

APPROVED AS A CORRECT RECORD
BOARD OFFICIAL

ASC(M)16/06
Minutes: 97 - 119

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Acute Services Committee held at
9.00am on Tuesday, 15 November 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 R Finnie (Committee Chair)

Ms S Brimelow	Ms J Donnelly
Ms M Brown	Mr J Legg
Mr S Carr	Dr D Lyons
Councillor G Casey	Dr R Reid
Mrs D McErlean	

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 R Calderwood
Dr De Caestecker	Dr M McGuire
Mr M White	

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

Mr J Best	..	Director, North Sector
Mr P Cannon	..	Deputy Head of Administration
Mr G Jenkins	..	Director, Regional Services
Mr A McLaws	..	Director of Communications
Mrs A MacPherson	..	Director of Human Resources & Organisational Development
Ms P Mullen	..	Head of Performance
Ms C Renfrew	..	Director of Planning & Policy
Dr D Stewart	..	Deputy Medical Director

97. APOLOGIES, WELCOME AND PRELIMINARIES

Apologies were intimated on behalf of Mr Fraser, Cllr MacMillan and Mr I Ritchie.

98. DECLARATIONS OF INTEREST

Dr Lyons declared an interest in relation to his membership of the Equality & Human Rights Commission in relation to item 113 – Disability Recruitment Statistics. There were no other declarations of interest

99. MINUTES OF PREVIOUS MEETING

On the motion of Mr Reid, and seconded by Dr Lyons, the Minutes of the Acute Services Committee meeting held on 20 September 2016 [ASC(M)16/05] were approved as a correct record subject to clarification at minute 92 that the Horatio's Garden scheme was undertaken with support from the Board's Endowment Funds.

NOTED

100. MATTERS ARISING

a) Rolling Action List

It was noted that there were a number of items which could be updated or possibly removed from the Rolling Action List and officers were asked to liaise with Mr Cannon to update the list accordingly.

101. TERMS OF REFERENCE

There was submitted a paper [Paper No 16/64] by the Deputy Head of Administration setting out a revised Terms of Reference for the Committee in the light of the impact of newly established Board Standing Committees. It was noted that the three Standing Committee Terms of Reference (Acute Services / Finance & Planning, and Clinical & Care Governance Committee(s)) will be submitted in a standardised format to the Board in April 2017 for approval.

Members' comments were noted and a further draft will be submitted to the March 2017 meeting.

**Deputy Head of
Administration**

NOTED

102. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT

There was submitted a paper [Paper No 16/65] by the Head of Performance setting out the integrated overview of NHSGGC Acute Services Division's performance. Of the 25 measures which had been assessed against a performance status based on their variation from trajectory and/or target, 12 were assessed as green, 3 as amber (performance within 5% of trajectory) and 10 as red (performance 5% outwith meeting trajectory). Exception reports had been provided for those measures which had been assessed as red.

It was noted that, while improvements were evident across a range of measures, there were key measures where the trend was showing reduced compliance with targets in areas including the percentage of new appointment DNAs, the number of patients waiting >6 weeks for a key diagnostic test, and the Board's overall financial performance.

In relation to performance overall, Mr Carr commented that there were a number of areas where performance was deteriorating and it would be helpful to see in future some trend analysis so that it was easier for members to track performance over a longer period, and it was also agreed that it would be useful to see how each measure compared with the national position to provide some context. Mr Calderwood

reminded members of the challenges facing the Board in meeting patient demands across a wide range of services, and that Officers were engaged in a series of specialty by specialty analyses to identify supply and demand ranges, and productivity gains, which will be required in 2017/18 in order to address supply imbalances across the system. Mr Calderwood agreed it would be useful to see trends and some national context and it was noted that the format of the report would be updated to reflect these suggestions.

T Mullen

In relation to delayed discharges, and in response to concerns raised by Ms Brown about Glasgow City HSCP, and the impact of patients from neighbouring NHS Boards, Ms Renfrew stated that Glasgow City HSCP had committed to reducing further the numbers of patients delayed, but that this had not been delivered at the levels expected, and there were still around 60 patients delayed on average. It was acknowledged that this was a significant improvement on previous year's levels but needed to improve further. Discussions were therefore ongoing with Glasgow City HSCP counterparts to agree a series of further actions to reduce the number of delayed patients on a sustained basis. It was also noted that there were regular engagements with neighbouring NHS Boards to discuss their own delayed patients. It was also acknowledged that Non Executive Members who were members of Integrated Joint Boards played a critical role in ensuring that this issue was discussed regularly and afforded the appropriate priority in each IJB.

