dunbartonshire, a paper was due to be considered by East Dunbartonshire Council imminently.

NOTED

**18. SCOTTISH PATIENT SAFETY PROGRAMME (SPSP) UPDATE**

A report by the NHS Board's Medical Director [Board Paper No 15/11] asked the NHS Board to note an update on the SPSP for Mental Health and Primary Care.

Dr Armstrong set out a broad description of the clinical processes being developed to operate with higher levels of reliability, the scope of testing work along with a brief outline of progress and challenges for both the Mental Health Services and Primary Care Services. She took each one in turn as follows:-

- Implementing SPSP in Mental Health Services – aimed to systematically reduce harm experienced by people receiving care from Mental Health Services in Scotland by supporting clinical staff to test, gather real-time data and reliably implement interventions. The work was being delivered through a four year programme running from September 2012 to September 2016. Within the programme, five national workstreams had been identified and Dr Armstrong summarised key activities in those areas as follows:-
  - Risk assessment and safety planning;
  - Communication at key transition;
  - Safe and effective medicines management;
  - Restraint and seclusion;
  - Leadership and culture.

Dr Armstrong explained that, as with all major change programmes, there were many challenges and she alluded to those identified in the Mental Health programme including its scale, quality improvement capacity and capability, competing priorities for ward staff and finding a good balance between local innovation and the need to benefit from NHS Board-wide standardisation and integration of care. She reported that consultation with the National Programme continued to consider extending SPSP-MH to crisis teams and/or sexual harm over the next year.

- Implementing SPSP in Primary Care Services – the aim was to reduce the number of patient safety incidents to people from healthcare delivered in any Primary Care setting. All NHS Boards and 95% of Primary Care clinical teams were tasked with developing their safety culture and achieving reliability in three high risk areas by 2016. In addition, an NHS GGC Polypharmacy Local Enhanced Service had been developed regarding polypharmacy and quality, safe and effective use of long-term medication. A medicines reconciliation component had been built into this Local Enhanced Service using the bundle approach and measurement by reporting monthly compliance. 252 practices participated in this. Dr Armstrong summarised activity in the following areas:-

- General practice;
- Safety climate survey;
- Trigger tool;
- Leadership walkrounds;
- Polypharmacy Local Enhanced Service 2014-15;
- Core programme (small scale testing);
- Outpatient communication;
- Results handling;
- Medicines reconciliation;
- 5-step screening tool called Malnutrition Universal Screening Tool (MUST);
- Falls and Catheter Acquired Urinary Tract Infections (CAUTI).

In terms of Community Nursing, Ms Crocket explained that further work was being undertaken in the wider implementation and spread of the bundle approach in Community Nursing with areas identified for improvement to patient safety which included falls, CAUTI, MUST and the continuation of the prevention of pressure ulcer work. To date, work had focused on pressure ulcers and MUST as follows:-

- Pressure Ulcer Prevention – district nursing teams in NHSGGC had been participating in the SPSP Pressure Ulcer workstream for approximately 18 months. All teams were now achieving 100% compliance. Work would now be progressed via the Clinical Nursing Information System (CNIS) to allow outcome data to be extracted. This would reduce time spent on input for district nurses and reports could be generated at practitioner, Senior Nurse and Head of Service level, commencing May 2015.
- MUST – within this workstream, a bundle had been developed and was being tested in five district nursing teams. Teams had received training on the methodology being used and data collection was being established. Across the five teams, results had been varied but had progressed well and coped with the restructuring of the district nurse service in some of these areas.

Rev Dr Shanks reported that he had accompanied Dr Armstrong on some of the walkrounds and recognised the challenges, particularly with the competing priorities which staff faced. In highlighting this, he encouraged the NHS Board to support protected time to ensure staff could meet clinical demands and competing organisational priorities which could hamper continuous focus on this work in some areas. Dr Reid agreed and recognised the importance in having intuitive IT systems to support the programme and its monitoring.

Mrs Brimelow welcomed the helpful work being taken forward in community nursing but recognised that the spread across NHSGGC was a challenge. Ms Crocket agreed but explained that, although the key aim was to achieve 95% compliance by 2016, the principles of the programmes would be ongoing.

Ms Micklem referred to the pace of development in general terms for SPSP and considered it difficult to judge whether NHSGGC was moving at a pace expected. She would welcome a report outlining what was going to plan as well as what was not. Dr Armstrong agreed to review progress and report developments in future reports. Ms Crocket added that all SPSP activity was linked to the Compliance Assessment and Analysis System (CAAS) which allowed the measurement of compliance against standards and this was integral to the spread in a more rigorous way.

