

DRAFT

ASC(M)15/02
Minutes: 17 - 37

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Acute Services Committee held at
9.30am on Tuesday, 15 September 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 H Cameron
Mr R Finnie
Mr I Fraser (To Minute 29)
Mr D Sime
Dr D Lyons
Mr A Macleod
Ms R Micklem
Cllr M O'Donnell

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
Mr R Calderwood
Ms R Crocket MBE
Mr A O Robertson OBE, DSc, LLB
Mr M White

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

Mr G Archibald .. Chief Officer, Acute Services
Mr J C Hamilton .. Head of Board Administration
Mr D Loudon .. Director of Facilities & Capital Planning (To Minute 34)
Ms A MacPherson .. Director of Human Resources & Organisational Development
Ms T Mullen .. Head of Performance
Ms C Renfrew .. Director of Planning and Policy (To Minute 24)
Mr J Steen .. Audit Scotland

17. APOLOGIES, WELCOME AND PRELIMINARIES

The Convener welcomed Mr John Steen, Audit Scotland, to his first meeting of the Acute Services Committee.

There was discussion about the timing of the meeting and presentation of the agenda. It was agreed that future meetings of the Committee would commence at 9:00am and that, as well as the electronic version of the agenda and papers being submitted to Members seven days prior to the meeting, the same arrangement would be made for those who receive hard copies of these documents. Consideration would also be given to incorporating approximate times for each agenda item.

**Head of Board
Administration**

Apologies were intimated on behalf of Prof A Dominiczak OBE, Cllr M Cunning, Cllr J McIlwee, Cllr A Lafferty, Cllr M Macmillan and Cllr M Rooney.

18. DECLARATIONS OF INTEREST

There were no declarations of interest.

NOTED

19. MINUTES OF PREVIOUS MEETING

On the motion of Mr D Sime and seconded by Mr A Macleod, the Minutes of the Acute Services Committee meeting held on 30 June 2015 [ASC(M)15/01] were approved as a correct record, subject to deletion of the final two sentences in the 5th paragraph of Item 11, “Care Accreditation and Assurance System (CAAS)”, and insertion of the following two sentences in their place:-

“Ms Crocket advised that the Corporate Inequalities Team were reviewing the Standards to ensure that inequalities were integral and embedded in the Standards. She added that the Corporate Inequalities Team review of the Standards would be submitted to a future meeting of the Committee for information”.

Nurse Director

NOTED

20. MATTERS ARISING

a) Rolling Action List

(i) Royal Hospital for Children – Child Psychiatry Ward and Garden – In relation to Minute 8 – South Glasgow University Hospital Campus – On the Move/Completion, Dr Lyons asked for an update with regard to the risk assessments on the Child Psychiatry Ward and Garden and the reference within the Rolling Action List to a further meeting being held on this issue. Mr Loudon advised that he had met with the Chairman, Ms M Brown and Mari Branigan, Director of Nursing, Partnerships, earlier in the week to discuss the operational risk assessments and he would ensure that an updated copy was passed to Members as soon as possible. Ms Brown advised that Ms Brannigan had agreed to take over the lead for the risk assessments in this area and would scrutinise the work undertaken to date and would review/update as necessary. There would be three monthly updates which would include the usage of the roof garden, although it was noted that it had not been used to date. Ms Brown advised that, regrettably, in relation to the Adult Hospital, no further action was planned with regard to ligature points although risk assessments would be undertaken to allocate “at risk” patients to appropriate wards.

Dr Lyons intimated that he had been concerned that the roof garden was not being used and that the lack of action had been disappointing.

Mr Loudon agreed that the updated risk assessments would be made available to Members shortly and he would report back on progress to the next meeting of the Committee.

**Director of
Facilities &
Capital Planning**

(ii) Disaggregation of data to track inequalities gap – In relation to Minute 49 – Integrated Quality & Performance Report – of the Quality & Performance Committee meeting on 19 May 2015 – Ms Micklem asked for

an update on the disaggregation of data for different population groups in order to track any narrowing of the inequalities gap. Ms Mullen advised that she continued to work with Public Health and Corporate Inequalities Team colleagues, and whilst it was proving difficult to get robust data, she would prepare a progress report for information to the next meeting of the Committee.

