

DRAFT

QPC(M)15/03
Minutes: 45 - 66

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Quality and Performance Committee at
9.00 am on Tuesday, 19 May 2015 in the
Board Room, J B Russell House, Gartnavel Royal Hospital,
1055 Great Western Road,
Glasgow, G12 0XH**

P R E S E N T

Mr I Lee (Convener)

Ms M Brown	Dr D Lyons
Dr H Cameron	Cllr J McIlwee (To Minute 57)
Cllr M Cunning (To Minute 57)	Mr A Macleod
Mr I Fraser (To Minute 55)	Ms R Micklem
Cllr A Lafferty	Mr K Winter

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

Dr J Armstrong	Professor A Dominiczak OBE (To Minute 57)
Mrs S Brimelow OBE	Mr R Finnie
Mr J Brown CBE	Dr R Reid
Mr R Calderwood	Mrs T McAuley OBE
Ms R Crocket MBE	Rev Dr N Shanks (To Minute 58)
Cllr M Devlin	Mr M White (To Minute 58)

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

Mr R Anderson	..	Head of Finance, Facilities (For Minute 54)
Mr G Archibald	..	Chief Officer, Acute Services
Ms V Cox	..	Management Trainee
Mr A Curran	..	Head of Capital Planning & Procurement (For Minutes 55 & 56)
Mrs C Curtis	..	Health Improvement Lead (For Minute 53)
Mr J C Hamilton	..	Head of Board Administration
Ms M A Kane	..	Head of Facilities (For Minute 54)
Mr D Loudon	..	Director of Facilities & Capital Planning
Mr A McLaws	..	Director of Corporate Communications
Mr S McLeod	..	Head of Specialist Children's Services (For Minute 49b)
Mrs J Miller	..	MSK Service Manager (For Minute 49a)
Ms T Mullen	..	Acting Head of Performance and Corporate Reporting
Mr K Redpath	..	Interim Chief Officer, West Dunbartonshire (For Minute 49a)
Ms C Renfrew	..	Director of Corporate Planning and Policy (To Minute 53)
Ms H Russell	..	Audit Scotland
Dr M Smith	..	Lead Associate Medical Director – Mental Health (For Minute 58)
Mr R Wright	..	Director of Health Information & Technology

45. APOLOGY

An apology was intimated on behalf of Mr D Sime.

46. DECLARATIONS OF INTEREST

Declarations of interest were raised by:-

- a) Mrs T McAuley – Agenda Item 12 – Update on Property Disposal Strategy - as she was a Non-Executive Board Member of the Scottish Environment Protection Agency (SEPA).
- b) Councillor J McIlwee – Agenda Item 11 – Hub Update – as he was a Councillor on Inverclyde Council.

47. MINUTES OF PREVIOUS MEETING

On the motion of Mr I Fraser and seconded by Councillor J McIlwee, the Minutes of the Quality and Performance Committee Meeting held on 17 March 2015 [QPC(M)15/02] were approved as a correct record.

NOTED

48. MATTERS ARISING

- (a) Rolling Action List

Minute 122: Patient's Story – 16 September 2014 – Ms Crocket agreed to consider a patient's story for the first Acute Services Committee meeting and Non-Executive Members would consider this, as appropriate, for Integrated Joint Boards when established.

Nurse Director

**Non-Executive
IJB Members**

NOTED

49. INTEGRATED QUALITY AND PERFORMANCE REPORT

There was submitted a paper [Paper No 15/40] by the Acting Head of Performance and Corporate Reporting setting out the integrated overview of NHSGGC's performance.

Of the 44 measures which had been assigned a performance status based on their variation from trajectory and/or target, 25 were assessed as green, seven as amber (performance within 5% of trajectory) and 12 as red (performance 5% outwith meeting trajectory).

The key performance status changes since the last report to the Committee were:-

- Detect Cancer Early had moved from red to green;
- Alcohol Brief Interventions had moved from red to green;
- New Outpatient Appointment; maximum 12 weeks had moved from red to green;
- Percentage of new DNAs (did not attend) appointments had moved from red to amber;

- Antenatal care (SIMD) had moved from amber to red;
- Community Nursing – record keeping standard had moved from amber to red.

