NHSGG&C(M)16/04
Minutes: 73 - 93

NHS GREATER GLASGOW AND CLYDE

**Minutes of a Meeting of the
NHS Greater Glasgow and Clyde Board
held in the William Quarrier Conference Centre, 20 St Kenneth Drive,
Glasgow, G51 4QD, on Tuesday, 16 August 2016 at 10a.m.**

PRESENT

Mr J Brown CBE (in the Chair)

Dr J Armstrong	Councillor A Lafferty
Ms S Brimelow OBE	Mr J Legg
Ms M Brown	Dr D Lyons
Mr R Calderwood	Mrs T McAuley OBE (To Minute No 88)
Dr H Cameron	Dr M McGuire
Mr S Carr	Mr A Macleod
Councillor G Casey	Councillor M Macmillan (To Minute No 78)
Mr A Cowan	Mr J Matthews OBE
Dr L de Caestecker (To Minute No 88)	Mrs A M Monaghan
Dame Prof A Dominiczak	Dr R Reid (To Minute No 88)
Ms J Donnelly	Mr I Ritchie
Mr R Finnie	Mrs R Sweeney
Ms J Forbes	Mr M White

IN ATTENDANCE

Dr S Ahmed	Public Health Protection Unit (For Minute No 84)
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Administration
Mr K Hill	Director, Women's & Children's Services (For Minute No 82)
Mr D Leese	Chief Officer, Renfrewshire HSCP (For Minute No 80)
Ms D McErlean	Representing the Area Partnership Forum in Mr D Sime's absence
Mr A McLaws	Director of Corporate Communications
Mrs A MacPherson	Director of Human Resources & Organisational Development
Mr B Moore	Chief Officer, Inverclyde Health & Social Care Partnership
Ms P Mullen	Head of Performance
Mrs K Murray	Chief Officer, East Dunbartonshire Health & Social Care Partnership
Mrs J Reid	Public Health Protection Unit (For Minute No 84)
Ms C Renfrew	Director of Planning & Policy (To Minute No 80)
Dr D Stewart	Deputy Medical Director/Programme Director, Unscheduled Care Review (To Minute No 79)

ACTION BY

73. WELCOME AND APOLOGIES

Mr Brown welcomed the NHS Board, press and members of the public to the meeting.

Apologies for absence were intimated on behalf of Councillor M Devlin, Mr I Fraser, Councillor M Kerr, Councillor M O'Donnell and Mr D Sime.

NOTED

74. DECLARATION(S) OF INTEREST(S)

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

NOTED

75. CHAIR'S OPENING REMARKS

(a) Mr Brown advised that, under the Standing Orders for the proceedings of the business of the Board, it was not his intention to permit members of the public to address the NHS Board or allow their participation in the debate that may take place in relation to the agenda items. With regard to the item "Proposed Approach to Engagement on Service Changes", the engagement process itself would allow all interested parties to make their views known.

(b) Mr Brown thanked the NHS Board Members for their participation in the Annual Review on 4 August 2016 with the Cabinet Secretary for Health & Wellbeing. Although no final response had yet been received from the Scottish Government, informal feedback had been positive in respect of hearing the views from staff and members of the public. When the official letter was received, this would be circulated to Members for information.

(c) Mr Brown referred to the ongoing governance review which included a review of NHS Board agendas including the need for a Chairman's and a Chief Executive's update. He also referred to the ongoing induction sessions for the new NHS Board Members and extended the invitation to existing members if they wished to attend the session with Scottish Government Health Directorate officials.

NOTED

76. MINUTES

On the motion of Dr R Reid, seconded by Dr D Lyons, the minutes of the NHS Board meeting held on Tuesday, 28 June 2016 [NHSGGC(M)16/03] were approved as an accurate record and signed by the Chair pending the following amendments:-

- Page 5, Minute No 49 "Health Promoting Health Service Annual Progress Report", 1st paragraph, delete the word "services" at the end of that sentence and insert "good" before "mental health".

