

NHSGG&C(M)17/01
Minutes: 01 - 23

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, Govan, Glasgow, G51 4QD,
on Tuesday, 21 February 2017 at 9.00am.**

PRESENT

Mr J Brown CBE (in the Chair)

Dr J Armstrong [To Minute 13]	Cllr M Kerr [To Minute 13]
Ms S Brimelow OBE	Cllr A Lafferty
Ms M Brown	Mr J Legg
Mr R Calderwood	Dr D Lyons
Dr H Cameron	Rev J Matthews OBE
Mr S Carr	Mrs A M Monaghan
Cllr G Casey	Mr A Macleod
Cllr J Clocherty [To Minute 13]	Cllr M Macmillan [To Minute 16]
Dr L de Caestecker [To Minute 13]	Mrs D McErlean
Councillor M Devlin	Dr M McGuire
Ms J Donnelly	Cllr M O'Donnell
Mr R Finnie	Dr R Reid
Ms J Forbes	Mrs R Sweeney
Mr I Fraser	Mr M White

IN ATTENDANCE

Mr J Best	Interim Chief Officer - Acute Services [To Minute 13]
Dr P Davies	Consultant in Paediatric Respiratory Medicine [For Minute 8]
Mr J C Hamilton	Head of Administration
Mr K Hill	Director, Women and Children's Services [For Minute 8]
Mr J Hobson	Assistant Director of Finance [To Minute 3]
Mr D Leese	Chief Officer, Renfrewshire HSCP [To Minute 3]
Ms S Manion	Chief Officer, East Dunbartonshire HSCP [To Minute 9]
Ms J Miller	Service Manager Prison Healthcare [For Minute 12]
Mr B Moore	Chief Officer, Inverclyde HSCP
Mrs J Murray	Chief Officer, East Renfrewshire HSCP [To Minute 3]
Mr A McLaws	Director of Corporate Communications
Mrs A MacPherson	Director of Human Resources & Organisational Development
Dr L Nairn	Consultant Paediatrician [For Minute 8]
Mr K Redpath	Chief Officer, West Dunbartonshire HSCP [To Minute 3]
Ms C Renfrew	Director of Planning & Policy [To Minute 11]
Ms J Rodgers	Chief Nurse, Paediatrics & Neonates [For Minute 8]
Ms M Smith	Secretariat Manager
Mr D Williams	Chief Officer, Glasgow City HSCP [To Minute 3]

ACTION BY

01. OPENING REMARKS

Mr Brown explained the rationale for discussing the single topic of Health & Social Care Partnerships (HSCPs) Budgets for 2017/18 in private session. It was important to discuss the budget allocations to the six HSCPs and to resolve issues around unrealised efficiency savings in 2015/16 and 2016/17 in a way that would not compromise or prejudice discussions at the individual IJB Committee meetings which have been

arranged over the next two to three weeks in order to set their budgets for 2017/18.

02. HEALTH & SOCIAL CARE PARTNERSHIPS BUDGET 2017/18

Mr Calderwood stated that the sums to be discussed amounted to £7.8m of unrealised savings carried forward from the two previous financial years, and £1.3m related to the IJBs contribution to a pensions and injury benefit costs reversal.

Mr White set out the overall HSCP allocation for 2017/18, in terms of passing through the (£23.7m) uplift set by Scottish Government, and that the Board had complied with its responsibilities to ensure that the HSCP allocations were no less than previous recurring budget settlements.

Mr White provided the background to the unrealised non recurring savings in 2015/16 and 2016/17. It was noted that in 2015/16 the Health & Social Care Partnerships had been given a savings target of £15m of which £7.8m of savings was not achieved recurrently, and this was covered centrally non-recurrently by the NHS Board and carried forward. In 2016/17 a further in-year savings target of £20m was set but the carry forward unmet savings continued to be covered by the Board. The Board had limited non-recurring reserves remaining into 2017/18, and the Chief Executive and Director of Finance therefore regarded the unmet savings of £7.8m to be the responsibility of IJBs to achieve in 2017/18.

Mr Williams responded on behalf of the IJB Chief Officers. Their collective and unanimous view was that the allocation of the sum of £7.8m as additional savings for IJBs to meet in 2017/18 would have a significant impact on the provision of community services, and at this point in the financial cycle, savings schemes had not been identified to cover this additional target. Each of the IJB Boards was due to meet in the next few weeks to agree their budgets for 2017/18 and these additional savings had not been factored into recent discussions. He pointed out that the Integrated Joint Boards were not legal entities at the time of the carry forwards from 2015/16 and in the view of the IJB Chief Officers should not be asked to achieve these additional savings.

Board Members discussed the views expressed by Mr White and Mr Williams. This included consideration of the shift from hospital based care to community based care, the priority that the Scottish Government attached to this direction of travel, the role of IJBs in shifting the balance of care, the key issue of delayed discharges, the impact of savings which would be taken forward by either the IJBs or the Acute Division, and the need for the IJBs and the Acute Division to work together to bring about changes in service provision, particularly reducing the demand on unscheduled care.

