

ASC(M)16/01
Minutes: 01 - 18

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Acute Services Committee held at
9.00am on Tuesday, 19 January 2016 in the
Board Room, J B Russell House, Gartnavel Royal Hospital,
1055 Great Western Road,
Glasgow, G12 0XH**

P R E S E N T

Mr I Lee (Convener)
Ms M Brown
Cllr G Casey
Professor A Dominiczak OBE
Mr R Finnie (To Minute 12)
Cllr A Lafferty
Dr D Lyons
Mr A Macleod
Cllr M Macmillan (To Minute 11)
Ms R Micklem
Mr D Sime

O T H E R B O A R D M E M B E R S I N A T T E N D A N C E

Dr J Armstrong
Mr J Brown CBE
Mr R Calderwood
Dr M McGuire
Mr M White

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

Mr G Archibald .. Chief Officer, Acute Services
Mr J C Hamilton .. Head of Board Administration
Mr D Loudon .. Director of Facilities & Capital Planning
Mr A McLaws .. Director of Corporate Communications
Ms A MacPherson .. Director of Human Resources & Organisational Development
Ms T Mullen .. Head of Performance
Ms C Renfrew .. Director of Planning and Policy
Mr R Wright .. Director of Health Information and Technology

01. APOLOGIES, WELCOME AND PRELIMINARIES

Apologies were intimated on behalf of Dr H Cameron, Mr I Fraser, Cllr Kerr, Cllr J McIlwee and Cllr M O'Donnell.

02. DECLARATIONS OF INTEREST

Declaration of interest – Professor A Dominiczak OBE, Regius Professor of Medicine and Vice Principal & Head of College, MVLS, University of Glasgow.

- Minute No 17 – Imaging Centre of Excellence – Full Business Case

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

03. MINUTES OF PREVIOUS MEETING

On the motion of Councillor A Lafferty and seconded by Ms M Brown, the Minutes of the Acute Services Committee meeting held on 17 November 2015 [ASC(M)15/03] were approved as a correct record.

NOTED

04. MATTERS ARISING

a) Rolling Action List

(i) Minute 28 – Older People in Acute Hospitals (OPAH) HEI Inspection Summary Report - Delirium

Dr Lyons asked for a fuller explanation about the prioritisation of delirium in relation to the Clinical Services Strategy. Dr Armstrong advised that delirium bundles were currently underway, however delirium had not been included within the Clinical Services Strategy which was launched in January 2015. It would be her intention to apply the same rigour to delirium as deteriorating patients and bring a report back to the Committee on the management of delirium patients.

Medical Director

It was also agreed that full explanations should be given in future in the progress column of the rolling action list.

(ii) Minute 25 – Quarterly Report on Cases Considered by the SPSO

Mr Lee advised that Dr Armstrong had recently provided him with a full explanation of the circumstance of the case he had raised at the September 2015 meeting and he was now satisfied with the actions being taken.

(iii) Minute 50 – Beatson WoS Cancer Centre Update

Dr Armstrong advised that the minutes of both meetings held with consultant staff in late November 2015 had been sent to all consultants and steps were now being taken to set up the Steering Group and the relevant sub-groups, with the intention of holding the first Steering Group meeting in early February.

Mrs MacPherson advised that a survey had been sent to all 178 staff and 50 responses had been received and were now being analysed by the Learning & Education and Organisational Development teams. Once analysed, together with reviewing the free text section within the survey, these would be discussed with Grant Archibald, Chief Officer, Acute Services, and the next stages shared with the Acute Services Committee.

**Director of HR
& OD**

Professor Dominiczak highlighted that with the employment status of many of the medical consultant staff being connected to the University of Glasgow, she would be willing to assist with the work being taken forward and Dr Armstrong welcomed this offer. Dr Armstrong also confirmed that she would let the Acute Services Committee have sight of a copy of the finalised membership of the Steering Group.