**Medical  
Director**

Councillor McIlwee asked about the Safety Climate Survey (Safequest) which had

been developed by NHS Education for Scotland (NES). Dr Armstrong reported that this was a very robust tool used currently in Primary Care – she agreed to explore whether it could be used also within Acute areas.

**Medical  
Director**

In response to a question from Dr Lyons, Dr Armstrong agreed to check how SPSP was being evolved within areas that included older adults in mental health.

**Medical  
Director**

NOTED

**19. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)**

A report of the NHS Board's Medical Director [Board Paper No 15/12] 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 (October to December 2014), NHSGGC reported 25.1 cases per 100,000 AOBs. NHS Scotland reported 30.5 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, October to December 2014, NHSGGC reported 33.3 cases per 100,000 AOBs, combined rate for all ages. This placed the NHS Board below the national average of 35.4 per 100,000 AOBs.

For the last available quarter (October to December 2014), the SSI rates for caesarean section and knee arthroplasty procedure categories were below the national average; repair of neck of femur procedures matched the national average and SSI rates for hip arthroplasty procedures remained above the national average.

The Cleanliness Champions Programme was part of the Scottish Government's Action Plan to combat HAI within NHS Scotland. To date, NHSGGC had supported 3,224 members of staff who were now registered as Cleanliness Champions.

Dr Armstrong referred to a Healthcare Environment Inspectorate (HEI) unannounced inspection at the Royal Hospital for Sick Children on 16 and 17 December 2014 which had resulted in three requirements and one recommendation.

In response to a question regarding the decrease in MSSA between December 2013 and December 2014, Dr Armstrong reported that this represented 17.3% and much of its success could be attributed to the new bundle introduced by NHSGGC after a successful pilot at the RAH.

In response to a question from Councillor Rooney regarding the data used for the “Out of Hospital Report Cards” and “Hospital Report Cards”, Dr Armstrong confirmed that these were monitored by the NHS Board’s Infection Control Committee and she agreed to give Councillor Rooney a further breakdown of the data.

**Medical  
Director**

In response to a question from Mrs Brimelow regarding the Vale of Level Hospital Inquiry Report, Dr Armstrong confirmed that NHSGGC had submitted its report on the implementation of the recommendations within the report to the Scottish Government, and that many of these linked with the HAI standards recently published. Compliance with the recommendations and the standards was considered by the NHS Board’s Infection Control Committee and the Clinical Governance Forum. A summary of progress would be considered by the NHS Board’s Quality and Performance Committee in the autumn.

**Medical  
Director**

In response to a question from Mrs McAuley, Dr Armstrong reported that local analysis of recurring C.Difficile infections (relapse/reinfection cases) for January to December 2014 indicated a recurrence in 16% of patient cases and work was being undertaken to understand what lay behind this. Dr Armstrong added that this was a UK-wide issue, and local colleagues were working with Health Protection Scotland to identify patterns.

NOTED

**20. PUBLIC HEALTH SCREENING PROGRAMMES ANNUAL REPORT 1 APRIL 2013 TO 31 MARCH 2014**

A report of the Director of Public Health [Board Paper No 15/13] asked the NHS Board to note the Public Health Screening Programme Annual Report from 1 April 2013 to 31 March 2014.

Dr Crighton presented information about the following screening programmes offered to residents across NHSGGC for the period 2013/14:-

- Cervical screening
- Breast screening
- Bowel screening
- Pregnancy screening:-
  - Communicable diseases in pregnancy
  - Haemoglobinopathies screening
  - Downs syndrome and other congenital anomalies
- New born screening:-
  - New born blood spot
  - Universal new born hearing
- Diabetic retinopathy screening
- Preschool vision screening
- Aortic abdominal aneurysm screening

Dr Crighton explained that screening was a public health service offered to specific population groups to detect potential health conditions before symptoms appeared. Screening had the potential to save lives and improve quality of life through early diagnosis of serious conditions.

In NHSGGC, the co-ordination of all screening programmes was the responsibility of the Public Health Screening Unit led by a consultant in public health medicine. Multi Disciplinary Steering Groups for the programmes were in place and the remit was to monitor performance, uptake and quality assurance.

