NHSGG&C(M)15/05
Minutes: 59 - 79

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, 18 August 2015 at 9:30a.m.**

PRESENT

Mr A O Robertson OBE, DSc, LLB (in the Chair)

Dr J Armstrong
Mrs S Brimelow OBE
Mr J Brown CBE
Ms M Brown
Mr R Calderwood
Dr H Cameron
Ms R Crocket MBE
Councillor M Cunning
Mr R Finnie
Mr I Fraser (To Minute No 73)
Councillor A Lafferty
Mr I Lee (To Minute No 73)
Dr D Lyons
Mrs T McAuley OBE
Mr A Macleod
Councillor M Macmillan
Councillor J McIlwee (To Minute No 72)
Ms R Micklem
Councillor M O'Donnell
Dr R Reid
Rev Dr N Shanks
Mr D Sime
Mr M White

IN ATTENDANCE

Dr S Ahmed	Consultant in Health Protection/Clinical Director, Health Protection Scotland (For Minute 67)
Mr G Archibald	Chief Officer, Acute Services Division
Dr E Crighton	Interim Director of Public Health
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Mr A McLaws	Director of Corporate Communications
Mrs A MacPherson	Director of Human Resources & Organisational Development
Ms P Mullen	Head of Performance
Ms C Renfrew	Director of Planning & Policy (To Minute No 72)

ACTION BY

59. WELCOME AND APOLOGIES

Mr Robertson welcomed Dr E Crighton, Interim Director of Public Health to her first NHS Board meeting covering Dr de Caestecker's secondment.

Apologies for absence were intimated on behalf of Councillor M Devlin, Professor A Dominiczak OBE, Councillor M Rooney and Mr K Winter.

NOTED

60. 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

61. CHAIR'S REPORT

(i) On 23 and 24 June 2015, Mr Robertson attended the NHS Scotland Event and Senior Leaders Forum. This year's theme was "Leading Integration for Quality". NHS Scotland's 2020 Vision for Health & Social Care was that by the year 2020, everyone was able to live longer, healthier lives at home or in a homely setting. The event provided a platform for some of the most exciting quality improvement techniques and innovative approaches in modern healthcare, showcasing the best in health and care from the public, private, voluntary, academic and scientific communities.

(ii) On 25 June 2015, Mr Robertson visited the Ardgowan Hospice and met with its Chief Executive to hear about their plans going forward.

(iii) On 26 June 2015, Mr Robertson attended Glasgow Airport where the Scottish Ambulance Service unveiled two new ambulance helicopters.

(iv) On 29 June 2015, Mr Robertson met with members of the Gartnavel Auxiliary Committee (one of the winners of last year's Chairman's Awards) to find out how they were getting on since the Celebrating Success event in November 2014.

(v) On 3 July 2015, Mr Robertson attended the official opening of the Queen Elizabeth University Hospital, Royal Hospital for Children and the Teaching and Learning Centre.

(vi) On 24 July 2015, Mr Robertson, accompanied by the Director General of Health and Social Care and Chief Executive, NHS Scotland, visited Esteem's Leverndale base and met with service users to discuss future opportunities and developments.

(vii) On 28 July 2015, Mr Robertson attended a meeting of the Endowment Management Committee, chaired by Dr R Reid.

(viii) On 5 August 2015, Mr Robertson attended the sod cutting for the third multi-storey car park at the Queen Elizabeth University Hospital.

(ix) On 6 August 2015, Mr Robertson attended the Young Carers' Festival, hosted by the Carers' Trust Scotland at West Linton.

(x) In noting Mr K Winter's apologies earlier, Mr Robertson reported that this would have been his last NHS Board meeting prior to his term of office as a Non-Executive Member coming to an end. Mr Robertson paid tribute to the significant work undertaken by Mr Winter over his six years as an NHS Board Member. His knowledge and experience had been invaluable particularly in relation to the development of the South Glasgow Hospitals Project. In addition, he undertook the roles of Chair of the Audit Committee and Vice Chair of Inverclyde Community Health Care Partnership (CHCP).

On behalf of the NHS Board, Mr Robertson recorded his appreciation and acknowledged that Mr Winter would be greatly missed.

NOTED

62. CHIEF EXECUTIVE'S UPDATE

(i) On 22 July 2015, accompanied by Ms R Crocket, Mr Calderwood attended the launch of the new Adult Acute Nursing Standards across NHSGGC. This event, held at the Queen Elizabeth Teaching & Learning Centre, unveiled the Care Assurance & Accreditation System (CAAS) which was designed to delegate more responsibility and control on Wards to the most senior nurses and midwives. NHSGGC was one of the first NHS Boards in Scotland to implement this new system in Scotland and its implementation would bring real benefit to patients on the Wards, ensuring effective close-team working and linkages to the core values of nursing and patient care at every level.