Mr Finnie commented that the delivery of performance in this area was a clear responsibility of the Integrated Joint Boards and that performance, and the adverse impact of high numbers of delayed discharges on Acute spend, should feature in discussions around financial allocations to IJBs in 2017/18.

In relation to Diagnostic waiting times, Mr Finnie asked if there was an issue in relation to physical capacity. Mr Calderwood stated that the Board had met an internal target of 4 weeks for many years, exceeding the national target of 6 weeks, but that this position was increasingly more difficult to maintain in the face of increasing demands.

In relation to Cancer targets, in particular the 62 day treatment target, and in response to a question from Dr Reid, it was noted that patients joining the Glasgow pathway who started their treatment in another Board, and who had been referred to Glasgow services late in the pathway were included in the overall number of patients reported to have been treated outwith the target. It was agreed that it would be helpful to show NHS GG&C and other Boards patients separately.

NOTED

103. ACUTE DIVISION LEADERSHIP EVENT

There was submitted a paper [Paper No 16/66] from the Director of Policy & Planning which set out a summary of the key themes emerging from an Acute Division Leadership event at the end of October 2016, which was arranged to discuss the unprecedented challenges which the Division was facing through this year and into 2017/18. It was noted that the main focus of the event was to discuss actions required to address those challenges while sustaining and improving patient services.

Members noted the emerging themes and that another follow up Leadership event will be arranged in early 2017.

NOTED

104. ACUTE SERVICES SUMMARY ON INTERIM REPORT FOR UNSCHEDULED CARE

There was submitted a paper [Paper No 16/67] by the Deputy Medical Director which set out the Interim Report on Improving Unscheduled Care. The interim report included details of the governance structure, the approach and an overview of the Board programme of work, and it was noted that a final report would be produced in March 2017. The summary paper described the key recommendations and the continued focus for the improvement programme.

Dr Stewart took members through the Interim Report in detail, highlighting that many of the measures being tested in individual Hospitals, would, if found to be effective, be rolled out to all Acute Emergency Departments.

Dr Stewart emphasised the ‘whole system’ approach to the unscheduled care challenge and had been engaging with colleagues in Primary Care and the Scottish Ambulance Service to respond to the challenge. A programme of clinically led improvement work was being progressed aligned to the National 6 Essential Actions framework to contribute to improving the Board’s UCC performance to deliver the National Standard.

In addition to delivering a final report, Dr Stewart emphasised that the governance structure will sponsor a programme of improvement activity over the next 12 months, to support continued improvement, aligned to the key recommendations. A GGC Programme Plan will be developed to describe the deliverables and timescales of the various projects and Sectors will be required to set up local Task & Finish Groups to progress the work. At Board level it was noted that the Programme Board had developed a comprehensive programme management approach including standard documentation, project plans and highlight reports. Sectors would now use this new approach to move from project set up through to implementation to allow the Board to effectively monitor and report progress. This approach will provide both transparency and assurance on the timescale and deliverables aligned to the key recommendations associated with improving unscheduled care.

In response to a question raised by Ms Brown, Dr Stewart indicated that while there was not a GP representative on the Programme Board there had been wide ranging engagement with Primary Care.

Mr Carr commented that there was no single measure that would improve matters quickly and commended the approach that was being adopted to look at every facet of the patient pathway so that small marginal changes could be made to a significant number of pathways to bring about sustained improvement in performance.

Mrs Brimelow highlighted the need to maintain focus on the quality of care as well as meeting targets and for any changes to be safe and sustainable.

Mr Finnie thanked Dr Stewart for his report, and for the efforts of the Programme Board and the wider clinical community in taking these initiatives forward.

NOTED

105. ACUTE SERVICES STRATEGY: FOLLOW UP TO BOARD TIME-OUT

There was submitted a paper [Paper No 16/68] from the Director of Policy &

Planning which set out a draft Acute Services Strategy, and it was noted that this had been developed to take account of feedback provided at the recent Board Away Day(s) on 1 / 2 November 2016, and that further refinement would be undertaken in order to develop the strategic plan for acute services. The objectives were to ensure that the Division was able to:-

- Set 2017/18 service change proposals in the context of a strategic plan.
- Establish a clear direction for further detailed clinical service planning;
- Establish early and comprehensive engagement with patients and the public;
- Deliver clear plans for each site and capital investment priorities.
- Enable coherent engagement and planning with HSCPs, particularly to ensure that their services synchronised with acute services.
- Define and deliver affordable acute services.