Dr Crighton highlighted that, as the screening programmes stretched across the whole organisation, successful delivery relied on a large number of individuals working in a co-ordinated manner towards common goals in a quality assured environment. It was essential that good information management systems were in place to monitor and evaluate each component and the overall performance of every screening programme offered to NHSGGC residents.

NHSGGC's Public Health Screening Unit was committed to working in partnership with voluntary and statutory services to identify innovative ways to tackle inequalities in health and encourage uptake of screening programmes. The report included analysis in uptake among people with learning disabilities, however, screening activity by ethnicity could not be provided as the data was not available.

Dr Crighton commended the efficiency of the screening programmes and reiterated that they could prevent disease. She responded to a range of members' questions by confirming the following:-

- Recognition that the huge amount of activity ongoing to improve uptake rates and address inequalities was a priority in order to close the inequality gap. Campaigns were designed and developed with particular target groups/age groups in mind to ensure all had access to relevant screening programmes.
- Collecting screening activity by ethnicity remained a challenge and work was ongoing to identify lessons learned in the pregnancy and newborn screenings where screening activity by ethnicity data was available – how could this be rolled out across the other screening programmes?
- What was the success in uptake rates from national campaigns versus more locally targeted campaigns? If differences were identified in advertising approaches, perhaps lessons could be learned in how best to attract certain client groups?
- The enhanced governance and audit of interval breast cancer data was useful and this intelligence would now provide more detail going forward. Detecting cancer early remained a priority but making better use of the data now available around interval breast cancer would be explored further.
- Work continued to improve local and national IT systems to support the array of screening programmes.
- Abdominal aortic aneurysm screening was available to male residents aged 65 in NHSGGC who were invited to participate in the programme. Based on evidence, one scan was sufficient and this was the best way to detect the presence of an abdominal aortic aneurysm. Based on research, no evidence was apparent, at the moment, to suggest further screening thereafter.
- The benefits in attending for screening could be highlighted more in the national/local campaigns and it would be useful to showcase individual instances where lives had been saved due to attendance at screening. Various approaches to advertising the different screening campaigns was considered regularly in terms of target audiences.

**Director of  
Public Health**

Mr Robertson, on behalf of the NHS Board, thanked Dr Crighton for her comprehensive summary of the Annual Report.

NOTED

## **21. ORGANISATIONAL REVIEW – PROPOSALS FOR FUTURE ORGANISATION OF CLINICAL GOVERNANCE**

A report of the Medical Director [Board Paper No 15/14], asked the NHS Board to note the new clinical governance arrangements for NHSGGC following the new organisational structure within the Acute Services Division and with the implementation of the six Health and Social Care Partnerships (HSCPs).

Dr Armstrong described the current position in NHSGGC in that, the delegated role and responsibilities of the Quality and Performance Committee was currently responsible for maintaining oversight of the quality of care provided through NHS Board services, either directly or commissioned. This Committee, on behalf of the NHS Board, provided the internal assurance statements that NHSGGC was meeting the statutory duty of care set by the Health Act 1999. Over and above that, the existing Board Clinical Governance Forum was responsible for oversight and strategic coordination of priorities and programmes aimed at improving and assuring safe, effective, person-centred care. It oversaw the work of the Acute Clinical Governance Forum, the Partnerships Clinical Governance Forum and the Mental Health Clinical Governance Forum and there was an extended structure of clinical groups operating in support of these strategic forums.

The Clinical Governance Support Unit was created in 2005 and was a corporately provided facility to support clinical quality improvement and governance. The Unit was initially organised around two key specialist functions of clinical improvement and risk. Staffing/resources were linked to the three main organisational domains of support; Corporate, Acute and Partnerships.

Dr Armstrong led the NHS Board through the drivers for change, alluding to external and internal challenges and reported that the advent of HSCPs necessitated a complete review of governance arrangements. There was a requirement for HSCPs, through their governance arrangements, to establish formal structures to link with the clinical governance structures of the NHS Board as well as Local Authority governance structures. In order to progress overall arrangements, it was important that the clinical governance structures at NHS Board level were set out together with the different levels of reporting and assurance to reflect the areas where the NHS Board retained direct responsibility for services and areas where the responsibility would be delegated to Chief Officers.

