

SCOTTISH HOSPITALS INQUIRY

**Bundle of documents for Oral hearings
commencing from 13 May 2025 in relation
to the Queen Elizabeth University Hospital
and the Royal Hospital for Children,
Glasgow**

Bundle 36 – Acute Services Committee Minutes and Relevant Papers

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DRAFT

ASC(M)15/01
Minutes: 01 - 16

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Acute Services Committee held at
9.30am on Tuesday, 30 June 2015 in the
Board Room, J B Russell House, Gartnavel Royal Hospital,
1055 Great Western Road,
Glasgow, G12 0XH**

P R E S E N T

	Mr I Lee (Convener)	
Ms M Brown		Cllr J McIlwee
Dr H Cameron		Mr A Macleod
Prof A Dominiczak OBE (To Minute 9)		Cllr M Macmillan (To Minute 10)
Mr R Finnie		Ms R Micklem (To Minute 12)
Cllr A Lafferty		Cllr M Rooney (To Minute 12)
	Mr D Sime	

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

Dr J Armstrong	Ms R Crocket MBE
Mr R Calderwood	Mr M White

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

Mr G Archibald	..	Chief Officer, Acute Services
Mr J C Hamilton	..	Head of Board Administration
Mr D Loudon	..	Director of Facilities & Capital Planning
Dr O Lucie	..	Consultant Geriatrician (To Minute 3)
Mr A McLaws	..	Director of Corporate Communications
Ms A MacPherson	..	Director of Human Resources & Organisational Development
Ms T Mullen	..	Head of Performance
Dr J Murtagh	..	Consultant Physician (To Minute 3)
Ms C Renfrew	..	Director of Corporate Planning and Policy (To Minute 10)
Ms H Russell	..	Audit Scotland

01. APOLOGIES

The Convener welcomed everyone to the first meeting of the Acute Services Committee.

Apologies were intimated on behalf of Councillor M Cunning, Mr I Fraser, Dr D Lyons and Councillor M O'Donnell.

02. DECLARATIONS OF INTEREST

Declarations of interest were raised by:-

- (i) Professor A Dominiczak as Regius Professor of Medicine, University of Glasgow in relation to the agenda items on the South Glasgow University Hospitals/On The Move and Enhanced Theatre Capacity – Institute of Neurology Sciences.
- (ii) Councillor M Macmillan as Leader, Renfrewshire Council in relation to the Clinical Services Review – Renfrewshire Development Programme Update.

NOTED

03. CLINICAL SERVICES FIT FOR THE FUTURE

There was submitted a paper [Paper No 15/08] by the Medical Director asking the Committee to note the progress on the Renfrewshire Development Programme, the aim of which was to assess the approach and support more detailed planning to both develop the confidence that the model could deliver the future position described and to allow costing of the approach to ensure that it was affordable and deliverable. The programme was focused on developing the interface services further, particularly in areas with the greatest impact on demand and capacity:-

- Timely access to high quality Primary Care;
- Comprehensive range of Community services, accessible 24/7 from Acute and Community settings;
- Coordinated care at crisis/transition points and for those most at risk;
- Hospital admission which focuses on early comprehensive assessment driving care in the right setting; inpatient stay for acute period of care only.

Dr Armstrong introduced Dr O Lucie, Consultant Geriatrician and Dr J Murtagh, Consultant Physician, who presented to Members on the current position and learning to date of running the Older Adults Assessment Unit at the Royal Alexandra Hospital which had now been open for seven months. Dr Lucie and Dr Murtagh described the model of care, benefits gained and challenges, and despite the challenges of patients being cared for within the unit who were outwith the criteria, the clinicians remained convinced that this was a good and workable model which provided the most appropriate care and improved outcomes for patients.

Ms Brown welcomed the presentation and was keen that, once any evaluation had been completed, the service offered was consistent and sustainable and continued to bring about improved outcomes for the patients it was designed to serve. Ms Micklem also welcomed the presentation but cautioned that to develop a proper evidence-base of the benefits and improvements for patients would take time and the project needed to be supported and protected as these benefits would not happen overnight. Dr Cameron agreed and recognised the need for additional data and comparisons to be made from the previous service to the new model particularly around the readmissions rate.

Dr Armstrong welcomed the Members support and acknowledged that more time was needed to see the full benefits of the Older Adults Assessment Unit and advised that to date, there had been a 97% patient satisfaction rate with the services provided and this had also been encouraging.

NOTED

04. ACUTE SERVICES COMMITTEE – REMIT AND MEMBERSHIP

There was submitted a paper [Paper No 15/01] by the Head of Board Administration asking Members to note the Remit and Membership of the Acute Services Committee as approved by the Board on its meeting on 23 June 2015, and to advise of any necessary amendments/additions. The Acute Services Committee had been formed by the NHS Board as a Standing Committee of the Board to bring a focus to monitoring performance and providing a governance framework for the work of the Acute Services Division.

Members welcomed the Remit and range of responsibilities of the new Committee and looked forward to working with Mr Archibald, Chief Officer, Acute Services and his team.

NOTED

05. FINAL Q&P COMMITTEE ROLLING ACTION LIST

There was submitted a paper [Paper No 15/02] by the Head of Board Administration, which set out where the outstanding actions from the former Quality and Performance Committee would be reported to, with the Lead Director identified and a timescale in which the action was to be achieved.

NOTED

06. PATIENT'S STORY

Ms Rosslyn Crocket, Nurse Director, read out a recent patient story in order to highlight some of the matters which were important to patients, visitors and their carers, which, with some more thought and consideration, could be improved upon within ward and clinical areas. Ms Crocket explained the reflective practice used in sharing this story with the team involved and other clinical teams across NHSGGC, and the key message had been that staff should give consideration to how their actions were perceived by others.

Councillor Lafferty welcomed the insights offered by the Patient's Story and could clearly distinguish between the clinical and personal needs of the patient/family.

NOTED

07. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT

There was submitted a paper [Paper No 15/03] by the Chief Officer, Acute Services setting out the integrated overview of NHSGGC Acute Services Division's performance. This was the first such report and Members were asked to give their thoughts and views on the content and format of the report to ensure it met the Committee's needs in future.