That afternoon, Mr Calderwood met with the Chief Executive of Catapult, Mr John McKinley, accompanied by Professor Dominiczak, to discuss the possible opportunity for the University of Glasgow to host the Scottish National Centre of Excellence of the Catapult for Precision Medicine. This would be progressed further at the end of September and was likely to be located on the Innovation Floor in the Queen Elizabeth Teaching and Learning Centre.

NOTED

63. MINUTES

On the motion of Mr D Sime, seconded by Dr Reid, the minutes of the NHS Board meeting held on Tuesday, 23 June 2015 [NHSGGC(M)15/04] were approved as an accurate record and signed by the Chair pending the following correction:-

- Minute No 34 (v) delete "Honorary Directorate of Science...." – insert "Honorary Doctorate of Science...."

NOTED

64. MATTERS ARISING FROM THE MINUTES

(i) The Rolling Action List of matters arising was noted.

(ii) In response to a question from Mrs McAuley regarding progress on implementing the recommendations from the Vale of Leven Inquiry Report, Dr Armstrong reported that this would be discussed at the September 2015 Acute Services Committee meeting and, thereafter, considered by the NHS Board at its October 2015 meeting. **Medical Director**

NOTED

65. SCOTTISH PATIENT SAFETY PROGRAMME (SPSP) UPDATE

A report of the NHS Board's Nurse Director [Board Paper No 15/38] asked the NHS Board to note updates in each of the three workstreams (paediatrics, maternal care and neonates) in terms of current activity, key areas of progress and key issues to note.

Ms Crocket explained that the Maternity and Children Quality Improvement Collaborative (MCQIC) encompassed the clinical improvement activity of the Scottish Patient Safety Programme's maternity, neonatal and paediatric strands. The 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. MCQIC was launched formally as a collaborative in March 2013 and was a programme of quality improvement that would run until December 2015.

Ms Crocket led the NHS Board through the update, referencing in particular, progress, strengths and challenges at the Princess Royal Maternity Hospital, the Queen Elizabeth University Hospital and Clyde, in relation to the maternity workstream. NHSGGC submitted its quarterly assessment of progress on 15 July 2015 and feedback was awaited from the national team.

In relation to the paediatric and neonatal elements of MCQIC, there were currently 18 teams supported across paediatric and neonatal services. Due to the significance of the Hospital's migration to the new site, there had been a recent drop in levels of data submission which, under the circumstances, was understandable. As teams were settling into the new facility, the good working practices of their previous units had been encouraged and there was currently no concern that compliance would be less than previously recorded.

In response to a question from Mr Sime regarding self assessment of progress, Ms Crocket explained that this was requested of NHS Boards every four months by the national team. Feedback for review period 4 (February 2015) was received in June 2015 and she acknowledged that no measurement was being undertaken around the nationally developed Safety Culture Survey due to the resources required to gather and analyse the data. She added, however, that NHSGGC was no different from any other NHS Board, as no NHS Boards were reporting data against this measurement for the same reasons. NHS Boards continued to work with Healthcare Improvement Scotland (HIS) to identify ways in which the data collection may be streamlined.

Mrs McAuley referred to one of the challenges in the maternity workstream regarding women who continued to smoke during and after pregnancy. Ms Crocket confirmed that such women were provided with a tailored package of antenatal care although there was limited capacity for a further two ultrasounds for those women who continued to smoke – work was underway to address this. In response to an additional question from Mrs McAuley, Ms Crocket reported that the debrief had shown reliability in some theatres but spread to other specialties was proving difficult. Debrief really required medical staff to believe in the benefits of the process and to be fully engaged for success to be possible. It was anticipated that, with some staff/leadership improvements, increased reliability would become evident.

Councillor Lafferty welcomed the MCQIC key events including a maternity care networking event and an annual NHS Scotland event particularly as such networking with key staff provided excellent opportunities to showcase new ideas. In response to his question about the midwifery and obstetric champions, Ms Crocket reported that two champions were now in place and would ensure completion of the period 3 self assessments.

Dr Lyons referred to Appendix 2 which identified progress score definitions at time intervals since teams became active in the work. Ms Crocket reported that the scoring was based on a HIS model and discussions continued to refine what the data showed in an attempt to differentiate where robust improvements could be made.