Exception reports had been provided to Members on measures which had been assessed as red.

Ms Micklem asked about the actions which were to be taken forward following the presentation on the Collusion of Exclusion and what was planned to bring about an improvement in this area. Ms Renfrew advised that the Primary Care Group were to discuss proposals and identify actions, and she would report the outcome to the Acute Services Committee.

**Director of
Corporate
Planning &
Policy**

Ms Brimelow raised a concern that record keeping for Community Nursing standards compliance had resulted in a dip in performance. Ms Mullen highlighted the comments in the exception report about the actions being taken including discussing the core audit results with senior nurses, identifying where compliance had not been achieved and generating an action plan, and re-auditing that area the following month and in future, core record keeping results would be a standing item at every District Nursing team meeting. In relation to a concern about the overtime usage increasing, Ms Mullen indicated that the report covered the increased activity over the winter period and the preparation and commissioning of moves to the new South Glasgow University Hospital and Royal Hospital for Sick Children.

Mrs McAuley was concerned that the equality implications and health inequality implications from the paper were difficult to determine and it was not possible to tell whether any overall improvement was being made. Ms Mullen advised that work was ongoing on disaggregating the data for all population groups to determine whether it would be possible to present the information in such a way as to show whether the inequalities gap was narrowing.

**Acting Head of
Performance &
Corporate
Reporting**

Dr Lyons was concerned at the lack of information on the actions being taken at the Royal Alexandra Hospital (RAH) to improve performance on the number of patients admitted to a Stroke Unit on the day of/day after presentation at hospital. Mr Archibald acknowledged this and would highlight the specific actions currently being taken within the RAH in the report to the Acute Services Committee. In relation to a question about GP practices and the 17c contract, Ms Mullen explained that the figures had changed as a result of the boundary changes when the areas of Cambuslang and Rutherglen and Chryston and Moodiesburn transferred to NHS Lanarkshire.

**Chief Officer,
Acute Services**

Ms Renfrew highlighted the performance in relation to delayed discharges for patients waiting over 28 days and 14 days. There had been improvements of circa 100 less blocked acute beds than in January 2015, and improvements had been made within West Dunbartonshire, Inverclyde and Glasgow. She also acknowledged the significant work undertaken within East Renfrewshire and South Lanarkshire Councils in anticipation of the moves from the Mansionhouse Unit to the new South Glasgow University Hospitals, however, there were still more than 200 patients delayed longer than two weeks and this was an important issue that Non-Executive Members of Integrated Joint Boards (IJBs) needed to raise at IJB meetings on a regular basis to ensure an improved performance position was achieved, and thereafter, sustained. Ms Brown agreed and continued to be concerned that, despite additional resources and a number of well-developed plans

being put in place, patients were not receiving the correct type of care and treatment relative to their needs. In addition, some patients were undergoing multiple moves which was clearly not in their best interests.

The immediate pressure point remained at Accident & Emergency departments and acute beds were still being compromised and the number of patients whose discharge had been delayed to a more appropriate setting remained unacceptably high. Discussions continued with the Councils, particularly Glasgow City Council, in an attempt to further improve and sustain performance in this area. The creation of the new South Glasgow University Hospital and subsequent hospital closures would result in less flexibility for the NHS for patients whose discharge was delayed while in an Acute hospital setting.

NOTED

(a) MUSCULOSKELETAL (MSK) PHYSIOTHERAPY WAITING TIMES REPORT

There was submitted a paper [Paper No 15/40a] by the Interim Chief Officer, West Dunbartonshire which provided an overview of the MSK Physiotherapy waiting times, investments made since 2012 to address waiting times, issues faced by the service, and changes planned during 2015.

