

NHSGG&C(M)15/07

Minutes: 100 - 122

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, 15 December 2015 at 9:30a.m.**

PRESENT

Mr J Brown CBE (in the Chair)

Dr J Armstrong	Councillor M Kerr
Mrs S Brimelow OBE	Councillor A Lafferty
Ms M Brown	Mr I Lee
Mr R Calderwood	Dr D Lyons
Dr H Cameron	Dr M McGuire
Mr S Carr	Mr A Macleod
Councillor G Casey	Councillor M Macmillan
Professor A Dominiczak OBE	Ms R Micklem
Mr R Finnie	Dr R Reid
Mr I Fraser	Rev Dr N Shanks
	Mr M White

IN ATTENDANCE

Mr G Archibald	Chief Officer, Acute Services Division
Ms R Campbell	Health Improvement Lead (Tobacco) [For Minute 109]
Dr E Crighton	Interim Director of Public Health
Mr A Curran	Head of Capital Planning & Procurement [For Minute 112]
Ms J Erdman	Head of Inequalities [For Minute 110]
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Mr D Loudon	Director of Facilities & Capital Planning
Mr A McLaws	Director of Corporate Communications
Mrs A MacPherson	Director of Human Resources & Organisational Development
Ms P Mullen	Head of Performance
Mrs K Murray	Director, East Dunbartonshire HSCP
Ms C Renfrew	Director of Planning & Policy
Professor C Williams	Consultant Microbiologist [For Minute 107]

ACTION BY

100. WELCOME AND APOLOGIES

Presiding over his first NHS Board meeting as Chairman, Mr Brown reported that there would be a number of new Non-Executive Board Member positions advertised early in the new year. To ensure wide ranging and diverse interest in these opportunities, a proactive marketing campaign would be launched detailing the work, influence and rewards of being a Non-Executive Director of Scotland's largest health board.

Apologies for absence were intimated on behalf of Councillor M Devlin, Mrs T MacAuley OBE, Councillor J McIlwee, Councillor M O'Donnell and Mr D Sime.

NOTED

101. DECLARATION(S) OF INTEREST(S)

Declaration of Interest – Dr D Lyons:-

- Agenda Item No 11 - “Equality Counts: Using Data to Understand and Tackle Inequality in NHSGGC”.

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

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

NOTED

102. CHAIR’S REPORT

Mr J Brown reported that he had had a very busy, informative and enjoyable first two weeks in his role as NHS Board Chair. He summarised his one-to-one meetings with individuals, attendance at meetings and visits to meet frontline staff and services including the following:-

- Various one-to-one meetings with Executive Directors, Senior Staff and, in particular, the NHS Board’s Chief Executive.
- Various Committee meetings including the NHS Boards Chairs meeting with the Cabinet Secretary for Health, Wellbeing and Sport on 30 November 2015, the NHS Board Seminar on 1 December 2015, the Area Clinical Forum meeting on 3 December 2015, the Staff Governance Committee meeting on 8 December 2015 and a meeting of Glasgow Centre for Population Health Board on 11 December 2015.
- Meetings with frontline staff at the Neuro Institute, Queen Elizabeth University Hospital (Accident & Emergency (A&E) department, Immediate Assessment Unit (IAU) and Clinical Decision Unit (CDU)), Royal Hospital for Children and Glasgow Royal Infirmary (A&E, IAU, CDU and Acute Receiving departments).

Mr Brown had also met with the Cabinet Secretary for Health, Wellbeing and Sport and the Chief Executive of NHS Scotland to provide them with an update on the following within NHSGGC:-

- Winter planning/unscheduled care;
- Langlands Unit and Care for Older People;
- Relationship with Health Improvement Scotland (HIS) and, in particular, its latest report on the Langlands Unit;
- Infection Control and the NHS Board’s relationship with Health Protection Scotland.

He was encouraged that the Cabinet Secretary had agreed to continue with his one-to-one meetings and also to meet with NHS Board Members at a time to be agreed in 2016.

In terms of Mr Brown's representational duties, he had attended the following:-

- A dedication ceremony for the sanctuary at the Queen Elizabeth University Hospital.
- The CLIC Sargent Hospitals' Christmas Carol Concert.
- The 100 years celebration event at Glasgow Royal Infirmary.