NOTED

66. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No 15/39] 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 and led the NHS Board through a summary of performance in relation to:-

- Staphylococcus aureus bacteraemias (SABs)
- Clodistrium Difficile (C.Diff)
- Surgical Site Infection (SSI) rates for caesarean section, knee anthroplasty, repair of neck of femur procedures and hip anthroplasty procedures
- The Cleanliness Champions Programme
- Healthcare Environment Inspectorate (HEI) inspections

Mrs McAuley congratulated the NHS Board on the statistically significant decrease in MSSA (Methicillin Sensitive Staph Aureus) and total SABs (staphylococcus aureus bacteraemias) at the year ending March 2015 compared with the previous year. She was disappointed, however, to note that, in the quarter April to June 2015, 26 patients had the source of their SAB identified as an intravenous (IV) access device. Dr Armstrong agreed that this was disappointing and outlined some of the measures being taken to address this performance including a Ward audit of IV access device care plans undertaken by the Infection Prevention and Control Team. This was collectively reported in the monthly enhanced SABs report. Furthermore, continued adherence to the CVC (Central Vascular Catheter) and PVC (Peripheral Vascular Catheter) Standard Operating Procedures for all healthcare workers within NHSGGC clinical teams remained crucial in reducing the number of hospital acquired or healthcare associated cases that were attributed to IV access devices.

Ms Brown echoed the good performance highlighted in this report and, in particular, the improved hand hygiene compliance amongst medical staff.

NOTED

67. UPDATE ON IMPLEMENTATION IN NHSGGC OF MAJOR DEVELOPMENTS TO IMMUNISATION PROGRAMMES

A report of the Interim Director of Public Health [Board Paper No 15/40] asked the NHS Board to receive and note the update on implementation in NHSGGC of major developments to immunisation programmes.

Dr Ahmed explained that, as a public health measure, immunisations had been very effective in reducing the burden of disease. Immunisation policy in the UK was

determined by the UK Health Ministers and devolved administrations with advice from the Independent Expert Advisory Group, namely the Joint Committee on Vaccination and Immunisation (JVCI). In December 2012, the SGHD, along with other UK administrations, announced the following major developments to immunisation programmes in the UK, implemented from July 2013:-

- Addition of Rotavirus vaccination to the Universal Childhood Vaccination Programme.
- Offer meningococcal C vaccine to adolescents (S3 pupils) and a decrease in the number of doses offered to infants from two to one. A catch-up programme for first time entrants to university who would otherwise miss out on the new programme over the next 4-5 years was also to be introduced.

- Introduction of Herpes Zoster (shingles) vaccine for all those aged 70 years with a catch-up for 70-79 years to be completed over a 4-5 year period.

- Extension of the seasonal flu immunisation programme to all children and young people aged 2-17 years.

A business case was previously presented to the NHS Board and three years (2013-2016) non recurring funding was approved to enable NHSGGC to deliver on these new programmes, including costs relating to primary care, nursing, school administration, pharmacy coordination and education/training. The SGHD paid for the vaccines from central resources.

Dr Ahmed led the NHS Board through progress to date:-

- **Rotavirus** – since the rotavirus immunisation programme was introduced in July 2013, there had been a very significant reduction in the number of laboratory-confirmed cases in infants of less than one year old. In addition, a reduction had also been observed in the number of young infants presenting at general practice and admitted to hospital with rotavirus.

- **Meningitis C, B and W** – A vaccine against Meningitis C infection was introduced in this country in 1999 in response to a major upsurge in the number of cases. Since then, the uptake rate of the vaccine reached over 95% and the number of cases declined by over 99% with Men C cases almost eliminated from the UK. Following the introduction of the Men C vaccination programme, serogroup B disease had become the most common strain of meningitis followed by meningococcal diseases caused by serogroups less common such as W and Y. Following the licence of a Men B vaccine, the JCVI recommended that the Men B vaccine should be introduced in the UK scheduling as long as the UK administrations could purchase the vaccine at a cost effective price. After successful negotiation with the Men B vaccine manufacturer, the UK administrations had announced the introduction of a Men B vaccine for infants from 1 September 2015 delivered through Primary Care. In addition to the addition of the Men B vaccine to the infant schedule and, in response to an unprecedented increase in the number of meningococcal cases caused by the serogroup W over the last two years, the JCVI recommended the following emergency programme and changes to existing programmes:-

    - The adolescent Men C booster dose, given at secondary school, should be replaced with Men ACWY conjugate vaccine, providing protection to all four serogroups A,C,W and Y.

    - An urgent catch-up programme for all 14-18 year olds offering Men ACWY.

- Men C freshers programme to be replaced with Men ACWY (first time university entrants in August/September 2015 up to the age of 25 years).

Replacing the Men C vaccine in adolescents with Men ACWY, along with the introduction of the Men B vaccine to infants, should offer much wider protection against meningococcal disease in this country.

