NHSGG&C(M)15/06
Minutes: 80 - 99

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, 20 October 2015 at 9:30a.m.**

PRESENT

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

Dr J Armstrong	Councillor A Lafferty
Mrs S Brimelow OBE	Mr I Lee
Mr J Brown CBE	Dr D Lyons
Ms M Brown	Mrs T McAuley OBE
Mr R Calderwood	Dr M McGuire
Dr H Cameron	Mr A Macleod
Mr S Carr	Councillor J McIlwee
Councillor G Casey	Ms R Micklem
Councillor M Devlin	Councillor M O'Donnell
Professor A Dominiczak OBE	Rev Dr N Shanks
Mr I Fraser	Mr D Sime

Mr M White

IN ATTENDANCE

Mr G Archibald	Chief Officer, Acute Services Division
Dr E Crighton	Interim Director of Public Health
Ms S Gordon	Secretariat Manager
Mr N Ferguson	Head of Planning, South Sector/Women's & Children's Services (To Minute No 90)
Mr J C Hamilton	Head of Board Administration
Mr D Leese	Director, Renfrewshire HSCP
Mr A McLaws	Director of Corporate Communications
Mrs A MacPherson	Director of Human Resources & Organisational Development
Mr B Moore	Director, Inverclyde HSCP
Ms F Moss	Head of Health Improvement, Glasgow City HSCP (To Minute No 89)
Ms P Mullen	Head of Performance
Ms C Renfrew	Director of Planning & Policy

ACTION BY

80. WELCOME AND APOLOGIES

Mr Robertson welcomed Councillor G Casey from West Dunbartonshire Council (replacing Councillor M Rooney), Mr S Carr (replacing Mr K Winter) and Dr M McGuire, Director of Nursing (replacing Ms R Crocket) to their first NHS Board meeting.

Apologies for absence were intimated on behalf of Councillor M Cunning, Mr R Finnie, Councillor M Macmillan and Dr R Reid.

NOTED

81. DECLARATION(S) OF INTEREST(S)

Declarations of Interest – Dr D Lyons:-

- Agenda Item No 9 - "Back to Basics – Biennial Report on Population Health in NHSGGC 2015-2017"
- Agenda Item No 10 – "NHSGGC Approach to Financial Inclusion and Welfare Reform"

Member of Scotland Committee of the Equality and Human Rights Commission.

No other declaration(s) of interest were raised in relation to any of the agenda items to be discussed.

NOTED

82. CHAIR'S REPORT

(i) On 18 August 2015, Mr Robertson attended a meeting of NHSGGC's Disabled Staff Forum and its follow-up meeting on 7 October 2015. He also attended a meeting of the Glasgow Disability Alliance on 28 August 2015 looking at Glasgow's draft priorities for disabled people and how best to address the challenges and issues already raised.

(ii) On 25 August 2015, Mr Robertson attended the official opening by the Cabinet Secretary for Health, Wellbeing & Sport, of the new Shields Health and Care Centre. This was an award-winning, modern, purpose-built facility for the people of East Pollokshields and offered local people the ability to see a wide range of community services all under one roof. Also that day, Mr Robertson attended the topping out ceremony of the new Health and Social Care Centre in Maryhill. Work began on the state-of-the-art facility in December 2014 and was planned to be completed by Spring 2016.

(iii) On 26 August 2015, Mr Robertson attended a development day for the Chairs and Vice Chairs of the Health & Social Care Partnership Integrated Joint Boards. This event focussed on learning and leading together for health and social care integration and featured a range of themed workshop sessions which provided an interactive opportunity for colleagues to engage in rich and full conversations.

(iv) On 27 August 2015, Mr Robertson attended Inverclyde Royal Hospital to say a few words at the Volunteer Thank You event.

(v) On 1 September 2015, Mr Robertson met with facilities staff to agree art work to be commissioned for the entrance foyer at JB Russell House commemorating the pioneering work of NHSGGC and representing its history since 1948.

(vi) On 17 September 2015, Mr Robertson attended the annual NHSGGC Qualifications Awards Ceremony, recognising the achievement of staff members who had completed a vocational qualification in the last year. Mr Robertson presented the certificates and reflected on the positive uplifting occasion.

(vii) On 18 September 2015, Mr Robertson attended an event to mark the exciting milestone in NHSGGC's Modern Apprenticeship Programme as many of the first cohort completed their apprenticeships and moved into substantive posts and a second cohort of apprentices were welcomed into the organisation.

(viii) On 29 September 2015, Mr Robertson attended the official opening of the new Mother & Baby Unit at Leverndale Hospital.

(ix) On 30 September 2015, Mr Robertson attended an "Eliminating Crowding – A Commitment to Unscheduled Care" summit bringing together NHS Board Chief Executives, Chairs, Unscheduled Care Executive Leads and Leaders in healthcare to review current performance of the urgent and emergency care system.

