



**40. MINUTES OF PREVIOUS MEETING**

On the motion of Dr D Lyons and seconded by Dr H Cameron, the Minutes of the Acute Services Committee meeting held on 15 September 2015 [ASC(M)15/02] were approved as a correct record.

NOTED

**41. MATTERS ARISING**

a) Rolling Action List

Dr Lyons pointed out that there were a number intimated as “in progress” with November 2015 completion dates. He asked that each one be dealt with prior to the next meeting and that the Rolling Action List show the outcome or full explanation as to the actions being taken and timescale for completion.

**All Directors/  
Chief Officer**

NOTED

b) Ward 4 – National Child Psychiatric Inpatient Service, Royal Hospital for Children: Risk Assessment Report

In relation to Minute 20a(i) – Royal Hospital for Children – Child Psychiatry Ward and Garden – there was submitted a paper [Paper No 15/29] from Mr Stephen McLeod, Head of Specialist Children’s Services, providing an overview of the clinical risk activity within Ward 4, Royal Hospital for Children in relation to:-

- Risk assessment
- DATIX and RIDDOR summary
- Work completed and outstanding
- Children and families feedback

It was acknowledged that there were outstanding issues which were impacting on the running of the service and on the patients, parents/carers’ experience of the service and where those were impacting on health and safety these were being managed by increased nurse staffing levels within the ward.

In relation to the issues identified under the risk assessment, Mr Loudon advised that where the timescale had not been identified within the paper, the intention was to complete these, subject to the delivery of specific pieces of equipment, all by the date of the next meeting of the Committee. Mr McLeod intimated that the temporary introduction of a walkie talkie system was mitigating some of the identified risks.

Mr Fraser expressed concern that one year on from the Members’ visit to the ward, discussions and actions were still ongoing in relation to the concerns raised within the risk assessments. The fault lay with the specification, design and sign-off process and Dr Lyons reiterated his concerns that the separate entrance could be seen as increasing the stigma of young people with mental health issues. He queried why the facility was on the top floor and not signposted, and believed that the roof garden should not be brought into operation.

Ms Brown was worried that Members having pursued this for so long, that it was only now that an accredited risk assessment tool was being used to assess the risks. She endorsed the suspension of use of the roof garden and remained dissatisfied with the actions to identify and remove ligature points in the hospitals and that this should be reviewed further with a plan for removal.

Mr Calderwood acknowledged the continued concerns and explained the process undertaken to bring about an improvement to the former service when the moves to the new hospital were being planned, and that this had included clinical staff, user groups and children's panels. He highlighted the formal and informal feedback arrangements being utilised to date. He would ask Officers to look again at the use or otherwise of the roof garden and, in taking forward any plans in relation to ligature points, this should be a Board-wide review. Lastly, in relation to the signage to the fourth floor and information provided to reception staff, this would be reviewed in order to improve the signage and also the information available to reception staff as well as the arrangements for access out of hours.

**Chief Officer,  
Acute Services**

NOTED

#### **42. SCOTTISH PATIENT SAFETY PROGRAMME UPDATE**

There was submitted a paper [Paper No 15/38] by the Medical Director focusing on the aim of reducing hospital mortality in hospitals within the Acute Services Division.

With the service reconfiguration undertaken in spring/summer and moving to the new QEUH, future reporting for HSMR would cover the following:-

- (1) Inverclyde Royal Hospital;
- (2) Glasgow Royal Infirmary/Stobhill Hospital;
- (3) Royal Alexandra (RAH) /Vale of Leven Hospitals;
- (4) Queen Elizabeth University Hospital.

Mr Crawford reminded Members that the HSMR for the RAH/Vale of Leven Hospitals had been flagged as being relatively high in the quarter from January to March 2014 and this had led to a Healthcare Improvement Scotland (HIS) visit in order to gain an understanding of what factors might be underlying the upward trend and where improvements might be required. The HIS visiting team had indicated a sense of being encouraged by the approach and work being undertaken at the RAH and discussions covered the local action plan together with the additional measures undertaken with the medical staff, which, amongst other actions, included moving towards a review or screening process for all inpatient mortality at the RAH. HIS's formal communication to the Board indicated that it was satisfied that now was the right time to conclude their formal dialogue with the Board on this matter, recognising that the responsibility for monitoring and delivery of the action plan, and addressing any concerns, rests with NHSGGC's own clinical governance system.