- **Introduction of Herpes Zoster (shingles) vaccine for people aged 70 years with a catch-up for 70-79 years** – offering the vaccination from the age of 70 years may result in boosting immunity to the disease thus providing protection to the individual in later years. The aim was to prevent the development of the disease in the first instance and to reduce the severity of the complications such as post-herpetic neuralgia. The JCVI recommendation to offer this vaccination to individuals aged 70-79 years was based on the economic analysis that suggested the vaccine would be most cost effective in this age group. The decision was based on the incidence of shingles, the severity and risk of complications, the efficacy of the vaccine and estimated duration of protection provided by the vaccine. As at the end of June 2015, shingles vaccination uptake in NHSGGC was 53.2% with significant variation among GP practices. Work was ongoing to encourage GP practices to effectively target and offer the vaccine in an effort to reduce inequality and the significant variation in uptake among practices.

- **Extension of the seasonal flu immunisation programme to all children and young people aged 2-17 years** – the school flu immunisation programme was the largest of the school immunisation programmes. In 2013-14, as part of the national school flu immunisation programme pilot, flu immunisation was offered to primary school aged children in 103 primary schools across NHSGGC. The programme extended in 2014/15 to include all primary school flu immunisations being delivered over a ten week period. Following the expansion of the school flu programme to include all primary schools in 2014/15, the SGHD agreed for NHS Boards to consolidate delivery of the programme in primary schools during 2015/16. There were no timescales as yet for delivering flu immunisations to secondary school aged pupils. The introduction of the flu immunisation programme for school age children had a significant impact on NHS Boards in relation to the planning, coordination and delivery of the range of vaccines. To date, school nursing teams throughout Scotland had played a key role in the planning, coordination and delivery of school immunisation programmes. NHS Boards would be required to develop alternative models to the planning, coordination and delivery of immunisation programmes for school age children in order to optimise the effectiveness of school nursing teams. In an effort to address issues regarding school nurse workforce capacity, NHSGGC was piloting a dedicated school immunisation team across two Health & Social Care Partnership (HSCP) areas – East Renfrewshire and Glasgow. Following the pilot evaluation and outcomes from national and local discussions regarding the legal arrangements to enable healthcare support workers to deliver immunisations, a sustainable delivery model for school immunisation programmes would be identified and adopted by NHSGGC.

Dr Ahmed explained that a national review of immunisations was currently taking place with the SGHD keen to reduce the significant variation in vaccination uptake and inequality.

Mr Robertson thanked Dr Ahmed for his insightful presentation and the following points were clarified during discussion:-

- Work continued locally in NHSGGC to persuade all staff to have the flu vaccination.

- There were no plans, at the moment, to introduce the Men ACWY vaccine population-wide. The age group targeted (and recommended by the JCVI) was the adolescent age group because this was the greatest source of infection and spread.

- International students would also be targeted in the same way as UK students and all would be reminded to receive the vaccination as soon as was practical.

- The variations in primary care of existing vaccinations were not just within NHSGGC but were a recognised national-wide pattern. By comparison, the many advantages of the national call/recall screening systems and school programmes were recognised and the SGHD were aware of the variances within GP practices Scotland-wide and this was being discussed at a national level.

- NHS Boards currently funded, on a non-recurring basis, for the delivery of the programmes. The SGHD paid for the vaccinations themselves. As such, associated ongoing costs to NHSGGC were incorporated into the NHS Board's Financial Plan.

- There was an obligation to educate local communities so that they were aware of what vaccinations were available for them and their families. NHS Health Scotland took the lead in taking forward a communications campaign in this regard. Local primary care establishments also tended to advertise vaccination programmes.

- Work would be undertaken with the Health & Social Care Partnerships (HSCP), looking at the best ways to collate associated information and to draw on best practice.

Dr Crighton thanked Dr Ahmed and confirmed that, locally, work would continue to engage with primary care practitioners to identify how best ongoing communications could be undertaken with members of the public.

NOTED

68. WINTER PLANNING FOR 2015/16

A report of the Chief Officer, Acute Services and Director of Planning and Policy [Board Paper No 15/41] asked the NHS Board to note progress on developing the Winter Plan for 2015/16.

Mr Archibald led the NHS Board through the planning arrangements for winter 2015/16, reporting that detailed planning was now underway across the piece to ensure that the NHS Board was prepared for the pressures on services anticipated over winter. He looked back on the NHS Board's performance in 2014/15 and, reflecting on the actions put in place, explained that a detailed review was currently underway to assess the effectiveness of the measures introduced with a view to building on those that were shown to have a positive impact. Furthermore, it would be important to identify those measures which could be improved upon and to agree new areas of focus in addressing the challenges for 2015/16.

Mr Archibald outlined the key areas of focus for improvement and explained that a number of discussions were planned to support the required whole system approach.

In 2014/15, as in previous years, the SGHD provided a level of non-recurring funding to assist with the winter plan and the NHS Board also made a significant allocation. The NHS Board would work with the SGHD to identify levels of investment this year and to identify its own investment provision. A full winter plan would be completed for submission to the NHS Board in October 2015 and, thereafter, submission to the SGHD. **Chief Officer, Acute Services**

In response to a question from Mr Finnie, Mr Calderwood described the mathematically calculated bed model used in NHSGGC that informed occupancy levels and provided the flexibility to handle peaks and troughs.