Mr Calderwood clarified that if a compromise agreement was to be suggested, that in terms of apportioning the £7.8m savings target pro rata based on Board budgets, members should note that this would amount to a 55% (Board - including Acute and Corporate budgets) / 45% (IJBs) split.

Councillor Clocherty proposed a motion:-

“That the NHS Board distributes the £7.8m savings across the NHS Board (Corporate and Acute Services) in 2017/18”.

This was seconded by Councillor Kerr.

The vote was by show of hands and was 13 in support and 13 against, and the Board

Chair used his casting vote against the motion, so the motion fell.

Dr Reid proposed a counter motion :-

“That the NHS Board distributes the £7.8m across the Board (Corporate and Acute Services) and the 6 HSCPs in 2017/18 on a pro-rata basis to the budget”.

This was seconded by Mr Carr.

The vote was by show of hands and was 15 in support and 12 against.

The counter motion was passed and accepted.

Mr Calderwood stated that the next stage was to arrange for IJBs to be formally notified of the Board’s budgetary proposal.

Director of Finance

PUBLIC BOARD MEETING

03. WELCOME AND APOLOGIES

Mr Brown welcomed the press and members of the public to the meeting and to the venue which had been chosen as it provided sufficient space for members of the public to be able to attend and observe the proceedings of the meeting.

Apologies for absence were intimated on behalf of Mr A Cowan, Prof. A Dominiczak, Mrs T McAuley OBE and Mr I Ritchie.

04. DECLARATIONS OF INTEREST

No declarations of interest were raised.

NOTED

05. MINUTES

In relation to Minute 124 (Outcome of Engagement on Service Changes: Centre for Integrative Care: Inpatient Services) Mr Reid clarified that he had highlighted the modest cost of treatment, but remained unconvinced of the benefits of homeopathy. The minute was revised to reflect this clarification:-

“Dr Reid advised that while he remained unconvinced by the benefits of homoeopathy he acknowledged the benefit patients gained from treatment in the CIC and noted the relatively modest costs of this treatment.”

With this amendment, on the motion of Mr Macleod, seconded by Dr D Lyons, the minutes of the NHS Board meeting held on Tuesday, 20 December 2016 (NHSGGC(M)16/06) were approved as an accurate record and signed by the Chair.

NOTED

05. MATTERS ARISING FROM THE MINUTES

Cllr Macmillan requested clarification with respect to Item 122a – whether publication of the National Maternity & Neonatal Strategy would affect the commencement of formal consultation on the Birthing Units within the Community Midwifery Units; and whether this could be discussed and decided during this Board meeting.

Mr Brown advised that the Nurse Director would be reporting to the Board in respect of the National Maternity & Neonatal Strategy at the next meeting, which would take place on 16th May 2017. Mr Calderwood commented that this was a lengthy and complex document with 79 recommendations which required detailed review by both the Nurse Director and the Medical Director to enable a comprehensive assessment of the impact of the report to be made available to the Board. In view of this, it would not be possible to fully address the impact of the National Maternity & Neonatal Strategy on whether or not the proposed closures to the Birthing Units within the Community Midwifery Units should go ahead until the Board meeting on 16 May 2017.

The Board Rolling Action List was noted with five actions recommended for closure and three still outstanding.

NOTED

06. CHAIR'S REPORT

Mr Brown highlighted the work of the Executive Team and their engagement with the support team from Scottish Government in relation to the unscheduled care programme.

Mr Brown reported on his activities in engaging with staff groups, which included a focus on Public Health and engaging with staff from the Public Health Directorate as well as in the Glasgow Centre for Population Health. Mr Brown had met with Mr Ian Manson of Clyde Gateway to look at the impact of employment and housing on public health and with the Director of Human Resources and Organisational Change in relation to developing employment opportunities for people from deprived areas.

A visit to the New Lister Building at Glasgow Royal Infirmary had been instructive in seeing the innovative work that staff in Laboratory Medicine undertake. Mr Brown had also visited the Glasgow Psychiatric Trauma Service and had been impressed with the work of front line staff, and he noted that NHSGGC was described as a leading authority in providing this service.

Mr Brown reported that he had met with representatives of both Royal Colleges. Mr Brown had also met with University of Glasgow Principal, Professor Anton Muscatelli, along with Professor Dominiczak.

It was noted that the BBC was filming once again in the Queen Elizabeth University Hospital for a follow up documentary series to be screened later this year. Mr Brown, and Executive Director colleagues, had been given an opportunity to see a preview, which clearly showcased the excellent patient care offered at the hospital.

Mr Brown also reported that the process to recruit a new Chief Executive was continuing and that an announcement in this regard was expected shortly.

NOTED

07. PETITIONS - PROTECT OUR ROYAL ALEXANDRA HOSPITAL SERVICES

A report of the Head of Administration [Board Paper 17/02] asked the Board to note that the Board had received four petitions in relation to the provision of inpatient paediatric services at the Royal Alexandra Hospital.