(x) On 12 October 2015, Mr Robertson met with the Senior Director and volunteers of the Royal Voluntary Service (RVS). This gave him the opportunity to thank them for all their continued support across NHSGGC's hospitals and, in particular, for their donation of over £500,000 into the NHS over the last two years.

NOTED

83. CHIEF EXECUTIVE'S UPDATE

(i) On 25 August 2015, Mr Calderwood attended the Herald and the Scottish Government Joint Health Summit in the Teaching & Learning Centre at the Queen Elizabeth University Hospital.

(ii) On 27 August 2015, Mr Calderwood, along with Professor Dominiczak, launched SHARE, the Scottish Health Research Register at the Queen Elizabeth Teaching & Learning Centre. This was a collaboration between Universities and the NHS in Scotland, supported by NHS Research Scotland and funded by the Chief Scientist's Office of the Scottish Government. It invited everyone in Scotland aged 16 or over to sign up to the Register to let the NHS inform them about current research studies and to give permission for the use of any leftover blood from routine clinical tests for research to help medical science.

(iii) On 1 September 2015, Mr Calderwood visited the Eastwood Health & Social Care development.

(iv) On 10 September 2015, Mr Calderwood, accompanied by Mr Robertson, attended the Inspiring City Awards where NHSGGC and partners, University of Glasgow, had been honoured with the prestigious Overall Judges' Award. This was presented in recognition of the contribution to the wellbeing of Scotland's largest city over the past 12 months and the commitment to the learning and development of the people of Glasgow.

(v) On 8 and 9 October 2015, Mr Calderwood chaired the Institute of Health Management conference, held at the Beardmore Hotel.

(vi) On 14 October 2015, Mr Calderwood attended the British Construction Industry Awards ceremony as the Queen Elizabeth University Hospital was a contender for "The Prime Minister's Better Public Building Award".

Rev Dr Shanks asked for some further detail about the event held on 26 August 2015 looking at the learning and leading of the Health & Social Care Integration Programme. Mr Robertson confirmed that the Cabinet Secretary for Health, Wellbeing and Sport gave an address at the meeting and that NHSGGC was represented by several Chairs/Vice Chairs of the Health & Social Care Partnership Integrated Joint Boards (IJBs). Although the discussions were useful, it was apparent that, across Scotland, the IJBs were moving at different paces and at different stages so many varying points were raised.

Mr Robertson agreed to pursue the write-up of the event and circulate the key actions and points raised when this was received. **Chairman**

NOTED

84. MINUTES

On the motion of Rev Dr N Shanks, seconded by Ms R Micklem, the minutes of the NHS Board meeting held on Tuesday, 18 August 2015 [NHSGGC(M)15/05] were approved as an accurate record and signed by the Chair pending the following additions:-

- Minute No. 70 – "Implementing the Clinical Services Strategy: Changes for 2015/16: Drumchapel Hospital" add a ninth paragraph to say "Ms Renfrew referred to the change to continuing care as outlined in a recent Health Department Letter (HDL). This consulted on the movement of continuing care patients to private nursing homes and Ms Renfrew referred to NHSGGC's reflections on the proposals. She agreed to circulate a copy of the HDL". **Director of Planning and Policy**

- Minute No. 75 – "Freedom of Information Monitoring Report for the Period 1 April 2014 to 31 March 2015" add a sixth paragraph to say "Mrs McAuley recorded the excellent leadership and achievement in FOI/EIR performance".

NOTED

85. MATTERS ARISING FROM THE MINUTES

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

(ii) Ms Renfrew updated on Minute No. 71 (Glasgow City Integration Scheme: Update). Since the August 2015 NHS Board meeting, both Glasgow City Council and NHSGGC's Chief Executives had met with the Scottish Government and had agreed some flexibility to include the management of the services and associated links of delegation for the whole system responsibility for Specialist Children's Services. Both organisations' lawyers were working to agree a form of words and to get to a position where both parties could sign off the Integration Scheme.

Mrs McAuley welcomed this progress and Ms Renfrew agreed to pick up with the Director of East Dunbartonshire Health & Social Care Partnership any local ramifications there as a result of this situation. **Director of Planning and Policy**

(iii) Ms Brown asked for an update on work to complete the Children's Garden at the Royal Hospital for Children. Mr Robertson confirmed that he would ask the NHS Board's Director of Facilities to provide an update for NHS Board Members at the next Acute Services Committee meeting. **Director of Facilities & Capital Planning**

(iv) In respect of Minute No 64(ii), Mr Macleod asked about progress on implementing the recommendations from the Vale of Leven Inquiry Report. Dr Armstrong reported that this was discussed at the September 2015 Acute Services Committee meeting and she would ensure that an update was provided to the NHS Board at its December 2015 meeting. **Medical Director**