Mrs Brimelow asked about seven day week consultant cover and its impact on patient flow. Mr Archibald confirmed that re-profiling work was ongoing at the moment, looking at how best to augment resources over the weekend whilst balancing "business as usual" services.

In response to a question from Ms Brown regarding the issue of discharge letters, Mr Archibald confirmed that progress continued to be made with this and increased use of the discharge lounge at the QEUH.

NOTED

69. NHS BOARD MEMBER DEVELOPMENT

A report of the Director of Human Resources and Organisational Development [Board Paper No 15/42] asked the NHS Board to note the NHS Board Development Activity and consider the plans to reintroduce monthly NHS Board Seminars and hold two Away Day sessions later in 2015.

Mr Robertson explained that he had been approached by some Non-Executive Members seeking additional opportunities to discuss the strategic issues facing the NHS Board. With this in mind, he outlined the various strands of ongoing NHS Board Member development work and plans for additional meetings of Members.

Mrs MacPherson outlined some of the national and local development activities for Non-Executive Members as part of a number of key, linked strategic activities at national level including the leadership strategy, developing the public appointments process, accountability and governance. In addition to reviewing the public appointments process and evaluating induction approaches across NHS Boards, the following activities were underway:-

- Portfolio of resources for Non-Executive Directors.
- Board effectiveness.
- Local activity.
- iMatter.

Rev Dr Shanks welcomed the proposal to reinstate the NHS Board Seminars which provided the opportunity to discuss how the NHS Board functioned as a collective unit. He asked that the programme of NHS Board Member visits and their participation in walkrounds be added to the forward planning. **Director of HR & OD**

Mrs McAuley agreed and was totally supportive of reinstating the NHS Board Seminars and having the opportunity to influence their agendas. She asked for further information about the national NHS network of Non-Executive Members and Mrs MacPherson agreed to pass this to her. **Director of HR & OD**

Mr Finnie referred to his observation that, historically, NHS Board Seminars adopted two different formats (some were for information/education and some were for development). He wondered if the agendas could be clear in advance. **Head of Board Administration**

Ms Micklem suggested that, on the months there was an Away Day arranged and also an NHS Board Seminar, that if the Board Seminar was to be cancelled, then this was done at an early date. **Head of Board Administration**

Mrs Brimelow and Dr Lyons suggested that the Non-Executive NHS Board Member role and accountability on the new Integrated Joint Boards (IJBs) should be discussed as a priority at the Away Day or October Seminar. **Head of Board Administration**

NOTED

70. IMPLEMENTING THE CLINICAL SERVICES STRATEGY: CHANGES FOR 2015/16: DRUMCHAPEL HOSPITAL

A report of the Director of Planning and Policy [Board Paper No 15/43] sought agreement from the NHS Board to engage on the proposed service changes which were aligned to the implementation of the NHS Board's Clinical Services Strategy.

Ms Renfrew reminded the NHS Board that the Local Delivery Plan, developed within the framework of the Clinical Services Strategy, included proposals for service change for Older People's Services in West Glasgow. These service changes would improve quality of care and patient experience as well as achieving more sustainable models of care. The NHS Board was working with the Scottish Health Council to shape public, patient and carer engagement on these proposed service changes.

She summarised the changes proposed and their expected benefits, explaining that the engagement process would enable the NHS Board to gain further views from patients, carers and the public. It was proposed to consolidate all of the rehabilitation services for the West Sector, Greater Glasgow into a single integrated service at Gartnavel General Hospital. This would see the transfer of current Drumchapel Hospital rehabilitation activity into the newly developed Rehabilitation Centre of Excellence at Gartnavel General Hospital.

Following the transfer of the Rehabilitation beds to Gartnavel General Hospital, the 28 NHS Continuing Care beds on the Drumchapel site would not continue to be sustainable. It was, therefore, proposed to reprovide these beds as part of the existing service at Fourhills Care Home. The future of these beds, beyond the short term, was subject to the review process established in light of the recent SGHD guidance which replaced NHS Continuing Care with hospital-based complex clinical care.

Ms Renfrew set out some key factors which were taken into account in developing the proposals and which would be considered further during the engagement process. She also described the proposed approach to engagement which would be developed further with the Scottish Health Council, Public-Partnership Forums and the Public Engagement Team.

In response to a question from Mr Sime, Ms Renfrew clarified that the engagement process would proceed on the basis that Ministerial approval for the proposed changes would not be required as the proposals were not of a major service change in nature. The Scottish Government could reconsider that position.