NOTED

103. CHIEF EXECUTIVE'S UPDATE

- (i) On 26 October 2015, Mr Calderwood attended a cutting of the sod of the ICE Building at the Queen Elizabeth University Hospital. This was conducted by Mr J Johnson, UK Minister for Science and Universities and Professor A Dominiczak was also in attendance. This represented the cementing of the relationship between the NHS Board and the University of Glasgow on the Queen Elizabeth University Hospital campus.
- (ii) On 4 November 2015, Mr Calderwood attended the Scottish Health Awards ceremony where four members of staff, across the organisation, picked up awards. He took the opportunity to congratulate them and paid tribute to the positive evening.
- (iii) On 20 November 2015, Mr Calderwood and Mr Archibald met with the Cabinet Secretary for Health, Wellbeing and Sport to discuss the NHS Board's Winter Planning arrangements.
- (iv) On 23 November 2015, Mr Calderwood attended an evening reception at the Queen Elizabeth Teaching & Learning Centre for NHSGGC's reservist staff. This was an excellent informal evening, recognising the contribution of the reservist forces. The event recognised that the regular training undertaken by the reserve forces enhanced and developed the skills and knowledge of NHSGGC's employees and that it was of long-term benefit to the organisation.
- (v) On 30 November 2015, Mr Calderwood met with Duncan McNeil MSP to discuss a wide range of issues, particularly around the future of NHS services in Inverclyde.

NOTED

104. MINUTES

On the motion of Professor A Dominiczak, seconded by Rev Dr N Shanks, the minutes of the NHS Board meeting held on Tuesday, 20 October 2015 [NHSGGC(M)15/06] were approved as an accurate record and signed by the Chair.

NOTED

105. MATTERS ARISING FROM THE MINUTES

The Rolling Action List of matters arising was noted.

NOTED

106. SCOTTISH PATIENT SAFETY PROGRAMME MATERNITY UPDATE

A report of the NHS Board's Nurse Director [Board Paper No 15/60] asked the NHS Board to note the progress reported from the Women's & Children's Directorate in implementation of the SPSP workstream for Paediatric, Maternal and Neonatal care.

Dr McGuire explained that the specific aim for this workstream was to achieve a 30% reduction in adverse events that contributed to avoidable harm in Neonatal and Paediatric services by December 2015. There were currently 18 teams supported across Paediatric and Neonatal services. Initially, following the move to the Royal Hospital for Children, it was considered prudent to continue with monthly data submissions even for those teams which had made good progress and were showing a reliable process had been embedded. A number of these teams had now shown sustained reliability through the move and could be stepped down to reduce levels of process measurement.

Dr McGuire led the NHS Board through a summary of the workstreams including Peri-op, critical care, PICU and neonate workstreams.

In terms of next steps, the Directorate had undertaken a review of current measures and mapped these against the clinical priorities. It had been agreed that the MCQIC work would concentrate on five areas as follows:-

- Women's satisfaction with their care;
- Smoking in pregnancy;
- Foetal heart rate monitoring;
- Post-partum haemorrhage;
- Significant events debrief.

In response to a question from Mr Lee regarding the clinical choice in using elastoplast to secure the PVC device instead of the recommended sterile PVC dressing, Professor Williams explained that, although this presented no infection risk, work continued with clinicians to ensure compliance with national standards. He understood, however, that the adhesiveness on an elastoplast was greater and, therefore, it stayed on longer which made it preferable for some clinicians.

Ms Micklem asked about outcome measures and when these would be available. Dr McGuire explained that, firstly, data had to be gathered in order to measure outcomes and identify benefits. Currently, the NHS Board was at the information gathering and data collecting stage for these workstreams. That way, baselines would be established before a move to identify improvements could be made.

Members agreed that the various graphs and tables could be difficult to decipher and understand. Dr McGuire explained that the format was set nationally but that she would refine the information to make it easier to understand in terms of local NHSGGC performance. It was suggested that future reports include a summary but highlight exception reporting. Dr McGuire agreed to work with Dr Armstrong and Mrs Brimelow to identify how the NHS Board could be provided with a more distilled version than the one provided to the Scottish Government. Dr McGuire agreed to provide the different report from February 2016 onwards in an attempt to make the

Nurse Director

text, graphs and tables easier to understand and add a glossary of terms, recognising that a fuller set of information was required to comply with the SGHD template.