The draft brought together the material and issues discussed through the prior discussion at Board meetings and Board Seminars and the Acute Services Committee was invited to contribute in taking the draft to the next stage of developing the strategy.

The draft paper set out the framework for Patient and Public Engagement and the next steps in the development of the draft Strategy. It was noted that a further iteration of the paper will be considered at the Finance and Planning Committee at the end of November and thereafter at the December seminar, with the intention of bringing the final strategy the December Board meeting.

Mr McLaws underlined the need to engage with clinical staff and for their views to be at the forefront of any wider public engagement processes.

Mr Carr commented that the paper should reflect the long term aspirations of the Board, and use data that was publically available and published by Audit Scotland, looking at 2030 predictions, as part of the framework for the Acute Strategy. Members concurred and Mr Calderwood suggested that the paper should be developed further to set out a longer term vision, moving beyond a series of challenges and questions. Mr Finnie agreed, and stated that it was important that the Strategy moved beyond questions to set out clear goals and future bed configurations.

It was noted that the Strategy would set out the aims and objectives, but that this would be followed up with a more detailed implementation paper setting out more detail around how the Strategy was to be implemented, looking at capital, workforce issues, sites, financial impacts and bed configurations. It was acknowledged that the overarching Strategy would set the framework, rather than set out the detail.

Dr Armstrong reminded colleagues that the Board's Clinical Strategy Review set out the direction of travel, and that this could provide building blocks for the development of the Acute Services Strategy.

Mr Finnie thanked Ms Renfrew for her efforts in developing the Strategy and looked forward to debating the content as this was developed in the coming weeks.

NOTED

106. SCHEDULED CARE IMPROVEMENT PROGRAMME

There was submitted a paper [Paper No 16/69] from the Director of Policy & Planning which set out the actions being taken forward to improve the productivity and efficiency of scheduled care. The paper provided examples of specialty reviews already undertaken using templates developed by Business Intelligence to identify areas where action could be taken to reduce unfunded waiting list initiatives and improve productivity.

Ms Renfrew reminded Members that the Board's 2016/17 Local Delivery Plan highlighted the challenges the Board expected to face in meeting the national outpatient and inpatient waiting time targets. Achieving those targets continued to be the aim but there was a gap between the required capacity to deliver that objective and funded capacity. The work to improve productivity was the means by which Officers were focused on reducing that gap, as far as possible.

Mr Calderwood highlighted the need to review all services across the Division to drive out inefficiencies and ensure that all services were, in the short term, utilising existing resources maximally. In addition, Mr Calderwood alluded to the range of additional measures being assessed around premium rate agencies, medical locums and other areas of discretionary spend, to establish a new baseline for describing the Division's capacity.

Dr Cameron welcomed the approach and also highlighted the need to look at alternatives to appointments with Consultants beyond the first appointment. There were many Allied Health Professionals and Nurses who could fulfil this requirement, freeing up Consultants to see and assess more new patients.

Ms Renfrew reported that these reviews were also useful in identifying areas where the interface between Acute Services and Primary Care could be improved and these discussions were being taken forward with the Primary Care colleagues.

Dr Lyons commented that patient focussed booking had been demonstrated to be successful in areas where this was used and welcomed the intention to roll this process out to all areas.

NOTED

107. HIS REVIEW OF BEATSON WEST OF SCOTLAND CANCER CARE CENTRE – UPDATE ON PROGRESS

There was submitted a paper [Paper No 16/70] by the Medical Director which set out an update on the actions taken and progress made to date against the four recommendations made in the Healthcare Improvement Scotland (HIS) review of the Beatson West of Scotland Cancer Care Centre in October 2015.

Dr Armstrong reminded Members that in May 2015 concerns were raised by medical staff which resulted in HIS visiting the BWoS CC in July 2015. On 7th October 2015 HIS published the report of its review, and Members were asked to note the progress update provided by Dr Armstrong in relation to each of the four recommendations. It was also noted that HIS had asked that the Board provided an update on progress by 9th December 2016. The paper and attached report set out in detail the actions taken and progress made to date against the four recommendations and was the proposed update report for submission to HIS in December.

Members noted the significant progress made and thanked Dr Armstrong and Mrs MacPherson for their efforts in addressing the four recommendations robustly and positively and for improving working relationships between consultants at the Beatson and the NHS Greater Glasgow and Clyde management team. Members also endorsed the recommendations made in the BWoSCC Future Steering Group Report.

NOTED

108. PERFORMANCE REVIEW GROUP FEEDBACK REPORT

There was submitted a paper [Paper No 16/71] by the Head of Performance which set out the key themes arising from the completion of the September 2016-17 Performance Review Group meetings (PRGs).