Councillor Lafferty asked where Fourhills Care Home was and it was confirmed that it was in West Glasgow (Maryhill). Mrs Brimelow asked if Fourhills Care Home had

the capacity and Ms Renfrew responded in the affirmative. In terms of quality of care provided, Ms Renfrew reported that NHSGGC had a current contract with the care home.

In response to a question from Ms Micklem regarding the engagement process, Ms Renfrew confirmed that replies received would feed into an Equality Impact Assessment (EQIA).

DECIDED

- That the proposed changes to Older People's Services in West Glasgow which reflected the Clinical Services Strategy approved by the NHS Board earlier this year (and were included in the 2015/16 Local Delivery Plan) be noted.

- That the public, patient and carer engagement on these proposed service changes in agreement with the Scottish Health Council, be approved. **Director of Planning & Policy**

- That the outcome of the engagement process towards the end of 2015 be considered before reaching final decisions be agreed. **Director of Planning & Policy**

71. GLASGOW CITY INTEGRATION SCHEME: UPDATE

A verbal report on the above was provided by the Director of Planning and Policy, Ms Renfrew, who had presented to the February 2015 NHS Board meeting draft Integration Schemes. The NHS Board had confirmed delegated authority to her and the respective Chief Officers to finalise the Schemes. Thereafter, there were a series of detailed exchanges with the SGHD. For the five HSCPs outside Glasgow City, agreement was reached with the SGHD and each Council and this had enabled formal submission and approval by Scottish Ministers.

In the case of Glasgow City, the assumption had been that the City would carry whole system responsibility for specialist children's services, with accountability to the NHS Board for that differential role. Those whole system responsibilities, additional to the Partnership core role, required the agreement of the Council. Through discussion with the Council this agreement was not reached.

NHSGGC had proceeded to establish separate management arrangements for these services alongside further dialogue with GCC to achieve integrated management by the Partnership for the services delivered within GCC but with the required differential line of sight to the NHS Board.

Ms Renfrew explained that specialist children's services had four components and that these services currently had dual arrangements with local management but also a line of accountability to a single General Manager who had the responsibility and capacity to achieve working across the system, supported by singular Clinical Director posts for each service, also operating across the system. Those whole system arrangements included:-

- management of the inpatient CAMHs and children's psychiatric facilities;
- participating in national and regional planning;
- coordination to address issues which arose across the whole care system;
- service redesign and improvement;
- development and delivery of consistent models of care;
- integrated care pathways between inpatient and community services;

- clinical governance for the whole service system.

Ms Renfrew provided some examples to illustrate how this worked:-

- Major issues with waiting times for CAMHs, single service model agreed and delivered across NHSGGC, staff redistributed to reflect that;
- Service gap in a small Partnership - staff redistributed to avoid service failure;
- Singular care pathways developed between community and inpatient services to ensure appropriate use of beds.

From the NHS Board's perspective, absolute confidence that these local and whole system balanced arrangements could continue was fundamental to the NHS Board's responsibilities for governance. There was no requirement to include these services within the delegation to an IJB but the aim in having these responsibilities sit under Chief Officers was to ensure there was integration with the general children's services which were delegated to IJBs.

NHSGGC proposed a form of words for the GCC Scheme which established the basis of delegation as operation within the NHS Board's requirement for whole system working. GCC was not happy with this wording and sought the view of the SGHD. That view was that the legislation which established IJBs meant the whole system construct could not be included in the Scheme. There was only one legal model of delegation through inclusion in the Integration Scheme and that left the NHS Board with no basis to require that whole system working, delegation through the Scheme could not constrain the IJB's freedom of action.

Ms Renfrew reported that a series of exchanges with GCC had continued to try to reach agreement. The current position was:-

- NHSGGC remained committed to integration of specialist children's services into the City Partnership but must have an arrangement which assured absolute security of whole system working;
- Both NHSGGC and GCC were agreed that the required position could not be achieved within the Scheme. The Council proposal of an operational protocol would not be binding on the IJB, would have no legal status and would not give the NHS Board any certainty that services would continue to operate, where required, as a single system.
- Therefore, NHSGGC had confirmed to the Council that these services could not be included in the Scheme.
- NHSGGC's advice was that there was a legal means by which integration could be agreed with the IJB once it was established.
- As the responsible organisation, NHSGGC had sought to explain why the whole system working needed to be legally established and was so important for small, high risk, specialist services, where mutual support across six Partnerships was critical.
- NHSGGC's proposal to GCC was that the Scheme was submitted as all the rest of it was agreed, with these services excluded, but with the NHS Board's commitment to integration to be agreed when the IJB was established. To date, the Council had been unwilling to proceed on that basis.

These services were included in four of the five approved Schemes but for the other Partnerships, there was a clear advantage, indeed imperative, to work in a whole system and, therefore, to agree to be part of arrangements established with the Glasgow City IJB as none had sufficient resources to act independently.