NOTED

107. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No 15/61] 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

Referring to the earlier discussion on SPSP, Dr Armstrong explained that the format of this report was similarly prescribed by the SGHD but she would attempt to simplify it and provide an executive summary for future NHS Board meetings.

**Medical
Director**

Dr Armstrong led the NHS Board through the actions being taken to address the disappointing increase in SABs for the April to June 2015 quarter. She explained that over half of the 116 SAB cases in NHSGGC during quarter 2 were hospital acquired. 26 patients had the source of their SAB identified as an intravenous access device (CVC or PVC). Eleven patients had no clear source identified for source of sepsis following thorough investigation by the Infection Prevention and Control Team and the local clinical team.

In looking at the outbreaks/exception reporting, Dr Armstrong summarised the situation which saw an increased incidence of serratia marascens in patients in the Neonatal Intensive Care Unit (NICU) at the Royal Hospital for Children. She explained that an action plan had been developed and agreed between Health Protection Scotland and NHSGGC. Progress against the plan was reported at each Incident Management Team meeting and Dr Armstrong summarised the actions being taken to date to address this.

In response to a question from the Chairman, Dr Armstrong clarified that, sadly, a very premature baby with complex medical problems died with serratia marascens present in the bloodstream.

In response to a question from Mr Finnie regarding the source of SABs being identified as a CVC or PVC, Dr Armstrong explained that, when doing improvement programmes, all efforts were made to embed the principles in wards and change local practice. Given the moves to the new Queen Elizabeth University Hospital, new staff were working in new wards and she acknowledged the need to revisit and further embed compliance with the Standard Operating Procedure for the insertion, care and maintenance of CVCs and PVCs. In response to a further question, she explained that this did indeed include how and when they were being used, their insertion and their

removal. This information was monitored via the Infection Prevention & Control Audit, the results of which were returned to the Chief Nurses for the area and included in the Sector monthly reports. That way, spikes were easily identifiable and resultant action initiated. Professor Williams added that a two part approach was being taken in that ward audits of IV access devices were undertaken and that a more detailed piece of work was being established to look at local barriers where compliance was not being sustained in an attempt to identify methods of improvement.

NOTED

108. PUBLIC HEALTH SCREENING PROGRAMMES ANNUAL REPORT: 1 APRIL 2014 TO 31 MARCH 2015

A report of the Interim Director of Public Health [Board Paper No 15/62] asked the NHS Board to note the “Public Health Screening Programmes Annual Report from 1 April 2014 to 31 March 2015”.

Dr Crighton presented information about the following screening programmes offered to residents across NHSGGC for the period 2014/15:-

- Cervical screening
- Breast screening
- Bowel screening
- Pregnancy screening:-
 - Communicable diseases in pregnancy
 - Haemoglobin apothics in screening
 - Down's syndrome and other congenital anomalies
- Newborn screening:-
 - New born blood spot
 - Universal new born hearing
- Diabetic retinopathy screening
- Preschool vision screening
- Aortic abdominal aneurysm screening

Dr Crighton explained that screening was a public health service offered to specific population groups to detect potential health conditions before symptoms appeared. Screening had the potential to save lives and improve quality of life through early diagnosis of serious conditions.

In NHSGGC, the co-ordination of all screening programmes was the responsibility of the Public Health Screening Unit led by a consultant in public health medicine. Multi Disciplinary Steering Groups for the programmes were in place and the remit was to monitor performance, uptake and quality assurance.

Dr Crighton highlighted that, as the screening programmes stretched across the whole organisation, successful delivery relied on a large number of individuals working in a co-ordinated manner towards common goals in a quality assured environment. It was essential that good information management systems were in place to monitor and evaluate each component and the overall performance of every screening programme offered to NHSGGC residents.

NHSGGC's Public Health Screening Unit was committed to working in partnership with voluntary and statutory services to identify innovative ways to tackle inequalities in health and encourage uptake of screening programmes.