Of the 28 measures which had been assigned a performance status based on their variation from trajectory and/or target, 13 were assessed as green, eight as amber

(performance within 5% of trajectory) and seven as red (performance 5% outwith meeting trajectory).

The measures which had been assessed as red were as follows:-

- Delayed discharge over 14 days;
- MRSA/MSSA bacterium (cases per 1,000 occupied bed days);
- Stroke care bundle;
- Non-elective inpatient activity;
- Sickness absence rate;
- e-KSF;
- New outpatient DNA as a % of all appointments offered.

Exception reports had been provided to Members on measures which had been assessed as red. Having taken Members through the structure of the paper, Mr Archibald then concentrated on those measures which had been assessed as red and the exception reports.

He agreed with the Convener that the downward shift in the Detect Cancer Early – Early Diagnosis & Treatment in First Stage Cancer for colorectal was worthy of a full report to the next Committee meeting, explaining the downturn and the actions being taken to bring about an improvement in order to reach the 2015/16 target.

**Head of
Performance**

In relation to the delayed discharges exception report, Ms Brown enquired as to what was causing the slower assessments for patients who were assessed as Adults with Incapacity. Mr Calderwood advised that the national campaign to encourage families to have Power of Attorney in place was helping. However, there was a long way to go before the majority of families had this in place and were therefore able to avoid the lengthy court process when families required a legal basis for the status of taking decisions for such family members in hospital. Those patients discharged from an acute hospital setting into a nursing home awaiting the final assessment of their needs continued to access medical care and this would continue until their assessment and placement in a more appropriate setting had been completed.

As of April 2015, the rate of sickness absence across the Acute Services Division was 5.8% against a national target of 4%. Ms MacPherson acknowledged that absence rates had been poorer in the last 18 months despite the ongoing work in tackling short-term sickness with a range of interventions and better management of long-term sickness absence.

Councillor Rooney was concerned about the significant rise in sickness and felt that the report would have benefitted from additional information in relation to the number of working days lost and the cost implications of sickness. Ms Brown highlighted, from the workforce planning information, that the workforce reflected the population served in terms of demography, gender, age, and staff who were ill should not be encouraged to attend hospitals and care for vulnerable patients. She and Mr Sime acknowledged that a measured and balanced response was needed in reviewing the performance against this national target which, Mr Sime reminded Members, had no evidence base to the setting of the 4% target. It was reported that

that total days lost was not captured, however, the information presented to Members represented the requirements of national reporting.

Mr Macleod was however, concerned at the trend of the rise of sickness absence within Acute Services, and was keen to see a note of the specific actions being undertaken to address this trend. Ms MacPherson agreed and would produce a report for the next meeting of the Committee on the steps being taken to manage the sickness absence within the workforce in Acute Services.

**Director of
Human
Resources &
Organisational
Development**

With regard to DNAs, Ms Micklem highlighted that this was an important target, particularly in terms of inequalities. As of May 2015, 13.3% of new outpatient appointments did not attend against a target of 11.4%. Members were disappointed to note that the patient-focused booking process, which should be advantageous in reducing DNA rates, was not functionally possible with Trakcare, and a technical solution was required.

Members welcomed the 1,200 reminder calls made per day to patients by the specialties covered by the Referral Management Centres, and also the improved patient information and communications. However, when linking this discussion with the April Seminar presentation on the Collusion of Exclusion, it was clear that more was required to be done to improve the attendance of those patients who most required to attend and access hospital services.

Members welcomed the focus on the Exception Reports and found the format and structure of the paper helpful in terms of future reporting. Members were concerned that Acute Services were not achieving the 80% target of staff with an online PDP i.e. e-KSF. Ms MacPherson acknowledged that the target had not been met and that Human Resources were supporting local Directors to increase activity in this area.

NOTED

08 THE SOUTH GLASGOW UNIVERSITY HOSPITAL CAMPUS – ON THE MOVE/COMPLETION

There was submitted a report [Paper No 15/09] by the Director of Facilities and Capital Planning summarising the transfer to and commissioning of the new South Glasgow University Hospital and the Royal Hospital for Sick Children as well as updating Members on the completion of the new office accommodation, completion of the Teaching and Learning Centre, progress on the final Multistorey Car Park and, lastly, progress with the demolitions and central park development.

As much of the report replicated the report submitted to the NHS Board meeting on 23 June 2015, Mr Loudon concentrated on the discussions with regard to the Teaching and Learning Centre. The Centre was completed and handed over on the 29 May 2015, the project being delivered on time and under budget. The Board and the University of Glasgow had commenced client fit-out stage of the project and this would be completed in time to allow the building to go live on 17 August 2015. The legal documentation between the Board and University of Glasgow concerning occupancy and operational matters had progressed well and would be finalised over the coming weeks. One concern however, was raised as the University was not in a position to offer a first ranking standard security in favour of the NHS Board and a compromise was sought from the University. The solution offered by the University through an exchange of letters and commitments, was acceptable to the NHS Board and its legal advisers, and in discussions, Members welcomed the outcome reached.

Ms Brown raised a concern that, after discussions at the Quality & Performance Committee meeting in January 2015, Board Members had not received the outcome of the further risk assessment carried out within the Child Psychiatry Ward and garden area in relation to ligature points and other high risks. Mr Loudon advised that the risk assessments identified earlier in the year had been implemented however, the recommendations and action plan to implement them had not been made available to Members and he would ensure that this was made available as soon as possible. Ms Brown found it regrettable that the specification for the area in question had not followed that of a psychiatric hospital. Mr Loudon noted that the design brief for the hospital had not asked for a full anti ligature specification throughout the building.

NOTED

09 ENHANCED THEATRE CAPACITY – INSTITUTE OF NEUROLOGY SCIENCES – SOUTH GLASGOW UNIVERSITY HOSPITAL

There was a paper submitted by the Director of Finance outlining the need to expand theatre capacity within the Institute of Neurology Sciences building on the South Glasgow University Hospital site and a proposition of how this could be achieved, together with early costing estimates and a proposed funding mechanism.