NOTED

86. SCOTTISH PATIENT SAFETY PROGRAMME (SPSP) UPDATE

A report of the NHS Board's Medical Director [Board Paper No 15/49] asked the NHS Board to note updates in three key areas (the developing national approach to the SPSP, SPSP for Mental Health and SPSP for Primary Care) in terms of current activity, key areas of progress and key issues to note. Dr Armstrong took each one in turn as follows:-

- SPSP Programme Approach – a conference was planned for 9 November 2015 which would bring together all of the SPSP programmes in a celebration of the fantastic work carried out in the improving safety programme. This would also allow delegates to learn from the experience of safety work across Scotland and beyond. The aim of the event was to bring together a community to share learning and help drive safer care across Scotland. NHSGGC was currently confirming staff to attend and building a storyboard of local work across all programmes to share with the rest of Scotland. Dr Armstrong reported that the timeline for the aims in the Adult Acute Programme were set to conclude in December 2015. There was also a shift in emphasis of care delivery given the integration of health and social care and this had prompted the SGHD and Healthcare Improvement Scotland (HIS) to initiate a review process prior to a major refresh of SPSP envisaged for 2016. Dr Armstrong expected that there would be a good opportunity to contribute to the review and would advise the NHS Board on the HIS consultative process when it was received.

- Update on SPSP for Mental Health – aimed to systematically reduce harm experienced by people receiving care from Mental Health Services in Scotland. The work was being delivered through a four year programme running from September 2012 to September 2016. In NHSGGC, there were currently 14 wards testing five workstreams. Each one now had an identified lead who attended the SPSP Mental Health Steering Group and Dr Armstrong led the NHS Board through a summary of the current position as it related to:-

  - Risk assessment and safety planning;
  - Communication at key transition;
  - Safe and effective medicines management;
  - Restraint and seclusion;
  - Leadership and culture.

  HIS advised recently that the Programme would be extending and future work would be taken forward with Children's Mental Health Services, Older People's Mental Health, Perinatal and Community Teams. The local Programme leads, however, were concerned that a shift in focus would dilute existing efforts prior to the work reaching a reasonable conclusion. The local plan was to maintain a focus on agreed local deliverables. On confirmation of these priorities, there would be a refresh of the testing and implementation for wards across Mental Health Services.

- Update on SPSP for Primary Care – its aim was to reduce the number of events which could cause avoidable harm from healthcare delivered in any Primary Care setting. Dr Armstrong summarised activity and progress in the following workstreams:-

  - Medicines reconciliation in GP Practices;
  - Pharmacy in Primary Care Collaborative;
  - High risk medicines;
  - Results handling;
  - Sepsis;

- Pressure ulcer care.

The range of activity within Primary Care reflected the desire to improve patient care through safe and effective practices and processes. A learning event was planned for the end of January 2016 which would provide an opportunity to bring all the workstreams together for shared learning. There were particular challenges with data recording for all the projects, however, the approach taken by the District Nursing Team using the "dashboard" may potentially provide a solution for other workstreams.

In response to a question from Rev Dr Shanks about HIS's intention to extend the SPSP for Mental Health, Dr Armstrong reiterated that the local plan was to maintain a focus on agreed local deliverables which currently were:-

- Full compliance with risk assessment bundle and evidence of improved and safer care as a result. Early indications suggested that there had been some confusion regarding clarity of data definitions which had been confirmed by visits to each ward and analysis of the data.
- Full compliance with the "as required" bundle with evidence of improved care and safety as a result.

She added that, on confirmation of these priorities, there would be a refresh of the testing and implementation plan for wards across Mental Health Services.

Dr Lyons welcomed all the good work taking place to meet the aspirations of SPSP but asked when outcomes of the Programmes would be available. Dr Armstrong confirmed that local wards had information on their outcomes since the implementation of the Programmes but that no agreed matrix had been settled on nationally to collate this.

In response to a question from Ms Micklem regarding the SGHD and HIS review of SPSP, Dr Armstrong agreed that one point of consideration should be in attempting to reduce the processes and paperwork involved in administering the workstreams. At a local level, work was being undertaken to look at whether an IT link could be made with the Care Assurance Accreditation Scheme (CAAS) systems but this was at a very early stage.

Mrs McAuley asked how SPSP processes were governed by the Health & Social Care Partnerships. Dr Armstrong confirmed that overall leadership was with the NHS Board but that locally, within the Partnerships, the Chief Officers and Clinical Directors took forward the governance. She added that there was a review ongoing of the GP contract in terms of their obligations.

NOTED

87. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No 15/50] 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

Councillor O'Donnell asked for a breakdown of the 3,290 members of staff who were now registered Cleanliness Champions. Dr Armstrong agreed to look at the spread and provide this for further reports. She explained that some staff were obliged to register (for example, those within high risk ward areas) and often others were as a result of focused resource in certain ward areas. **Medical Director**

NOTED

88. BACK TO BASICS – BIENNIAL REPORT ON POPULATION HEALTH IN NHSGGC 2015-2017

A report of the Interim Director of Public Health [Board Paper No 15/51] asked the NHS Board to note the draft report of the Director of Public Health and to support the recommendations for action for health behaviours.