Mr Fraser reminded Members that he had requested information on MSK Physiotherapy waiting times and the steps being taken to work towards achieving the four week waiting target by the end of March 2016. He welcomed the report and noted the rise in referrals and the service issues but asked which actions were going to make a difference in improving waiting times for patients. Ms Janice Miller, MSK Physiotherapy Service Manager, advised that the introduction of the single IT system (Trakcare) across NHSGGC allowed the setting up of a central referral management centre, and this had already improved efficiency and productivity as well as waiting times. As an example, she indicated that within Clyde, the waiting times had fallen from 24 weeks to ten weeks through offering patients the next available appointment within NHSGGC.

Mr Lee wondered if treating patients earlier would lead to less physiotherapy treatment required subsequently, however, Ms Miller advised that this could be the case in some situations but not all. There was also a rise in more complex orthopaedic cases as well as the number of self-referrals. In addition, following an initial assessment, a number of patients were able to self-manage and they would, therefore, not appear in the waiting list thereafter.

A request was made for information on the range of waiting times for physiotherapy services rather than just the average waiting time. Ms Miller provided information on the NHS Inform website and NHS 24's pilot in relation to the national GP MSK resource which, once completed and evaluated, may impact on a reduced number of patients seeking physiotherapy.

Members thanked Mr Redpath and Ms Miller for the helpful information contained within the report.

NOTED**(b) UPDATE ON CAMHS REDESIGN PROGRAMME**

There was submitted a paper [Paper No 15/40b] by the Director, North East Sector which summarised the progress in redesign and service developments within CAMHS, the workplan to deliver these changes, and the plans and structure for progressing the redesign of Skye House Adolescent Inpatient Unit care pathways. The paper had been prepared for the Committee following Members' questions and the fact that there had been a rising demand and more referrals for the CAMHS service.

With the significant increase in demand, Mr S McLeod, Head of Specialist Children's Services, explained this can have a significant impact on small teams and steps had been taken to have cross-system coverage for all teams with the flexibility of moving staff and resources when required. The 18 week target was being maintained with a median wait of seven weeks, and NHSGGC continued to perform above the national average on waiting times. In response to a question, Mr McLeod acknowledged that there were different types of referrals, and Tier 3 (severe mental disorders) were being maintained, however, more robust Tier 2 arrangements would lead to less pressure and possibly fewer inappropriate referrals. Local targets would be set within Integrated Joint Boards' Strategic Planning arrangements, recognising local priorities and the need to meet national targets.

Dr Lyons asked about the admission of young people to Adult Mental Health wards and whether that number was coming down yet. Ms Renfrew advised that following the opening of an inpatient unit in the north of Scotland, NHSGGC would now be able to concentrate on providing services for its own regional patients, acknowledging that local support and services within health boards outwith NHSGGC may not be as robust as those within NHSGGC. Mr McLeod emphasised that with the support of Psychology, steps were being taken to still consider alternatives rather than admitting young people to Mental Health Inpatient beds.

NOTED**50. NATIONAL PERSON-CENTRED HEALTH & CARE COLLABORATIVE: STRATEGIC REPORT AND WORK PLAN**

There was submitted a paper [Paper No 15/41] by the Nurse Director setting out the current position on the NHS Board's progress in implementing the National Collaborative for Person-Centred Health and Social Care. This was the eleventh report highlighting work being undertaken within NHSGGC under the National Person-Centred Health and Care Collaborative. This report covered the period from January to March 2015.

It was reported that there had been 463 conversations with patients, relatives and carers, 17,500 responses to questions within the themed conversations and circa 96% of responses from patients were indicative of a positive care experience.

Mrs McAuley asked about the mealtime experience and Ms Crocket advised that within the mealtime bundles, support was given to patients in eating (where necessary). The challenge for Facilities was to get the correct meal to the correct patient at the right time and that the meals met the Food and Health Policy

standards. It was recognised that there could always be improvements and that this was a constant challenge and it was hoped that the moves to the single rooms within the new South Glasgow University Hospital would help and make it easier for patients to have protected mealtimes. Mr Archibald echoed Ms Crocket's comments and indicated that all steps were being taken to continue to build on progress including at Inverclyde Royal Infirmary and the Royal Alexandra Hospital.