The Institute of Neurology Sciences accommodated elective and emergency surgery for the Neurosurgical and Oral Maxillofacial Surgery patients in the West of Scotland. Of the seven operating theatres, five were used by Neurosurgery and Oral Maxillofacial and two by Ear, Nose & Throat (which has since transferred to the new South Glasgow University Hospital, freeing up two theatres to support the planned development of Neurosurgery and Oral Maxillofacial Surgery).

The planned expansion of Neurosurgery and Spinal work for the West of Scotland (revenue funding) has been agreed with the referring Boards, namely NHS Ayrshire & Arran and NHS Lanarkshire. In addition, the NHS Board has submitted a proposal to National Services Division to provide a National Deep Brain Stimulation Service which would require two additional theatre sessions per week.

With the need to expand the facilities to accommodate the additional theatre sessions and subsequent staff, it was acknowledged that with the reduced capital allocation for 2015/16, capital funds were not available for this project to be completed. Discussions had, therefore, been entered into with the University of Glasgow in which the University would assume ownership and, therefore, risk of the overall building, and the NHS Board would then be a tenant for only the part of the building it used. This would potentially lead to an upfront lease payment and thereafter a nil or peppercorn rent for the defined period of the lease. The NHS Board would then be responsible for the rates for the part of the building it occupied and the Board's Capital Budget for 2016/17 would be able to meet the fit out costs of the NHS floor currently estimated at [REDACTED].

Professor Domiczak supported this proposal and in response to a question from Mr Finnie, Mr Calderwood advised that it would be a lease for 45 years with the right of extension for a further 15 years, this being the same terms as the Teaching and Learning Centre.

Mr Macleod asked about the sign off dates and planning implications and Mr Calderwood advised that planning authority had been granted for a three storey

building and planning consideration continued around the possibility of a four storey building. The intention was to sign off on the arrangement in August 2015 with the NHS Board and University demolishing existing buildings during the course of August and a start onsite thereafter.

Mr Calderwood advised that the additional twelve staff would be underwritten by the West of Scotland Health Board funding and, if successful with its application for a Deep Brain Stimulation Service, the National Services Division would fund that service. In response to Councillor Rooney's question, Mr White explained that an upfront payment of [REDACTED] in 2015/16 would be annualised over the period of the lease.

DECIDED

- That the proposition to provide the new theatres and reconfiguration of the existing theatre accommodation be endorsed.
- That the funding mechanism and accounting treatment be endorsed.

**Director of
Finance**

**Director of
Finance**

10 NATIONAL PERSON-CENTRED HEALTH & CARE COLLABORATIVE: STRATEGIC REPORT AND WORK PLAN

There was submitted a paper [Paper No 15/04] by the Nurse Director setting out the current position on the NHS Board's progress in implementing the National Collaborative for Person-Centred Health and Social Care within the Acute Services Division.

Ms Crocket highlighted that the clinical teams collectively were able to demonstrate since May 2014 that more than 90% of feedback received was indicative of a positive care experience and that this achievement had thus far been sustained. It would be important to see a continuation of this high level of positive feedback within the new South Glasgow University Hospital.

In addition, Ms Crocket highlighted the two examples of improvement approaches and interventions being used in the clinical teams, namely "What Matters to Me?" and the "Personalised Contact". Members welcomed the outcome in both.

NOTED

11 CARE ACCREDITATION AND ASSURANCE SYSTEM (CAAS)

There was submitted a paper [Paper No 15/05] by the Nurse Director which provided an update on the progress of developing a model of care assurance and accreditation across NHSGGC.

Ms Crocket explained that the Care Assurance and Accreditation System was a continuous improvement approach to achieving a set of Standards for the delivery of safe, effective and person-centred care. It would allow senior charge nurses to locally benchmark their team's progress against the Standards and to identify where support was needed for further improvement. In addition to local self assessment there would be an external peer review of the Standards and observation of care, resulting in ratings of red, amber or green. Wards would be revisited and reassessed at a frequency dependent on their rating and full accreditation status would only be achieved if the ward attained green status on three consecutive

assessments.

NHS Ayrshire & Arran and NHS Lanarkshire were also introducing this system at the same time and a joint NHS Board Steering Group was leading the collaborative approach to the development of the Standards and a Senior Charge Nurse Network had been developed to share experiences and learn from each other. Locally, a multidisciplinary Steering Group would oversee development of the Standards and progress would be reported through the Directorate Clinical Governance Fora and the NHS Board Clinical Governance Forum.

Councillor Rooney commented that the approach and Standards seemed to be audit based through the compilation of documents and evidence to highlight continuous improvement. Ms Crocket advised that local teams would carry out self assessments and measure themselves against expected targets and the accreditation element would follow on from the external assessor's observation/review and one of the main aims was to drive improvements within different ward areas from this approach and follow-up visits.

Ms Micklem welcomed this development, in particular the whole system approach, however, she was surprised that the Care Assurance and Accreditation System did not make mention of inequalities. Ms Crocket advised that the Corporate Inequalities Team had been involved with reviewing the Standards to ensure that inequalities were integral and embedded in the Standards. She added that the expertise of the Corporate Inequalities Team would continue to be integral to CAAS.

Mr Lee enquired about the additional tasks required by Nursing Staff to complete the requirements of the system and Ms Crocket advised that there were no additional standards to be measured, rather that they were just being undertaken in a more systematic way. Feedback had suggested thus far that the teams had found them helpful and they had brought clarity to areas they were doing well in and in areas in which improvement could result.

Mr Macleod asked about the IT solution and costs and Ms Crocket advised that information was only being gathered where existing IT systems were in place and the Chief Nursing Officer for Scotland was moving towards a minimum dataset approach which may assist in future years with funding for the appropriate systems to support such data collection and monitoring.

Members welcomed the proposal and Ms Crocket would ensure that regular reports were submitted to the Committee for further review.

Nurse Director

NOTED

12 SCOTTISH PATIENT SAFETY PROGRAMME: UPDATE

There was submitted a report [Paper No 15/06] by the Medical Director setting out the progress against the Scottish Patient Safety Programme (SPSP) in relation to changes in reporting to the National Scottish Adult Acute Safety Programme, an update on plans to change reporting and tracking of progress, and lastly, an update on plans to develop improvement support and so accelerate the spread of SPSP workstreams.