It was noted that the detail of the actions agreed at each of the PRGs was attached in an appendix and that progress against the key actions identified will be considered during the next round of PRG meetings scheduled to take place between December 2016 - January 2017.

NOTED

109. PATIENT ADVISED UNAVAILABILITY

There was submitted a paper [Paper No 16/72] by the Director, North Sector, which set out the position at November 2016 in relation to patient advised unavailability.

Mr Best reminded Members that following the publication of a national Information Services Division (ISD) Report that showed the use of locational unavailability by NHS Greater Glasgow and Clyde was higher than other NHS Boards in Scotland, a joint programme of work was agreed with the Scottish Government. It was noted that the Scottish Government Access Team had allocated £2m of non recurring funding to address this. The work focussed on addressing the use of locational unavailability across NHS Greater Glasgow and Clyde area.

In June 2016 the use of locational unavailability ceased across NHS Greater Glasgow and Clyde and a Short Life Working Group was established to ensure a consistent approach across the Sectors and Directorates going forward. Work commenced initially in General Surgery to identify and treat patients who had had locational unavailability applied and had been waiting long periods.

It was noted that one of the impacts of this change was that the number of patients on the true waiting list had increased and it had also led to an increase in the number of patients who had waited more than 12 weeks for inpatient and day case treatment. This was particularly noticeable in those sites where previously a large number of patients wished to be treated locally – i.e. Inverclyde Royal Hospital and the Victoria Infirmary.

It was noted that the next phase of work had commenced and was progressing well. Over 250 surgical patients will be treated by the end of January 2017.

NOTED

110. PUBLIC HEALTH SCREENING PROGRAMMES

There was submitted a paper [Paper No 16/73] by the Director of Public Health which described progress in addressing the challenges to the acute services in NHSGGC that arise from its public health screening programmes.

Dr De Caestecker asked Members to note that the Public Health Screening Unit coordinates screening programmes that are delivered by national, regional and local services. The screening unit works with acute services to identify and manage issues that were described in the report in detail, programme by programme.

Mr Finnie thanked Dr De Caestecker for her detailed and informative update.

NOTED

111. DETECT CANCER EARLY

There was submitted a paper [Paper No 16/74] by the Director, Regional Services which highlighted some of the work undertaken by health improvement teams and in conjunction with the CRUK Cancer Facilitator Programme aligned to the National Detect Cancer Early Programme, namely:

- Board-wide promotion of national campaign materials to staff and NHSGGC population
- Targeted awareness raising with low-uptake of screening groups and those at highest risk of developing cancer
- Engagement and sharing of best practice with GP Practices.

Mr Jenkins reminded Members that this paper had been sought at an earlier meeting to provide reassurance that deprived areas and patients with protected characteristics were being appropriately addressed.

Dr Lyons welcomed the report and highlighted that in his experience the role of the voluntary sector was key to reaching patients with learning disability, and Dr De Caestecker agreed, and indicated that the Board did work closely with colleagues in the Third Sector.

NOTED

112. NHSGG&C'S CESSATION PLAN TO DISCONNECT 'OFF CONTRACT' PREMIUM RATE AGENCY USE

There was submitted a paper [Paper No 16/75] by the Nurse Director which provided the Board response to a request from Scottish Government to all NHS Health Boards to cease using Premium Rate Agency (PRA) to address supplementary staffing issues.

The paper described the current staffing issues being experienced by the nursing and midwifery profession and why supplementary staffing has been incrementally rising over the last few years. The measures NHSGGC were putting in place to ensure efficient use of supplementary staffing to provide safe and effective patient care in conjunction with the planned national cessation of NHS Boards use of Premium Rate Agency (PRA) were also described.

It was noted that a general high level risk assessment had been carefully considered at

a sector/directorate, corporate nursing and midwifery level in consultation with Scottish Executive Nurse Directors and the Chief Nursing Officer for Scotland. Dr McGuire reassured the Committee that all possible measures were being taken and acted upon to mitigate foreseeable risk.

It was noted that it was intended to bring this cessation about from 1 December 2016, although it was also acknowledged that some areas will continue to be prioritised until all use of premium rate nursing can be eradicated from 1 February 2017.

NOTED

113. DISABILITY RECRUITMENT STATISTICS

There was submitted a paper [Paper No 16/76] by the Director of Human Resources & Organisational Change on Disability Recruitment statistics.

Mrs MacPherson reminded the Committee that at the previous Acute Services Committee, and the Staff Governance Committee of 3 May 2016, concern was raised regarding the level of successful applicants with a recorded disability. It was agreed that a full audit of data would be undertaken with a further report issued to the Acute Services Committee.