Members noted the improved HSMR figures for the RAH/VOL hospitals in the most recently published data.

NOTED

**43. HEALTHCARE ASSOCIATED INFECTION: EXCEPTION REPORT**

There was submitted a paper [Paper No 15/40] by the Medical Director updating the Committee on the NHS Board's performance against HEAT and other Healthcare Associated Infection targets and performance measures. The most recently validated results for quarter two of 2015 (April to June) confirmed a total of 116 SAB cases, this equating to a rate of 33 cases per 100,000 acute occupied bed days. This was consistent with the NHS Scotland rate of 33 cases for the same quarter. Early indications from non-validated national data suggested that quarter three (covering July to September) has a similar outcome.

In relation to clostridium difficile, the validated results for the first quarter of 2015 confirmed a total of 107 cases, equating to a rate of 30.2 cases per 100,000 acute occupied bed days.

Professor Williams highlighted the steps taken in relation to the two actions which came out of the Committee's consideration of the report at the last meeting. In relation to the Renal Unit at Stobhill Hospital, performance had now returned to within normal parameters following the completion of an action plan which included additional theatre sections. In relation to the figures for Community in relation to people using IV illicit drugs, the percentage up to 46% SABs was being taken forward in discussions with the Public Health department.

Professor Williams highlighted the increased incidence of serratia marcescens in patients in the NICU at the Royal Hospital for Children. Weekly screening identified 13 patients, of whom 12 had been colonised and the organism was found on routine weekly screening specimens. Not all cases involved the same strain of the organism, and three different strains of the bacteria had been identified. An action plan had been developed and agreed with Health Protection Scotland and there had been no new cases since 26 October 2015.

Ms McNamee spoke about the increase in surgical site infections at the Queen Elizabeth University Hospital and Royal Alexandra Hospital orthopaedic departments. In relation to a question from the Convener, Ms McNamee advised that the bringing together of three different teams onto one site was still taking some time to come together in a single process of best practice and a consistent pathway for patients.

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

NOTED

**44. PATIENT'S STORY**

Dr Margaret McGuire, Nurse Director, read out a recent patient story from the Breast Cancer Unit which highlighted particular lessons in listening to the patient and taking on board their insights, evidence and thoughts on their care. Getting the balance right was important, and additionally, ensuring the provision of as much relevant information as possible to those patients who may not have access to evidence in relation to their own diagnosis/condition.

NOTED**45. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT**

There was submitted a paper [Paper No 15/30] 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 Mr Archibald took Members through each one in turn.

In particular, Mr Archibald highlighted the actions being taken in relation to the cancer wait times (62 day and 31 day standards), particularly in relation to urology, head & neck, and breast cancers, with an additional non-recurring resource allocation being made available to alleviate a number of ongoing pressures in these areas.

Ms Renfrew highlighted that whilst delayed discharge rates had been improving, there had been a slight increase again and discussions were ongoing with the City Council in order to seek further improved performance, and Members of Integrated Joint Boards would bring about local scrutiny of the figures at their IJB Board meetings.

In relation to the sickness absence report, Ms MacPherson highlighted the issues discussed at the last meeting of the Committee, and advised that the Resolve absence tool would be used across the NHS Board and she reported that the support teams were now in place to provide specialist advice and support to managers when managing absence within their areas. In addition, a transition advisor was also available to support discussions with staff on long term absences and staff side were engaged with this process. It was recognised that stress was a particular concern, and the stress action plan was being refreshed and made available to managers.

NOTED**(a) DISAGGREGATE DATA FOR A RANGE OF POPULATION GROUPS TO TRACK A NARROWING OF THE INEQUALITIES GAP**

There was submitted a paper [Paper No 15/31] by the Director of Planning and Policy which outlined the progress made to date in providing an overview of performance against measures with disaggregated data currently reflected within the Acute Services Integrated report alongside proposals to further disaggregate data in relation to other existing measures.

The integrated performance report currently contained performance measures where disaggregated data was used to track a narrowing of the inequalities gap. These measures comprised antenatal care (SIMD) and new outpatient Do Not Attends (sex and SIMD). In addition, 38 Equality Impact Assessments (EQIAs) had been carried out from April 2013 to 2015, in 2015/16 the focus of the EQIA programme was on the quality rather than the quantity. A total of 26 new EQIAs were planned in 2015/16 together with the 6-12 month review date of EQIA action plans.