- Page 21, Minute No 67 "GP Out of Hours Services: Changes to Drumchapel Service", 4th paragraph, delete "Dr Reid considered that the priority was in providing out-of-hours patients with a service held on a site with a wider range of clinical services and facilities" and insert "Dr Reid was supportive of the proposal but sought information on the number of patients who required access to a wider range of clinical services". **Director of Planning & Policy**

NOTED

77. MATTERS ARISING FROM THE MINUTES

The Rolling Action List of matters arising was noted. Mr Brown led the NHS Board through some points of clarification and Mr Hamilton confirmed that, in relation to the termination of the contract with Birdston Care Home, the initial agreement for the replacement services would be included in the papers for the October NHS Board meeting. **Head of Administration**

In relation to Minute No 67, "GP Out of Hours Services: Changes to Drumchapel Service", 4th paragraph, Dr Lyons added that, as well as having a concern about signage at the Gartnavel General Hospital site, he was also concerned that the service at Gartnavel General Hospital was able to continue to operate sustainably in light of the additional activity that would have to be absorbed. Ms Renfrew assured Dr Lyons that that had been included in the service to be provided from Gartnavel General Hospital. **Director of Planning & Policy**

NOTED

78. PROPOSED APPROACH TO ENGAGEMENT ON SERVICE CHANGES

A report of the Director of Planning & Policy, Nurse Director and Medical Director [Board Paper No 16/45] asked the NHS Board to approve the proposed approach to public engagement in respect of a series of service changes agreed at the June 2016 NHS Board meeting.

Ms Renfrew referred back to the NHS Board's June 2016 meeting when it approved the Local Delivery Plan which proposed four service changes requiring processes of public engagement. She led the NHS Board through a more detailed description of each of the four proposed service changes, explaining that they reflected the NHS Board's Clinical Services Strategy as approved in January 2015. This established a clear framework to redesign, improve and modernise the NHS Board's clinical services. The proposed service changes were in line with the direction set by the National Clinical Strategy and with other service-specific national strategies.

Ms Renfrew referred to the national guidance "Informing, Engaging and Consulting People in Developing Health and Community Care Services" which required appropriate and proportionate processes reflecting the scale and impact of the service change proposed. She confirmed that engagement on the four proposed service changes reflected this national guidance and she alluded to the engagement approach set out for each of the proposed changes. She explained that the material to be used for the engagement and consultation stages would be developed from the content of the NHS Board paper, however, a stakeholder reference group would be put in place for each of the four proposals, to work with the NHS Board on the engagement materials and processes. Furthermore, discussions with the Scottish Health Council had shaped the approach to each proposal and the NHS Board's final approach to engagement for each of the proposals would be discussed further with the SHC before engagement gets underway at the beginning of September 2016.

By way of summary, she outlined the four proposed service changes as follows:-

- Paediatric services at the Royal Alexandra Hospital;
- Older peoples and rehabilitation services in North East Glasgow – Lightburn Hospital;
- Delivery services in the Community Maternity Units;
- Inpatient care at the Centre for Integrative Care.

Councillor Macmillan reiterated his views made at Minute No. 58 of the June 2016 NHS Board meeting that he considered the process to be flawed, particularly as, on previous occasions, the Scottish Government had not supported these changes. He considered, therefore, that to consult on these made no sense when past history suggested that the proposals would not be supported at Scottish Government level.
Mr Calderwood respected Councillor Macmillan's views but emphasised the NHS Board had already agreed to conduct engagement on these proposals in its Local Delivery Plan which had since been approved by the Scottish Government. He added that, following the engagement processes for the four service reviews, the outcome would be reported back to the NHS Board.

Ms Renfrew summarised the position for each of the proposed changes as follows:-

- The changes to Ward 15, Royal Alexandra Hospital, were previously deemed by the NHS Board to be major and the process to date had reflected that as did the final proposed step of public consultation.