**Head of
Performance**

(iii) Car Parking at Glasgow Royal Infirmary – In relation to Minute 54 – Car Parking at Glasgow Royal Infirmary – of the Quality & Performance Committee meeting of 19 May 2015 – Mr Loudon advised that initial meetings had been held with the Scottish Government Health Directorate (SGHD) following the submission made by the Board to seek discussions on whether capital funding could be made available to bring the car park back into the control of the NHS. A response was awaited however, it was clear that the SGHD capital programme was fully committed over the next two years with no likely slippages which may have assisted with this scheme.

NOTED

21. PATIENT'S STORY

Ms Rosslyn Crocket, Nurse Director read out a recent patient story from Inverclyde Royal Hospital which focused on the patient's assessment of their care and the outcome of the clinical care. The patient highlighted the excellent care they had received from all members of the clinical team which had respected their dignity and had felt completely personal to themselves. The patient's story highlighted the benefits of multi-disciplinary team working and the concept of person-centred care and this had been shared with other clinical teams across NHSGGC as highlighting an excellent example of the type of team working which can lead to high levels of satisfaction from patients.

Members welcomed the positive aspects of this patient's story and hoped it would resonate with other clinical teams in trying to achieve personalised and person-centred care.

NOTED

22. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT

There was submitted a paper [Paper No 15/12] by the Chief Officer, Acute Services setting out the integrated overview of NHSGGC Acute Services Division's performance. Of the 29 measures which had been assessed a performance status based on their variation from trajectory and/or target, 16 were assessed as green, six as amber (performance within 5% of trajectory) and seven as red (performance 5% outwith meeting trajectory). Exception reports had been provided for those measures which had been assessed as red and each one was discussed in turn as follows:-

(a) Suspicion of Cancer Referrals (62 days)

As at July 2015, 87.3% of patients with a suspicion of cancer started their treatment within 62 days of urgent referral, the target being 95%. There had been a slight increase in performance from the previous month,

however, the two main areas of pressure were urology cancers and head and neck cancers.

Mr Archibald described the staffing factors in relation to urological cancers and the highly specialist nature of some of the work undertaken, which no other centre in Scotland offered. Patients had been referred to England for their treatment and Mr Archibald advised that two new posts had been advertised as a long-term solution to the ongoing demand within this service.

In relation to head and neck cancer, again, Mr Archibald explained the staffing issues, particularly in relation to receiving no applicants following a recent advertisement for one of the consultant vacancies. A series of actions had been put in place to address the pressures and these were set out in the paper.

This was recognised as an important area for the NHS Board and Mr Archibald explained that he met Directors on a weekly basis, reviewing named patient lists to ensure there was a continued focus and attention on meeting this important target.

(b) Delayed Discharges

As at August 2015, 24 patients were delayed for over 14 days against a target of 0, and 16 patients were delayed for over 72 hours. This was an improvement on the 86 reported in August 2014 and, of the 24 patients delayed in August 2015. Twelve were residents of Glasgow, two from East Dunbartonshire, one from Renfrewshire and the remaining nine were delayed from outwith the NHS Board's area.

Ms Renfrew described the actions being taken to address the performance and highlighted a meeting the Board Chair was having at the end of the week with the Health & Social Care Partnership Chairs at which this issue and its impact on the wider Winter Planning arrangements would be discussed. The Chairs of South Lanarkshire and Argyll Health & Social Care Partnerships were also invited to attend this meeting.

Dr Lyons enquired as to why the 61 patients who had been delayed over 14 days for legal reasons, and who lacked capacity (adults with incapacity) had been excluded from these figures and that he had raised this matter at the Annual Review with the Cabinet Secretary for Health And Wellbeing and was keen that this point continued to be raised with Scottish Ministers. This point had been re-emphasised at a recent SGHD workshop and Ms Renfrew advised that the 61 patients were not occupying Acute Services beds but had been placed in nursing home care and that the geriatricians had now seen the benefits of this type of arrangement.