Medical Director

NOTED

05. PATIENT'S STORY

Dr Margaret McGuire, Nurse Director, read out a recent carer's story from a ward within the Langlands Unit at QEUH. This was a carer who had seen mention of the recent HEI report about the Langlands Unit in the media and had offered to speak with the Inspectors about their families experiences in relation to her father's care. While this offer had not been taken up, she highlighted the number of positive aspects about the care but also the real need for information to also be made available to carers to help them support and understand the changes brought about by the circumstances of someone's changing health status. Dr McGuire advised that the themes of this patient's story had been shared with dementia carers and nurses across NHSGGC.

NOTED

06. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT

There was submitted a paper [Paper No 16/02] 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 against a performance status based on their variation from trajectory and/or target, 16 were assessed as green, five as amber (performance within 5% of trajectory) and eight 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 report.

(i) Detect Cancer Early

For the period April to June 2015, the percentage of patients diagnosed at the first stage of cancer was 24.2%; lower than the trajectory figure of 27.6%. Mr Archibald highlighted the actions taken to address performance and indicated that the Director of Regional Services was also liaising with the Interim Director of Public Health to achieve an improvement in performance in this area.

Ms Micklem asked about the connection between Detect Cancer Early and the Suspicion of Cancer referrals and in response, Mr Archibald agreed to provide a paper to the next meeting of the Committee which captured the full journey of the patient together with highlighting the key targets which required to be met in that patient's journey.

**Chief Officer,
Acute Services**

Ms Brown asked whether patients were informed if they were outwith the 62 day referral target and Mr Archibald indicated that he would confirm this with colleagues and notify the Committee.

**Chief Officer,
Acute Services**

Mr McLeod enquired as to why the data being reported covered the first quarter of the year when the other targets were for the second quarter (July to September 2015). Ms Mullen advised that there was a significant time lag in Information Services Division (ISD) receiving all the validated data from each NHS Board in Scotland and publishing it, and while NHSGGC submitted its data timeously, that was not always the case with all boards. The point would, however, be raised with ISD to see if an improvement could be brought about in this area.

(ii) Delayed Discharges > 14 Days

Ms Renfrew advised that the December 2015 position of 14 patients delayed beyond 14 days represented the lowest number of monthly delayed discharges since the introduction of the standard in April 2013 and this was having a positive impact on the overall number of bed days lost to delayed discharge. It was hoped that a further push would be made to reduce the figure even further, and the arrangements for Glasgow City Council to discharge to Social Care Homes had been helpful.

Ms Brown was keen that patients did not stay within social care homes for significant periods of time, and Ms Renfrew advised that whilst that was not the intention, she would raise this at the next Chief Officers' Meeting and seek an additional reporting standard in order to monitor the length of time patients were in social care homes having been discharged from hospital. Such reports would thereafter be reviewed by the individual IJB Boards at their Committee meetings.

**Director of
Planning &
Policy**

Dr Lyons highlighted that delirium persisted beyond an acute medical ailment so he was keen that there was a joined-up approach across the Acute Services Division and IJBs in managing delirium.

(iii) Sickness Absence & e-ksf/PDP Completion

Mrs MacPherson advised that in relation to sickness absence, a review had been undertaken of 200 long-term sickness cases (excluding members of staff who were seriously ill). This had highlighted that about a third of staff had experienced underlying issues/domestic violence and the NHS was now able to support these staff through the system in a way that had not been possible previously.

All Heads of People & Change had been asked to review any areas of absence over 8% with the intention of ensuring that managers were using the trigger points within the policy and discussing individual cases where appropriate with partnership colleagues. Mr Sime referred to the Resolve Attendance Support Sessions and acknowledged that this was a system which largely supported staff in relation to returning to work.

With regard to e-ksf, Mrs MacPherson highlighted that the South Sector of the Acute Services Division had recently been targeted for improvement and she had a report to be submitted to the March meeting of the Acute Services Committee on the audit on the quality of e-ksf/PDPs.