Dr Crighton commended the efficiency of the screening programmes and reiterated that they could prevent disease. She responded to a range of Members' questions by clarifying the following:-

- Efforts were made to engage with communities where there was low uptake in the screening programmes. Given that previous evidence suggested that attitudes and health behaviours were different in some communities, every effort was made to address their needs – these efforts would continue in deprived areas to address the shortfall in uptake.
- Although huge improvements had been made in the pre-school vision screening programme compared to previous years, a lot of work continued, not only in meeting with local nurseries but in making contact with those children not registered with a nursery.
- A priority was to engage with the hard-to-reach communities. Although this continued to be a challenge it would be a priority to ensure that the inequalities gap did not widen. However, it was also important to celebrate success and what had been achieved so far in the uptake of the screening programmes. The lack of uptake in some areas should not influence the areas where the screening programmes did well.
- Screening programmes were national programmes and any intent to extend would be a national decision.
- Agreement that the report should be considered locally by IJBs to analyse performance within localities in more detail.
- Work was being undertaken nationally to look at interval cancers and compare these nationally/internationally to undertake some benchmarking with a view to looking at the merits of extending the programmes, in particular, breast screening.

NOTED

109. PROPOSED AMENDMENT TO NHSGGC SMOKEFREE POLICY

A report of the Interim Director of Public Health [Board Paper No 15/63] asked the NHS Board to note the report and support implementation of two recommendations (firstly, to amend the current Smokefree Policy to allow the use of e-cigarettes in designated areas within NHSGGC's grounds and, secondly, to establish a Board-wide process to develop a shared criteria for identifying suitable arrangements allowing the use of e-cigarettes on NHSGGC's grounds).

Dr Crighton explained that NHSGGC's current Smokefree Policy (2014) prohibited smoking on all NHSGGC sites including all buildings, vehicles and grounds. It also currently included e-cigarettes and smokeless cigarettes. The policy stated that the position around e-cigarettes would be reviewed in accordance with emerging evidence around the potential role that they could contribute towards tobacco control.

Dr Crighton alluded to the emergence of new evidence that showed e-cigarettes to be an effective tool in tackling harmful tobacco smoking rates and that their controlled use would further support the drive to try and make all NHSGGC sites completely tobacco-free in line with the national policy. Based on this new evidence, a review of the NHS Board's Smokefree Policy position on e-cigarettes was timely and would improve consistency between the use of e-cigarettes within NHS grounds and the "e-cig friendly" approach being recommended for cessation services.

In response to a question, Ms Campbell outlined that the Scottish Government’s position on e-cigarettes was more positive than negative with a recently proposed Bill focusing on restricting e-cigarettes advertising and sales to under 18s but not imposing stronger restrictions on location of use.

Currently, only NHS Lothian allowed e-cigarette use in designated areas although a number of other NHS Boards were now reviewing this situation in light of the evidence that had been published recently. Dr Crichton was clear that the NHS was not promoting the use of e-cigarettes but seeing their potential as a way to reduce the mortality and morbidity caused by combustible tobacco.

Given the evidence available, the NHS Board was supportive of the change to its policy with the following suggestions around how this could be managed locally:-

- Specific areas within NHSGGC’s grounds where e-cigarettes would be permitted would be identified. The policy change did not mean that e-cigarettes could be used anywhere on the NHS Board’s grounds, but in designated areas only.
- A communications plan for patients, staff and visitors would be developed to make clear that tobacco and e-cigarettes were treated differently and advise where people could use e-cigarettes on the NHS Board’s grounds.

DECIDED

- That, the report be noted.
- That, the current Smokefree Policy be amended to allow the use of e-cigarettes in designated areas within NHGGC’s grounds.
- That, a Board-wide process to develop a shared criteria for identifying suitable arrangements allowing the use of e-cigarettes on NHSGGC’s grounds be established.

**Interim
Director of
Public Health**

“ “

110. EQUALITY COUNTS: USING DATA TO UNDERSTAND AND TACKLE INEQUALITY IN NHSGGC

A report of the Director of Planning & Policy [Board Paper No 15/64] asked the NHS Board to receive the update on using data to understand and tackle inequality in NHSGGC and support the six recommendations for action.

Ms Erdman explained that tackling inequality was one of NHSGGC’s five priorities. Patterns of inequality were evident in the way NHSGGC’s population made use of health services. Historically, health and social care services had largely been planned without taking into account patients’ needs in relation to inequality and discrimination. Sometimes this had been because everyone in the target group was considered excluded or vulnerable or simply because the data was not available to identify the needs of groups within groups. In order to understand the population and develop better services, the NHS Board needed to collect and use a wide range of evidence to help build up a more complete picture. Data on patients’ use of services and health outcomes by protected characteristics, patient/client feedback by equality groups, and equality impact assessments could be used to build that picture.