(c) MRSA/MSSA Bacterium (cases per 1,000 acute occupied bed days)

As at March 2015, the number of MRSA/MSSA cases per 1,000 acute occupied bed days was 0.26, which was higher than the target of 0.24. Dr Armstrong highlighted that 38% of hospital acquired SABs in the first quarter of 2015 were intravenous access device related. The two new standard operating procedures remained paramount in the continued need to reduce all bloodstream infections and not just those caused by SABs. She explained the ongoing work within the renal unit at Stobhill as this was

a recognised high-risk area and Ms Micklem advised that as part of the SPSP walkround she had attended recently at this unit, it was clear that the staff were aware of the extra scrutiny in that area. Dr Armstrong agreed to bring back further detail on this issue to the next meeting of the Committee.

Medical Director

Dr Armstrong indicated that she would check whether the figure of 44% of community cases which were attributed to people who used intravenous illicit drugs and would advise Members if this figure required to be corrected.

Medical Director

(d) Non-Elective Patient Activity

As at July 2015, the year to-date non-elective inpatient activity reported was 108,641, which represented a 9.5% upward variance from last year. Mr Archibald advised that this demonstrated a material growth in overall non-elective inpatient activity, most notably at Glasgow Royal Infirmary and Queen Elizabeth University Hospital (QEUE). The figures had accounted for a planned increase in activity at Glasgow Royal Infirmary due to the redesign of services and the diversion of some patients who had previously used the Western Infirmary together with new pathways at the QEUE leading to changes in how some patient activity was now recorded.

(e) Sickness Absence

There was a separate report submitted to the Committee for consideration on this matter.

(f) e-ksf/PDP Completions as at July 2015

e-ksf/PDP completion rate across the Acute Services Division was at 67.35% against a target of 80%. This was a decrease from the 70.91% recorded in May 2015 and the 76.29% reported in July 2014.

The difference was partly explained by the movement of the good performance by Facilities from the report and Ms MacPherson outlined the ongoing work on refresher training, review of named staff lists, monitoring, and the need for managers to continue to focus on this important area for staff.

Dr Cameron asked what work was undertaken to ensure the quality of e-ksf/PDPs and Ms MacPherson advised that an annual audit together with spot checks was undertaken which reviewed quality of e-ksf/PDP entries to the system and highlighted to managers where they were found to be unacceptable. She would provide a paper to the next meeting of the Committee covering the steps to improve performance in the completion rates of e-ksf/PDPs together with the quality assurance checks undertaken to ensure they are both relevant and helpful to staff.

**Director of
HR&OD**

(g) Percentage of Patients as “Did Not Attends” (DNAs) as Percentage of All Appointments Offered

As at July 2015, 12.4% of new patients did not attend as a percentage of all appointments offered against a target of 11.4%. The figure was 12.9% for the same period last year.

Mr Archibald explained that a series of actions had been put in place to

address the DNA rates including text message reminders within paediatric services, patient reminders (with approximately 1,200 reminder calls made to patients each day), patient communications (information leaflets with details of the appointment and the need to telephone if unable to attend together with the referring clinician outlining to the patient their responsibilities for keeping an appointment) and the referral template now included a question seeking information if the patient had additional needs.

In response to a question from Mr Fraser, Mr Archibald confirmed that one of the areas being targeted for improved performance was indeed within paediatrics, and in responding to Councillor O'Donnell's question, he advised that patients were able to seek a new appointment if their appointment date fell when they were on holiday; their wait time guarantee would not be affected.

Ms Micklem asked about the difficulties in using Trakcare for patient-focused booking and Mr Archibald agreed to discuss this with Mr Robin Wright, Director of Health & Information Technology, and provide a briefing note to Members on this issue.

**Chief Officer,
Acute Services**

Members welcomed the chance to concentrate on the areas where performance had been rated as red and the detailed discussions which had taken place against each topic. Dr Cameron understood the need to focus on the SGHD target, but enquired how the Committee would be able to scrutinise other clinical activity within Acute Services, for example healthcare scientists and allied health professionals. There was a series of service performance targets against which directorates and departmental teams were assessed and reviewed, however, not every aspect of clinical activity was measured. It was agreed that Ms Renfrew would discuss this further with Dr Cameron, and, if suitable, could form a future topic for an NHS Board Seminar in terms of describing the performance processes.

**Director of
Planning &
Policy /
Physiotherapy
Professional
Lead**

Dr Lyons was pleased to see the improvement highlighted in the papers in relation to the stroke bundle at the Royal Alexandra Hospital.