- NHSGGC would continue to engage with the Scottish Government about the Lightburn proposal. The similar proposals from Drumchapel; closing that site and transferring beds and services to Gartnavel General Hospital were not deemed major service change. In any event, the extensive processes NHSGGC was proposing would meet the requirements for a major service change.

- NHSGGC viewed the changes to the Community Maternity Units as not meeting the criteria for major service change. The impact was on a very small number of patients and the proposed process reflected that position and the fact that there had been an extensive previous process including public consutlation.

- The Centre for Integrative Care changes did not affect the range or location of services for patients and were in line with national policy to shift care to ambulatory delivery. NHSGGC did not believe the change met the criteria for major service change.

In response to a question from Mr Carr, Ms Renfrew confirmed that the documents used for the engagements/consultations would be developed with input from the stakeholder reference groups in order to ensure they were easy to read and understand. Responding to his additional question, she confirmed that the role of the NHS Board was to consider the outcome of the appropriate public engagement processes; reach decisions for the CIC and CMUs and on whether to move to public consultation on the Lightburn and Ward 15 proposals.

In response to points made by Councillor Casey, Ms Renfrew reported that, following the previous consultation on the future of the Community Maternity Units (CMUs), the NHS Board had agreed to undertake an extensive programme of communication to try to increase the number of women opting to use the delivery services. There had been a range of marketing activity to achieve this and midwifery staff at both CMUs had actively promoted births within the units. The Vale Vision, at that time, committed NHSGGC to continue the delivery service for three years to try to increase numbers. The data included in the board paper illustrated that those efforts had not succeeded with 11 births at the IRH and 35 births at the Vale in 2015/16.

Dr Lyons raised points around capacity, sustainability of remaining services and transport analysis. Mr Calderwood confirmed that further detail around these points would be included in the final engagement papers. He added that transport modelling had included input from the Scottish Ambulance Service.

Ms Brown asked for clarification around the commitment to "consult" versus that to

"engage". Ms Renfrew explained that these terms reflected the requirements of the guidance referred to in the papers, the stages of the process and the scale of each change. The approach will be further developed for each proposed service change with the Scottish Health Council and the stakeholder reference groups.

Mr Calderwood referred to the NHS Board's Annual Review on 4 August 2016, hosted by the Cabinet Secretary for Health & Wellbeing and in response to a question, the Cabinet Secretary confirmation that she was aware of the Board's proposals to engage in respect of these proposed service changes. This was in accordance with due process and, following the NHS Board's decision made at its June 2016 meeting to engage on these proposals.

Councillor Macmillan proposed to move against the substantive motion, namely, "to proceed with public engagement on a series of service changes, this paper invites the Board to approve the proposed approach to public engagement". The NHS Board agreed to vote on the motion proposed by Councillor Macmillan and seconded by Councillor Casey. The result was as follows:-

- 2 for;
- 22 against;
- 3 abstentions.

The move against the recommendation therefore, fell.

DECIDED

- That the NHS Board approve the proposed approach to public engagement following its decision made in June 2016 to proceed with public engagement on a series of service changes.

Director of Planning & Policy, Nurse Director, Medical Director

79. NHSGGC UNSCHEDULED CARE PROGRAMME – AUGUST 2016

A report of the Deputy Medical Director/Programme Director, Unscheduled Care Review [Board Paper No 16/46] asked the NHS Board to note actions to improve unscheduled care and the governance structure, approach and overview of the work led by the Programme Board.

Dr Stewart explained that, during 2015/16, NHSGGC had delivered an extensive programme of improvement work across the Acute Division structure. Whilst significant improvements had been made, there was still work to be done to deliver consistently the 95% unscheduled care compliance standard. He explained that the NHS Board had established clinically led governance arrangements ensuring that all relevant people would be able to contribute to improving the NHS Board's unscheduled care performance to deliver the national standard.