She explained that collecting data by protected characteristics was part of the requirements of the equality legislation, and ideally, the NHS Board should ask and record patients' ethnicity, sex, disability, age, sexual orientation and religion/belief. The Scottish Index of Multiple Deprivation (SIMD), based on postcode, was used as a proxy for socioeconomic status.

Ms Erdman led the NHS Board through where NHSGGC collected data on the protected characteristics, how it was used to make improvements to services to tackle inequalities, and where there was still need to make progress. She summarised the following points:-

- Collection of patient data by protected characteristic and actions required to improve the collection;
- Using patient information on additional support needs to improve access and quality of service in Acute;
- Using equality data to monitor performance on tackling inequality and to drive change which would improve health outcomes;
- Using equality data to prevent ill health through screening;
- Using equality population data to plan services.

She alluded to the recommendations to achieve improvements and explained that it had been challenging to find measures that would close health gaps between groups, even though data was routinely collected on sex, age and socioeconomic status. This was further compounded by a lack of disaggregated data in many NHS data collection systems on other protected characteristics covered by the Equality Act 2010.

NHS Board Members commended the paper and the opportunities that collecting this data would provide. Some suggestions were made around the wording of some of the proposed equalities data collection and Ms Erdman agreed to take these on board.

**Director of
Planning &
Policy**

In response to a question regarding public health screening programmes, Ms Renfrew explained that Public Health had reviewed its screening data to see where the data collected could be disaggregated by protected characteristics. The data had been used to identify low levels of uptake and late uptake by some groups in the population which could then be targeted with specifically tailored approaches. It was not the case that some people were "opting out" of the screening programmes themselves.

Ms Micklem was encouraged by recognition for the need for new data systems or migrated data systems to include the necessary fields to take forward this work. She encouraged the NHS Board to undertake an Equalities Impact Assessment (EQIA) on the systems themselves to see how best they could be developed.

**Director of
Planning &
Policy**

In response to a question concerning the Community Health Index (CHI), it was reported that, as this was a national system, it could not be adapted locally. It was, however, hoped that, nationally, discussions would take place regarding the need for additional information on a person's CHI to include some of the data required by the Equality Act 2010.

Ms Brown suggested some advertising posters for members of the public to reassure them that these additional questions were being asked in an attempt to improve services and target specific groups. Ms Erdman agreed with this important point.

**Director of
Planning &
Policy**

DECIDED

- That, the update on Equality Counts: Using Data to Understand and Tackle Inequality in NHSGGC report be received.
- That, the six recommendations for action to understand and tackle inequality in NHSGGC be supported.

**Director of
Planning &
Policy**

111. UPDATE ON GLASGOW IJB – SCHEME OF ESTABLISHMENT

A report of the Director of Planning and Policy [Board Paper No 15/65] asked the NHS Board to note the final Scheme of Establishment for the Glasgow City Integration Joint Board.

Ms Renfrew explained that, in January 2015, the NHS Board considered the draft Schemes of Establishment for the six Integration Joint Boards. The NHS Board gave the Director of Planning and Policy and the respective Chief Officers delegated authority to finalise and submit the Schemes. Five of the six Schemes had received SGHD approval. In relation to the one outstanding, Glasgow City, the remaining matter that the Chief Executives of the NHS Board and Council had been jointly working on since May 2015 had been the detail of scope and wording within the Integration Scheme in relation to specialist children's services.

Ms Renfrew summarised the four components of specialist children's services and reported that these services currently had dual arrangements with local management but also a line of accountability to a single general manager who had the responsibility and capacity to achieve working across the system, supported by singular Clinical Director posts for each service, also operating across the system. She outlined the whole system arrangements and the NHS Board's two objectives in the discussion with Glasgow City Council. The legal framework which underpinned the creation of Integration Joint Boards meant that these objectives could only be achieved by differentiating these services from those which were fully delegated and the revised draft Scheme of Establishment now achieved that. All matters that were highlighted by the SGHD following submission on 31 March 2015, which were largely textual and technical, had been resolved and agreed by both parties and civil servants.

Councillor Kerr confirmed that the revised draft Scheme had been submitted to Glasgow City's Executive Committee where it had been approved.

In response to a question from Dr Reid concerning the definition and interpretation of "Acute Services", Ms Renfrew confirmed that this was set in legislation.