Ms Micklem noted the start made and commented that although two targets were shown in relation to the measurement for inequalities, she had hoped more might have been identified for now and the future. New equality outcomes would be identified from April 2016 however, she was hoping that the existing ones which were possibly coming to an end could have been highlighted and measured showing the progress/outcome to date. She would welcome the Equalities Team highlighting those measures that they believe should be prioritised for the forthcoming years.

Ms Brown felt that the public health report would assist with this work, particularly in relation to age-specific death rates and how resources were allocated within NHSGGC.

Ms Renfrew indicated that this was only one piece of work within Acute Services, and it did not present a full picture of everything that was undertaken within the Equalities agenda. The Equality Annual Report would be submitted to the December NHS Board for consideration and this would cover the full range of work undertaken, although it did remain a challenge to disaggregate data in a meaningful way. She would ensure however, the paper to the Board in December would set out priorities for the future for the NHS Board and the IJBs.

**Director of  
Planning &  
Policy**

NOTED

**(b) KSF ACTIVITY**

There was a paper [Paper No 15/32] submitted by the Director of Human Resources and Organisational Development setting out, at the Committee's request from the last meeting, the position within Acute Services in meeting the compliance and quality of local activity associated with the e-Knowledge Skills Framework (e-KSF).

The target was 80% compliance and the latest monthly figures indicated a compliance rate of 67.2% (which was down from the same period last year).

The paper set out the progress and actions taken to improve compliance including the assignment of the correct manager on e-KSF following the hospital moves to the Queen Elizabeth University Hospital over the last few months; a focus on KSF compliance was part of the regular monitoring process to managers; advice, training and support to managers to be provided by the Learning & e-Support Team, KSF Staff Side Advisor, KSF Leads, Learning & Education Advisors and website resources. In relation to improving the quality of the KSFs and Performance Development Plans (PDPs), audits would be carried out to review the quality and to inform further actions to make improvements.

In addition, a series of roadshows to promote new resources and support would be held together with a series of drop in sessions and Ms MacPherson advised that a national review was underway with the key priority to make the web-based resource more user friendly and intuitive.

In relation to a question from Dr Cameron, Ms MacPherson agreed to share the outcomes of the audits with the Committee.

**Director of HR  
& OD**

NOTED

**(c) UNSCHEDULED CARE PLANNING: WINTER PLAN 2016/17**

There was submitted a paper [Paper No 15/33] by the Chief Officer, Acute Services and Director of Planning & Policy attaching the final Winter Plan for approval by the Committee. The focus of the detailed planning had been to deliver high quality patient care throughout the pressurised period of winter and to make the national target to deliver care to 95% of Accident & Emergency attenders within four hours. The plan had been developed through a detailed review process within Acute Services Division and the Partnerships and the collective consideration by the Board Chief Executive, Chief Officers and Directors. Acute, Community, Primary Care and Social Services were interdependent and needed to operate as a coherent system to achieve the objective to deliver high quality patient care throughout the winter. The paper highlighted that additional funding of £7.1m had been made available from the Scottish Government in relation to delayed discharges which had been provided direct to the Partnerships, and £1.67m for the Six Essential Actions programme and this money had already been committed as required. In addition, a further £1.8m had been added to the Board Financial Plan to the already committed £4.5m of non-recurring winter funding.

Following the redesign of Acute Services, fewer beds would be available this winter than previously, and the Scottish Government had already agreed £5m additional funding to enable the new ways of working across the Acute Services Division to become embedded throughout the first six months of 2015. The additional funding underpinned baseline activity and capacity relevant to achieving the government's waiting time targets.

In addition, the paper provided an overview setting out the latest key performance indicators in relation to meeting the four hour A&E waiting time target. The overall weekly performance for the six week period from 4 October to 8 November 2015 ranged from 92 to 94% with the number of attendances varying between 6,447 and 6,905. Admissions ranged from 1,909 to 2,038 per week and the paper highlighted the actions which continued to be taken in order to meet the four hour A&E waiting time target. The most recent figures for the last completed week indicated that the Queen Elizabeth University Hospital was at 94.3% and the overall Board performance was at 94.8%.