He explained that the objective was to design a process for centrally supporting priority unscheduled care improvement work that had been identified through robust analysis of demand and capacity across the NHS Board and summarised the governance structure set up to support this. He alluded to eight programme workstreams which would provide the framework for the three geographic sectors within the Acute Division to develop their key priorities. Additionally, a Task and Finish Group was being established for each key priority with both clinical and managerial leads assigned to develop an improvement action plan, agree timescales and drive progress.

In response to a question, Dr Stewart confirmed that, in addition to the demand and capacity analysis, a high level generic patient flow model had been developed that

enabled the understanding of various routes into the hospital, relevant pathways, and to isolate the associated number of patients moving through pathways on a daily and hourly basis. This approach provided insight where demand at peak times could result in flow blockages and, therefore, provided another vehicle to support the key prioritisation process within the sectors.

Deputy Medical Director/ Programme Director, Unscheduled Care Review

Mr Carr asked about timescales and Dr Stewart explained that the eight workstreams had various timeframes and that much of the learning would be from analysis undertaken as the workstreams developed into the longer term. He would ensure, however, that the NHS Board received regular update reports on progress.

In response to a question from Ms Brown, Dr Stewart confirmed that the review encompassed all services including porterage, pharmacy and patient discharge processes.

NOTED

80. TRANSITION TO HOSPITAL BASED COMPLEX CARE: UPDATE

A report of the Director of Planning & Policy [Board Paper No 16/47] asked the NHS Board to note progress made by NHSGGC since May 2015, when the Scottish Government announced that the provision of Continuing Care by the NHS would end and be replaced by the concept of Hospital-Based Complex Care (HBCC) establishing a simple test for eligibility.

Ms Renfrew reported that the NHS Board had established a planning process with the Health & Social Care Partnerships to plan the services to replace Continuing Care, reporting that these continuing care beds would be replaced by HBCC provided on the Acute Hospital sites and extended community and care home services provided by Health & Social Care Partnerships.

She summarised some of the work underway to develop and implement the new arrangements and reported that transition arrangements were being put in place to ensure the continued use of former continuing care beds while new forms of care were developed and implemented.

Ms Brimelow highlighted that moving to such new arrangements was complex with the need to deal appropriately with individual patients, reshape contracted services and develop new models of clinical care in hospitals, care homes and in the community. She welcomed the progress being made in NHSGGC and, in response to her question, Ms Renfrew explained that the new arrangements did not include specialist palliative care.

NOTED

81. CARERS ACT COMMENCEMENT DATE

A report of the Director of Nursing [Board Paper No 16/48] asked the NHS Board to endorse the importance of the role of carers within NHSGGC, support the process outlined to achieve "readiness" in time for commencement of the Carers Act, and receive a further update in 12 months.

Dr McGuire explained that the Carers (Scotland) Act 2016 was passed on 4 February 2016. It gained Royal Assent on 9 March 2016. The implementation of the provisions in the Act, which were designed to support carers' health and wellbeing, would

commence on 1 April 2018 and build on the aims and objectives set out in the National Carers & Young Carers Strategy 2010-2015. She outlined the main proposals in the Act and summarised local progress in NHSGGC, in particular, development of the NHSGGC Carer Pathway and the Carer Development Plan. Additionally, a Patient & Carers Experience Group would support the development of the plan and robust links with carers' centres and local HSCPs would further support carer and front line engagement.

In response to a question from Dr Lyons, Dr McGuire explained that Local Authorities similarly had a duty to comply with the Act and, locally, this would be driven by HSCP Leads.

DECIDED

- That the importance of the role of carers within NHSGGC be endorsed. **Nurse Director**
- That the process outlined to achieve "readiness" in time for commencement of the Carers Act be supported. **" "**
- That a further update in 12 months be received. **" "**

82. NAMING OF PLAY AREAS AT THE ROYAL HOSPITAL FOR CHILDREN

A report of the Director, Women's & Children's Services [Board Paper No 16/49] asked the NHS Board to approve the proposal for determining the name for each play area at the Royal Hospital for Children.