Dr Crighton reported that this was the fifth Biennial Report of the Director of Public Health and thanked Dr de Caestecker for her contribution and insight prior to going on secondment earlier in the year. Covering the period 2015-2017, she explained that it drew on the findings of NHSGGC's Health and Wellbeing survey.

Dr Crighton explained that the report would be formally launched on 2 November 2015 with the intended audiences including NHSGGC, planners, policy makers, service providers and politicians. She explained that one fifth of Scotland's population lived in the NHSGGC area. It had grown steadily over recent years and was predicted to keep growing, albeit there were variations, for example, the population had risen in Glasgow City and the North West Sector but had fallen in Inverclyde and West Dunbartonshire.

NHSGGC was the most ethnically diverse area of Scotland with 7.5% of the NHSGGC population from a black and minority ethnic group. This ranged from 14.2% in the Glasgow South area to 1.4% in Inverclyde. Life expectancy was increasing in all areas but female life expectancy was still five years longer than male. There was a seven year age gap in life expectancy between the least affluent and most affluent Local Authority areas, this being 73 years in Glasgow City and 80.5 years in East Dunbartonshire. NHSGGC's population was ageing and dependency ratios were predicted to increase in all areas but with marked variations to over 70 in East Dunbartonshire compared to under 50 in Glasgow City. Furthermore, NHSGGC had a greater proportion of vulnerable groups compared to the rest of Scotland including those living in poverty, homeless, unemployed, carers, lone parents and those with long-term conditions. Vulnerability was not evenly distributed and Glasgow City supported a greater proportion of vulnerable groups than East Renfrewshire and East Dunbartonshire.

She led the NHS Board through an overview of population health indicators by Health and Social Care Partnership and summarised the results of the survey in the following key areas:-

- Indicators for perceptions of health and illness;
- Indicators for health behaviours;
- Indicators for social health;

- Indicators for social capital.

In terms of recommendations of action for health behaviours, Dr Crighton highlighted the following:-

- Increase recognition and awareness of the impact of obesity within the population and develop understanding and skills to enable individuals to increase or maintain physical activity levels, cook and eat a healthy diet and effectively self-manage their weight on a long term basis.

- Develop an effective targeting strategy for weight management services which addresses the needs of men in achieving a healthier weight and actively support young women who were more likely to become obese to lose weight at levels which would provide health gain. This strategy should be complimentary to a universal weight management service widely available in areas of deprivation.

- Increase the routine identification of individuals who were overweight within Primary and Secondary Care settings and provide appropriate services to support weight loss including the development of life skills to support longer term weight management. Current uptake of weight management services was lower than anticipated across NHSGGC.

- An upstream population approach with local and national partners was imperative to address the wider obesogenic environment. Both nationally and locally a more strategic and encompassing approach was required with partners to respond to the obesogenic environment; influencing the food and drink sector; retailers and caterers creating an exemplary position of public sector provision; improving food access in deprived local communities as well as creating an active physical environment supporting green space and active travel.

Many questions were asked of Dr Crighton and she clarified the following points:-

- The overview of population health indicators by HSCPs provided a good template for local action. It also provided an insight into outliers and it would be important for HSCPs to learn more about these within their specific areas as well as identifying what was going well in their locale.

- The indicators for social health gave a clear indication that working with local communities, recognising their needs and having localised action plans to address these was paramount.

- Much needed to happen at Partnership level to tackle these outcomes meaningfully and to support/challenge/identify with partners to look at better ways of delivering health improvement and health promotion work within NHSGGC. It would also be important for HSCPs to rethink the historical way of looking at population health indicators and to provide a platform for wider engagement with local communities as well as identifying with modern evidence going forward.

- The national funding formula and the current models of resource were explained and the linkages to establish the determinants of health recognised as well as the ongoing fact that NHSGGC had a greater utilisation of health services than the current model afforded. This restricted the way in which resources were allocated.

- Depression was recorded via two indicators, namely, self-reporting and admission rates to hospitals.

- Much of the local work would be taken forward at HSCP level and their associated local strategic planning processes but there was also an NHS Board imperative. In terms of a progress update, however, it would be important that the NHS Board was kept abreast of developments as well as local reporting to the HSCPs.

DECIDED

- That the draft report and launch plans of the Director of Public Health be noted.
- That the recommendations for action for health behaviours be supported.
- That a progress report be provided to the NHS Board (as well as the HSCPs) in six months time.

Interim Director of Public Health

89. NHSGGC APPROACH TO FINANICAL INCLUSION AND WELFARE REFORM

A report of the Interim Director of Public Health [Board Paper No 15/52] asked the NHS Board to receive an update on financial inclusion activity in NHSGGC and support the recommendations for action to maintain the role of NHSGGC in addressing financial inclusion for communities and patients moving forward.