Councillor Macmillan asked about the discussions with the Scottish Government and the availability of resources for winter planning and Mr Calderwood advised that monthly discussions were held with Scottish NHS Board Chief Executives and Scottish Government officials, and the NHS Board Chairs also had monthly meetings with officials and the Cabinet Secretary and a regular feature of these meetings was resources and wait times targets.

From April 2016, the Integrated Joint Boards would have responsibility for strategic planning in relation to unscheduled care and these would be important discussions/considerations for the IJBs in relation to planning unscheduled care and planning for the winter pressures. Mr Archibald and Ms Renfrew offered to provide specific and detailed information to local IJBs in relation to the services within their areas and where their population accessed services and would attend meetings to discuss these matters if it was helpful. Different IJBs would approach these matters in different ways and the role of Non-Executive Members at the discussions would be important in shaping the outcomes.

**Chief Officer,  
Acute Services/  
Director of  
Planning &  
Policy**

NOTED

**46. QUEEN ELIZABETH UNIVERSITY HOSPITAL – IMMEDIATE ASSESSMENT UNIT (IAU) UPDATE**

Mr Archibald and Mr George Welch, Chief of Medicine, South Sector, Acute Services, provided Members with a verbal update on the issues relating to the IAU at the QEUH following media reports of the death of an elderly person who had waited over eight hours for a medical review. Mr Welch provided the details associated with this case. He highlighted that it had been a particularly busy Monday evening with attendances at the Accident & Emergency department 11% up from the eleven week average and there had been a 15% increase in attendances at the IAU, with pressures on beds such that the ability to discharge to a bed had been 16% down. A significant clinical incident review was underway and the Procurator Fiscal had been advised of the death.

The IAU had been set up to receive referrals from GPs and to date, the number being referred in was higher than expected/planned and as this had now been sustained over a period of time, additional space was being identified within the IAU, there would be a realignment of critical care staffing, a review of junior doctor staffing and how the patient flows were handled.

The purpose of the IAU retained clinical support, however, the demand had been much greater than expected, and steps were being taken to retain the model but in a more workable and acceptable way for the staff.

Councillor Macmillan asked what timescale was proposed for dealing with the additional capacity in a way that the IAU model was seen to be working. Mr Archibald advised that it would be a challenge, but part of that challenge was also assisting patients in getting the most appropriate care and treatment in relation to their needs, and that was not always within a hospital setting. A GP telephone triage and hot clinic appointments (appointments on the same day) would be considered, and a more joined-up and aligned process would assist in achieving a better experience and outcome for patients. Mr Calderwood intimated that the Royal Alexandra Hospital pilot worked well and was successful, however, the additional resources this attracted had assisted in meeting the increased attendances. The Queen Elizabeth University Hospital still needed time to settle into new ways of working with the coming together of different teams. The bringing together of three Adult Acute hospitals which were not meeting the A&E waiting time targets was always going to be a major challenge for the new hospital to turn this performance around into a sustained high performing unit. All indications were that the elective elements of the patient experience were good but he and his fellow Directors recognised the test that lay ahead in relation to the winter pressures from now until Easter.

Ms Micklem wondered if introducing further stages of triage brought the risk of potentially missing the deteriorating patient. It was reported that the triage tool to be used was designed to be specifically sensitive to patients' needs and recognise the risk factors in listening to patients' descriptions of their symptoms.

Ms Brown intimated that the whole system approach was critical to this and that IJB members needed to be focused on unscheduled care and all parts of winter planning. She appreciated the clinical staff being keen to retain the IAU model however, recognising that clinical leadership was important, the NHS Board needed to also provide reassurance to some of those staff who remained disaffected. She mentioned that she and a few other Board Members had felt that they should have received earlier notification of the circumstances surrounding the death of the

**Director of  
Corporate  
Communications**

elderly patient within the IAU and she asked that this be reviewed and considered for future occasions.

Dr Lyons highlighted the anticipatory care issue for IJBs and welcomed the possible ambulatory care options for patients attending the IAU. However, he did not believe it was coincidental that the incident discussed occurred on a Monday evening. There were higher levels of attendance on Monday evenings and this needed to be planned and catered for going forward. Mr Calderwood acknowledged this point and that the expansion of the space made available to the IAU was one of the key actions in recognising the increased activity on a Monday night. Mr Archibald indicated that discussions were ongoing with the broader clinical body about the flow from the IAU, A&E, Acute Receiving and GPs, and it was important to get this aspect of the new hospital working in a way which gave greater confidence to patients and others.