Ms Micklem welcomed the report and commented that she had found the presentation of the information in the previous report to the Committee more helpful. Ms Crocket acknowledged this and indicated that the purpose of the different presentational styles was to seek Members' comments on what suited best.

Ms Brimelow provided comments about the length of the write-up of the Learning Session and highlighted the issues raised about Care at Night. In response to a further question, Ms Crocket advised that Healthcare Improvement Scotland (HIS) had shared NHSGGC's approach with other NHS Boards, however, at this time she understood that HIS no longer had a Collaborative team.

NOTED

51. FINANCIAL OUT-TURN REPORT FOR THE 12 MONTH PERIOD TO 31 MARCH 2015

There was submitted a paper [Paper No 15/42] by the Director of Finance that set out the NHS Board's financial performance for the year to 31 March 2015. The NHS Board reported an underspend of £1.2m, subject to audit and had broken even against its 2014/15 capital allocation (again, subject to audit). Mr Finnie congratulated the NHS Board staff in achieving an excellent out turn for an organisation with a revenue expenditure of £2.9bn.

NOTED

52. FUTURE PERFORMANCE MANAGEMENT ARRANGEMENTS

There was submitted a paper [Paper No 15/43] by the Director of Corporate Planning and Policy, briefly outlining the current accountability and Performance Management arrangements and describing in detail the planned changes to reflect the new organisational structure and the establishment of Integrated Joint Boards (IJBs) as new statutory bodies. The intention was that these arrangements, when finalised, would come into effect as Integrated Joint Boards were formally established.

The paper set out the existing accountability and Performance Management arrangements across NHSGGC and went on to highlight the proposed changes to Committee performance reporting. The NHS Board continued to have responsibility for the allocation of resources, strategic direction (working with the IJBs) and a statutory governance role across a range of domains. Reporting needed to reflect the requirement for the Board to exercise oversight of these responsibilities.

Detailed Committee scrutiny would be through arrangements which replaced the current Quality and Performance Committee with a new Acute Services Committee, undertaking detailed scrutiny of the Acute Service Division's

performance. Each IJB would undertake detailed scrutiny of the new Partnerships' planning and operational responsibilities, which covered financial, staff, clinical and quality governance with further discussion needed to develop the detail of the clinical reporting routines. Lastly, the paper outlined that the Board's Chief Executive would exercise his line management responsibilities through one-to-one meetings with the Partnership Chief Officers and a system-wide group chaired by the Chief Executive and attended by all Chief Officers to consider and address any whole-system performance issues. One-to-one meetings would be held with the Chief Officer, Acute Services and the Chief Executive chairing a group which would scrutinise high level performance issues and support the role of the new Acute Services Committee. Lastly, for whole-system, these arrangements would replace the current organisational performance review process and the Board-wide Performance Team would manage the flow of information and reporting to support these arrangements.

With the need for the NHS Board to have a continued role in responsibility for the allocation of resources, strategic direction and statutory governance, the plans set out were acknowledged to have an inherent duplication of roles although the challenge was to avoid any unnecessary duplication and be clear as to who was responsible for which areas. It was acknowledged that this was an evolutionary process and Mr Calderwood emphasised that the Board meetings would undertake an overview of performance across NHSGGC and the challenge was tackling any areas of significant local variation or poor performance. This would be a challenge for Non-Executive Directors sitting on the NHS Board as well as being members of different IJBs.

Members welcomed the proposals as set out in the paper.

NOTED

53. HEALTH PROMOTING HEALTH SERVICE (CEL 2012) ANNUAL REPORT

There was submitted a paper [Paper No 15/44] by the Director of Public Health setting out the 2014/15 (year 3) submission which continued to support implementation of health improvement programmes in hospital settings.

Ms Claire Curtis, Health Improvement Lead, attended to present the paper and highlighted that the Health Promoting Health Service (HPS) action in hospital settings and aimed to build on the concept that every healthcare contact was a health improvement opportunity, recognising the important contribution that hospitals could make to promoting health and enabling wellbeing in patients, families, visitors and staff. This was the third year of providing an Annual Report to the Scottish Government Health Directorate (SGHD) and although the initiative was due to finish in April 2015, SGHD had extended it for a further year and further national guidance would be issued in due course.