Ms Moss briefed the NHS Board on current action to address poverty through financial inclusion work and sought support to maintain and develop this focus within the new organisational arrangements. She referred to the previous biennial report of the Director of Public Health that highlighted the pivotal importance of poverty in shaping health at key life stages in people's lives. Action was required to reduce the circumstances through which poverty was created, prevent people falling into poverty and mitigate the impact of poverty. She explained that financial inclusion contributed historically to mitigating poverty and, more recently, prevention through programmes such as Healthier, Wealthier Children.

Ms Moss led the NHS Board through progress made and outlined the challenges which faced NHSGGC as more people were affected by welfare reform changes. In NHSGGC, the main action was equipping staff to ask questions about money worries and creating referral routes to advice services. Staff were not expected to be experts on the benefits system but to recognise the impact of poverty on health. Given this, NHSGGC had a role in the work of financial inclusion and the impact of poverty and welfare reform was concentrated in areas with the highest requirement for (and contact with) health care. Furthermore, the Welfare Reform Act 2012 introduced the most significant transformation of the benefits system since its inception. These changes had a direct impact on the healthcare system, reducing the income of many who were already living in poverty yet further. The reforms were also changing the structure of the benefits system and introducing elements with which claimants were entirely unfamiliar. The consequence of the changes would be an increase in demand for advice and assistance from Local Authorities and other services including the voluntary sector.

Ms Moss explained that NHSGGC currently addressed financial inclusion as a strategic partner, as a service provider and as an employer. A Boardwide policy group currently operated, reporting to NHSGGC, the role of which was to identify the strategic direction for financial inclusion and welfare reform and provide support and leadership for implementation within respective entities.

Moving forward, NHSGGC activity was clearly described in line with the Health Scotland Inequalities Action Framework under three broad headings of "undo", "prevent" and "mitigate".

NHSGGC was making a real difference to patients and communities with wide ranging and effective action on financial inclusion, however, patients and staff were facing a range of negative financial impacts. To maintain momentum and progress NHSGGC's work on financial inclusion, Ms Moss asked the NHS Board to support a series of recommendations and further action to maintain progress within Acute hospital services as well as HSCPs.

There was broad support for the recommendations and NHS Board Members welcomed any extension of the work being undertaken in challenging poverty. It was broadly accepted that financial inclusion was just one action to address poverty but a whole range of actions needed to be addressed.

In response to a question, Ms Moss explained that interventions were currently targeted at those most affected by welfare reform (for example, lone parents, people with disabilities, people with mental health problems, people with alcohol and drug problems, asylum seekers and refugees, and homeless people), with community engagement a key feature of the approach. She agreed that it was paramount that the Partnerships and Acute Services learned from each other in terms of carrying out Equality Impact Assessments (EQIAs) and taking forward their associated recommendations. Rolling out best practice and lessons learned was hugely beneficial in taking this work forward.

The NHS Board supported consideration of a Board Champion on Poverty who could support a strategic approach to future action and Ms Moss agreed to define this role further and outline how it would link in with current Community Planning structures so that NHS Board Members could consider an appointment to this role. **Head of Health Improvement & Inequality**

Dr Lyons suggested an additional action in relation to mitigating the impact of welfare reform and finding out how it was affecting patients. Given that the NHS Board's population was hugely disadvantaged he considered it imperative to continue to lobby both Scotland and Westminster governments.

Ms Moss welcomed the support and agreed to take on board the general comments to move forward, particularly in relation to learning from other areas and sharing best practice. She explained, however, that as around 90% of the funding for financial inclusion was non-recurring, it remained a challenge to extend this work.

DECIDED

- That the update on financial inclusion activity in NHSGGC be received.
- That the recommendations for action to maintain the role of NHSGGC in addressing financial inclusion for communities and patients moving forward be supported. **Interim Director of Public Health**
- That the NHS Board's efforts to lobby Scotland and Westminster governments in respect of financial inclusion and welfare reform be continued. **" "**

90. UNSCHEDULED CARE PLANNING: WINTER PLAN 2016/2017

A report of the Director of Planning & Policy [Board Paper No 15/53] asked the NHS Board to note and comment on a plan for unscheduled care this winter as part of the process through which it would be finalised by the end of the month.

Ms Renfrew explained that she had reported to the August 2015 NHS Board meeting work in progress to develop NHSGGC's plan for this winter. She led the NHS Board through the draft plan for consideration and comment as part of the process through which it would be finalised by the end of the month.

The focus of the detailed planning was to deliver high quality patient care throughout the pressurised period of the winter and to meet the national targets to deliver care to 95% of accident and emergency attendees within four hours.

Ms Renfrew summarised the draft plan and reported that further discussion would take place at the NHS Board's Member Away Day on 29 October 2015. She, however, highlighted the following points:-

- NHSGGC had taken a whole system planning approach, therefore, included in the paper were the operational plans being developed by Partnerships and these were a critical element of the NHS Board's ability to deliver in Acute Services. As such, it was important that HSCPs were engaged with and scrutinised these plans.