The National SPSP Programme Board had agreed to remove the requirement to submit data on the Safety Essentials to Healthcare Improvement Scotland (HIS).

The intention would be that local assurance mechanisms would be verified through a new process for review of each NHS Board being developed by HIS, this being the Quality of Care reviews. Initial evaluation of the safety elements earlier this year had highlighted that levels of reliability and spread were being maintained.

Dr Armstrong highlighted the move to Programme Leads, establishing more specific local aims and implementation objectives against which progress would be analysed and hopefully understood more effectively. She drew attention to the concerns over the Hospital Standardised Mortality Ratio (HSMR) at the Royal Alexandra Hospital (RAH) and advised of the acceleration of the SPSP workstream on the deteriorating patient, and that the Steering Group had now incorporated that objective into its overall accountability and all wards within the RAH were to become actively involved in the workstream by the end of the calendar year.

NOTED

13 BEATSON WEST OF SCOTLAND CANCER CENTRE (BWoSCC): UPDATE POSITION

There was submitted a report [Paper No 15/07] by the Medical Director providing a detailed background on the proposed model for the Beatson West of Scotland Cancer Centre (BWoSCC) to support deteriorating patients. The report also provided information on the development of a High Acuity Unit (HAU). The paper provided a summary overview of the clinical concerns expressed regarding the supporting infrastructure for the BWoSCC, the solutions implemented and a summary update on the first 25 days of activity through the HAU.

Dr Armstrong indicated that a number of clinical concerns had been raised by the BWoSCC Consultant Committee in relation to the revised clinical infrastructure of the Gartnavel General Hospital site. These primarily related to the transfer of key clinical services, particularly the High Dependency Unit, to the South Glasgow University Hospital. She summarised the detail of the concerns highlighted and the steps taken following detailed clinical discussions.

An exceptional HAU Clinical Governance Subcommittee was set up and met for the first time on 23 June and reviewed the six transfers in detail. No adverse outcomes or suboptimal clinical events had occurred in relation to patient safety as a result of the implementation of the HAU. A number of recommendations were agreed by the Subcommittee and it would meet again in four weeks.

The financial profile associated with the development of the above service was being costed but it was expected that this would be in the region of [REDACTED] per annum. Mr Sime and Ms Brown welcomed the paper and the assurance that it contained, particularly in relation to patient safety and anticipated costs. It would be important to ensure that a sustainable and consistent service, adequately staffed, was put in place, and the formation of the HAU Clinical Governance Subcommittee to review and monitor this service was welcomed.

Mr Finnie was concerned that the consultant clinical staff had felt it necessary to escalate their concerns to the General Medical Council (GMC). Mr Calderwood acknowledged that this had indeed been regrettable but had appreciated that there had been a breakdown in communication from the initial meetings last year through to the reporting of the various workstreams by the end of 2014 and the meeting held in January 2015. It was clear that by spring, the clinical staff were unhappy with the delays and outcome and this had led to them being frustrated and raising

their concerns direct with the GMC. Dr Armstrong was dealing with the correspondence from the GMC and advised that HIS would be more appropriately involved in monitoring the services and patient safety.

This remained an ongoing issue and costs were still being finalised and it was agreed therefore that a further report would be submitted to the Committee at its September meeting.

Medical Director

14 IN-YEAR FINANCIAL MONITORING WITHIN ACUTE SERVICES TO 31 MAY 2015

The Director of Finance advised that there was no requirement to formally report to the Scottish Government Health Directorate on the financial monitoring of the first two months of the financial year. Within NHSGGC, budgets had been remodelled, taking account of the new hospitals and Mr White advised that at the end of Month 2, the NHS Board was [REDACTED] overspent with the pressures mainly associated with pay and bank/agency staff and this had been expected in relation to the moves from the demitting sites to the new South Glasgow University Hospitals.

NOTED

15 ACUTE STRATEGIC MANAGEMENT GROUP: MINUTES OF A MEETING HELD ON 28 MAY 2015

There was submitted a paper [Paper No 15/10] enclosing the Acute Strategic Management Minutes of the meeting held on 28 May 2015.

NOTED

16 DATE OF NEXT MEETING

9.30am on Tuesday 15 September 2015 in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 12:45pm

DRAFT

ASC(M)15/02
Minutes: 17 - 37

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Acute Services Committee held at
9.30am on Tuesday, 15 September 2015 in the
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P R E S E N T

	Mr I Lee (Convener)
Ms M Brown	Dr D Lyons
Dr H Cameron	Mr A Macleod
Mr R Finnie	Ms R Micklem
Mr I Fraser (To Minute 29)	Cllr M O'Donnell
Mr D Sime	

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

Dr J Armstrong	Ms R Crocket MBE
Mr R Calderwood	Mr A O Robertson OBE, DSc, LLB
	Mr M White

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

Mr G Archibald	..	Chief Officer, Acute Services
Mr J C Hamilton	..	Head of Board Administration
Mr D Loudon	..	Director of Facilities & Capital Planning (To Minute 34)
Ms A MacPherson	..	Director of Human Resources & Organisational Development
Ms T Mullen	..	Head of Performance
Ms C Renfrew	..	Director of Planning and Policy (To Minute 24)
Mr J Steen	..	Audit Scotland

17. APOLOGIES, WELCOME AND PRELIMINARIES

The Convener welcomed Mr John Steen, Audit Scotland, to his first meeting of the Acute Services Committee.

There was discussion about the timing of the meeting and presentation of the agenda. It was agreed that future meetings of the Committee would commence at 9:00am and that, as well as the electronic version of the agenda and papers being submitted to Members seven days prior to the meeting, the same arrangement would be made for those who receive hard copies of these documents. Consideration would also be given to incorporating approximate times for each agenda item.

**Head of Board
Administration**

Apologies were intimated on behalf of Prof A Dominiczak OBE, Cllr M Cunning, Cllr J McIlwee, Cllr A Lafferty, Cllr M Macmillan and Cllr M Rooney.

18. DECLARATIONS OF INTEREST

There were no declarations of interest.