Mr Archibald asked if he could update Members on an ongoing issue in relation to the Institute of Neurosciences. Four of the seven theatres had been affected over the last month by an ingress of water and it had been necessary to prioritise emergency treatments for this period which in turn, had resulted in around a dozen patients having their waiting time guarantees breached. The theatres would be back in operation this week and all efforts would be made to prioritise those patients who had waited the longest.

NOTED

22(a) DETECT CANCER EARLY – EARLY DIAGNOSIS AND TREATMENT IN 1ST STAGE CANCER

There was submitted a paper [Paper No 15/13] by the Chief Officer, Acute Services setting out, at the Committee's request at the last meeting, an update on performance on the Detect Cancer Early Local Delivery Plan standard.

The Detect Cancer Early standard was based on three tumour types, namely, breast, colorectal and lung. As at July 2015, NHSGGC was diagnosing 26.6% of cancers at stage 1 against a local trajectory of 27.2% and the detail against each tumour type was set out within the table within the paper. Overall performance in relation

to “stage not known” presentations had decreased from 10% in 2010/11 to 5.4% in 2013/14. However, recent performance in the first quarter of 2015 highlighted that this figure had risen to 6.5%.

The Committee noted that the Regional Directorate team was working in conjunction with Cancer Audit to undertake specific analysis by quarter and cancer type, and fuller information would be provided to the Committee at a later date by Public Health.

**Interim Director
of Public Health**

NOTED

22(b) ATTENDANCE MANAGEMENT INTERVENTIONS AND ACTION PLAN

There was submitted a paper [Paper No 15/14] by the Director of Human Resources and Organisational Development providing the Committee with an update in relation to the performance management interventions with regard to achieving an improvement in staff attendance levels across the Acute Services Division. Members had requested a detailed paper on attendance management following the review which had indicated that as at June 2015, the rate of sickness absence was reported as 5.6% against a target of 4%. The rate for the same period last year had been 5.5%. Ms MacPherson explained that the same pattern of absences was apparent for both long term and short term absences.

Information was now available on reasons for staff absence by directorate and this highlighted that anxiety/stress was the top factor within each of the six directorates with musculoskeletal and gastrointestinal being the second and third most common factors in absences from work. It was appreciated that anxiety and stress was wide ranging and not always work related, and the focus for managers and human resources staff was to assist staff in getting back to work together with the proper and efficient use of the occupational health service.

Ms Brown was concerned at the level of anxiety/stress and outlined the model used within Local Authorities in referring such cases to Occupational Health. She also asked what consideration had been given to money advice services, bullying and harassment, and support for staff. Ms MacPherson explained that there was a step-by-step checklist/triage system to work through if staff presented with anxiety/stress. Money advice matters had been discussed with the Area Partnership Forum and it was likely that the outcomes from the i-matters survey would help managers concentrate on the issues and concerns expressed by staff to see if greater support could be provided in the areas of need.

Councillor O'Donnell asked if there were inconsistencies in the application of access to the work-life balance policies which could result in staff using sick leave instead. Ms MacPherson advised that this had possibly been the case in the past but there had been a greater level of consistent application of these policies by managers and their availability continued to be highlighted to managers to ensure appropriate access to such policies for planned and unplanned absences.

Ms MacPherson also highlighted the review which had been undertaken of the Employee Counselling Service and, through the work and support of a sub-group of the Area Partnership Forum, it had agreed to provide this in future as an in-house employee counselling service for staff hosted by the Occupational Health Department.

Members welcomed the detail and steps being taken in relation to absence

management and would continue to monitor this topic as part of the Integrated Performance Report.

NOTED

23. FINANCIAL MONITORING REPORT

There was submitted a paper [Paper No 15/26] by the Director of Finance setting out the financial position within the Acute Services Division for the four month period to 31 July 2015.

Expenditure within Acute Services was overspent by £4.4m when compared to the budget at 31 July 2014 and the overall position for the NHS Board for the same period was an overspend of £5.5m. The Board's projected funding for 2015/16 was currently £2,958.4m and it was planned to manage the anticipated cost pressures in order to deliver a break even outturn for the year end.