Mr Hill explained that the NHS Board was being asked to approve a proposal to determine a shortlist of preferred names and, through a patient participative process, decide a name for the Royal Hospital for Children's rooftop garden and external play park.

In response to two points, Mr Hill explained that the Glasgow Children's Hospital Charity representative proposed for the naming panel membership would represent all the respective charities. Given that there was a third play area within the grounds of the Royal Hospital for Children, it was suggested that this also form part of the naming process so that all three areas received a formal name from the naming panel. This was agreed. **Director, W&C Services**

DECIDED

- That the proposal for determining the name for each of the three play areas within the Royal Hospital for Children, be approved and that this be undertaken by the short term naming panel. **Director, W&C Services**

83. REVIEW OF GOVERNANCE ARRANGMENTS – REVISED COMMITTEE AND IJBS MEMBERSHIPS

A report of the Head of Administration [Board Paper No 16/50] asked the NHS Board to approve the memberships of the NHS Board's Standing Committees and Non-Executive membership of the Integrated Joint Boards (IJBs). Members were asked to note two alternations to the paper; Ms Donnelly was unable to take the position up on the Glasgow IJB due to a work conflict of interest and was replaced by Mr Finnie. In addition, Ms Donnelly would join the Staff Governance Committee.

In response to a question from Ms Brimelow, Mr Hamilton confirmed that the membership of the Pharmacy Practices Committee had been within the scope of the review and that the paper would be updated to reflect this.

Mr Carr made a plea that non executive and executive members should, wherever possible, have NHS Board papers sent to them electronically to reduce the administrative burden on NHS Board Secretariat staff who had to hard-copy papers for certain members and officers especially in view of the decision taken by the NHS Board, at the last meeting, to establish two new sub committees. Mr Carr asked if both new sub committees could be supported by the current team and Mr Hamilton confirmed that that was the case. Mr Brown echoed these remarks and also highlighted the excellent support that members enjoyed from the Secretariat team.

DECIDED

- That the NHS Board's Standing Committees' memberships be approved. **Head of Administration**
- That the Non-Executive membership of the Integrated Joint Boards be approved. **" "**

84. IMMUNISATION PROGRAMMES IN NHSGGC 2015-2016

A report of the Director of Public Health [Board Paper No 16/51] asked the NHS Board to note the report and, in particular, the uptake rates across a number of immunisation programmes and the new delivery model being implemented in NHSGGC to deliver school immunisation programmes.

Dr Ahmed delivered a presentation providing an overview of all of vaccination programmes and their uptake rates which were a key performance measure of any immunisation programme, particularly because, if immunisation rates fall, the possibility of disease transmission increases. He explained that uptake across all programmes was shared with key stakeholders on a regular basis to encourage continuing efforts to improve. He led the NHS Board through a summary of the following programmes and their uptake rates:-

- Routine childhood immunisation programme;
- HPV immunisation programme;
- Teenage booster immunisations;
- Seasonal flu vaccination;
- Herpes zoster (shingles) vaccination.

He reported that there was currently a need for NHS Boards across Scotland to review delivery models for school immunisation programmes and, following a pilot in East Renfrewshire and South Glasgow Health & Social Care Partnerships in 2015/16 using trained nurses with support from healthcare support workers to administer the flu nasal spray, extremely useful learning was generated and was now informing full implementation across NHSGGC. Given this, NHSGGC was leading on the recruitment and implementation of four dedicated school immunisation teams that would deliver the primary school flu, HPV and teenage booster immunisation programmes with the teams hosted by Glasgow City HSCP. These teams would be supported by staff from Child Health, Public Health Pharmacy, Public Health and the nurse bank, and would have many advantages.