There were approximately 6,500 paper / on line signatures and 48 letters.

The petitions and letters were available to any Member who wished to see them.

NOTED

08. OUTCOME OF CONSULTATION ON TRANSFER OF PAEDIATRIC INPATIENT AND DAY CASE SERVICES FROM WARD 15 ROYAL ALEXANDRA HOSPITAL (RAH) TO THE ROYAL HOSPITAL FOR CHILDREN (RHC) AND NEXT STEPS

A report of the Director of Planning and Policy and the Medical Director [Board Paper 17/03] asked the Board to note the outcome of the consultation on the proposed changes to paediatric inpatient and day case services at Ward 15 of the Royal Alexandra Hospital (RAH), included in the approved 2016/17 Local Delivery Plan; and to approve the submission of the proposed changes to the Cabinet Secretary for Health and Sport for consideration.

Mr Brown invited the Medical Director and the Director of Planning and Policy to provide an overview of the proposal and an update on the consultation process.

The Medical Director introduced clinical colleagues who currently worked within the paediatric service at Royal Alexandra Hospital (Dr L Nairn (Consultant Obstetrician), Dr P Davies (Consultant in Paediatric Respiratory Medicine) and Ms J Rodgers (Chief Nurse, Paediatrics & Neonates)) as well as the Director for Women and Children's Services, Mr K Hill.

Dr Armstrong led the Board Members through the detail of the proposal, emphasising that the proposal was about improving clinical care for children. It was recognised that staff within Ward 15 at the RAH had provided excellent paediatric care over many years, but there was also a recognised need for change to drive forward improvements in clinical care for children.

Dr Armstrong reminded Board Members that the key driver of the proposal was co-location of medical staff and the benefit this would bring in the care of children across NHSGGC. The proposal would enable NHSGGC to meet national standards on the RHC site that could not currently be met because medical staff were spread across two Hospital sites. The transfer of services would allow for immediate access to specialist services at RHC rather than the transfer of children from the RAH site to RHC to access these specialist services. Dr Armstrong emphasised that RHC was built and designed with assistance from children and their families and carers and had the benefit of being able to offer overnight stays to parents and carers during a child's inpatient stay. There were also a range of other facilities, such as the Medicinema, that were available in the RHC which provided additional support to patients and families.

Members were reminded that many services would stay at the RAH, and within the Clyde area, with a wide range of community paediatric services remaining along with

an outpatient service continuing at RAH. The Emergency Department would remain for self referrals and neo-natal care would continue to support the obstetric provision at RAH. Paediatric Consultants and senior nursing staff would continue to support the Hospital.

Dr Armstrong emphasised that this proposal was driven by the need to offer the best clinical care and was supported by the clinical teams on both RAH and RHC sites.

Ms Renfrew took Members through the a detailed summary of the engagement and consultation process including the information and engagement activity and the range of ways in which patients, parents and the public were able to make their views on the proposal known.

Ms Renfrew summarised the issues raised through the process for Members, highlighting the high value placed on the Ward 15 service by patients and their families – in particular in relation to continuity of care and direct access to the ward for complex, chronically ill patients. There was a psychological impact on those families losing a local service, particularly for the most vulnerable patients living closest to the RAH. It was noted that most patients who had accessed both services were positive about the RHC. Ms Renfrew emphasised that the RHC has had extensive family support services which would offer a wide range of support for those children and their families who would be affected.

Ms Renfrew underlined that the community paediatric services would not be affected and would continue to be developed for the future. She highlighted the changing pattern of paediatric admissions with the number of these admissions reducing overall, as well as the durations of stay declining.

The capacity of RHC to subsume the activity to be transferred from the RAH had been raised as a concern and the Board paper included information on the bed availability at the RHC which demonstrated that capacity was available. It was emphasised that the Emergency Department of the RHC was separate from that of the Queen Elizabeth University Hospital, with a very high performance level against the four hour target time for patients to be seen being consistently met in the RHC.

Concerns had also been raised about the longer journeys by ambulance, and Ms Renfrew confirmed that should this proposal go ahead, there would be changes made in the delivery of ambulance services to ensure that ambulance services were aligned to support the new model of care.

The changing status of the RAH was a concern for the local community; Ms Renfrew explained that many major hospitals did not have a paediatric ward, including Glasgow Royal Infirmary, and the Western General Hospital in Edinburgh.

Ms Renfrew took Members through the analysis carried out in the consultation phase in response to issues raised during the engagement process, in respect of access. Ms Renfrew outlined the catchment areas for the RAH and the RHC, as well as issues raised in respect of public transport, travel time, financial costs and parking.

Some issues had been raised about the way the consultation process had been taken forward emphasising that NHSGGC had worked closely with the Scottish Health Council during the informing, engaging and consultation process and their report confirmed compliance with national guidance on consultation. Ms Renfrew agreed to circulate the Health Council report, which had only just become available.