**Director of
Planning and
Policy**

NOTED**112. HUB PROJECTS – UPDATE**

A report of the Director of Facilities & Capital Planning, and the Head of Capital Planning & Procurement [Board Paper No 15/66] asked the NHS Board to note the updated programme for the delivery of Hub projects and the amendments to the Share Holder Agreement (SHA) and Territory Partnering Agreement (TPA) documentation between the NHS Board and Hubwest Scotland which would require to be agreed and signed in January 2016.

Mr Curran led the NHS Board through an update on the funding issues for Hub and the updated Hub programme. He described the funding background and discussions that had taken place between Scottish Futures Trust (SFT), the Scottish Government and the Office for National Statistics (ONS) on the changes that were required to the contract documentation to ensure that all projects were privately classified and off balance sheet. He provided a Hub programme update on the following:-

- Eastwood Health & Care Centre and Maryhill Health Centre;
- Woodside Health & Care Centre and Gorbals Health & Care Centre;
- Inverclyde Adult & Older People's Continuing Care Beds;
- Lennoxton Community Hub;
- Greenock Health & Care Centre and Clydebank Health & Care Centre.

In response to a question concerning guaranteed revenue support, Mr White reported that it was likely the Schemes may cost more to the NHS Board but the challenge, at the moment, was that there was no clarity of the financial implications. It was recognised, however, that there was urgency to implementing the Inverclyde Adult & Older People's Continuing Care Scheme and SGHD had agreed to underwrite the inflationary increase caused by the delay. On that basis the scheme was moving towards financial close on 29 January 2016 and a commencement on site in March 2016.

NOTED

113. VALE OF LEVEN INQUIRY: UPADTE ON PROGRESS IN THE IMPLEMENATION OF THE RECOMMENDATIONS

A report of the Medical Director [Board Paper No 15/67] asked the NHS Board to note progress on implementation of the Vale of Leven Hospital Inquiry recommendations within NHSGGC.

The SGHD wrote to all NHS Boards asking that they implement the 65 NHS Board recommendations in the Vale of Leven Hospital Inquiry report and provide the SGHD with an update which was submitted in January 2015. The Scottish Government established an Implementation Group to oversee implementation of all 75 recommendations and a Reference Group was also established, with representatives of the patients and families of those affected, and the Group's role would be to support and challenge the Implementation Group.

The national Implementation Group was in the process of developing a national plan with timescales and milestones to show progress against each recommendation, and it was anticipated that SGHD would issue further guidance on this in early 2016.

Dr Armstrong reported that ten of the recommendations required further guidance from the SGHD and one required further guidance from the Crown Office and Procurator Fiscal Service. Of the remaining 64 recommendations, NHSGGC had fully implemented 47 and partially implemented 16. Good progress was demonstrated against those partially implemented with a number depending on progress of major developments.

A sub-group of the NHS Board's Infection Control Committee would convene in January 2016 to review ongoing progress and the further guidance from the SGHD. A subsequent update would be provided to the NHS Board meeting in February 2016.

**Medical
Director**

In discussion about seeking NHS Board assurance in the implementation of the recommendations, it was agreed that the Medical Director and Nurse Director work with four NHS Board Members (Chair, Mr J Brown, Vice Chair, Mr I Lee, Joint Chair of Staff Governance Committee, Ms M Brown and Ms S Brimelow, along with a representative from the Area Clinical Forum) to seek evidence and provide assurance on the implementation of each NHS Board's recommendation and timescale for completion of those currently partially completed. The outcome would be reported back to the NHS Board.

DECIDED

- That, a Short-Life Group be formed to seek assurance on the implementation and progress of the NHS recommendations and report back to the NHS Board later in the year.

**Medical
Director/
Nurse Director**

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

A report of the Director of Planning & Policy [Board Paper No 15/68], asked the NHS Board to note the engagement and public consultation on changes to Older People's Services in North/West Glasgow (which reflected the Clinical Services Strategy approved by the NHS Board earlier in 2015 and was included in the 2015/16 Local Delivery Plan) and approve the transfer of rehabilitation beds, day hospital and outpatient services to Gartnavel General Hospital from Drumchapel Hospital and the re-provision of NHS Continuing Care in other suitable locations across North and West Glasgow.

Ms Renfrew set out the outcome of the public engagement and consultation on proposed changes to Older People's Services in North/West Glasgow and sought approval to proceed with the proposed service changes. It described the services and the drivers for change in that the Clinical Services Strategy established a clear framework to redesign, improve and modernise the NHS Board's Clinical Services. This approach was designed to ensure an individual's stay in hospital was for the Acute period of care only and that people were supported to return to their community as soon as possible.