In response to a question from Dr Lyons regarding the uptake of the flu vaccine amongst those aged 65 years and over, Dr Ahmed recorded that there was room for improvement in NHSGGC and work would continue with practices to ensure this

group continued to be targeted. Similarly, with those "at risk" where uptake was significantly lower, this was not unique to NHSGGC. In response to a further question about the uptake rate for immunisation in the learning disability patient group, Dr Ahmed reported that NHSGGC worked with specialist schools and uptake rates could be identified via that route.

Dr Reid asked about the shingles vaccination which was available to those aged 70 years, with a phased catch-up for 71-79 year olds. In response to his question, Dr Ahmed explained that this was UK policy and that over 80 year olds, although not in the target group, could be immunised following individual clinical assessment.

In response to a question from Mr Cowan, Dr de Caestecker confirmed that the NHS Board (and HSCPs) were heightening work with practices to address the declining trend in cervical screening. Dr Ahmed also added that all data was shared with NHSGGC's practices so that lessons could be learned and they had the opportunity to benchmark against, not only others within their area, but within NHSGGC. In response to a further question from Mr Cowan about the four new school immunisation teams in NHSGGC, Ms Reid explained that, prior to their conception, modelling work was undertaken, looking at volume and capacity, so she expected this would meet demand.

Mr Matthews wondered, in general terms, whether there were any lessons for the broader NHS in relation to uptake rates to the programmes. Dr Ahmed responded in the affirmative and referred to the approach taken at schools where there was a captive audience rather than expecting patients to engage with primary care services of their own accord. It also highlighted the value of universal programmes to tackle inequalities.

Ms Brown welcomed the information that this report provided and encouraged the enhanced involvement of HSCPs with practices and primary care colleagues to work towards improvements. She also alluded to the continued difficulty in increasing staff uptake, particularly in respect of the flu vaccination and Dr Ahmed agreed that this remained a challenge but Public Health staff would continue to support Occupational Health staff in their efforts to improve uptake.

NOTED

85. CLINICAL GOVERNANCE ANNUAL REPORT 2015/16

A report of the Medical Director [Board Paper No 16/52] asked the NHS Board to note the NHSGGC Clinical Governance Annual Report 2015/16 and the clinical governance priorities outlined for the forthcoming year.

Dr Armstrong reported that, each year, the NHS Board provided an Annual Report reflecting on its clinical governance arrangements and the progress it had made in improving the quality of clinical care. The report was structured around the three main domains set out in the National Quality Strategy (safe, effective, person-centred care), and also contained a section on the Nursing, Midwifery and Allied Health Professionals Directorate. Under each of these themes, she summarised some examples of completed, continuing and newly commissioned programmes of work.

Dr Armstrong highlighted the role of clinical governance and a number of changes to the clinical governance arrangements in a period of substantial change and reorganisation within both the Acute Services Division structure and the integration and development of the HSCPs.

She concluded by describing a range of areas which NHSGGC required to progress over the coming year.

Mrs McAuley commended the report and its comprehensive look back on improvement work undertaken by the Clinical Governance Team. In response to her question, Dr McGuire described how feedback from people using NHSGGC's services at the point of care was used specifically to influence and drive improvements and to design improvement interventions and actions through a coaching, mentoring and support relationship with clinical teams.

Mr Carr asked how NHSGGC measured its success in this regard and Dr McGuire referred to the use of a data dashboard and patient experience surveys. Both quantitative and qualitative feedback was gathered over consecutive monthly cycles and was reported directly back to the clinical teams and their managers. The continuous cycle of gathering feedback helped the clinical teams to evaluate the impact and outcome of the improvement interventions and actions they had implemented on the care experience of people they came into contact with.