**Director of
Planning and
Policy**

Mr Brown thanked Dr Armstrong and Ms Renfrew for their detailed input and underlined that the consultation had demonstrated the value placed on the Ward 15 service and the contribution that staff had made. Mr Brown reminded Members that the proposal had clinical support and that the consultation process had been compliant with national guidelines, before opening the discussion more widely and inviting questions.

Cllr Macmillan raised points in relation to the general provision of services at the RAH for the local community.

Cllr Clocherty raised concern about travel difficulties for the local community and for access to the RHC by emergency ambulance during peak traffic times.

Dr Lyons commented that he was persuaded by the clinical case for a single hospital for paediatric care, and noted that any unintended consequences of the proposal should be considered carefully. Dr Lyons asked for reassurance in particular about capacity for day cases at the RHC. Dr Lyons also raised concerns about additional travel time to the RHC from remoter parts of the catchment area, as well as the lack of public transport to the RHC from Paisley and the surrounding area, and asked for details on how these issues could be mitigated.

Mr Hill responded by detailing that the RHC undertook 12,000 day cases per annum. Offers for admission were made to patients on staggered time basis, with early appointments and overnight hotel stays available. The 23 hour ward (a ward which managed the patient's surgical admission within a 23 hours period) provided a pre-operative assessment service. Mr Hill reassured Members that Day Surgery, Day Case Unit and the 23 hour Ward provided a combined total of 47 beds with an occupancy rate of 74%. He reassured Dr Lyons that there was sufficient capacity at the RHC to accommodate the transferred activity.

Dr Armstrong responded to the concern raised about emergency ambulance journey times by noting that the consultation process had shown similar or shorter ambulance journey times for most of the catchment to the RHC compared with the RAH. It was essential to note that treatment started as soon as the ambulance arrived. Dr Davies advised that should a child suffer a serious accident and be taken directly to the RHC, specialist services such as imaging and intensive care facilities would be immediately available, with no requirement for a secondary transfer, as would be the case should they be taken firstly to the RAH.

Ms Renfrew highlighted that there was significant support for the clinical case for change; and that consideration had been given to how to mitigate the issues raised. Any loss to the immediate area was outweighed by the gains that would be made in clinical care. The Board could illustrate the provision of wide ranging specialist paediatric services across the Board which compared favourably to services in the rest of Scotland. In relation to public transport, Ms Renfrew advised that very few patients' families used public transport to get to hospital; bus services were limited due to low public uptake.

Mr Fraser acknowledged and supported the clinical case made, and added that he did not share the transport concerns raised, given that the Board must consider provision of care for children across the whole of the Board area.

Mr Macleod commented that Barrhead was served by Ward 15 at the RAH and had a local bus service to support this. There was no similar service in place to the RHC. He

underlined that more weight should be attached to the transport issues raised.

Mrs Monaghan noted that the ability to self refer to Ward 15 would continue for local families and asked if the resultant close relationships with staff would be replicated at the RHC. Mrs Monaghan also asked for detail in terms of where the savings in resources would be re-invested, and if staff would re-locate to the RHC.

Dr Nairn confirmed that although there is no direct access service at the RHC, chronic patients were fast tracked through the Emergency Department. Most of the medical staff (including consultants and trainee doctors) already worked across both sites so that the team at RAH would continue to foster close relationships with patients and their families at the RHC.

Ms Rodgers confirmed that the majority of nurses would move over to the RHC, with some remaining at the RAH to support remaining local services. Nursing staff would be matched to required posts at the RHC according to their skills, so those nurses specialising in acute receiving care and day surgery would move across to the RHC. Ms Rodgers reassured Members that each Nursing unit operated as small teams, and this would continue so that close relationships could continue to be nurtured with families attending the RHC.

In response to a question from Mrs Monaghan about the speed of admission offered by the direct access service at the RAH, Dr Davies advised that there was a different system in place at the RHC which provided for close relationships with the broader clinical teams. Dr Davies emphasised the very close working relationships with patients and their families across the Board area by the paediatric team at the RHC.

Ms Brimelow added her support to the proposal commenting that the clinical case for change was overwhelming. Mr Matthews wished to acknowledge the local support for the Ward 15 service and to credit the staff for this, whilst acknowledging that the clinical case was overwhelming, provided that any unintended consequences were given careful consideration.

Ms Sweeney also offered support for the clinical case and asked for clarification on which national clinical standards the Medical Director had referred to when introducing the proposal. Dr Armstrong clarified that this referred to national UK Standards; Dr Nairn explained that the Royal College for Paediatrics and Child Health standard required 24 hour consultant led care. This was not being offered currently, and co-location of services would enable this standard to be met.