- The final plan would include a detailed assessment of the resources required and Ms Renfrew summarised the current position and the additional funding received from the SGHD.

- Current performance challenges would be described further in a future NHS Board paper.

Ms Renfrew outlined the key areas of work-in-progress as follows:-

- Analysis of activity, capacity and demand challenges presenting at the new configuration of Acute Services.
- Improvement actions covering a wide range of changes.
- Stronger focus on clear indicators and linking to escalation.
- Elective capacity.

She also alluded to cross-NHS Board elements including up-to-date information on the vaccination programme and the activity led by the NHS Board's Corporate Communications Team to ensure a wide range of public information was available.

In response to a question, Ms Renfrew confirmed that, in light of the reconfiguration of Acute Services, NHSGGC had, in total, fewer beds available this winter than previously and, therefore, this year's plans were being developed within a significantly different context. New service models had been introduced for the management of GP urgent care referrals bypassing A&E into purpose designated assessment units. She agreed that the changes made the ability to forecast demand using historic trends more challenging but that the NHS Board now had approximately 20 weeks of experience upon which to build an understanding of the new patient flows both across the city and within the Queen Elizabeth University Hospital.

In response to a question from Councillor O'Donnell regarding a recent investment announcement made by the SGHD, Ms Renfrew explained that confirmation was still awaited on what NHSGGC's share of that would be going forward.

Mr J Brown asked for some further information to be made available at the Away Day on 29 October 2015 on staff attendance and attendance management particularly over the winter period. Ms Renfrew agreed to provide this. On this point, Mr Robertson encouraged all NHS Board Members to submit further questions or areas of interest that they wished greater detail on at the 29 October 2015 event, to him so that NHS Board Executive Officers could ensure it was provided on the day. **Director of Planning & Policy**

NOTED

91. REVALIDATION OF NURSES AND MIDWIVES

A report of the Nurse Director [Board Paper No 15/54] asked the NHS Board to note NHSGGC's position on nursing and midwifery revalidation and the key areas of work for the Steering Group.

Dr McGuire explained that the Nursing & Midwifery Council (NMC) made the decision on 8 October 2015 to introduce revalidation for all nurses and midwives in the UK with the first nurses and midwives progressing to revalidation on 1 April 2016. This meant that everyone on the NMC register would have to demonstrate, on a regular basis, that they were able to deliver care in a safe, effective and professional way. All nurses and midwives would have to show they were staying up-to-date in their practice and living the values of the NMC code by reflecting on their practice and engaging in discussions with colleagues. For the first time, they would also have to obtain confirmation that they had met all the requirements before they applied to renew their place on the register every three years.

In NHSGGC, a Revalidation Steering Group had been established to ensure that the NHS Board was prepared and ready for the new revalidation model. NHSGGC was working closely with the Scottish pilot site (NHS Tayside and partners), the SGHD and other NHS/non-NHS sites across Scotland. It had carried out a scoping exercise and had identified that there were 500 nurses and midwives due to revalidate between April and June 2016. Further work was being undertaken to develop a central programme for recording revalidation dates and revalidation compliance on all nurses and midwives employed in NHSGGC and to provide Acute and Partnerships with regular alerts/updates on nurses within their service approaching revalidation.

Dr McGuire reported that, on 10 August 2015, a Revalidation Awareness Event was held in the Queen Elizabeth University Hospital Teaching & Learning Centre with 370 nurses and midwives in attendance. This identified that nurses and midwives required support on building an e-portfolio and reflective practice. A toolkit of information was available on the NHSGGC Nursing Portal with links to the NMC and the NES Knowledge Network. Furthermore, materials developed during the NMC pilot and any good practice initiatives shared in the Scottish Revalidation Newsletter, were cascaded via the NHSGGC Steering Group and were posted on the Nursing Portal. Planning was also underway to provide support for nurses and midwives to prepare for revalidation and the NMC was providing NHS Boards with revalidation training in November 2015. 34 delegates would attend from NHSGGC and this would equip key staff within the NHS Board who would then cascade this knowledge back to local colleagues. Sectors and Partnerships would continue to roll out smaller events using a standard presentation which was available on the Nursing Portal. Nurses and midwives were being encouraged to discuss revalidation at all professional meetings.

In response to a question from Councillor O'Donnell regarding resource implications, Dr McGuire confirmed that she hoped this would be minimised but that the actual impact was unknown as the obligation to revalidate rested with the nurses and midwives themselves. She confirmed that NHSGGC was risk managing the issues as they arose as best it could.

NOTED

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

A report of the Head of Performance [Board Paper No 15/55] asked the NHS Board to note the content and format of the NHS Board's Integrated Performance Report.

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 accompanied 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.

Ms Mullen summarised performance and highlighted key performance status changes since the last report to the NHS Board including performance improvements, performance deterioration and measures rated as red.