Following clinical and management engagement, discussion papers were developed for each of the three major clinical service areas (Acute, Partnerships and Mental Health). These set out the current position together with the future changes and described proposals to change the clinical governance arrangements. The planned improvements had been discussed with senior managers and clinicians. It was proposed that the basic structure of a Board-wide approach to Acute, Mental Health and Partnership governance was retained, however, the reporting arrangements and remit would change to reflect the new organisational arrangements for both HSCPs and Acute Care. Both the Acute Clinical Governance Forum and the Mental Health Services (for which the NHS Board was directly accountable) would have a direct reporting line to the NHS Board's Clinical Governance Forum. Other services would report directly to the HSCP governance structures with an assurance/information line to the NHS Board's Clinical Governance Forum.

Dr Armstrong summarised the remit of the Acute, Mental Health and Partnership Governance Forums and explained that these would be adapted to reflect the changing accountabilities and organisational arrangements.

The role of the Clinical Governance Support Unit would be retained as a central function to ensure that there was a critical mass of skilled staff to support clinical

governance functions in the new organisational arrangements. This also ensured that there would be a consistent approach to implementing key clinical governance policies, ensuring the patient safety programmes were developed and implemented, and providing advice and support on clinical effectiveness guidance.

Dr Armstrong explained that the process of transition to the planned organisational arrangements was underway and acknowledged that ongoing development would occur but to mitigate transition risks, she described a number of key caveats. It was expected that HSCPs would submit proposed clinical governance arrangements for review to the Board Clinical Governance Forum. This forum would then advise the Board if they complied with current policy.

Rev Dr Shanks recognised the complexity in the arrangements, particularly between the NHS Board and the six Integrated Joint Boards (IJBs) and wondered how this would play out operationally. Mr Calderwood described the independence of IJBs but emphasised their interface with the NHS Board particularly in areas such as clinical quality and clinical standards. He recognised the tension between the strategic commissioning and the delivery agent role but cautioned that there had to be an assurance that IJBs were adhering to the strategic coordination of clinical governance as set by the NHS Board's Clinical Governance Forum.

Mr Sime considered that the success going forward would be in ensuring transparency especially at NHS Board level. NHS Board Members should be able to see and identify problems and seek assurances via reports from the Medical Director and Director of Nursing roles.

Mr Finnie asked about the NHS Board's role in directly managed services. Mr Calderwood explained that the Schemes of Delegation from the NHS Board to the HSCPs set out the key functions of the NHS Board's Clinical Governance Forum and its role in both directly NHS Board-managed services within Acute Care and selected regional Mental Health Services together with its role of quality assurance for each HSCP's directly managed services. He conceded that there would be a bedding down period over the summer but that the strategic commissioning lay with the IJB's Chief Officers and the HSCPs as sub-committees of the NHS Board. The NHS Board was the body corporate and, therefore, answerable to the Scottish Parliament, so it was paramount that NHS Board Members satisfied themselves in terms of monitoring and performance of the IJBs.

Ms Renfrew referred to the issues highlighted and explained that there would be an opportunity to look further at how this would all play out operationally at the May 2015 Quality and Performance Committee meeting where transition arrangements would be discussed further.

**Director of  
Corporate  
Planning &  
Policy**

Dr Lyons welcomed this opportunity, particularly further discussion around the three diagrams illustrated in the NHS Board paper. Councillor O'Donnell also welcomed the opportunity to discuss this in more detail, particularly around Mental Health and Learning Disabilities and how contracts with the third sector would be managed at IJB level.

NOTED

## **22. STRATEGIC DIRECTON AND LOCAL DEVELOPMENT PLAN**

A report of the Director of Corporate Planning and Policy [Board Paper No 15/15] asked the NHS Board to note the submission of the Strategic Direction and Local Delivery Plan to the Scottish Government in March 2015.

The Local Delivery Plan for 2015-16 was developed as an integral part of finalising NHSGGC's Strategic Direction for the coming year.

Ms Renfrew noted the risks and outstanding issues highlighted in the Local Delivery Plan which would be subject to further discussion with the Scottish Government. These related to:-

- Financial Issues – a number of risks within the Financial Plan still required to be finalised.
- Targets and Standards – given the financial and service pressures across the system, there would be significant challenges to deliver all of the required targets in 2015-16.
- Delayed Discharges – the plan required a major reduction in the current level of delayed discharges, including consistent delivery of the national targets to enable the Acute Sector to achieve the bed reductions included in the Savings Plan and improve unscheduled care.
- Service Change Proposals – the plan included a number of service change proposals which needed to be delivered during 2015-16 to achieve in-year balance and also proposals to be delivered from the start of 2016/17 to ensure that recurring balance was restored.