Mr White took Members through the paper in detail and highlighted that the main cost pressures rested in medical pay, where significant expenditure on agency and locum cover had been incurred in order to support increased clinical activity levels. As reported in an earlier agenda item, non-elective inpatient activity for the April-June 2015 period was well above the expected target level. The higher than anticipated activity levels were driven in part by waiting list initiatives and had led to temporary unscheduled care beds which had been open last winter, remaining open in order to provide additional capacity, resulting in an additional cost of £1.1m per month. Other pressures included nursing pay, surgical sundries and CSSD supplies - all largely driven largely by additional clinical activity.

One of the key components of the overspend had been the increased usage and cost of medical agency staff and for the first four months of 2015/16 this had represented an increase of 46% on the same period last year. This had related to the impact of activity, sickness/absence, capacity and transitional arrangements, and lastly, a general increase in the rates being charged by the agencies. There had also been an increase in the usage and cost of bank and agency staff for nursing, which had represented an increase of 13% on the same period last year.

Mr White advised that the majority of the £40.9m saving schemes was due to impact in the last half of the financial year and this explained the current under-recovery of savings within the Acute Services Division to date. Mr White advised that he intended to present a detailed review of the Financial Plan for 2015/16 at the October Away Session and it would include a range of scenarios and options in order to achieve the intended balanced outturn by 31 March 2016.

**Director of
Finance**

Mr Finnie noted the worrying trend within the first four months of the financial year and advised that the Chief Executive had warned the NHS Board of the possibility of this developing scenario. The annual significant saving target set for NHSGGC had made it more difficult without contemplating major service change or redesign. Without pursuing such options, the continued need to meet national and local targets would be a significant challenge for the NHS Board over the next two years and some hard decisions with possible reputational issues for the Board would have to be faced sooner rather than later.

Mr Calderwood intimated that he had asked for a forensic investigation of the true cost base in order that this could be fully discussed with Members at the Board's Away Day at the end of October. He was keen to understand how the double

running costs played into the financial plan; the impact of the new nursing workforce requirements, the impact on winter planning and the availability of beds, and review the projects and service redesign schemes which could contribute to savings being achieved in 2015/16 and the following year. Lastly, he was keen to review the Board's agency, locum and bank costs to get them down to more manageable levels. This work would all be undertaken prior to the October Away Day together with any other areas of improved efficiency.

Members welcomed the new format of presentation contained within the Financial Monitoring Report and agreed that this matter be further discussed in detail at the October Away Day.

Director of Finance

NOTED

24. NATIONAL PERSON-CENTRED HEALTH & CARE COLLABORATIVE: STRATEGIC REPORT AND WORK PLAN

There was submitted a report [Paper No 15/15] by the Nurse Director setting out the current position of the NHS Board's progress in implementing the National Collaborative for Person-Centred Health & Care for the Acute Services Division.

Ms Crocket highlighted that circa 95% of responses received from patients, relatives and carers were indicative of a positive care experience over the two month period of May and June 2015 within the Acute Services Division. 148 in-depth conversations with people using the services had been undertaken together with 5,624 responses/enquiries which had been collected during the themed conversations.

Ms Micklem highlighted the frequency of checking on patients which should be based on the needs of patients following a risk assessment, compared to the feedback from the patient experience which indicated that patients did not believe they had enough contact with clinical staff. Ms Crocket agreed to look further into the two different positions described, and discuss this further with Ms Micklem outwith the meeting.

Nurse Director

Dr Lyons intimated that he found it very helpful meeting with Ms Crocket and Mr Andy Crawford, Head of Clinical Governance, and it had given him a greater understanding of the work of the collaborative. He was keen to see if the sample size could be given when individual feedback was given and Ms Crocket agreed to include this in future reports. It was explained that the term "active care" was determined by the patient's care, patient's needs and social needs.

Nurse Director

NOTED

25. QUARTERLY REPORT ON CASES CONSIDERED BY THE SCOTTISH PUBLIC SERVICES OMBUDSMAN: 1 APRIL TO 30 JUNE 2015

There was submitted a report [Paper No 15/16] by the Nurse Director which set out the first Acute Services Report on the actions taken against the recommendations made by the Scottish Public Services Ombudsman in relation to investigative reports and decision letters issued in the period from 1 April to 30 June 2015. One investigative report had been issued together with 18 decision letters, resulting in a total of 27 recommendations.