Mr Finnie suggested that the information provided in paragraph 4.1.2 be highlighted earlier in the document as it set some real time context, illustrating the scale of activity associated with NHSGGC. **Medical Director**

Mr Ritchie referred to "Avoiding Serious Event Monitoring" and Dr Armstrong explained that such events were considered in greater detail as part of the Scottish Patient Safety Programme (SPSP). She added however, that such events in NHSGGC were of a very small number. Furthermore, the Significant Clinical Incident (SCI) process included a systematic route/cause analysis and further information could be shared with Board Members in future. **Medical Director**

Dr Cameron also commended the report, particularly its focus on outcomes rather than outputs and the way it balanced patient safety as well as quality.

NOTED

86. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No 16/53] 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 NHSGGC 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

Dr Armstrong was asked to submit a paper to the October 2016 NHS Board Meeting setting out how actions around SABs and changes to practice were being implemented. **Medical Director**

Ms Brimelow requested that future reports provide more detail on any HEI reports that had been issued in relation to NHSGGC's services. Dr Armstrong acknowledged that a link was included in the NHS Board paper, at the moment, but that further detail could be provided in future reports. She added however, that more detail on recommendations from the inspections were considered by the NHS Board's Clinical Governance Forum. **Medical Director**

NOTED

87. NHSGGC'S INTEGRATED PERFORMANCE REPORT

A report of the Head of Performance [Board Paper No 16/54] 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 approved 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 within which performance would improve.

Ms Mullen provided:-

- A summary providing a current performance overview.
- 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

88. FINANCIAL MONITORING REPORT FOR THE 3 MONTH PERIOD TO 30 JUNE 2016

A report of the Director of Finance [Board Paper No 16/55] asked the NHS Board to note the financial performance for the three month period to 30 June 2016.

Mr White reported that the NHS Board was currently reporting an overspend outturn against budget of £9.5m. At this stage, however, the NHS Board forecast that a year-end break even outturn remained achievable through additional savings and non-recurrent coverage. There was a risk however, that the NHS Board entered 2017/18 with minimal reserves.

He led the NHS Board through expenditure on Acute Services, NHS Partnerships, Corporate Services and other budgets.

At this stage in the year, the NHS Board was behind its year to date cost savings target

against plan.

Capital expenditure in the year to date amounted to £8.3m and it was anticipated that a balanced year-end position would be achieved against the NHS Board's capital resource limit. This was incurred chiefly in respect of continuing works at the Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC) campus. Regular programme reviews would be undertaken throughout the year in order to identify the extent to which revised plans needed to be put in place to ensure that the 2016/17 capital position remained in balance.

In response to a question, Mr White reported that, in terms of quantifying risk inherent in achieving break-even, he estimated the plan carried financial risk of between £20m to £25m. Should this risk crystallise, there were insufficient reserves to provide cover and it would require receipts from projected land sales to ensure financial balance but this carried a high degree of risk due to the complexity and uncertainty over the timing and level of capital receipts.

Dr Lyons asked about the Partnerships' position and Mr White explained that, as at 30 June 2016, the Partnerships' position was an overspend of £4m. At this stage, no non-recurring in-year relief had been allocated to individual Partnerships but this would be confirmed and allocated by the end of the month 5 reporting period. Councillor Lafferty followed this up by seeking further information about the additional savings that had to be made locally at the six IJBs level. Mr Calderwood reported that negotiations would continue with each of the six IJBs, looking at their cost improvement programmes, budgets and the National Resource Allocation Committee (NRAC) share formula funding model.

In response to a question from Mr Ritchie and Mrs McAuley about medical locum overspend on premium agency staff, Mr Calderwood summarised some of the analysis that had been undertaken including a number of difficult to fill consultant posts, sickness absence (and the need to backfill) and occasions where senior staff "acted down" to meet medical cover requirements. These remained a key focus for cost containment initiatives and would be an important factor in dealing with the financial challenge in 2016/17.