Ms Renfrew summarised the engagement and consultation proposals in relation to rehabilitation and NHS Continuing Care, and explained that NHSGGC worked with the Scottish Health Council to develop an engagement and consultation process to facilitate the participation of a range of stakeholders in the discussions concerning the changes to Older People's Services in North/West Glasgow. She summarised the comments received and the key themes raised, explaining that it was proposed that the NHS Board proceed with the following:-

- Creation of a Rehabilitation Centre of Excellence at Gartnavel General Hospital and transfer rehabilitation inpatient, outpatient and day hospital services from Drumchapel Hospital to Gartnavel General Hospital.
- Closure of NHS Continuing Care Beds at Drumchapel Hospital.

In addition to the identified clinical benefits, the proposal generated a saving of £1.4m.

In response to a question from Ms Brimelow, Ms Renfrew outlined, in further detail, the proposals for NHS Continuing Care patients.

Although previously it had been agreed that 14 patients were likely to be transferred to Fourhills Nursing Home, feedback from families and relatives suggested that discussions should be made on an individual basis regarding a patient's placement

rather than all 14 being placed in Fourhills Nursing Home. That individual assessment and process would take place.

DECIDED

- That, the engagement and public consultation on changes to Older People's Services in North/West Glasgow, which reflected the Clinical Services Strategy approved by the NHS Board earlier in 2015 and included in the 2015/16 Local Delivery Plan, be noted.
- That, the transfer of rehabilitation beds, day hospital and outpatient services to Gartnavel General Hospital from Drumchapel Hospital and the reprovision of NHS Continuing Care to other suitable locations across North/West Glasgow, be approved.

**Director of
Planning &
Policy**

115. NHSGGC 2014/15 ANNUAL REVIEW: SCOTTISH GOVERNMENT FEEDBACK LETTER AND ACTION NOTE

A report of the Head of Performance [Board Paper No 15/69] asked the NHS Board to note the 2014/15 Annual Review letter and Action Note from the Cabinet Secretary for Health, Wellbeing and Sport. The letter summarised the main points discussed and actions arising from the review and from the meetings which took place on 20 August 2015 as part of the review process.

Rev Dr Shanks was disappointed that there was no reference to many of the issues raised by Non-Executive Members of the NHS Board. He was encouraged, however, to see the intent to have meaningful engagement with local clinicians in taking forward both the critical health and social care integration agenda and other local service redesign programmes. Similarly, Dr Cameron welcomed this commitment, recognising that engagement with clinicians was key and one route to do this was via the Area Clinical Forum.

NOTED

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

A report of the Head of Performance [Board Paper No 15/70] 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.

The paper provided:-

- 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%.

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.

NOTED

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

A report of the Director of Finance [Board Paper No 15/71] asked the NHS Board to note the financial performance for the seven month period to 31 October 2015.

Mr White reported that the NHS Board was currently reporting an overspend outturn against budget of £6.6m. 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 and it was conditional on the success in month 8 of current cost saving measures and identifying additional measures to further reduce expenditure or on securing sources of additional funding during the remainder of the year.

In response to a question from Mr Finnie, Mr White explained that the methodology for the notional set aside budgets for hospital services within the scope of Integration Schemes had now been agreed with the HSCPs. As Chair of the Audit Committee, Mr Finnie offered his support to look at these in more detail and as an assurance on behalf of the Audit Committee and the NHS Board. Mr White thanked Mr Finnie for the offer.

**Director of
Finance**

In response to a question, Mr White reported that, during October 2015, the NHS Board received £5.477m of additional funding to deliver the Treatment Time Guarantee and reduce waiting times, and an additional £1.3m for winter pressures. The only other allocations received during the month were £0.835m from the Mental Health Innovation Fund and £0.123m to commission the Patient Portal.

In response to a question from Ms Brimelow regarding the current overspend outturn against budget, Mr White reported that ongoing analysis was taking place to seek to control the causes of overspend in the region of £1m per month.

NOTED

118. HEALTHCARE IMPROVEMENT SCOTLAND: OLDER PEOPLE IN ACUTE CARE UNANNOUNCED INSPECTION: QUEEN ELIZABETH UNIVERSITY HOSPITAL AND LANGLANDS UNIT (7-11 SEPTEMBER 2015)

A report of the Nurse Director [Board Paper No 15/73] asked the NHS Board to note the HIS report, the improvements and actions taken and agree that an update report on Older People's Care would be presented to the NHS Board in six months' time.