Dr Lyons asked what the process was when the Ombudsman upheld an issue or complaint. Mr Archibald explained that it was shared with the relevant director and across the directorates together with the process where the Chief Executive wrote to the director asking for an assurance that a review was undertaken about the lessons learned from upheld decisions on SPSO reports/decision letters. Mr Lee asked about the circumstances of a particular report in relation to paediatrics and Dr Armstrong agreed to look into the detail of that case and report back to Mr Lee.

Medical Director

Ms Brown asked if a future NHS Board Seminar could incorporate the process and methodologies for undertaking significant clinical incidents and an investigation process which supported an SPSO report/decision letter. This was agreed.

Medical Director

NOTED

26. ACUTE INPATIENT NURSING WORKFORCE REVIEW 2015

The paper on the Adult Inpatient Nursing Workforce Review 2015 had, unfortunately, not been submitted to Members prior to the meeting and Ms Crocket apologised for this. A copy would be sent to Members immediately after the meeting. She agreed to discuss the content of the paper with Members and, clearly, the implication of implying a standard Nursing Workforce Model to adult inpatient wards within hospitals would be discussed at the NHS Board Members' Away Day in October in relation to the additional net costs of implementing this tool.

Ms Crocket advised that this was a mandatory national tool and the review covered the new QEUH and Royal Children's Hospital and followed on from the investment in Acute Nursing in September 2013 of £6.7m which delivered enhanced staffing in inpatient areas with particular emphasis on Emergency Care and Medical Services and Rehabilitation and Assessment. That investment increased the time available for supervisory duties for Senior Charge Nurse/Midwife from one day to two days per week.

Councillor O'Donnell asked if the Nursing Workforce Model reflected shift patterns and Ms Crocket advised that while not highlighted within the paper, there were 12 hour shifts within nursing. In relation to Mr McLeod's question about the timescale to comply with the outcome of the review, Ms Crocket advised that that was a decision for the Board however, bank staff were able to be used to cover the new model/rostering system. In relation to the impact of the single room layout within the new hospitals, Ms Crocket advised that there was no validated national tool for single rooms at this stage.

In relation to an e-rostering system, it was reported that Mr R Wright was discussing this with a key supplier in terms of their business model and how it could be applied to the Scottish health service.

It was agreed that, on receipt of the paper, this would be discussed at the October NHS Board's Away Day in relation to the financial plan for 2015/16 and beyond.

Nurse Director

NOTED

27. BRIEFING NOTE ON MIDWIVES LEGAL CHALLENGE

There was submitted a paper [Paper No 15/18] by the Nurse Director providing a background to the current situation regarding the high profile legal process involving two midwives who held conscientious objections to abortion, specifically in relation to the supervision and delegation of staff within the labour ward.

The position in relation to the legal processes was noted as was the current position with regards to the employment tribunal claims.

NOTED

28. OLDER PEOPLE IN ACUTE HOSPITALS (OPAH) HEI INSPECTION SUMMARY REPORT

There was submitted a paper [Paper No 15/19] by the Nurse Director updating Members on the Older People in Acute Hospitals Inspection of NHSGGC by Healthcare Improvement Scotland (HIS) and, in particular, the inspection carried out at the Vale of Leven Hospital on 23 and 24 June 2015.

The HEI inspectors received the NHS Board's self assessment prior to the visit and spoke to staff, used a formal observation tool as well as a mealtime observation tool, conducted patient interviews and used patient and carer questionnaires. The report identified six areas of strength and 12 areas for ongoing improvement, with no requirements/recommendations. An action plan was submitted to HEI on 12 August 2015.

Ms Brown was disappointed that the areas of nutrition, hydration and dementia continued to come up in all such reports and Ms Crocket advised that the implementation of the Care Accreditation and Assurance System (CAAS) would hopefully address such issues across all wards where it was implemented. Dr Lyons indicated that these issues continued to be raised across the Scottish health service and enquired as to whether delirium was a particular focus for the Acute Services Strategy. Dr Armstrong would review this and indicated, following discussions with clinical colleagues yesterday, that it had been agreed to appoint a lead for the Delirium Bundle.