Ms Donnelly acknowledged the clinical case and for the comprehensive consultation process, and commented that it was important to view the proposal through the eyes of the service user and that the local community may wish services at RAH to be extended in line with those at RHC. Ms Donnelly also referred to the emphasis from the Scottish Government on locality planning. Ms Renfrew agreed that the consultation had demonstrated the genuine feeling in this regard in the local community and that the challenge for the Board was to make the right clinical decision within this context.

Dr Armstrong emphasised that it was not possible to replicate the range of specialist services available at the RHC within a single ward in the RAH. Dr Davies added that the RHC offered specialist care to children throughout the Glasgow and Clyde areas, as well as beyond the Board area. The specialist nature of this care could only be offered on a large scale, with more complex cases from the Clyde area already being seen at the RHC. Dr Davies reminded Members of the family friendly facilities at the RHC

which catered for patients and their families travelling from all over Scotland.

Ms Brown wished to offer recognition to the experience of individual patients as well as the critical mass of patients across the Board area and was supportive of the proposal.

Cllr Macmillan the amended motion :-

“ That the proposed changes to Ward 15 at the Royal Alexandra Hospital are not approved and therefore not submitted to the Cabinet Secretary for consideration.”

This was seconded by Cllr Clocherty.

The vote was by way of show of hands with 7 in support and 20 against the amendment motion.

DECIDED

- To approve the submission of the proposed changes to the Cabinet Secretary for consideration.

**Chief
Executive**

09. COMPLAINTS HANDLING - NEW POLICY AND PROCEDURE

A report of the Nurse Director [Board Paper 17/04] asked the Board to note and approve the revised Complaints Policy and Procedure (and accompanying Public Facing Documents and Self Assessment) to allow for implementation from 1st April 2017.

Dr McGuire provided Members with a summary of the key changes in the Complaints Policy and Procedure and advised that this would change the way that complaints were handled by the Board. This mainly related to an emphasis on early resolution with a triage mechanism on receipt of complaints being introduced, as well as a change in reporting of performance.

Dr Lyons highlighted the improvements to the Board's Policy derived from the National Model Complaints Policy, and he welcomed this approach.

Ms Brimelow welcomed the changes, particularly the emphasis on early resolution, which would assist in the local resolution of complaints, meaning that this process should not be additionally burdensome for staff. Ms Brown noted the involvement of both Acute Services as well as the Integrated Joint Boards.

Mrs Monaghan raised a concern about the functionality of the Datix system and noted that it was an ambition for the system to record data effectively. Mr Macleod raised a concern about the Board's readiness to implement the policy in terms of staffing and resources. Dr McGuire responded that preparations were underway with staff training in place within the clinical teams, as well as additional support for the complaints team being available from the clinical and care governance team as well as the patient experience team. NHS Education for Scotland would also provide support with ready to use training materials. The issue with Datix functionality was being addressed nationally, but locally contingency plans were in place should this not be feasible for 1 April 2017.

Mr Best commented that Acute Services welcomed early resolution and were already

taking this approach in complaints handling. There was additional emphasis on training nursing staff and ensuring that the management teams contact details were clearly displayed throughout hospital premises to enable patients and their families to make contact directly and easily.

DECIDED

- That the revised Complaints Policy and Procedure (and accompanying Public Facing Documents and Self Assessment) should be submitted to Scottish Government for approval to allow for implementation from 1st April 2017.

**Head of
Administration**

10. NHS GREATER GLASGOW & CLYDE INTEGRATED PERFORMANCE REPORT

A report of the Head of Performance [Paper No 17/05] asked the Board to note and discuss the content of the NHS Greater Glasgow & Clyde Integrated Performance report. This paper brought together high level information from several reporting strands to provide an integrated overview of the NHS Greater Glasgow and Clyde's performance in the context of the 2016/17 Strategic Direction and Local Delivery Plan.

Ms Renfrew 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 (where performance has had an adverse variance of more than 5%).

Ms Renfrew highlighted that the Board continued to exceed target in relation to access to drug and alcohol interventions, psychological therapies and IVF treatment. In addition, performance continued to exceed target in relation to the number of key access and waiting time targets, including 18 week referral to treatment.

The number of patients waiting longer than the national waiting times standards for a number of key Local Delivery Plan targets continued to show a month on month deterioration, namely in relation to the 12 week treatment time guarantee, the number of new outpatients waiting in excess of 12 weeks for a new outpatient appointment and the number of patients waiting in excess of six weeks for a key diagnostic test. The number of patients waiting less than four hours in the Emergency Department from arrival to admission, discharge or transfer for treatment had also deteriorated in December 2016.

It was noted that the figures in relation to complaints performance were for Acute Services only and not the NHS Board and that the Head of Administration would circulate the NHS Board position separately.

**Head of
Administration**

Ms Brown raised the issue of how to address the delayed discharge of patients to see significant improvement in this area and Ms Renfrew confirmed that the Board Seminar on 7 March 2017 would review this critical issue.

Dr Reid asked for clarification that the figures released in the report met the requirements and principles of the Data Protection Act. Mr Calderwood clarified that ISD took a national stance in this area and that Board followed this principle and recognised the difficulty in providing meaningful information where absolute numbers were less than five.