Ms Curtis advised that the Annual Report had been submitted to SGHD due to timescale issues, however, if Members had any comments or suggested amendments; these would be submitted to SGHD if required.

Rev Dr Shanks, as the Non-Executive Champion of the HPS, welcomed this report and spoke of the massive exercise for all the staff involved and commended the very significant achievements which had been made over the last year. Mrs McAuley agreed and was delighted to read about the achievement of the gold

standard for Healthy Working Lives. In answer to a question, Ms Curtis explained that, within food and health, patient nutrition was not part of the programme.

In relation to Dr Reid's question about smoking within hospital grounds, it was clear that, at this stage, legislation would not be forthcoming in restricting smoking within hospital grounds. However, as it remained an NHSGGC Policy, the Chief Executive and Director of Public Health were giving consideration to providing temporary wardens for three months within the new South Glasgow University Hospital complex to try and discourage smoking from the initial opening.

**Chief Executive
& Director
of Public Health**

DECIDED

- That, the 2014/15 Annual Report to SGHD be ratified.

54. CAR PARKING AT GLASGOW ROYAL INFIRMARY

There was submitted a paper [Paper No 15/45] by the Chief Executive seeking agreement for the NHS Board to enter into discussions with the car park contractor at Glasgow Royal Infirmary with a view to establishing a price at which a sale could be concluded in order to take ownership of the car park into the NHS.

Ms Mary Anne Kane and Mr R Anderson presented the background and current arrangements with regard to the Private Finance Initiative development with Impregilo in relation to the building of a multi-storey car park at the Glasgow Royal Infirmary site and the introduction of the managed car park arrangements in 2002.

Mr Winter and other Members supported this proposal and asked a range of questions around the original contract, its terms and the options going forward.

DECIDED

- That, the NHS Board Officers enter into discussions with the car park contractor with a view to establishing a price at which a sale could be concluded for the car park at Glasgow Royal Infirmary and also enter discussions with SGHD about whether a source of capital funding could be made available for this purpose, if required.

**Director of
Facilities &
Capital Planning**

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55. HUB UPDATE

There was submitted a paper [Paper No 15/46] by the Head of Capital Planning & Procurement which provided a progress report on the NHSGGC projects being procured through Hub West Scotland as part of the SGHD's approach to the delivery of new community infrastructure.

Mr Curran highlighted the key points, and in particular, the continued discussions on the Inverclyde Adult and Older People's Continuing Care Beds which had been delayed due to national accounting issues. A revised Final Business Case, taking account of the updated pricing offers and the original Stage 2 submission, would be considered by the SGHD Capital Investment Group at its meeting on 9 June 2015. Councillor McIlwee indicated that he was pleased at this recent progress as Ravenscraig Hospital required replacement as soon as possible and he had met with

the patients and carers recently and they had remained positive about a final solution being found in the near future.

NOTED

56. UPDATE ON PROPERTY DISPOSAL STRATEGY

There was submitted a paper [Paper No 15/47] by the Head of Capital Planning & Procurement which provided the Committee with a progress update on the property disposal programme being undertaken by NHSGGC.

Members welcomed this very full update and Dr Reid enquired about the disposal of the land at the former Broomhill Hospital in relation to the sale of the endowment lands associated with the hospital. It was acknowledged that the endowment funds would get a capital gain from the sale relative to the sale value of the endowment lands when sold.

NOTED

57. SCOTTISH PATIENT SAFETY PROGRAMME: UPDATE

There was submitted a report [Paper No 15/48] by the Nurse Director setting out the progress against the Scottish Patient Safety Programme (SPSP) in relation to the Maternity and Children Quality Improvement Collaborative (MCQIC).

This collaborative encompassed the clinical improvement activity of the SPSP maternity, neonatal and paediatric strands, with the overall aim of improving outcomes and reducing inequalities in outcomes and providing a safe, high quality care experience for all women, babies and families in Scotland. It was launched in March 2013 and was a programme of quality improvement which would run until December 2015. The aim was to achieve a 30% reduction in adverse events which contributed to avoidable harm in neonatal and paediatric services by December 2015.