**Director of HR
& OD – March
ASC**

(iv) Outpatients DNA as a % of All Appointments Offered

Mr Archibald advised that a new appointment "Did Not Attend" (DNA) rate of 12.2% was reported for November 2015 against the target of 11.4%. The hospitals reporting the highest DNA rates were Stobhill (13.9%), Queen Elizabeth University Hospital (QEUH) (12.9%), Glasgow Royal Infirmary (12.5%), Victoria ACH (12.3%) and the Vale of Leven Hospital (12.1%).

A series of actions continued to be in place in relation to encouraging patients to attend appointments including text reminders for paediatric services, outpatient reminder calls (1200 per day) for specific specialties and the Gateway referral used by GPs now incorporated a question about whether a patient had additional needs. All new outpatients were sent an outpatient information leaflet along with details of their appointment, a reminder to cancel or change the appointment if required, and patients were

offered appointments at their local hospital site, wherever possible.

Mr Archibald then gave a presentation to the Committee on the unscheduled care performance for the NHS Board covering November to December 2015 and specifically on individual hospitals covering the last four weeks on a week-to-week basis. Members welcomed the detailed and comprehensive information and reflected on the exceptional performance given by many frontline members of staff in coping with such increased levels of attendance at A&E departments. The media coverage did not always highlight the improvements made in performance from last year and the Chief Executive advised that he would consider with colleagues internal communications within NHSGGC to ensure staff were appropriately thanked and appreciated for their efforts over this busy period and to highlight the improvements made despite increased attendances.

Mr Brown highlighted his recent visits to A&E departments to thank staff for their efforts. Members welcomed Mr Brown's comments and his reflections on his visits to staff in frontline services.

NOTED

07. FINANCIAL MONITORING REPORT FOR THE 8 MONTH PERIOD TO 30 NOVEMBER 2015

There was submitted a paper [Paper No 16/03] by the Director of Finance setting out the financial position within the Acute Services Division for the eight month period to 30 November 2015. Expenditure within Acute Services was overspent by £7.5m and Mr White highlighted that the variance to date within the North and South Sectors was £8.9m and the primary reasons were associated with the medical and nurse staffing budget overspends. The main cost pressure rested in medical pay, where significant expenditure on agency and locum cover had been incurred to support activity levels. Non-elective inpatient activity had increased significantly for the year to-date. In addition, difficulties recruiting resulting in long-term vacancies added to the requirement for waiting list initiatives to achieve waiting time targets. Other pressures were being experienced within nursing pay, surgical sundries and CSSD supplies – all largely driven by activity, with high sickness absence levels a key driver behind the nursing overspend.

Mr Finnie highlighted from Figure 1 of the Financial Monitoring Report, the trend of medical agency spend and the peak which occurred in month 4 (July) and the downward trend thereafter, and he enquired as to how that had been managed. Mr Calderwood advised that July was traditionally a month when there was a higher requirement than usual to backfill for junior doctors prior to the commencement of their new responsibilities on 1 August, together with paying in July the backfill arrangements required in May/June as part of the hospital moves associated with the opening of the QEUH.

The difficulties experienced within NHSGGC to fill particular consultant and junior doctor vacancies due to more attractive opportunities being available elsewhere in the UK or wider was discussed. Professor Dominiczak highlighted that one of these issues was the continued attraction to experienced consultants of the Distinction Awards Scheme still operating within England, Wales and Northern Ireland, and Ms Renfrew also highlighted the difficulty in providing sustainable services across too many sites.

Mr Calderwood agreed that this would be one of the issues which would be discussed in greater detail when considering the budget setting for 2016/17 at the NHS Board's Away Day on 29 February 2016.

**Director of
Finance**

NOTED

08. OPERATON OF THE QEUH IMMEDIATE ASSESSMENT UNIT (IAU)

There was submitted a report [Paper No 16/04] by the Chief Officer, Acute Services providing an update on the operation of the Immediate Assessment Unit (IAU) at the QEUH.

This 28 bed area was created for the assessment and admission of patients following referral from a general practitioner. It was planned that the unit would receive circa 59 referrals per day and discharge around 40-50% of these patients following a 12-24 hour stay. Since the QEUH opened, the referrals received had averaged 94 patients per day on week days and 40 on weekends, and this had led to difficulties in meeting demand, particularly in the late afternoons/early evening when most patients arrived. This had resulted in fewer patients than planned being discharged.