Ms Sweeney raised the issue of the impact of new ways of working on emergency care performance. Mr Best accepted that it had been a challenging winter period especially over the seasonal period. A number of initiatives had been put in place in relation to unscheduled care. Triage Plus had been working practice in Glasgow Royal Infirmary for several months - whereby a senior consultant would supplement nurse triage and could facilitate quicker ordering of diagnostic testing. A Consultant from Glasgow Royal Infirmary had been working within the Queen Elizabeth University Hospital to establish the practice there.

Ms Brimelow asked about how to measure the pace of change and Mr Calderwood commented that the Deputy Medical Director as well as the Interim Chief Officer for Acute Services were leading on testing the changes so that a further view could be taken on how resources could be best utilised, within the context of demand for other services.

NOTED

11. CLINICAL GOVERNANCE OVERVIEW

A report of the Medical Director and the Nurse Director [Board Paper No 17/06] asked the Board to note the key messages and advise on areas where assurance may be required.

Dr Armstrong led Members through an overview of the report and emphasised the Board's duty of quality through the maintenance of effective arrangements, which included collaboration with partner organisations.

Within clinical safety, a four step process was commonly used to manage clinical risks, namely recognising and reporting adverse events, reviewing events using root cause analysis, implementing changes, and then monitoring progress in reducing clinical risk. The Board wide monitoring of clinical risk management was supported by two key reports for Acute Services, and for the Health and Social Care Partnerships.

Dr Armstrong highlighted that the level of Significant Clinical Incident (SCI) Reporting within Acute Services Division often resulted in action plans drawing out cross system learning themes. Within the Health and Social Care Partnerships, a key issue was the recording of mental health incidents.

Dr Armstrong noted that the new Duty of Candour regulations were likely to become law in April 2018 and that NHSGGC would establish the strategic leadership requirements in line with the introductory guidance issued by the Scottish Government. At the National Scottish Patient Safety Programme conference held in November 2016, examples of improvement work carried out within NHSGGC were referenced.

Dr McGuire provided an overview on patient feedback provided from August to September 2016. There were three centrally supported methods of feedback: universal feedback, NHSGGC online feedback and Patient Opinion. In the main, feedback was positive and there were two main challenges relating to patient information and communication. Dr McGuire highlighted the training being carried out within the Board with an emphasis on all staff taking responsibility at all levels.

Mr Matthews commented that it was a prerequisite for the Board to engage with patients who were often vulnerable and may require a family member or friend to represent them at key clinical interactions. Dr McGuire agreed and provided

reassurance that patients' families and carers were encouraged to attend with them and that this was fundamental to good communication and good clinical outcomes.

NOTED

12. PRISON HEALTHCARE UPDATE

A report of the Medical Director [Board Paper 17/07] asked the Board to note an update on prison healthcare.

The Medical Director introduced Ms Miller, Service Manager, Prison Healthcare, who then took Members through an overview of prison healthcare, since responsibility for delivering healthcare to prisoners had transferred from the Scottish Prison Service to the NHS in November 2011. She explained that prison healthcare was a hosted service with Glasgow City HSCP, with appropriate governance arrangement in place as well as regular liaison meetings with the Scottish Prison Service.

Ms Miller encouraged Members to visit the prisons in which NHSGGC has responsibility for the delivery of healthcare: Barlinnie, Low Moss, Greenock and she provided a description of each site.

There were some challenges in the delivery of healthcare particularly related to the physical premises and in delivering safe and effective healthcare in a locked and secure environment. Further challenges were experienced in delivering healthcare to a deprived population who often suffered inequalities or had not engaged with health services in the community.

Ms Miller explained that prison healthcare was a hosted service with Glasgow City HSCP, with appropriate governance arrangement in place as well as regular liaison meetings with the Scottish Prison Service.

In December 2016, a new process for suicide risk management was introduced by the Scottish Prison Service, and work was underway to develop the role for nursing professionals within this approach.

Ms Miller summarised the findings of a routine inspectorate report carried out on HMP Barlinnie by Her Majesty's Inspectorate for Prisons, which was positive. Following publication of the report, an Action Plan with links to governance arrangements was developed to address those issues pertaining to healthcare.

Mr Fraser commented that he had visited Low Moss Prison with Mr Legg as part of an IJB led visit, and he had been very impressed with the healthcare team. Ms McErlean noted the positive level of integration between the healthcare team and the Scottish Prison Service. Mr O'Donnell agreed, suggesting that Low Moss Prison demonstrated effective partnership working and highlighted the overall direction of travel with community justice, and the role that conditions within prisons can play.

Ms Sweeney advised that that more information on performance would be beneficial across wider areas e.g. infection control. Ms Miller confirmed that work was underway to develop a performance template and that a challenge to this related to the IT system in collection of data.