Ms Crocket took Members through the detail of the paper and current position within NHSGGC.

Ms Micklem, in acknowledging that the overall aim was to improve outcomes and reduce inequalities, advised that the paper did not specifically highlight any reduction in inequalities or how it was intended to tackle these inequalities. Ms Crocket acknowledged this, and, while she highlighted the breast feeding improvement rates within the more deprived population, she would look at improving the future presentation of information in relation to inequalities.

Nurse Director

Ms Brimelow was not seeing a clear picture of improvements within maternity or how the overall aim would be achieved by the end of the calendar year. Ms Crocket advised that it had been difficult to identify tangible measures to present and she would look again at this with colleagues to try and identify specific areas where progress could be shown.

Nurse Director

NOTED

58. CLINICAL RISK MANAGEMENT REPORT: SURVEILLANCE OF ADVERSE CLINICAL INCIDENTS AND FAIS

There was submitted a report [Paper No 15/49] by the Medical Director presenting a new format for the presentation of handling of adverse clinical incidents within Acute Services Division and Partnerships, together with the investigation reports for three significant clinical incidents in relation to maternal care services and, lastly, an update on the current Fatal Accident Inquiries.

Dr Armstrong took Members through the Clinical Risk Management report for Acute Services and for Partnerships, and identified key areas for Members' information, including the process and timescale for handling Significant Clinical Incident investigations. Appendix 1 had highlighted potential new significant clinical incidents and recent suicides. She invited Dr Michael Smith, Lead Associate Medical Director, Mental Health, to discuss this aspect of the report. He intimated that the suicide rate across Scotland was falling, and as well as the risk assessment, communications and better contacts with family members, it remained an important aspect of all cases, that this was a learning process in which the intention was to encourage open and honest feedback so that the learning from each incident was available in order to improve the handling of any future cases. He also highlighted the out-of-hours service, crisis teams and addictions role and reviews which were underway to bring about further improvements to these services.

Dr Lyons enquired about a Directorate's handling and investigations of significant clinical incidents and the degree of independence in carrying out such investigations, and lastly, asked if the suicides covered in the report were all those known to the service. Dr Smith emphasised that the process was designed to avoid any bias in the investigating process and the staff did not get to investigate themselves, they were included in those to be interviewed and there was an external investigator. Dr Smith advised that all suicides known to the service were indeed investigated.

Ms Brown found the report helpful, including the head injuries review. She continued to be concerned about the high level of "others" recorded within DATIX as well as the lessons highlighted from the three maternal deaths.

Ms Brimelow praised the well-documented maternal SCIs and wished to be assured that anti-microbial policies were being adhered to in relation to the incidence of C.Difficile in one of the SCIs. Lastly, she raised the issue of pressure ulcer care. Dr Armstrong thanked her for her comment and advised that, in relation to C.Difficile, it was rarely seen in the cohort of post-partum women and therefore the learning was to ensure that all maternity units were aware of C.Difficile prevention measures. In relation to pressure ulcers, there was a variety of different reporting templates from different teams. This led to difficulties interpreting the data: for example, it was difficult to establish which pressure ulcers had developed in the community and which in hospital. The intention was that this would be improved when recording future SCIs with the new DATIX field.

Mr Finnie welcomed the independent and objective examination and investigation undertaken for SCIs and noted that he would have more confidence in the NHS Complaints Procedure if this was the model followed in investigating formal complaints by patients, relatives and carers. He remained concerned that those who were complained against still had a role in investigating that complaint and quite often, this led to an SPSO report highlighting a failure in NHSGGC's investigation

and outcome of a complaint. Dr Armstrong acknowledged that for SCIs, the philosophy was very much about learning for the organisation and not apportioning blame. This was something that needed to be considered further in the handling of formal complaints.

Nurse Director

Lastly, Dr Armstrong intimated that the processes and procedures within General Practices included a significant event analysis reporting. The Clinical Governance Team had tested out a fuller SCI method with some practices.