An area adjacent to the IAU which was designed for Allied Health Professional assessments, but not yet opened, had been changed into a dedicated Clinical Decision Unit (CDU) with the Allied Health Professionals' assessments now being undertaken in ward areas or in the main therapy department. The unit opened on 16 November 2015 and since then a total of 271 patients had been seen with a discharge rate of 78%. The unit had dedicated staffing of consultant sessions, a doctor in training and nurse staffing. It was planned to continue to develop the area along with the adjacent hot clinics to provide rapid assessment, discharge and follow up for patients who did not require hospital admission.

It was important to understand why patients were arriving through the route they did, and what had changed from the planning expectations for this unit. In addition, protocols for medical assessment units would be reviewed for all Acute hospitals within NHS GGC and we would build on the experience from other parts of the country.

NOTED

09. VALE OF LEVEN INQUIRY: EXECUTIVE REVIEW SHORT LIFE WORKING GROUP – PROPOSED TERMS OF REFERENCE

There was submitted a report [Paper No 16/05] by the Medical Director and Nurse Director asking for approval of the proposed Terms of Reference for the Short Life Working Group to be formed to review the progress made to date in implementing the recommendations from the Vale of Leven Public Inquiry Report.

Members noted the Terms of Reference and Membership and noted that an update would be provided to the March meeting with a finalised report to Acute Services and the NHS Board by July 2016.

**Medical
Director/
Nurse Director**

DECIDED

- That the proposed Terms of Reference for the Short Life Working Group and Membership be approved.

10. CLINICAL GOVERNANCE UPDATE

There was submitted a paper [Paper No 16/06] by the Medical Director which provided an overview of the clinical risk activity within the Acute Services Division in relation to significant clinical incidents, new issues identified by clinical risk teams and avoiding serious events monitoring.

It was highlighted that this new report represented a move away from the focus on the Scottish Patient Safety Programme in order to provide a complete reflection of the Acute Services Division's progress in improving and assuring quality, linked to clinical governance arrangements.

The main priorities for the NHS Board around safety and quality were medicines reconciliation and the deteriorating patient, and these issues were critical to the safety and wellbeing of patients.

Dr Armstrong took Members through each section of the paper, highlighting key areas in relation to the improvements and handling of significant clinical incidents as well as highlighting two particular cases in terms of lessons learned from both. She emphasised that clinical issues had to be at the forefront of decision making around clinical redesign and that the linking of databases in relation to patient safety and performance management was a key area going forward.

Ms Brown welcomed the approach described and enquired about the monitoring of mental health and learning disabilities. Dr Armstrong advised that a recent audit report had mapped out the processes and governance arrangements and this included learning disabilities cases. It would in addition include prison healthcare matters and suicides and these reports would come to the Board through the IJB's Clinical Governance Fora.

Members welcomed the new format and detailed information contained within the clinical governance update.

NOTED

11. HEALTHCARE ASSOCIATED INFECTION: EXCEPTION REPORT

There was submitted a paper [Paper No 16/07] 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 3 of 2015/16 (July to September 2015) confirmed a total of 116 SAB cases, equating to a rate of 34.3 cases per 100,000 acute occupied bed days. This was above the NHS Scotland rate of 31.6 cases for the same period.

In relation to clostridium difficile, the validated results for quarter 3 confirmed a total of 101 cases, equating to a rate of 29.5 cases per 100,000 acute occupied bed days and this remained below the HEAT target. Dr Armstrong advised that the

unvalidated figures for October to December 2015 indicated a 9.5% increase in patient cases and an action plan had been presented to the Acute Services Infection Control Committee meeting on 11 January and the paper set out the aims of the action plan in relation to bringing about an improvement in this area.

The paper also highlighted the increased incidence of *serratia marcescens* in the Neonatal Unit associated with the Royal Hospital for Children and that the last new case had been identified from screening carried out on 21 December 2015.