In response to a question about delayed discharges and the increase in the number reported during the same period the previous year, Ms Renfrew reported that work continued to identify and address the issues causing delays. It was also hoped that the specific actions developed within the draft winter plans (discussed earlier) would support the reduction in delays. The revised scrutiny and escalation arrangements in place with Glasgow City Council continued to have an impact in that the number of patients delayed more than 14 days had reduced in August 2015 when compared to the same period the previous year. The aim was to achieve immediate and continued reductions in the number of patients delayed, given the pressures on hospital beds particularly as winter approached. On this point, Mr Calderwood went on to describe the new governance arrangements for HSCPs and the NHS Board, particularly around delayed discharges. Non-Executive NHS Board Members, in particular, were unclear of their position as Members of HSCPs on delayed discharge performance when it had such a knock on effect on overall Acute Division performance. Mr Calderwood agreed that this would be a useful topic to discuss further at the NHS Board Away Day on 29 October 2015. **Chief Executive**

Ms Micklem asked about the Scottish Government's Cancer Performance Support Team that had been established to monitor performance in real time and take action to obviate potential patients waiting longer than the 62 day standard. Mr Archibald reported that, in recognition of the impact that the patients currently waiting longer than 62 days would have on NHSGGC's ability to recover the 62 day position, an

additional non-recurring resource allocation would be made to alleviate a number of ongoing pressures in relation to urology, breast, colorectal, upper GI, head and neck and lung tumours. He was confident that this additional resource would restabilise the ability of NHSGGC to meet the 62 day standard by the end of the next quarter.

Mr Macleod referred to the rate of sickness absence across the NHS Board which was 5.3% and wondered what measures the NHS Board was taking to reduce this. Mrs MacPherson reported that further detail on this had been considered by the NHS Board's Acute Services Committee and each Directorate was working with managers to look at interventions to help address this. Staff side had been involved in specific pieces of work to help progress this. She also added that all staff were invited to participate in the flu immunisation clinics and managers were asked to encourage individuals to maintain their health and wellbeing by engaging in NHS Board initiatives to promote good health and to seek support from their line manager if they had any health issues which impacted on their ability to attend work.

In response to a question from Mrs McAuley concerning the gastroenterology position in Clyde, Mr Archibald explained that this had been impacted by short notice leave taken by a locum consultant. A number of booked patients had to be rescheduled and the service could not accommodate all patients within their guaranteed date. This had been further impacted by consultant sickness which also resulted in clinical cancellations and patient rescheduling. The sector continued to experience capacity pressures and was working to manage patients as effectively as possible.

Mr Calderwood reported that further discussion would take place on 29 October 2015 regarding the bridging finance and the non-recurring resources from the SGHD provided to meet unscheduled care targets. Funding from the SGHD had been ring-fenced for that very specific purpose. **Chief Executive**

NOTED

93. FINANCIAL MONITORING REPORT FOR THE 5 MONTH PERIOD TO 31 AUGUST 2015

A report of the Director of Finance [Board Paper No 15/56] asked the NHS Board to note the financial performance for the five month period to 31 August 2015.

Mr White reported that the NHS Board was currently reporting an overspend outturn against budget of £5.3m. 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 £11m 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.

In response to a question from Mr Lee, Mr White explained that expenditure on Acute Services remained £4.4m over budget at the end of month five.

The Acute Management Team was working on plans to contain these overspends and pressures and identify additional measures to achieve its target of break even by the year end albeit the identification of these provided a significant challenge. As a result, the NHS Board had released funding earmarked for winter earlier than planned in order to alleviate service pressures associated with beds that had remained open from winter 2014 in order to meet demand.

This action had mitigated an element of the current financial pressure but would reduce flexibility to deal with emerging pressures in the second half of the year.

NOTED

94. ENDOWMENTS STRATEGY UPDATE

A report of the Director of Finance [Board Paper No 15/57] updated the NHS Board on progress towards developing an overall strategy for the management of the NHS Board's Endowment Funds.

Mr White summarised the Endowments Management Committee Trustees responsibilities and high level strategy for endowments. He explained that the Trustees were responsible for preparing the Trustees Report and the Annual Accounts in accordance with applicable law and regulations. They were responsible for keeping adequate accounting records that were sufficient to show and explain the charity's transactions and disclose with reasonable accuracy, at any time the financial position of the charity, and enable them to ensure that the financial statements complied with the requirements of Regulation 8 of the Charities Accounts (Scotland) Regulations 2006. Furthermore, they were responsible for safeguarding the assets of the charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Mr White highlighted that the primary objective of the charity, as defined by the NHS (Scotland) Act 1978, was the advancement of health for the population of NHSGGC. The Act also said that Trustees should consider pursuing this through five key objectives and it was the practice of the Trustees to use the charity's resources to support projects and initiatives not normally funded by the health service where relevant to the NHS Board's objectives.