NOTED

19. MINUTES OF PREVIOUS MEETING

On the motion of Mr D Sime and seconded by Mr A Macleod, the Minutes of the Acute Services Committee meeting held on 30 June 2015 [ASC(M)15/01] were approved as a correct record, subject to deletion of the final two sentences in the 5th paragraph of Item 11, “Care Accreditation and Assurance System (CAAS)”, and insertion of the following two sentences in their place:-

“Ms Crocket advised that the Corporate Inequalities Team were reviewing the Standards to ensure that inequalities were integral and embedded in the Standards. She added that the Corporate Inequalities Team review of the Standards would be submitted to a future meeting of the Committee for information”.

Nurse Director

NOTED

20. MATTERS ARISING

a) Rolling Action List

(i) Royal Hospital for Children – Child Psychiatry Ward and Garden – In relation to Minute 8 – South Glasgow University Hospital Campus – On the Move/Completion, Dr Lyons asked for an update with regard to the risk assessments on the Child Psychiatry Ward and Garden and the reference within the Rolling Action List to a further meeting being held on this issue. Mr Loudon advised that he had met with the Chairman, Ms M Brown and Mari Branigan, Director of Nursing, Partnerships, earlier in the week to discuss the operational risk assessments and he would ensure that an updated copy was passed to Members as soon as possible. Ms Brown advised that Ms Brannigan had agreed to take over the lead for the risk assessments in this area and would scrutinise the work undertaken to date and would review/update as necessary. There would be three monthly updates which would include the usage of the roof garden, although it was noted that it had not been used to date. Ms Brown advised that, regrettably, in relation to the Adult Hospital, no further action was planned with regard to ligature points although risk assessments would be undertaken to allocate “at risk” patients to appropriate wards.

Dr Lyons intimated that he had been concerned that the roof garden was not being used and that the lack of action had been disappointing.

Mr Loudon agreed that the updated risk assessments would be made available to Members shortly and he would report back on progress to the next meeting of the Committee.

**Director of
Facilities &
Capital Planning**

(ii) Disaggregation of data to track inequalities gap – In relation to Minute 49 – Integrated Quality & Performance Report – of the Quality & Performance Committee meeting on 19 May 2015 – Ms Micklem asked for

an update on the disaggregation of data for different population groups in order to track any narrowing of the inequalities gap. Ms Mullen advised that she continued to work with Public Health and Corporate Inequalities Team colleagues, and whilst it was proving difficult to get robust data, she would prepare a progress report for information to the next meeting of the Committee.

(iii) Car Parking at Glasgow Royal Infirmary – In relation to Minute 54 – Car Parking at Glasgow Royal Infirmary – of the Quality & Performance Committee meeting of 19 May 2015 – Mr Loudon advised that initial meetings had been held with the Scottish Government Health Directorate (SGHD) following the submission made by the Board to seek discussions on whether capital funding could be made available to bring the car park back into the control of the NHS. A response was awaited however, it was clear that the SGHD capital programme was fully committed over the next two years with no likely slippages which may have assisted with this scheme.

NOTED

21. PATIENT'S STORY

Ms Rosslyn Crocket, Nurse Director read out a recent patient story from Inverclyde Royal Hospital which focused on the patient's assessment of their care and the outcome of the clinical care. The patient highlighted the excellent care they had received from all members of the clinical team which had respected their dignity and had felt completely personal to themselves. The patient's story highlighted the benefits of multi-disciplinary team working and the concept of person-centred care and this had been shared with other clinical teams across NHSGGC as highlighting an excellent example of the type of team working which can lead to high levels of satisfaction from patients.

Members welcomed the positive aspects of this patient's story and hoped it would resonate with other clinical teams in trying to achieve personalised and person-centred care.

NOTED

22. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT

There was submitted a paper [Paper No 15/12] by the Chief Officer, Acute Services setting out the integrated overview of NHSGGC Acute Services Division's performance. Of the 29 measures which had been assessed a performance status based on their variation from trajectory and/or target, 16 were assessed as green, six as amber (performance within 5% of trajectory) and seven as red (performance 5% outwith meeting trajectory). Exception reports had been provided for those measures which had been assessed as red and each one was discussed in turn as follows:-

(a) Suspicion of Cancer Referrals (62 days)

As at July 2015, 87.3% of patients with a suspicion of cancer started their treatment within 62 days of urgent referral, the target being 95%. There had been a slight increase in performance from the previous month,

however, the two main areas of pressure were urology cancers and head and neck cancers.

Mr Archibald described the staffing factors in relation to urological cancers and the highly specialist nature of some of the work undertaken, which no other centre in Scotland offered. Patients had been referred to England for their treatment and Mr Archibald advised that two new posts had been advertised as a long-term solution to the ongoing demand within this service.

In relation to head and neck cancer, again, Mr Archibald explained the staffing issues, particularly in relation to receiving no applicants following a recent advertisement for one of the consultant vacancies. A series of actions had been put in place to address the pressures and these were set out in the paper.

This was recognised as an important area for the NHS Board and Mr Archibald explained that he met Directors on a weekly basis, reviewing named patient lists to ensure there was a continued focus and attention on meeting this important target.

(b) Delayed Discharges

As at August 2015, 24 patients were delayed for over 14 days against a target of 0, and 16 patients were delayed for over 72 hours. This was an improvement on the 86 reported in August 2014 and, of the 24 patients delayed in August 2015. Twelve were residents of Glasgow, two from East Dunbartonshire, one from Renfrewshire and the remaining nine were delayed from outwith the NHS Board's area.

Ms Renfrew described the actions being taken to address the performance and highlighted a meeting the Board Chair was having at the end of the week with the Health & Social Care Partnership Chairs at which this issue and its impact on the wider Winter Planning arrangements would be discussed. The Chairs of South Lanarkshire and Argyll Health & Social Care Partnerships were also invited to attend this meeting.

Dr Lyons enquired as to why the 61 patients who had been delayed over 14 days for legal reasons, and who lacked capacity (adults with incapacity) had been excluded from these figures and that he had raised this matter at the Annual Review with the Cabinet Secretary for Health And Wellbeing and was keen that this point continued to be raised with Scottish Ministers. This point had been re-emphasised at a recent SGHD workshop and Ms Renfrew advised that the 61 patients were not occupying Acute Services beds but had been placed in nursing home care and that the geriatricians had now seen the benefits of this type of arrangement.