In relation to the increased incidence of RSV in patients within the Beatson Oncology Centre, the relevant ward had been closed to admissions/transfers on 9 December 2015 following the report of a fourth confirmed patient case. A total of eight patients and two staff members tested positive for RSV over the course of the outbreak and it had been re-categorised as red within the Hospital Infection Incident Assessment Tool following the death of a confirmed patient with two further deaths soon thereafter. The ward reopened on 17 December and returned to green status on 21 December.

Ms Micklem enquired about Health Protection Scotland guidelines and the fact that NHSGGC was not currently following the guideline associated with the application of alcohol solutions for skin preparation. Dr Armstrong advised that consensus with the medical staff had not yet been reached over this guideline however, she would report back in greater detail on this issue at the next meeting.

Medical Director

NOTED

12. INTERNAL REVIEW OF PAEDIATRIC CARDIAC SERVICES

There was submitted a report [Paper No 16/08] by the Chief Officer, Acute Services and the Medical Director asking the Committee to note the external review team report and action plan/recommendations in relation to the paediatric cardiac service based at the Royal Hospital for Children.

There had been four significant reviews between 2009 and 2014, however the Medical Director and Directorate Management Team believed that further improvements could be identified in order to deliver a safe, effective and efficient paediatric cardiac service. The external report identified 25 recommendations which were to be addressed through an action plan developed by the Directorate, and reported back to the Acute Services Committee.

The external report recognised that the nature of the work of the service was amongst the most challenging and complex in contemporary medicine and current difficulties derived, to a significant extent, from the complexity and intensity of this work. The report confirmed that the service had access to clinical resources and facilities which were on a par with or exceeded the best currently available anywhere, and was provided by staff who displayed an extremely high level of skill, commitment and ability. The review team was particularly concerned, however, about specific problems within the team and this had been actioned following the external review team's visit to the Royal Hospital for Children in mid-August in 2015.

Ms Micklem found the report very helpful and wondered if there were any other areas of concern which had not yet been drawn to the NHS Board's attention and enquired as to what safeguards were in place to ensure that these could be identified. Mrs MacPherson described the arrangements in place to try and identify

significant issues of concern which included recruitment processes, staff surveys, whistleblowing arrangements, liaison with partnership colleagues, and policies supporting the No Tolerance approach to the issue of stress. Mr Calderwood added that it would always be difficult to highlight where interpersonal relationships between key clinical staff were having an adverse effect on relationships, especially when the performance of the unit remained high and had no obvious areas of concern. Management teams and, in particular, Clinical Directors and Chiefs of Medicine were more sighted on the possibility of such issues and were able to identify specific matters and confront them when appropriate. However, he was aware of incidences which were being actively managed by managerial and clinical colleagues. Dr Armstrong highlighted that the revalidation process had been a significant change in engaging clinical staff in such areas, as significant clinical incidents, patient complaints, General Medical Council reviews and feedback from patients. Junior doctors were now much more confident in reporting unacceptable behaviours from more senior members of the clinical team. It was recognised that systems and processes required to be in place to identify such issues rather than relying on staff drawing such matters to management's attention.

Mr Lee wondered if there was a commonality of issues between the Beatson and the Paediatric Cardiac Service however, Mr Calderwood intimated that, whilst there were similarities, they were not the same and had different factors at the centre of the problem.

Professor Dominiczak asked about the training and support which was available to Chiefs of Medicine and Clinical Directors and Dr Armstrong advised that while they had a common set of objectives and personal development plans, it was highlighted at a recent session of all Chiefs of Medicine and Clinical Directors that they were keen that management training was made available to them to allow them to deal with managerial, staffing and stressful situations. This was now being arranged.

The updated action plan would be presented to the Committee at its meeting in March 2016.

Medical Director

NOTED

13. ANALYSIS OF LEGAL CLAIMS

There was submitted a report [Paper No 16/09] by the Head of Board Administration providing an overview of the handling and settlement of legal claims within the Acute Services Division as at 30 September 2014 and 30 September 2015. The paper also provided background information in relation to the role of the Central Legal Office and the Clinical Negligence and Other Risks Scheme (CNORIS) and how significant claims were handled.