Dr McGuire summarised the Healthcare Improvement Scotland (HIS) Inspection report from its unannounced inspection to the Queen Elizabeth University Hospital (QEUH) from Monday 7 to Friday 11 September 2015. The inspectors visited eight wards in the QEUH and five wards in the Langlands Unit. She led the NHS Board through the areas of good practice identified as well as areas for improvement, particularly on the Langlands Unit where specific concerns were raised in relation to wards 56 and 57.

In looking at the main issues identified, Dr McGuire explained that actions necessary to address the recommendations were being taken forward in a multidisciplinary approach in order to ensure that the necessary actions and improvements were being taken forward across NHSGGC. She provided an outline of some of the improvement work that had been taking place prior to the inspection and ongoing, including:-

- Documentation;
- Falls;
- Pressure area care;
- Food, fluid and nutrition;
- Person-centred care;
- Delirium;
- Adults with Incapacity, Do Not Attempt Cardiopulmonary Resuscitation and Medicines Reconciliation.

In response to a question, Dr McGuire emphasised that staff in the Langlands Unit were particularly concerned by the findings of the report and the impact it may have on their patients and families. Senior staff were supporting them and putting in place positive interventions. Staff were very keen to make improvements and work in an multi-disciplinary way to ensure quality care, outcomes and patient satisfaction.

In response to a question from Ms Brimelow, Dr McGuire outlined that the report and resulting media coverage caused significant public anxiety and had upset staff in the stroke wards of the Langlands Unit. The report's description of the care of two patients in particular, had caused concern especially as the NHS Board had provided a full explanation of the circumstances. Dr McGuire informed the NHS Board that she had shared their concerns and raised them with HIS and the SGHD Chief Nursing Officer. Dr McGuire welcomed the offer from Ms Brimelow to be involved in the group looking at the issues raised and would report back to the NHS Board on GGC-wide improvements in August 2016.

Nurse Director

DECIDED

- That, the contents of the HIS report be noted.
- That, the improvements and actions taken be noted.
- That, an update report on Older People's Care come to the NHS Board in six months' time be agreed.

Nurse Director

119. QUARTERLY REPORTS ON COMPLAINTS AND FEEDBACK: 1 JULY TO 30 SEPTEMBER 2015

A report of the Nurse Director [Board Paper No 15/72] asked the NHS Board to note the quarterly reports on complaints and feedback in NHSGGC for the period 1 July to 30 September 2015, as well as extracts from the ISD and SPSO's Annual Reports 2013/14.

Complaints handling performance had been 79% of complaints responded to within 20 working days achieved against a target of 70%.

The paper 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. It 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.

Ms Micklem asked about the self assessment outcome in relation to the Participation Standards 2014/15. Mr Hamilton explained that the Scottish Health Council had completed its final analysis of NHSGGC's self assessment of two sections of the Participation Standard and agreed that both were level ones (developing). This reflected the NHS Board's aspiration to reorganise its complaints function into a more centralised way with the intention of leading to an improved performance and consistency NHS Board-wide.

In response to a question from Mr I Fraser regarding the continued increase in prison complaints, Dr McGuire reflected that this was Scotland-wide and NHSGGC had been asked to be one of the pilot NHS Boards to look at how better engagement can take place with the prisoner population around their health services. NHSGGC looked forward to being part of that process, and details, as they emerged, would be included in future reports.

Nurse Director

Dr Lyons referred to feedback relating to single room provision at the QEUH and, in response to his question, Dr McGuire described how staff worked/positioned themselves around the hospital floors to achieve maximum visibility.

NOTED

120. AREA CLINICAL FORUM MINUTES: 1 OCTOBER 2015

The minutes of the Area Clinical Forum meeting held on 1 October 2015 [ACF(M)15/05] were noted.

NOTED

121. PHARMACY PRACTICES COMMITTEE MINUTES: 28 OCTOBER 2015

The minutes of the Pharmacy Practices Committee meeting held on 28 October 2015 [PPC(M)2015/02] were noted.

NOTED

122. CLOSING REMARKS

The Chair wished all Members and those in attendance a very merry Christmas and best wishes for 2016.

The meeting ended at 1:10pm.