(c) MRSA/MSSA Bacterium (cases per 1,000 acute occupied bed days)

As at March 2015, the number of MRSA/MSSA cases per 1,000 acute occupied bed days was 0.26, which was higher than the target of 0.24. Dr Armstrong highlighted that 38% of hospital acquired SABs in the first quarter of 2015 were intravenous access device related. The two new standard operating procedures remained paramount in the continued need to reduce all bloodstream infections and not just those caused by SABs. She explained the ongoing work within the renal unit at Stobhill as this was

a recognised high-risk area and Ms Micklem advised that as part of the SPSP walkround she had attended recently at this unit, it was clear that the staff were aware of the extra scrutiny in that area. Dr Armstrong agreed to bring back further detail on this issue to the next meeting of the Committee.

Medical Director

Dr Armstrong indicated that she would check whether the figure of 44% of community cases which were attributed to people who used intravenous illicit drugs and would advise Members if this figure required to be corrected.

Medical Director

(d) Non-Elective Patient Activity

As at July 2015, the year to-date non-elective inpatient activity reported was 108,641, which represented a 9.5% upward variance from last year. Mr Archibald advised that this demonstrated a material growth in overall non-elective inpatient activity, most notably at Glasgow Royal Infirmary and Queen Elizabeth University Hospital (QEUEH). The figures had accounted for a planned increase in activity at Glasgow Royal Infirmary due to the redesign of services and the diversion of some patients who had previously used the Western Infirmary together with new pathways at the QEUEH leading to changes in how some patient activity was now recorded.

(e) Sickness Absence

There was a separate report submitted to the Committee for consideration on this matter.

(f) e-ksf/PDP Completions as at July 2015

e-ksf/PDP completion rate across the Acute Services Division was at 67.35% against a target of 80%. This was a decrease from the 70.91% recorded in May 2015 and the 76.29% reported in July 2014.

The difference was partly explained by the movement of the good performance by Facilities from the report and Ms MacPherson outlined the ongoing work on refresher training, review of named staff lists, monitoring, and the need for managers to continue to focus on this important area for staff.

Dr Cameron asked what work was undertaken to ensure the quality of e-ksf/PDPs and Ms MacPherson advised that an annual audit together with spot checks was undertaken which reviewed quality of e-ksf/PDP entries to the system and highlighted to managers where they were found to be unacceptable. She would provide a paper to the next meeting of the Committee covering the steps to improve performance in the completion rates of e-ksf/PDPs together with the quality assurance checks undertaken to ensure they are both relevant and helpful to staff.

**Director of
HR&OD**

(g) Percentage of Patients as “Did Not Attends” (DNAs) as Percentage of All Appointments Offered

As at July 2015, 12.4% of new patients did not attend as a percentage of all appointments offered against a target of 11.4%. The figure was 12.9% for the same period last year.

Mr Archibald explained that a series of actions had been put in place to

address the DNA rates including text message reminders within paediatric services, patient reminders (with approximately 1,200 reminder calls made to patients each day), patient communications (information leaflets with details of the appointment and the need to telephone if unable to attend together with the referring clinician outlining to the patient their responsibilities for keeping an appointment) and the referral template now included a question seeking information if the patient had additional needs.

In response to a question from Mr Fraser, Mr Archibald confirmed that one of the areas being targeted for improved performance was indeed within paediatrics, and in responding to Councillor O'Donnell's question, he advised that patients were able to seek a new appointment if their appointment date fell when they were on holiday; their wait time guarantee would not be affected.

Ms Micklem asked about the difficulties in using Trakcare for patient-focused booking and Mr Archibald agreed to discuss this with Mr Robin Wright, Director of Health & Information Technology, and provide a briefing note to Members on this issue.

**Chief Officer,
Acute Services**

Members welcomed the chance to concentrate on the areas where performance had been rated as red and the detailed discussions which had taken place against each topic. Dr Cameron understood the need to focus on the SGHD target, but enquired how the Committee would be able to scrutinise other clinical activity within Acute Services, for example healthcare scientists and allied health professionals. There was a series of service performance targets against which directorates and departmental teams were assessed and reviewed, however, not every aspect of clinical activity was measured. It was agreed that Ms Renfrew would discuss this further with Dr Cameron, and, if suitable, could form a future topic for an NHS Board Seminar in terms of describing the performance processes.

**Director of
Planning &
Policy /
Physiotherapy
Professional
Lead**

Dr Lyons was pleased to see the improvement highlighted in the papers in relation to the stroke bundle at the Royal Alexandra Hospital.

Mr Archibald asked if he could update Members on an ongoing issue in relation to the Institute of Neurosciences. Four of the seven theatres had been affected over the last month by an ingress of water and it had been necessary to prioritise emergency treatments for this period which in turn, had resulted in around a dozen patients having their waiting time guarantees breached. The theatres would be back in operation this week and all efforts would be made to prioritise those patients who had waited the longest.

NOTED

22(a) DETECT CANCER EARLY – EARLY DIAGNOSIS AND TREATMENT IN 1ST STAGE CANCER

There was submitted a paper [Paper No 15/13] by the Chief Officer, Acute Services setting out, at the Committee's request at the last meeting, an update on performance on the Detect Cancer Early Local Delivery Plan standard.

The Detect Cancer Early standard was based on three tumour types, namely, breast, colorectal and lung. As at July 2015, NHSGGC was diagnosing 26.6% of cancers at stage 1 against a local trajectory of 27.2% and the detail against each tumour type was set out within the table within the paper. Overall performance in relation

to “stage not known” presentations had decreased from 10% in 2010/11 to 5.4% in 2013/14. However, recent performance in the first quarter of 2015 highlighted that this figure had risen to 6.5%.

The Committee noted that the Regional Directorate team was working in conjunction with Cancer Audit to undertake specific analysis by quarter and cancer type, and fuller information would be provided to the Committee at a later date by Public Health.