In addition to the usual monitoring report around claims settled, the number of new claims, outstanding claims and breakdown of live claims by Directorate, the paper highlighted that NHSGGC had 194 of the 374 claims raised with Scottish NHS Boards arising from the treatment involving TVT mesh products.

NOTED

14. NATIONAL CHILD PSYCHIATRIC UNIT – ROYAL HOSPITAL FOR CHILDREN

There was submitted a report [Paper No 16/10] by the Director of Planning & Policy and the Director of Facilities & Capital Planning providing an update on progress on completing the outstanding issues in ward 4, National Child Psychiatry Service, Royal Hospital for Children.

Mr Loudon took Members through the update position in relation to the patient/staff alarm system; outdoor therapeutic space; flooring; childproof locks; sprinkler system and fire alarm guards. Mr Brown reported on the visit that he, Morag Brown and David Loudon had made on 12 January 2016 to the ward where additional works had been agreed. These had included finding alternative space for the washing machine/tumble dryer, alterations to the soft surface areas and looking at the possibility of fitting a retractable roof. Mr Lee asked if the signage issue which had been highlighted at the last meeting had been actioned, and Mr Loudon indicated that this was indeed the case, together with CCTV being provided at the entrance door/reception.

Ms Brown indicated that she had found it very helpful to talk to the staff, particularly about the roof options, however, she was disappointed not to be made aware that a recent Mental Welfare Commission visit and report had been produced which had included comments on the roof garden. Ms Renfrew indicated that a copy would be obtained and provided to Members as soon as possible. Dr Lyons indicated that he had some anxiety about the roof netting however, it was confirmed that this was circa 6m off the ground and therefore, not accessible by the patients.

**Director of
Planning &
Policy**

It was agreed that a final report be submitted to the March meeting to show the outcomes against all actions and hopefully confirm that all matters had now been attended to.

**Director of
Planning &
Policy/Director
of Facilities &
Capital Planning**

NOTED

15. ACUTE STRATEGIC MANAGEMENT GROUP: MINUTES OF MEETINGS HELD ON 22 OCTOBER AND 26 NOVEMBER 2015

There was submitted a paper [Paper No 16/11] enclosing the Acute Strategic Management Minutes of meetings held on 22 October and 26 November 2015.

NOTED

16. BOARD CLINICAL GOVERNANCE FORUM: MINUTES OF MEETINGS HELD ON 6 NOVEMBER AND 7 DECEMBER 2015

The minutes of the Board Clinical Governance Forum meetings held on 6 November 2015 [BCCF(M)15/05] and 7 December [BCGF(M)15/06] were noted.

NOTED

17. IMAGING CENTRE OF EXCELLENCE – FULL BUSINESS CASE

A late addition was made to the agenda by the Director of Finance and Director of Facilities & Capital Planning explaining the process which had been undertaken in seeking approval by the Scottish Government Health Directorate (SGHD) Capital Investment Group to the Full Business Case of the Imaging Centre of Excellence.

Changes had taken place in the financial profile from lease payments to the University of Glasgow to the NHS Board, committing capital funds in excess of £5m and therefore, as time was of the essence, a Full Business Case was submitted direct to the SGHD Capital Investment Group for consideration of the final scheme to tie in with the commitments already made by the University in relation to the imminent signing of the contract for the works. In approving the Full Business Case, the Capital Investment Group accepted the NHS Board's assessment that this was key for safe and sustainable clinical services for not only NHSGGC but also the wider NHS Scotland and any delay would have significant service and cost implications.

NHS Board Members had approved the previous Business Case and in supporting the steps taken, agreed to endorse the approval process followed on this occasion for committing NHS Board Capital Funds to their element of the Imaging Centre of Excellence.

DECIDED

- That the Committee endorse the approvals process to commit NHS Board Capital Funds to the NHS Board's element of the Imaging Centre of Excellence.

**Director of
Facilities &
Capital Planning**

18. DATE OF NEXT MEETING

9.00am on Tuesday 15 March 2016 in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 12:25pm