It was agreed that a further update on the operation of the IAU would be submitted to the January meeting of the Committee.

**Chief Officer,  
Acute Services**

NOTED

**47. FINANCIAL MONITORING REPORT FOR THE 7 MONTH PERIOD TO 31 OCTOBER 2015**

The Director of Finance provided a presentation to Members on the financial position within the Acute Services Division for the seven month period to 31 October 2015. Expenditure within Acute Services was overspent by £6.6m and this was the same figure for the overall NHS Board overspend. Mr White highlighted that the variance to date within the South and North Sectors was £7.7m and the primary reasons were associated with the medical staffing and nursing staffing budget overspends.

The higher levels of activity were a factor, however, it was also recognised that the higher sickness rates of staff were resulting in additional costs for locums, bank and agency staff, particularly for Glasgow Royal Infirmary and the Queen Elizabeth University Hospital.

Mr Fraser raised his concern at the high levels of overexpenditure within the South Sector and the fact that it would now need to deliver a saving of £1m per month to achieve break even. He asked if it would be possible to over-recruit numbers of staff in anticipation of vacancies and reduce the need to use bank and agency staff. Dr McGuire advised that this was already underway, especially when recruiting qualified nurses, however, the recruitment in some specialist areas was for the first time now more difficult than previously. The national workforce tool was being rerun across seven wards in order to determine the correct staffing, acuity of patients and necessary observations, and she observed that 12 hour shift absences were challenging when trying to obtain cover from bank staff.

Mr Calderwood indicated that the target was to bring an end to the £1m per month overspend, however, it remained a major challenge to deal with the cumulative overspend in a recurring way. Therefore, there would be a review of the opening budgets, the use of non-recurring funds, and a look at discretionary spends to see whether some elements could be deferred until a later date. A number of short term arrangements had to be put in place in relation to the QEUH i.e. anaesthetic cover for the Beatson West of Scotland Cancer Centre, bone marrow transplant and resolving these in a more substantive way would assist. There was also a concern

that additional funding was provided to the Glasgow Royal Infirmary however, the level of sickness absence, while remaining consistent, was now proving more costly to backfill and a further review of that whole area would be required over the coming weeks.

In relation to the Convener's question about the timing and further discussions, Mr Archibald intimated that there would be an opportunity for further discussion at the NHS Board Seminar on 1 December 2015, the planned Away Day on 22 December, and at the next Acute Services Committee meeting on 19 January 2016.

**Chief Officer,  
Acute Services**

NOTED

**48. PERSON-CENTRED HEALTH & CARE PROGRAMME: STRATEGIC REPORT AND WORK PLAN**

There was submitted a report [Paper No 15/36] by the Nurse Director setting out the current position on the NHS Board's progress in implementing the Person-Centred Health & Care Programme. Dr McGuire drew attention to the number of prominent reporting requirements made available to the NHS Board and its Standing Committees in relation to different strands of Person-Centred Care. She advised that it was her wish to bring forward proposals on reporting to Members in a way which fully reflected the scope of feedback on patient experience, the various improvement programmes, the priority of care experience within the strategic commitment to quality, and using the information gained from complaints, feedback, comments and concerns. Members welcomed this intention and recognised that the new way of reporting would occur over the coming months.

**Nurse Director**

The Person-Centred Health & Care Programme reported:-

- 1) 94% of responses received from patients, relatives and carers within the Acute Services Division were indicative of a positive care experience over the three month reporting period.
- 2) 196 in-depth conversations with people had been undertaken and 7,448 responses had been gathered in relation to the themed conversations.
- 3) Recent months had shown an improvement in patients' views of the mealtime experience.
- 4) A further review of the clinical teams currently being supported by the Person-Centred Health & Care Programme had been undertaken and that the coaching and mentoring support provided to date would now be concentrated on a new cohort of clinical teams in future.

NOTED

**49. QUARTERLY REPORT ON CASES CONSIDERED BY THE SCOTTISH PUBLIC SERVICES OMBUDSMAN: 1 JULY TO 30 SEPTEMBER 2015**

There was submitted a report [Paper No 15/37] by the Nurse Director which set out the 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 July to 30 September 2015. Three investigative reports had been issued together with 23 decision letters. Dr

McGuire, in highlighting key points from the report, advised Members that elements of offering patients and complainants an apology was still not consistently and systematically happening, and the benefit of an apology being offered in the very early stages needed to be reinforced with frontline staff.