Ms Brimelow commented that this was a helpful and reassuring report, and that the Clinical and Care Governance Committee would review the themes that arose in more

**Medical
Director**

detail, and that a future report on palliative care and the healthcare needs of older prisoners had been requested. Dr Lyons agreed and emphasised the issue of mental health within prisons.

NOTED

13. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the Medical Director [Board Paper No 17/08] asked the 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);
- Local improvement actions within orthopaedic surgery procedures included in the national surgical site infection (SSI) programme;
- SSI rate for Caesarean sections which are within confidence levels.

To aid understanding of the infection case numbers within the report, Dr Armstrong highlighted the breakdown of data in measurement of C.Diff and SABs.

Dr McGuire outlined that three unannounced Healthcare Environment (HEI) / Healthcare Improvement Scotland (HIS) inspections had taken place since the last HAIRT report and that these had taken place in the Princess Royal Maternity Hospital (PRM) in October 2016, and the Queen Elizabeth University Hospital in December 2016 and January 2017.

The report into the PRM visit was published in January 2017, with seven requirements and no recommendations; all of these had been addressed. The report highlighted good hand hygiene and that staff, patients and parents were complimentary about the standard of cleanliness overall.

The reports following the QEUH visits were not yet available and Dr McGuire reassured Members that immediate, critical, feedback had been addressed robustly.

NOTED

14. FINANCIAL MONITORING REPORT FOR 9 MONTH PERIOD TO 31 DECEMBER 2016

A report of the Director of Finance [Board Paper No 17/09] asked the NHS Board to note the financial performance for the nine month period to 31 December 2016 and Mr White provided an assessment of the year end projection and details of the actions required to deliver the a break even outturn for the year.

He outlined the key issues in terms of operational performance, efficiency savings and use of non-recurring reserves. He emphasised that the Corporate Directorates and Health and Social Care Partnerships were operating broadly within operational budget. Performance in month 9 had indicated that cost containment measures and actions were

taking effect within the Acute Services Division; medical locum and premium rate nursing monthly spend showed particular decreases.

Board Directors were working to identify new, recurring, cash releasing efficiency savings across all areas of the Board, with the Acute Services Committee and the six Integrated Joint Boards would monitor ongoing performance. The Board's Finance & Planning Committee would continue to support financial management across NHSGGC.

Ms Brimelow asked for clarification in respect of whether the additional winter beds would be closed on 31st March 2017, as well as the ongoing position in relation to funding of waiting list initiatives. Mr Calderwood confirmed that in relation to the winter bed plan, some beds would now close and that further work would take place on waiting list initiatives phased across 2017/18.

Mr Macleod commented that an update on national shared services would be helpful and Mr Calderwood confirmed that a new set of schemes were being brought forward which would require to be tested robustly in respect to efficiency and demand management to ensure value for NHS Scotland. Mr Calderwood also explained that the NHS Board would be responsible for the local delivery of national initiatives.

NOTED

15. ACUTE SERVICES TRANSFORMATION

A report of the Director of Corporate Communications [Board Paper 17/10] asked the Board to note the approach being developed to communicate how stakeholder engagement with the planning process for Acute Services Transformation was being taken forward.

Mr McLaws took Members through the approach to informing key stakeholders on their involvement in the work being undertaken to plan for the transformation in the delivery of acute services. This involved significant effort to translate the detail contained within Board papers in a way that would inform and engage. The paper provided some examples of this approach both in relation to communicating with staff, as well as more widely through social media and news outlets. Video footage and information graphics would be developed to engage and involve a wide range of stakeholders.

Ms Brown commented that it would be beneficial to highlight the work of the Public Health Directorate in population health and impact of life opportunity on individual health.

Ms Brimelow suggested that the language used could be refined. Mr McLaws agreed that careful and considered use of language in the process would be critical to successful engagement.

Mr Carr stressed the timescale for change and the importance of joint working with the HSCPs in this process. Mr McLaws commented that it was important to set the direction of travel, and that the overall timescale was not yet determined. Mr Brown advised that the Transformation Executive Group was already in place and that work was underway to address the detail required.

Mr Matthews highlighted the need for a whole population approach and the need to

look at the direction of travel within society as a whole, e.g. the shift in attitudes to smoking in public places was a good example of promoting change.

Mrs Monaghan stressed the importance of ensuring that the literature used addressed all service users, patients and families including those with protected characteristics to effectively reach out to all. Mr McLaws underlined that this work would be focussed through Equality Impact Assessment. Mr Brown added that it was important to think about the target audience and use the expertise of the Communications Team and wider staff groups to progress this work.

Dr Cameron raised the issue of engaging with clinical teams at all levels, not just clinical leaders. Ms MacPherson commented that work was being carried out to ensure all staff and Partnership Forums would be engaged on this work. Mr Calderwood responded to the point on clinical staff engagement by outlining that there were 10 individual clinical streams ongoing and that all resource decisions needed to be credible with clinical teams.