**Interim Director
of Public Health**

NOTED

22(b) ATTENDANCE MANAGEMENT INTERVENTIONS AND ACTION PLAN

There was submitted a paper [Paper No 15/14] by the Director of Human Resources and Organisational Development providing the Committee with an update in relation to the performance management interventions with regard to achieving an improvement in staff attendance levels across the Acute Services Division. Members had requested a detailed paper on attendance management following the review which had indicated that as at June 2015, the rate of sickness absence was reported as 5.6% against a target of 4%. The rate for the same period last year had been 5.5%. Ms MacPherson explained that the same pattern of absences was apparent for both long term and short term absences.

Information was now available on reasons for staff absence by directorate and this highlighted that anxiety/stress was the top factor within each of the six directorates with musculoskeletal and gastrointestinal being the second and third most common factors in absences from work. It was appreciated that anxiety and stress was wide ranging and not always work related, and the focus for managers and human resources staff was to assist staff in getting back to work together with the proper and efficient use of the occupational health service.

Ms Brown was concerned at the level of anxiety/stress and outlined the model used within Local Authorities in referring such cases to Occupational Health. She also asked what consideration had been given to money advice services, bullying and harassment, and support for staff. Ms MacPherson explained that there was a step-by-step checklist/triage system to work through if staff presented with anxiety/stress. Money advice matters had been discussed with the Area Partnership Forum and it was likely that the outcomes from the i-matters survey would help managers concentrate on the issues and concerns expressed by staff to see if greater support could be provided in the areas of need.

Councillor O'Donnell asked if there were inconsistencies in the application of access to the work-life balance policies which could result in staff using sick leave instead. Ms MacPherson advised that this had possibly been the case in the past but there had been a greater level of consistent application of these policies by managers and their availability continued to be highlighted to managers to ensure appropriate access to such policies for planned and unplanned absences.

Ms MacPherson also highlighted the review which had been undertaken of the Employee Counselling Service and, through the work and support of a sub-group of the Area Partnership Forum, it had agreed to provide this in future as an in-house employee counselling service for staff hosted by the Occupational Health Department.

Members welcomed the detail and steps being taken in relation to absence

management and would continue to monitor this topic as part of the Integrated Performance Report.

NOTED

23. FINANCIAL MONITORING REPORT

There was submitted a paper [Paper No 15/26] by the Director of Finance setting out the financial position within the Acute Services Division for the four month period to 31 July 2015.

Expenditure within Acute Services was overspent by [REDACTED] when compared to the budget at 31 July 2014 and the overall position for the NHS Board for the same period was an overspend of [REDACTED]. The Board's projected funding for 2015/16 was currently [REDACTED] and it was planned to manage the anticipated cost pressures in order to deliver a break even outturn for the year end.

Mr White took Members through the paper in detail and highlighted that the main cost pressures rested in medical pay, where significant expenditure on agency and locum cover had been incurred in order to support increased clinical activity levels. As reported in an earlier agenda item, non-elective inpatient activity for the April-June 2015 period was well above the expected target level. The higher than anticipated activity levels were driven in part by waiting list initiatives and had led to temporary unscheduled care beds which had been open last winter, remaining open in order to provide additional capacity, resulting in an additional cost of [REDACTED] per month. Other pressures included nursing pay, surgical sundries and CSSD supplies - all largely driven largely by additional clinical activity.

One of the key components of the overspend had been the increased usage and cost of medical agency staff and for the first four months of 2015/16 this had represented an increase of 46% on the same period last year. This had related to the impact of activity, sickness/absence, capacity and transitional arrangements, and lastly, a general increase in the rates being charged by the agencies. There had also been an increase in the usage and cost of bank and agency staff for nursing, which had represented an increase of 13% on the same period last year.

Mr White advised that the majority of the [REDACTED] saving schemes was due to impact in the last half of the financial year and this explained the current under-recovery of savings within the Acute Services Division to date. Mr White advised that he intended to present a detailed review of the Financial Plan for 2015/16 at the October Away Session and it would include a range of scenarios and options in order to achieve the intended balanced outturn by 31 March 2016.

**Director of
Finance**

Mr Finnie noted the worrying trend within the first four months of the financial year and advised that the Chief Executive had warned the NHS Board of the possibility of this developing scenario. The annual significant saving target set for NHSGGC had made it more difficult without contemplating major service change or redesign. Without pursuing such options, the continued need to meet national and local targets would be a significant challenge for the NHS Board over the next two years and some hard decisions with possible reputational issues for the Board would have to be faced sooner rather than later.

Mr Calderwood intimated that he had asked for a forensic investigation of the true cost base in order that this could be fully discussed with Members at the Board's Away Day at the end of October. He was keen to understand how the double

running costs played into the financial plan; the impact of the new nursing workforce requirements, the impact on winter planning and the availability of beds, and review the projects and service redesign schemes which could contribute to savings being achieved in 2015/16 and the following year. Lastly, he was keen to review the Board's agency, locum and bank costs to get them down to more manageable levels. This work would all be undertaken prior to the October Away Day together with any other areas of improved efficiency.

Members welcomed the new format of presentation contained within the Financial Monitoring Report and agreed that this matter be further discussed in detail at the October Away Day.

**Director of
Finance**

NOTED

24. NATIONAL PERSON-CENTRED HEALTH & CARE COLLABORATIVE: STRATEGIC REPORT AND WORK PLAN

There was submitted a report [Paper No 15/15] by the Nurse Director setting out the current position of the NHS Board's progress in implementing the National Collaborative for Person-Centred Health & Care for the Acute Services Division.

Ms Crocket highlighted that circa 95% of responses received from patients, relatives and carers were indicative of a positive care experience over the two month period of May and June 2015 within the Acute Services Division. 148 in-depth conversations with people using the services had been undertaken together with 5,624 responses/enquiries which had been collected during the themed conversations.

Ms Micklem highlighted the frequency of checking on patients which should be based on the needs of patients following a risk assessment, compared to the feedback from the patient experience which indicated that patients did not believe they had enough contact with clinical staff. Ms Crocket agreed to look further into the two different positions described, and discuss this further with Ms Micklem outwith the meeting.