The Chairman thanked Ms Renfrew for the briefing.

Rev Dr Shanks commented that, as an IJB member, there was frustration that this remained a sticking point. He emphasised the need to move forward. Ms Renfrew confirmed that, from the NHS Board's perspective, the position was not preventing the Scheme from being approved.

In response to a question from Mr Sime, Ms Renfrew agreed to circulate the finalised versions of the other Schemes of Establishment. **Director of Planning & Policy**

In response to a question from Councillor Cunning regarding at what stage this became a substantive issue, Ms Renfrew confirmed that it became clear in the last few weeks as the NHS Board worked with GCC to ensure whole system working was secure. Councillor Cunning highlighted that GCC was putting in a service which covered a number of Council, social work out-of-hours and could not understand why these services were different. Ms Renfrew indicated that the service was contracted by Councils and the other Partnerships were not legally bound to the Glasgow City service, they could give notice and shift out of the service. Glasgow City's inclusion in the Scheme did not take away from those Council's statutory responsibility and decision making power over provision of that service.

In response to a question from Councillor O'Donnell, Ms Renfrew explained that all Chief Officers of the Health and Social Care Partnerships were aware of these discussions as it was certainly the case that whole system working was critical for the other Partnerships.

In response to a question asking whether the SGHD would impose a Scheme, Ms Renfrew reported that the inclusion of children's services was a matter for the Council and the NHS, there was no block from the NHS to submitting a Scheme which complied with the legislation and met the requirements of the Government.

Dr Reid welcomed the detailed understanding of the issue and supported the persuasive argument of the importance of securing whole system working. Mrs McAuley concurred and emphasised the importance of moving to get the Scheme agreed.

Ms Renfrew ended by re-affirming that there was no delay required on the Scheme from the NHS Board's perspective, timing of process was now a Council matter. GCC, NHSGGC and lawyers were scheduled to meet again soon to discuss how the post establishment integration could be achieved.

Mr Calderwood confirmed that if parties were not able to find a way forward outside the Scheme then the NHS Board would need to establish an alternative management structure for these services outside the Partnerships but that was absolutely not NHSGGC's preferred option.

NOTED

72. NHS GREATER GLASGOW & CLYDE'S INTEGRATED PERFORMANCE REPORT (INCLUDES WAITING TIMES AND ACCESS TARGETS)

A report of the Head of Performance [Board Paper No 15/45] asked the NHS Board to note the content and format of the NHS Board's Integrated Performance Report. Members were also asked to note that the report continued to remain as a work in progress requiring further development.

Ms Mullen explained that this report brought together high-level system-wide performance information (including all of the waiting times and access targets previously reported to the NHS Board) with the aim of providing the NHS Board with a clear overview of the organisation's performance in the context of the 2015/16 Strategic Direction – Local Delivery Plan. An exceptions report would accompany all indicators with an adverse variance of 5% or more, detailing the actions in place to address performance and indicating a timeline for when to expect improvement.

Ms Mullen led the NHS Board through:-

- A summary providing a performance overview of current position.

- A single scorecard containing actual performance against target for all indicators. These had been grouped under the five strategic priorities identified in the 2015/16 Strategic Direction.

- An exception report for each measure where performance had an adverse variance of >5%.

She explained that the most up-to-date data available had been used which meant that it was not the same for each indicator. The time period of the data was provided and performance compared against the same time period in the previous year. From this, a direction of travel was calculated.

Following comments received at the last NHS Board meeting, the report now included commentary for those measures rated as amber that showed deterioration in performance when compared with the same period the previous year. In addition, the report also provided a summary of key performance status changes since previously reported to NHS Board Members. Ms Mullen summarised performance and highlighted key performance status changes since the last report to the NHS Board meeting, including performance improvements, performance deterioration and measures rated as red.

In response to a question regarding neurology outpatient waiting times, Mr Archibald explained that there was a UK-wide shortage of consultant neurologists. Posts had been advertised on multiple occasions but it had proven difficult to recruit locum cover except via high-cost agencies. NHSGGC currently had an advert out for two consultants, interviews for which were scheduled for November 2015.

He remained optimistic that NHSGGC would be able to recruit consultant staff this time, however, staff appointed may not be able to take up posts until early 2016. In the short term, to cover the positions as early as possible in 2015, the feasibility of increasing the capacity currently held with the independent sector was being actively explored.

Dr Lyons asked about the gastroenterology service and Mr Archibald reported that this had been under pressure for a number of months due to the increase in referrals.

The number of referrals had risen by 22% since July 2014. In addition, there had been a reduction in the number of junior doctors available to assist with the outpatient work due to a reduction in overall numbers. The service reported that there was a significant gap between capacity and demand at present. Contributory factors also included staff leave, with one consultant currently off on long-term leave and another on maternity leave.