Medical Director

An unannounced HEI had been undertaken to the QEUH and initial verbal feedback indicated that there would be areas for further improvement.

NOTED

29. CLINICAL SAFETY UPDATE

There was submitted a report [Paper No 15/20] by the Medical Director which provided the first Clinical Safety Update which incorporated the clinical risk management reports, Adult Acute Safety Programme, an indepth workstream review on patient falls, an indepth workstream review on tissue viability, SPSP Deteriorating Patients workstream, Health Improvement Scotland National Adverse Events Framework and the regular Fatal Accident Inquiries update.

The report had initially been presented and reviewed by the Acute Services Clinical Governance Forum and the Board Clinical Governance Forum. Key points in

relation to the Significant Clinical Incident (SCI) process were as follows:-

- The number of actions completed following SCIs increased with circa 20% incomplete at the three month monitoring period;
- The frequency of SCIs being investigated remained stable over the last 18 months but showed a longer term increase;
- The major factor in the increase was the investigations of SCIs with less severe patient outcomes indicating greater endeavours to learn from near-miss events;
- In 2014, in 88% of SCIs, learning was identified which would improve care;
- A cluster of SCIs related to the care of patients with brain injury and these were highlighted within the report;
- A review of factors was undertaken which may have led to delays in progressing the investigation of SCIs. This had arisen from concerns over problems in some areas where difficulties were experienced in completing the process within the intended three month timescale. This had seen a reduction in the number of SCIs over the three month period.

Dr Armstrong welcomed comments on the presentation of the information, appreciating the need to balance the possible presentation of too much detailed information against ensuring that the Acute Services Committee felt it received the appropriate assurance around clinical safety within NHSGGC.

Mr Finnie indicated that he found the presentation of information very helpful and would be keen to see whether the measures put in place across a range of initiatives had been effective in future reports. In relation to the tables provided, he found them helpful but could benefit from information on the total volume of activity for each.

Councillor O'Donnell enquired about the issue of aggressive behaviour/brain injury patients and how these were handled within clinical areas. Dr Armstrong described the specialist care arrangements, appropriate care settings and the use of medication when appropriate.

Ms Brown indicated that she felt it would be useful to see comparative data with other NHS Boards. In addition, she asked if it was possible to show any actions taken outwith the protocols/guidelines and if so, flag this in future reports.

Medical Director

Ms Micklem welcomed the information and the increase in reporting trends as she was keen to ensure there were no disincentives on staff in reporting incidents and near-misses.

NOTED

**30. BEATSON WEST OF SCOTLAND CANCER CENTRE (BWoSCC):
UPDATE POSITION**

There was submitted a report [Paper No 15/21] by the Medical Director and the Chief Officer, Acute Services on the clinical model to support deteriorating patients

at the Beatson West of Scotland Cancer Centre, including the newly opened High Acuity Unit. This paper highlighted the progress since the last meeting in June as follows:-

- Accelerated implementation of the documentation in ward B5 around early recognition of the deteriorating patient, with appropriate clinical response;
- The introduction of treatment escalation plans for deteriorating patients;
- The Hospital at Night enhancements with dedicated on-site anaesthetic support;
- Clear standard operating procedures for accessing advice from other specialities;
- Clear pathways for advice and, if required, transfer of patients needing additional levels of care or invasive monitoring to the QEUH with a retrieval team;
- Onsite facilities at the BWoSCC for enhanced care of the ill patient.

Dr Armstrong highlighted the patient activity up to 31 July 2015 and the increase in critical care outreach activity with the average contacts per patient increasing from 2.7 in June to 4.5 in July 2015. The temporary return of the Bone Marrow Transplant Unit to the BWoSCC from the QEUH had generated further demand for this service.

The staffing model and financial implications were noted and a formal review of the temporary measures would be undertaken in order to develop a plan for a sustainable service going forward. Discussions would continue to be held with clinical staff on the basis of maintaining patient safety as the key priority and it would be important to resolve the anaesthetic cover issue and the training experiences for junior doctors.