In considering finalising the Local Delivery Plan, Ms Renfrew explained that it was important to note that the 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. This had a range of implications for the Local Delivery Plan process.

The Scottish Government had provided initial feedback on the draft plan and discussion would continue over the next few weeks with a particular focus on the issues and risks outlined.

In response to a question from Councillor Rooney, Ms Renfrew confirmed that the financial elements would be included in a later version of the Local Delivery Plan – this version was a draft only that had been submitted to the Scottish Government. Councillor Rooney noted that non-recurring resources would be used to deliver the financial position for 2015-16 and worried about funding this gap in the future.

Mrs Brown looked forward to seeing the revised draft in June which would be more specific around about the financial projections.

Councillor Rooney commented that the prescribing of the new hepatitis C drugs was a social justice issue and, as drugs were now available to cure this, NHS Boards had an obligation to provide this and, accordingly, ensure associated prescribing costs were included in the financial plan.

NOTED

**23. MEETING THE REQUIREMENTS OF EQUALITIES LEGISLATION – A FAIRER NHSGGC – MONITORING 2013-15**

A report of the Director of Corporate Planning and Policy [Board Paper No 15/16] asked the NHS Board to approve “A Fairer NHSGGC Monitoring Report 2013-15” and note the issues requiring further progress for 2015-16.

Ms Erdman explained that NHSGGC produced its third Equalities Scheme and Action Plan for 2013-16 to build on previous equalities work and the NHS Board was now two years into delivering these actions. She summarised the requirements on public sector organisations to comply with the Equality Act 2010, one of which was a requirement, by law, to publish this report on 27 April 2015.

Ms Erdman led the NHS Board through the monitoring report, which was constructed in two parts, with both an internal and external audience in mind. Firstly, it gave details of progress made in applying and understanding of discrimination into mainstream organisational activity such as planning, performance, leadership, listening to patients, service delivery, service redesign and increasing workforce knowledge and skills on equality issues. Secondly, it described progress against the equality outcomes where significant further work had been identified and was required to meet the three general duties.

She emphasised that the report showed the breadth of work on tackling inequality across all parts of NHSGGC and highlighted areas of good practice. It demonstrated the NHS Board’s commitment to providing the highest quality services which were transparently fair and equitable for everyone.

Ms Micklem commended the huge amount of work ongoing and welcomed the halfway report on progress so far, given that there remained a list of further work required. She suggested future reports looked, in more detail, at data collection and the analysis of this so that continuous improvement was evident. In response to her further question, Ms Renfrew reported that the IJBs would be required to comply with the requirements in the Equality Act 2010 and further thought would be given as to how this would be undertaken locally as well as reported at NHS Board level.

**Director of  
Corporate  
Planning &  
Policy**

Ms Brown welcomed the detail in the report and linked it back to her comments made when discussing the Public Health Screening Programmes Annual Report 2013-14 where she alluded to the need for further equalities data information in relation to screening programmes uptake.

**DECIDED**

- That, the “A Fairer NHSGGC Monitoring Report 2013-15” be approved.
- That, the issues requiring further progress for 2015-16, be noted.

**Director of  
Corporate  
Planning &  
Policy**

**24. WAITING TIMES AND ACCESS TARGETS**

A report of the Chief Officer, Acute Services [Board Paper No 15/17] asked the NHS Board to note progress against the national targets as at the end of February 2015.

Mr Archibald led the NHS Board through the report highlighting the actions being taken to deliver the waiting times and access targets. This included general waiting

times - 18 Weeks Referral to Treatment (RTT) and the waiting times for various specific treatments including accident and emergency, cancer, chest pain and stroke. He also highlighted the number of patients awaiting discharge from hospital beds across NHSGGC.

Councillor Macmillan sought more information around the Accident & Emergency waiting times, particularly at Glasgow Royal Infirmary and the Royal Alexandra Hospital. Mr Archibald reported that clinical and managerial staff had been working closely with Government colleagues to progress actions intended to reduce the length of time patients spent in NHSGGC's Emergency departments. These included regular on-site meetings of staff from all areas, "huddles", ensuring that discharge prescriptions were ready more quickly, ensuring discharge lounges were used to their full capacity and that discharge decisions were made as soon as possible. Furthermore, waiting times for the main Emergency Departments were now published weekly. Mr Archibald took the opportunity to refer to the hard work being undertaken by staff looking at "cause and effect" over the recent challenging few months. He paid tribute to their commitment in taking forward improvement actions to date.