In response to a question from Ms Brimelow about national initiatives and any impact they may have on NHSGGC, Mr White provided some examples including initiatives looking at shared services, reducing private sector spend as well as medical locum spend. He confirmed that work was ongoing and that further detail would be provided in future reports. **Director of Finance**

In response to a question from Mr Matthews about a monetary value for staff sickness absence, Mr Calderwood referred to the various strains of sickness absence and the NHS Board's Attendance Management Policy to tackle these. He added that it was very difficult now to absorb clinical staff sickness into the workforce without the use of backfill staff and it was this that incurred the expense locally. Mr White added that it was possible to include further information about sickness absence in future reports. **Director of Finance**

Mr Brown referred to the new NHS Board Standing Committee (Finance & Planning Committee) due to be established shortly and confirmed that this would have a role in scrutinising all elements of the NHS Board's financial plan. He also suggested that, given the level of interest in the topic, that the NHS Board add a session to its Board Development Programme on managing sickness absence. This was agreed. **Head of Administration**

NOTED

89. FREEDOM OF INFORMATION MONITORING REPORT FOR THE PERIOD 1 APRIL 2015 TO 31 MARCH 2016

A report of the Head of Administration [Board Paper No 16/56] asked the NHS Board to note the annual monitoring report on the operation of the Freedom of Information (FOI) Scotland Act 2002 and the Environmental Information (Scotland) Regulations (EIR) 2004 within NHSGGC for the period 1 April 2015 to 31 March 2016.

Mr Hamilton led the NHS Board through the statistical summary of overall number of FOI/EIR requests received by NHSGGC during 2015/16 and summarised the detail of these requests. He reported that, with the creation of Integrated Joint Boards/HSCPs, the new bodies were each responsible for responding to FOI requests in the same way as the NHS Board and for other obligations under the Act such as the requirement to adopt a model publication scheme.

As well as thanking the two Non-Executive Members who had been involved in considering the requests for review, Mr Hamilton thanked the newly formed dedicated team who now dealt with the majority of FOI requests to NHSGGC.

Dr Lyons was impressed that only 1.7% of FOI requests led to an appeal and Mrs McAuley commended the overall performance, noting that 92% of requests were responded to within the requirement of 20 working days.

NOTED

90. ACUTE SERVICES COMMITTEE MINUTES: 17 MAY 2016

The minutes of the Acute Services Committee meeting held on 17 May 2016 [ASC(M)16/03] were noted.

NOTED

91. AREA CLINICAL FORUM MINUTES: 2 JUNE 2016

The minutes of the Area Clinical Forum meeting held on 2 June 2016 [ACF(M)16/03] were noted.

NOTED

92. AUDIT COMMITTEE MINUTES: 21 JUNE 2016

The minutes of the Audit Committee meeting held on 21 June 2016 [A(M)16/03] were noted.

NOTED

93. ANY OTHER BUSINESS

(a) In closing the meeting, Mr Brown thanked all those in attendance. He welcomed back Dr de Caestecker from her 12 month secondment as well as the eight new Non-Executive Members. He also introduced Mrs McErlean, in attendance to represent Mr Sime, on this occasion, but from 1 October 2016 would be the Chair, Area Partnership Forum and, therefore, an NHS Board Member (as Employee Director). In welcoming Mrs McErlean, he commended the contribution made to the NHS Board and the Staff Partnership Forum by Mr Sime who was due to retire from the NHS on 30 September 2016.

Mr Brown also recorded his appreciation to Mrs Murray as she was retiring as Chief Officer of East Dunbartonshire HSCP and he wished her well for the future. He also recorded the NHS Board's thanks for the contribution made by Councillor McIlwee who had resigned from the NHS Board and his replacement was awaited from Inverclyde Council.

(b) After 45 years NHS service and nearly eight years as Chief Executive of NHSGGC, Mr Calderwood announced his retirement to the NHS Board from the end of January 2017. Mr Brown, on behalf of the NHS Board recognised and thanked Mr Calderwood for the significant contribution he had made to the NHS in Scotland over his long and successful career. Mr Brown added his personal thanks for the advice and support Mr Calderwood had given him since becoming Chair.

The meeting ended at 1:25pm.