NOTED

16. MIDWIFERY SUPERVISION

A report of the Nurse Director [Board Paper No 17/11] asked the Board to note the change in government legislation to allow for the transition from the Nursing & Midwifery Council regulation model to an employer led model. The Board was asked to agree the development of a Transition Action Plan by Maternity Services to facilitate a seamless transfer to an employer led restorative supervision model for midwives; note the potential risks, mitigating actions and recommendations and agree that updates on the progress of Midwifery Supervision Training would be provided to the Board.

DECIDED

- That the development of a Transition Action Plan by Maternity Services be agreed.
- That updates on the progress of Midwifery Supervision Training would be provided to the Board through the Clinical & Care Governance Committee.

Nurse Director

17. REVIEW OF STANDING COMMITTEE MEMBERSHIPS/REMITTS AND MANAGEMENT GROUP STRUCTURE

A report of the Head of Administration [Board Paper 17/12] asked the Board approve the revised memberships of the NHS Board's Standing Committees and the Non-Executive membership of Glasgow City Health & Social Care Partnership. The Board was asked to approve the updated remits of the Finance & Planning Committee, the Acute Services Committee the Clinical & Care Governance Committee and the Public Health Committee; and note the structure of committees at management level.

In response to a question from Ms Brimelow, Mr Hamilton confirmed that agendas and papers should be distributed 5 working days / 7 calendar days in advance of the meeting wherever possible.

DECIDED

- That the revised memberships of the NHS Board's Standing Committees and

the Non-Executive membership of Glasgow City Health & Social Care Partnership, be approved.

- That the updated remits of the Finance & Planning Committee, Acute Services Committee, Clinical & Care Governance Committee and the Public Health Committee be approved.
- That the structure of Committees / Groups at management level be noted.

18. SETTING THE AGENDA – THE NHSGGC BOARD WORK PROGRAMME FOR 2017/18

A report of the Head of Administration [Board Paper 17/13] asked the Board to approve the proposal to introduce and develop an NHSGGC Board Work Programme; and note that an initial version of a 2017/18 Board Work Programme will be submitted to the Board Seminar in March 2017 for discussion and thereafter to the Board Meeting in May 2017 for approval.

Mr Brown thanked all those involved in this work, and emphasised the aspiration of a better workplace in conjunction with delivery of better healthcare.

Mr Hamilton outlined the structure of the Board Work Programme of activities which would be grouped under three main headings: strategy, governance and leadership & culture. The Programme would be a live and flexible document covering a wide range of topics.

Mr Brown highlighted that a fully developed Board Work Programme would underpin the relationship between the Board and the Executive Team.

DECIDED

- That the proposal to introduce and develop a NHSGGC Board Work Programme be approved.

**Head of
Administration**

19. ACUTE SERVICES COMMITTEE MINUTES : 15 NOVEMBER 2016

The Minutes of the Acute Services Committee meeting held on 15 November 2016 [ASC(M)16/06] were noted.

20. FINANCE & PLANNING COMMITTEE : 28 NOVEMBER 2016

The Minutes of the Finance & Planning Committee meeting held on 28 November 2016 [F&P(M)16/02] were noted.

21. AREA CLINICAL FORUM MINUTES : 1 DECEMBER 2016

The Minutes of the Area Clinical Forum meeting held on 1 December 2016 [ACF(M)16/06] were noted.

22. CLOSING REMARKS

The Board Chairman wished to acknowledge the contribution made by the local authority councillors who would necessarily stand down from the Board on 30 April 2017, ahead of the forthcoming Local Council elections. Mr Brown expressed the

Board's gratitude for their service and wished each of them well for the future.

Mr Brown also noted that Dr Reid's term of office came to an end on 31st March 2017 and, on behalf of the Board, thanked Dr Reid for his significant contribution to the Board and for the dedication and commitment shown in three highlighted areas, namely, as chair of the Endowments Committee, as chair of the Organ Donation Committee, and Dr Reid's considerable support to the Freedom of Information Team in reviewing responses.

On behalf of the Board, Mr Brown also took the opportunity to pay tribute to Mr Calderwood who would be retiring as Chief Executive of NHSGGC on 31st March 2017. Mr Brown highlighted Mr Calderwood's extensive career in the NHS, in a range of posts in healthcare authorities in the West of Scotland, which began in 1971. Mr Brown also paid tribute to the significant contribution Mr Calderwood made throughout his service, particularly, in acute services, and highlighted the establishment of the Beatson West of Scotland Cancer Centre, the new Ambulatory Care Hospitals and the Queen Elizabeth University Hospital and the Royal Hospital for Children as tangible examples of his enduring legacy. Mr Brown offered the Board's sincere thanks to Mr Calderwood for his unstinting service to patients throughout the West of Scotland, and the NHS in Scotland as a whole, as well as the Board's best wishes for his future retirement.

23. DATE & TIME OF NEXT MEETING

Tuesday 16 May 2017, 10.00am.

The meeting ended at 2.25pm