NOTED

59. HEALTHCARE ASSOCIATED INFECTION: EXCEPTION REPORT

There was submitted a report [Paper No 15/50] by the Medical Director providing information on performance against national targets for key infection control measures.

For SABs the most recent validated figures for the last quarter of 2014 confirmed a total of 93 SAB cases for NHSGGC between October and December 2014 and this equated to an SAB rate of 25.1 cases per 100,000 Acute Occupied Bed Days (AOBDs).

In relation to Clostridium Difficile (C.Diff), the most recent validated results for quarter 4 of 2014 demonstrated a C.Diff infection rate of 33.3 per 100,000 total occupied bed days (OCBDs) which was below the national average of 35.4. NHSGGC achieved a rate of 29.3 per 100,000 OCBDs in 2014.

NOTED

60. MEDIA COVERAGE OF NHSGGC MAR/APR 2015

There was submitted a report [Paper No 15/51] by the Director of Corporate Communications highlighting outcomes of media activity for the period March - April 2015. The report supplemented the weekly media roundup which was provided to NHS Board members every Friday afternoon and summarised media activity including factual coverage, positive coverage and negative coverage.

NOTED

61. QUARTERLY REPORT ON CASES CONSIDERED BY THE SCOTTISH PUBLIC SERVICES OMBUDSMAN: 1 JANUARY TO 31 MARCH 2015

There was submitted a report [Paper No 15/52] by the Nurse Director setting out the actions taken by the responsible operational areas in response to recommendations made by the Scottish Public Services Ombudsman in Investigative Reports and Decision Letters.

In response to a question from Mrs McAuley, Ms Crocket advised that East Dunbartonshire CHP hosted Oral Health Services including the General Dental Practitioners and therefore any SPSO cases in relation to General Dental Practitioners would fall to East Dunbartonshire CHP.

Members expressed continued concern that initial improvement in the number of

upheld cases from the Ombudsman's Report was not being sustained and the handling of some complaints within NHSGGC had been criticised in the Ombudsman's Investigative Reports and decision letters. There was recognition, as highlighted in an Investigative Report attached with the paper, that the Ombudsman obtained clinical advice from down South and some of these interpretations had been challenged on previous occasions.

Concerns were expressed that administrative/managerial failings were identified by the Ombudsman and this needed to be considered when reviewing how complaints should be handled in future. Mrs McAuley emphasised the Ombudsman's work on preparing the new standardised complaints policy and procedures for the NHS may improve the handling of future complaints.

Mr Calderwood and Ms Crocket explained the current processes for handling complaints at local level and that a second episode was required to be handled by a different Directorate under the Complaints Policy, to ensure some degree of independence to the review and outcome.

NOTED

62. PROPERTY COMMITTEE MINUTES OF MEETING HELD ON 12 MARCH 2015

There was submitted a paper [Paper No 15/53] enclosing the Property Committee Minutes of the meeting held on 12 March 2015.

NOTED

63. STAFF GOVERNANCE COMMITTEE MINUTES OF MEETING HELD ON 3 MARCH 2015

There was submitted a paper [Paper No SGC(M)15/01] enclosing the Staff Governance Committee Minutes of the meeting held on 3 March 2015.

NOTED

64. QUALITY POLICY DEVELOPMENT GROUP MINUTES OF MEETING HELD ON 14 APRIL 2015

There was submitted a paper [Paper No 15/54] enclosing the Quality Policy Development Group Minutes of the meeting held on 14 April 2015.

NOTED

65. BOARD CLINICAL GOVERNANCE FORUM MINUTES AND SUMMARY OF MEETING HELD ON 20 APRIL 2015

There was submitted a paper [Paper No 15/55] enclosing the minutes of the Board Clinical Governance Forum meeting held on 20 April 2015.

NOTED

66. DATE OF NEXT MEETING

This was the final meeting of the Quality & Performance Committee. The next meeting to be held on Tuesday 30 June 2015 at 9:30am would be the **Acute Services Committee**, which would have an amended remit and membership. It will be held in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 12:50pm