Ms Micklem noted and welcomed the improvement in Accident & Emergency performance.

NOTED

73. FINANCIAL MONITORING REPORT FOR THE 3 MONTH PERIOD TO 30 JUNE 2015

A report of the Director of Finance [Board Paper No 15/46] asked the NHS Board to note the financial performance for the three month period to 30 June 2015.

Mr White reported that the NHS Board was currently reporting an overspend outturn against budget of £4.4m. At this stage, however, the NHS Board forecast that a year-end break even outturn would be achieved but that there were significant risks underpinning this forecast.

He led the NHS Board through expenditure for the period as it related to Acute Services, Partnerships, Corporate Services and other budgets and capital.

Capital expenditure in the year to-date amounted to £6.9m and it was anticipated that a balanced year-end position would be achieved against the NHS Board's capital resource limit. At this point of the year, the NHS Board was behind in its year to-date cost savings target against plan.

NOTED

74. 2014/15 ANNUAL REVIEW: SELF ASSESSMENT AND "AT A GLANCE"

A report of the Head of Performance [Board Paper No 15/47] asked the NHS Board to note the 2014/15 Annual Review papers.

Ms Mullen explained that, as part of the Annual Review process, NHS Boards were required to produce a set of performance related papers to the Scottish Government in advance of the Annual Review taking place. Following approval from the Scottish Government, these papers were then made available to the public on the day of the Annual Review and used to illustrate key aspects of local performance.

Ms Mullen led the NHS Board through the draft Annual Review papers as submitted to the Scottish Government comprising the following:-

- An "At a Glance" handout consisting of two parts:- outcome indicators and performance against HEAT targets/standards.

- A copy of the Chairman's presentation slides on key achievements and challenges.

- A copy of the NHS Board's self assessment which included a short report on the action points agreed at the 2013/14 Annual Review and set out the NHS Board's main local achievements and challenges under the three national quality ambitions. She added that this paper would be made available on the NHSGGC website on the day of the Annual Review. Furthermore, each of these papers would also be used to inform most of the discussion at the private

NHS Board session.

In response to a question regarding the content and format of the Annual Review documents, Mr McLaws reported that these were set by the Scottish Government and that an edition of the Health News magazine would also be available at the Annual Review and had a more informal format for ease of reading.

NOTED

75. FREEDOM OF INFORMATION MONITORING REPORT FOR THE PERIOD 1 APRIL 2014 TO 31 MARCH 2015

A report of the Head of Board Administration [Board Paper No 15/48] asked the NHS Board to note the Annual Monitoring Report on the operation of the Freedom of Information (FOI) (Scotland) Act 2002 and the Environmental Information (Scotland) Regulations (EIR) 2004 within NHSGGC for the period 1April 2014 to 31 March 2015.

Mr Hamilton reported that the overall number of FOI/EIR requests received by NHSGGC during 2014/15 remained fairly static compared to requests in 2013/14.

Mr Hamilton led the NHS Board through the report which detailed, amongst other issues, the source of requests, the type of information requested, performance monitoring and requests for review. He highlighted that no decisions were required to be issued by the Scottish Information Commissioner during 2014/15 in relation to cases involving NHSGGC.

In response to a question from Rev Dr Shanks regarding the handling of FOIs/EIRs at IJB level, Mr Calderwood reported that work was ongoing with IJB colleagues to ensure that this function was undertaken at Health & Social Care Partnership level.

In response to a question from Mr Brown, Mr Calderwood agreed to discuss with the NHS Board's Director of Health Information & Technology the publication of an Annual Report on the NHS Board's information security. **Chief Executive Officer**

NOTED

76. ACUTE SERVICES COMMITTEE MINUTES: 30 JUNE 2015

The minutes of the Acute Services Committee meeting held on 30 June 2015 [ASC(M)15/01] were noted.

NOTED

77. AREA CLINICAL FORUM MINUTES: 4 JUNE 2015

The minutes of the Area Clinical Forum meeting held on 4 June 2015 [ACF(M)15/03] were noted.

NOTED

78. AUDIT COMMITTEE MINUTES: 16 JUNE 2015

The minutes of the Audit Committee meeting held on 16 June 2015 [A(M)15/03] were noted.

NOTED

79. ANY OTHER BUSINESS

Mr Robertson reported that this would be the last NHS Board meeting attended by the current Nurse Director, Rosslyn Crocket. Ms Crocket was retiring at the end of September 2015 after many years service to the NHS, nursing and midwifery as well as allied health professions. Mr Robertson thanked Ms Crocket for her insight and commitment to the nursing profession and the NHS Board and wished her well in her retirement.

NOTED

The meeting ended at 12:45pm.