The report set out the results of the audit which was undertaken in April 2016. In carrying out this analysis it was noted that the Equality monitoring data was supplemented by use of information collected through the Job Interview Guarantee Scheme (JIG) as candidates tended to report more accurately on their disability status through JIG rather than through the Equalities Opportunities Monitoring form.

This provided a more accurate picture of the overall position going forward and from June 2016 onwards the JIG data has been added to the equal opportunities information to track the progress of candidates declaring a disability. As a result of this change it was noted that there had been an improvement in the success rate of candidates declaring a disability since April 2016.

In the context of the results from the audit of the recruitment and selection process and the results of the equal opportunities/JIG monitoring since April 2016, the Committee were reassured that there was no evidence of an underlying bias in the recruitment and selection processes of NHSGGC towards candidates declaring a disability, and noted that a series of additional actions were being taken forward, and that progress will be reported to the Staff Governance Committee in due course.

NOTED

114. CAPITAL PLANNING – STRATEGIC ASSESSMENTS

There was submitted a paper [Paper No 16/77a, b and c] by the Director of Property, Procurement & Facilities Management which sought approval for three Strategic Assessment for:-

- Remodelling of the Intensive Care Unit at the Royal Alexandra Hospital [Paper No 77a]
- Extension to the Rowanbank Clinic [Paper No 77b]
- Redevelopment of the theatre complex within the Institute of Neurological Sciences, QEUH campus [Paper No 77c]

In all three cases, the Committee were asked to note that the Strategic Assessments had already been submitted to the Scottish Government Capital Investment Group (CIG) with an agreement that they would be withdrawn should Acute Services Committee (ASC) approval not be granted. This situation had arisen due to a clash between CIG and ASC dates and the need to maintain the delivery programme. The Strategic Assessments were approved.

APPROVED

115. FINANCIAL MONITORING REPORT

There was submitted a report [Paper No 16/78] by the Director of Finance setting out the financial position within the Acute Services Division for the six month period to 30th September 2016.

Mr White took members through the report in detail which it was noted was showing an adverse variance of £6.592m at the end of September 2016 after taking account of non recurring relief. It was noted that the main cost pressures continued to be in Medical Pay, Nursing Pay, prescribing costs, surgical sundries and CSSD supplies.

The Director of Finance reported that the overspending trend evident in the earlier part of the year had continued, a position which Mr White described as unsustainable. Members noted that there was a separate paper on the agenda on cost containment which provided further detail on measures being discussed to bring about financial stability.

In response to a question from Mrs McAuley, Mr White confirmed that the £10m share of the National Shared Services savings had not materialised from Scottish Government and that this was adding to the pressures for 2016/17. Mr White added that these schemes were longer term in nature, and work was continuing, and it was hoped that these would deliver some savings in 2017/18 and beyond. Members expressed their disappointment that these savings had not been realised in the current financial year, and the impact that this had on the Board's overall position.

NOTED

116. ACUTE FINANCIAL PLANNING: REVIEW OF COST CONTAINMENT PLANS

There was submitted a paper [Paper No 16/79] by the Director of Finance setting out an update on the main elements of the Acute Cost Containment Programme. The report provided a formal update on the proposals to invoke cost containment measures within the Acute Division, in line with the previously Board agreed Acute Cost Containment Programme and as presented and discussed at the Board Away Day (1st/2nd November 2016) and provided an update on previously agreed CRES schemes.

Members noted

- the cost containment measures put in place within the Acute Division - risks and impact;
- the allocation of additional funding from the SG to manage outpatient waits;
- the engagement with an external supplier to manage medical locums; and
- the previously agreed CRES scheme to close the Western MIU.

A range of work-streams and initiatives were set out in the paper to support the Programme. These were summarised in the report covering winter beds, waiting list initiatives, medical and nursing agency spend and confirmation that specialist staff deployed at the West Minor Injuries Unit will be redeployed in other Emergency Departments or Minor Injuries Units, and the Unit will close on Friday 23rd December 2016.

The measures described were noted.

NOTED

117. ACUTE STRATEGIC MANAGEMENT GROUP MINUTES OF MEETINGS HELD ON 25 AUGUST & 22 SEPTEMBER 2016

NOTED

118. ACUTE PARTNERSHIP FORUM MINUTES OF MEETING HELD ON 22 AUGUST 2016

NOTED

119. DATE OF NEXT MEETING

9.00am on Tuesday 15 January 2017 in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 1.30pm