Mr Calderwood described some proactive changes being made to address the challenging patient flow issues from Accident & Emergency departments. In NHSGGC, there was a significantly higher demand placed on Acute Services in terms of our population, than in other NHS Board areas. Going forward, it had been made clear that there would be no additional resources or funding. The priority, therefore, was to work within current resources and to ensure that the Local Delivery Plan was affordable in terms of providing unscheduled care in the future.

Dr Lyons referred to the delayed discharges information and noted the management actions being taken to address these, both at NHS Board and Local Authority level. Mr Archibald agreed that performance was disappointing and that IJBs would work to seek local solutions.

NOTED

**25. FINANCIAL MONITORING REPORT FOR THE 11 MONTH PERIOD TO 28 FEBRUARY 2015**

A report of the Director of Finance [Board Paper No 15/18] asked the NHS Board to note the financial performance for the 11 month period to 28 February 2015.

Mr White reported that the NHS Board was currently reporting a break-even outturn against budget for the 11 month period for 28 February 2015. 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.

NOTED

**26. QUARTERLY REPORT ON COMPLAINTS: 1 OCTOBER – 31 DECEMBER 2014**

A report of the Nurse Director [Board Paper No 15/19] asked the NHS Board to note the quarterly report on complaints in NHSGGC for the period 1 October to 31 December 2014.

Ms Crocket led the NHS Board through the detail presented on complaints received and completed in the quarter, confirming that an overall complaints-handling performance of 78.5% of complaints responded to within 20 working days had been achieved.

Ms Crocket alluded to the issues attracting most complaints and highlighted that, across Partnerships and the Acute Services Division, these were clinical treatment, date for appointment, staff attitude/behaviour, and oral communication. She outlined some of the service improvements and actions being taken to address complaints both within the Acute Services Division and at Partnership level. She also noted the Scottish Public Services Ombudsman's reports and the recommendations contained therein which were submitted to the NHS Board's Quality and Performance Committee for monitoring purposes.

Ms Micklem referred to the online patient feedback system and noted that 118 received were praise for care. She asked how such praise was communicated back to the service and Ms Crocket reported that, on receipt, this was fed back immediately to the relevant staff.

In response to a question from Mrs McAuley regarding the consistent theme of staff attitude/behaviour in complaints, Ms Crocket agreed to provide more information in a future report, focusing on what local actions are being taken to address this.

**Nurse Director**NOTED**27. NHSGGC – ANNUAL REVIEW OF GOVERNANCE ARRANGEMENTS - STANDING ORDERS, COMMITTEE REMITS AND MEMBERSHIPS AND OTHER ARRANGEMENTS**

A report of the Head of Board Administration [Board Paper No 15/20] asked the NHS Board to approve, note and agree any revisions to the governance arrangements in place within NHS Greater Glasgow and Clyde.

Mr Hamilton led the NHS Board through the changes which provided a solid governance framework for the NHS Board to properly discharge its responsibilities and statutory functions.

DECIDED

1. That, the Standing Orders for the proceedings and business of the NHS Board and decisions reserved for the NHS Board be approved.
2. That, the Remits of the Standing Committees – Quality and Performance Committee, Audit Committee, Staff Governance Committee, Pharmacy Practices Committee and Area Clinical Forum be approved.

**Head of Board Administration****Head of Board Administration**

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| 3. That, the memberships of the NHS Board's Standing Committees and the Non-Executive Membership of the Interim Committees and Integrated Joint Boards (once established) be approved. | <b>Head of Board<br/>Administration</b> |
| 4. That, the membership of the Adults with Incapacity Supervisory Body be approved.  | <b>Head of Board<br/>Administration</b> |
| 5. That, the list of Authorised Officers to sign healthcare agreements and related contracts be approved.  | <b>Head of Board<br/>Administration</b> |

**28. QUALITY AND PERFORMANCE COMMITTEE MINUTES: 20 JANUARY 2015**

The minutes of the Quality and Performance Committee meeting held on 20 January 2015 [QPC(M)15/01] were noted.

NOTED

**29. AREA CLINICAL FORUM MINUTES: 5 FEBRUARY 2015**

The minutes of the Area Clinical Forum meeting held on 5 February 2015 [ACF(M)15/01] were noted.

NOTED

**30. AUDIT COMMITTEE MINUTES: 24 FEBRUARY 2015**

The minutes of the Audit Committee meeting held on 24 February 2015 [A(M)15/01] were noted.

NOTED

The meeting ended at 12:25pm.