Mr White highlighted the following points:-

- Funds were currently invested by Blackrock, whose contract had been extended on two occasions without competition/tender and, in the interim, the Trustees had extended the Blackrock appointment until 31 March 2016. The Trustees had decided, however, to place this contract out to tender.

- It was agreed, in principle, that reducing the number of current endowment accounts would be beneficial. This process began in 2013/14 and had been successful. It was agreed to start by targeting dormant accounts and reviewing those which currently sat within hospitals which had recently closed.

- The Trustees decided, in relation to spending the capital element within the Endowment Funds, to "partial utilisation of capital, using the remainder of capital to generate a lower level of income, thereby supporting a mix of one-off and specific projects. This would be utilised for a particular project in the future which the Committee agreed required funding".

- Trustees agreed on a need for wider promotion of the access to endowment funds. A document would be placed on Staffnet to advise all NHS staff of the available funding with the objective of encouraging more and varied applications.

In response to a question from Ms Micklem regarding the tender process for fund investors, Mr White confirmed that a key criterion was ethical investment.

Mr Macleod referred to the welcomed promotional approach advising NHS staff of the existence of endowment funds and suggested that some further detail around the size of the fund (capital and revenue) might be useful for staff in considering an application to give them an idea of the scale of what was available. Mr White agreed to take this comment on board. **Director of Finance**

Ms Brown cross referred to the earlier discussion on the financial challenges for the Financial Inclusion Project and wondered if this was a source of revenue that could be utilised for that purpose?

NOTED

95. QUARTERLY REPORTS ON COMPLAINTS AND FEEDBACK: 1 APRIL TO 30 JUNE 2015

A report of the Nurse Director [Board Paper No 15/58] asked the NHS Board to note the quarterly report on complaints and feedback in NHSGGC for the period 1 April to 30 June 2015.

Dr McGuire led the NHS Board through the detail presented on complaints received and completed in the quarter, confirming that an overall complaints handling performance of 81.5% of complaints responded to within 20 working days had been achieved against a target of 70%.

She referred to the patient, carer and public feedback report which looked at feedback, comments and concerns received centrally and in local services and identified service improvements and ongoing developments. She noted the issues attracting most complaints in the Partnerships and the Acute Services Division which centred around clinical treatment and the attitude and behaviour of staff and touched on how NHSGGC was taking forward system learning from complaints and feedback as well as from recommendations made in the Scottish Public Services Ombudsman (SPSO) reports.

In response to a question from Councillor O'Donnell concerning prison complaints, Dr McGuire agreed it was important that these statistics were relayed within governance structures in prisons and community planning in the future. She also agreed, in future, to attempt to better describe prison complaints and break these down into categories rather than simply a total figure. **Nurse Director**

Mrs McAuley welcomed the report and its focus on looking, in more depth, at how complaints were handled, empowering staff on the front line to reach satisfactory resolutions. She also recorded the excellent achievement in response performance.

Ms Brimelow referred to "Universal Feedback" where a card was given to all inpatients on the day of their discharge from a ward or clinic. She noted that these cards were opened by the ward Senior Charge Nurse at the end of every month and

wondered if this might result in negative comments not being reported. Dr McGuire explained that the cards were scanned electronically to produce the ward's numerical "score" and a copy of all the comments as written by patients.

These were reviewed by a Patient Experience Public Involvement Officer before publishing.

NOTED

96. ACUTE SERVICES COMMITTEE MINUTES: 15 SEPTEMBER 2015

The minutes of the Acute Services Committee meeting held on 15 September 2015 [ASC(M)15/02] were noted.

NOTED

97. AREA CLINICAL FORUM MINUTES: 6 AUGUST 2015

The minutes of the Area Clinical Forum meeting held on 6 August 2015 [ACF(M)15/04] were noted.

NOTED

98. BOARD CLINICAL GOVERNANCE FORUM MINUTES: 8 JUNE AND 10 AUGUST 2015

The minutes of the Board Clinical Governance Forum meetings held on 8 June and 10 August 2015 [Board Paper 15/59] were noted.

NOTED

99. ANDREW O. ROBERTSON

Mr Lee reported that this would be the last NHS Board meeting attended by the Chair, Mr A O Robertson. His term of office was due to cease at the end of November 2015 and he paid tribute to his outstanding leadership throughout his tenure of eight years as NHSGGC's Chair. He had led the NHS Board in a fair and just way and his great strength was his ability to communicate with all staff, NHS Board Members, the SGHD, politicians, media and, most importantly, patients. He had been an effective and efficient NHS Board Chair with good humour and had been open and respectful in keeping the NHS Board business on track. He had been easy to approach at all times and would be greatly missed.

Mr Robertson, in turn, thanked Mr Lee for his kind words which he had taken warmly. He confirmed it had been a joy to work with the NHS Board and thanked NHS Board Members for their support in taking forward the many challenges faced and wished them well for the future.

The meeting ended at 12:55pm.