Ms Brown highlighted the issues drawn out from the investigative report in relation to the Community Midwife Unit at the Vale of Leven Hospital. The clinical safety of the Unit again required to be considered and Mr Calderwood intimated that this continued to be discussed with the Scottish Government Health Directorate. The Medical Director and Nurse Director were considering the issue and hoped to submit a paper to a future meeting of the Committee for review and consideration. It would need to show what was different from the previous submissions and be evidence based.

**Medical  
Director/  
Nurse Director**

Councillor Lafferty asked about legal claims as a result of an SPSO report and whilst it was acknowledged this was possible and did happen, the numbers were very low.

NOTED

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

There was submitted a report [Paper No 15/39] by the Chief Officer, Acute Services and the Medical Director which attached the Healthcare Improvement Scotland (HIS) report on its findings on a recent Inquiry Visit to the Beatson West of Scotland Cancer Centre (BWoSCC). Concerns had been raised by medical staff in relation to clinical support for the continuing activity and case mix managed within the oncology and blood cancer services.

The HIS Inquiry Team has asked NHSGGC to carefully consider the four recommendations and prepare an improvement plan to address these by April 2016.

The paper advised that meetings had been arranged with the medical consultant staff from the BWoSCC on 25 November, and with the wider medical staff including critical care, anaesthetics and physician/consultant colleagues on 30 November. It was important to move forward jointly in a constructive way with the medical staff at the Beatson and it was hoped that this could be achieved in taking forward the recommendations in a positive and supportive way.

Ms Brown indicated that the report had been interesting reading and she felt it was critically important that management worked with all clinicians in a facilitative and supportive way in order to ensure a trusting environment for both parties. Dr Cameron indicated that, while it was important to ensure appropriate engagement with the medical staff, it was equally important to engage with the wider clinical staffing, not just in the Beatson but within NHSGGC. Clinical teams were made up of much more than just medical staff, and working with all relevant clinical colleagues would be essential in achieving good relationships and outcomes.

In relation to the recommendation about the Area Clinical Forum, Mr Calderwood indicated that he had discussed this with Dr Armstrong, and it would be important to give further consideration as to how best the Senior Management Team engaged with the Area Clinical Forum and the professional advisory structure. The review to be undertaken would be shared with the Area Clinical Forum for its comments and views before being finalised and submitted to HIS.

**Head of Board  
Administration**

NOTED

**51. SURGICAL REDESIGN: VALE OF LEVEN HOSPITAL**

There was submitted a report [Paper No 15/41] by the Director of Planning & Policy asking the Committee to approve the proposal to re-provide Ward 6 activity in the Surgical Day Bed Unit for day cases and Lomond Ward for inpatients.

The Clyde Sector Management Team, in reviewing services and activity across Clyde, was aware that there was insufficient surgical activity on the Vale of Leven hospital site to justify the retention of both Ward 6 and the Surgical Day Bed Unit. To re-provide the activity on Ward 6 within the Surgical Day Bed Unit, the Unit would require to extend its opening hours. Patients requiring an inpatient stay would continue to have their care provided in the Lomond Ward and therefore the proposed redesign would have no impact on the surgical activity which was currently carried out within the Vale of Leven hospital.

From a workforce perspective, there was the opportunity to accommodate the majority of the staffing team on the site through internal redeployment while releasing savings which could be used and reinvested to support capacity elsewhere within the Clyde Sector.

DECIDED

- That, the proposal to re-provide Ward 6 activity within the Surgical Day Bed Unit for day cases, and Lomond Ward for inpatients, on the Vale of Leven hospital site, be approved.

**52. ACUTE STRATEGIC MANAGEMENT GROUP: MINUTES OF MEETINGS HELD ON 27 AUGUST AND 24 SEPTEMBER 2015**

There was submitted a paper [Paper No 15/42] enclosing the Acute Strategic Management Minutes of meetings held on 27 August and 24 September 2015.

NOTED

**53. DATE OF NEXT MEETING**

9.00am on Tuesday 19 January 2016 in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 12:10pm