Medical Director

NOTED

31. HEALTHCARE ASSOCIATED INFECTION: EXCEPTION REPORT

There was submitted a paper [Paper No 15/22] by the Medical Director updating the Committee on the NHS Board's performance against HEAT and other healthcare association infection targets and performance measures. The most recent validated results for quarter one of 2015 confirmed a total of 102 SAB cases, this equating a rate of 27.1 cases per 100,000 acute occupied bed days. Early indications were that there was an increase between April and June 2015.

In relation to clostridium difficile, the validated results for the first quarter of 2015 confirmed a total of 87 cases for NHSGGC, this equating to a rate of 24.6 cases per 100,000 occupied bed days (OCBDs).

The paper also highlighted the completion rate of the infection prevention and control related training modules on LearnPro as well as the impact of the norovirus on wards and bed days lost.

NOTED

32. VALE OF LEVEN INQUIRY: UPDATE ON PROGRESS IN THE IMPLEMENTATION OF THE RECOMMENDATIONS

There was submitted a paper [Paper No 15/23] by the Medical Director and Nurse Director updating the Committee on the recommendations from the Vale of Leven Hospital Inquiry report. The National Implementation Group was in the process of developing a national plan with timescales and milestones to show progress against each recommendation by all NHS Boards. It was anticipated that the SGHD would issue their guidance during Autumn 2015 on how best to show the implementation of the report's recommendations.

The paper attached a template and gap analysis detailing progress within NHSGGC against each recommendation; ten of the recommendations required further guidance from SGHD and one required further guidance from the Crown Office/Procurator Fiscal Service. Of the remaining 64 recommendations, NHSGGC had fully implemented 47 and partially implemented 16, with good progress shown against those partially implemented. One recommendation was not applicable to NHSGGC.

A further update would be submitted to the Committee following the issue of further guidance from SGHD.

**Medical
Director/
Nurse Director**

NOTED

33. QUEEN ELIZABETH UNIVERSITY HOSPITAL CAMPUS DEVELOPMENT UPDATE

There was submitted a paper [Paper No 15/25] by the Director of Facilities and Capital Planning which updated members on the compensation events to date, commissioning of the new Adult and Children's Hospitals including the air quality issues within the Bone Marrow Transplant rooms in the Adult Hospital, and progress with the final multi-storey car park, demolitions, the ICE building and the Institute of Neurosciences entrance and overcladding.

Mr Loudon further explained the issue of air quality affecting the Bone Marrow Transplant rooms in relation to the use of suspended ceilings as opposed to a permanent ceiling and the contractors were now undertaking this work with a completion date of the end of October 2015.

Mr White highlighted the mechanism of funding in relation to the ICE building and the University of Glasgow.

NOTED

34. ACCESS POLICY

There was a verbal update by the Chief Officer, Acute Services indicating the process for the intended review of the Access Policy, in particular, in relation to a patient choosing to receive a service from a local hospital or named consultant. NHSGGC was keen to come into line with the rest of the Scottish health service. In exercising that choice, patients would defer their rights to the Waiting Time Guarantee.

Ms Micklem asked that the Equality Impact Assessment action plan be reviewed to ensure the policy was updated in relation to the points raised and further assessment be undertaken in relation to the changes proposed. Taking positive action to prioritise certain patients' access to services was raised but difficult to achieve under current arrangements.

**Chief Officer,
Acute Services**

Mr Archibald indicated that the revised policy, which clearly highlighted the key changes and implications, would be submitted to the NHS Board for consideration and approval.

**Chief Officer,
Acute Services**

NOTED

35. ACUTE STRATEGIC MANAGEMENT GROUP: MINUTES OF MEETINGS HELD ON 25 JUNE AND 23 JULY 2015

There was submitted a paper [Paper No 15/27] enclosing the Acute Strategic Management Minutes of meetings held on 25 June and 23 July 2015.

NOTED

36. MS ROSSLYN CROCKET – NURSE DIRECTOR

The Convener intimated that this would be the last meeting that Ms Rosslyn Crocket, Nurse Director, would be attending prior to her retiral at the end of the month. He wished to thank her for the contribution to the work of the Committee and her responsiveness to this and the former Quality & Performance Committee's scrutiny and questions, and wished her well for a healthy and happy retirement.

37. DATE OF NEXT MEETING

9.00am on Tuesday 17 November 2015 in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 1pm