Nurse Director

Dr Lyons intimated that he found it very helpful meeting with Ms Crocket and Mr Andy Crawford, Head of Clinical Governance, and it had given him a greater understanding of the work of the collaborative. He was keen to see if the sample size could be given when individual feedback was given and Ms Crocket agreed to include this in future reports. It was explained that the term "active care" was determined by the patient's care, patient's needs and social needs.

Nurse Director

NOTED

25. QUARTERLY REPORT ON CASES CONSIDERED BY THE SCOTTISH PUBLIC SERVICES OMBUDSMAN: 1 APRIL TO 30 JUNE 2015

There was submitted a report [Paper No 15/16] by the Nurse Director which set out the first Acute Services Report on the actions taken against the recommendations made by the Scottish Public Services Ombudsman in relation to investigative reports and decision letters issued in the period from 1 April to 30 June 2015. One investigative report had been issued together with 18 decision letters, resulting in a total of 27 recommendations.

Dr Lyons asked what the process was when the Ombudsman upheld an issue or complaint. Mr Archibald explained that it was shared with the relevant director and across the directorates together with the process where the Chief Executive wrote to the director asking for an assurance that a review was undertaken about the lessons learned from upheld decisions on SPSO reports/decision letters. Mr Lee asked about the circumstances of a particular report in relation to paediatrics and Dr Armstrong agreed to look into the detail of that case and report back to Mr Lee.

Medical Director

Ms Brown asked if a future NHS Board Seminar could incorporate the process and methodologies for undertaking significant clinical incidents and an investigation process which supported an SPSO report/decision letter. This was agreed.

Medical Director

NOTED

26. ACUTE INPATIENT NURSING WORKFORCE REVIEW 2015

The paper on the Adult Inpatient Nursing Workforce Review 2015 had, unfortunately, not been submitted to Members prior to the meeting and Ms Crocket apologised for this. A copy would be sent to Members immediately after the meeting. She agreed to discuss the content of the paper with Members and, clearly, the implication of implying a standard Nursing Workforce Model to adult inpatient wards within hospitals would be discussed at the NHS Board Members' Away Day in October in relation to the additional net costs of implementing this tool.

Ms Crocket advised that this was a mandatory national tool and the review covered the new QEUH and Royal Children's Hospital and followed on from the investment in Acute Nursing in September 2013 of [REDACTED] which delivered enhanced staffing in inpatient areas with particular emphasis on Emergency Care and Medical Services and Rehabilitation and Assessment. That investment increased the time available for supervisory duties for Senior Charge Nurse/Midwife from one day to two days per week.

Councillor O'Donnell asked if the Nursing Workforce Model reflected shift patterns and Ms Crocket advised that while not highlighted within the paper, there were 12 hour shifts within nursing. In relation to Mr McLeod's question about the timescale to comply with the outcome of the review, Ms Crocket advised that that was a decision for the Board however, bank staff were able to be used to cover the new model/rostering system. In relation to the impact of the single room layout within the new hospitals, Ms Crocket advised that there was no validated national tool for single rooms at this stage.

In relation to an e-rostering system, it was reported that Mr R Wright was discussing this with a key supplier in terms of their business model and how it could be applied to the Scottish health service.

It was agreed that, on receipt of the paper, this would be discussed at the October NHS Board's Away Day in relation to the financial plan for 2015/16 and beyond.

Nurse Director

NOTED

27. BRIEFING NOTE ON MIDWIVES LEGAL CHALLENGE

There was submitted a paper [Paper No 15/18] by the Nurse Director providing a background to the current situation regarding the high profile legal process involving two midwives who held conscientious objections to abortion, specifically in relation to the supervision and delegation of staff within the labour ward.

The position in relation to the legal processes was noted as was the current position with regards to the employment tribunal claims.

NOTED

28. OLDER PEOPLE IN ACUTE HOSPITALS (OPAH) HEI INSPECTION SUMMARY REPORT

There was submitted a paper [Paper No 15/19] by the Nurse Director updating Members on the Older People in Acute Hospitals Inspection of NHSGGC by Healthcare Improvement Scotland (HIS) and, in particular, the inspection carried out at the Vale of Leven Hospital on 23 and 24 June 2015.

The HEI inspectors received the NHS Board's self assessment prior to the visit and spoke to staff, used a formal observation tool as well as a mealtime observation tool, conducted patient interviews and used patient and carer questionnaires. The report identified six areas of strength and 12 areas for ongoing improvement, with no requirements/recommendations. An action plan was submitted to HEI on 12 August 2015.

Ms Brown was disappointed that the areas of nutrition, hydration and dementia continued to come up in all such reports and Ms Crocket advised that the implementation of the Care Accreditation and Assurance System (CAAS) would hopefully address such issues across all wards where it was implemented. Dr Lyons indicated that these issues continued to be raised across the Scottish health service and enquired as to whether delirium was a particular focus for the Acute Services Strategy. Dr Armstrong would review this and indicated, following discussions with clinical colleagues yesterday, that it had been agreed to appoint a lead for the Delirium Bundle.

Medical Director

An unannounced HEI had been undertaken to the QEUH and initial verbal feedback indicated that there would be areas for further improvement.

NOTED

29. CLINICAL SAFETY UPDATE

There was submitted a report [Paper No 15/20] by the Medical Director which provided the first Clinical Safety Update which incorporated the clinical risk management reports, Adult Acute Safety Programme, an indepth workstream review on patient falls, an indepth workstream review on tissue viability, SPSP Deteriorating Patients workstream, Health Improvement Scotland National Adverse Events Framework and the regular Fatal Accident Inquiries update.

The report had initially been presented and reviewed by the Acute Services Clinical Governance Forum and the Board Clinical Governance Forum. Key points in

relation to the Significant Clinical Incident (SCI) process were as follows:-

- The number of actions completed following SCIs increased with circa 20% incomplete at the three month monitoring period;
- The frequency of SCIs being investigated remained stable over the last 18 months but showed a longer term increase;
- The major factor in the increase was the investigations of SCIs with less severe patient outcomes indicating greater endeavours to learn from near-miss events;
- In 2014, in 88% of SCIs, learning was identified which would improve care;
- A cluster of SCIs related to the care of patients with brain injury and these were highlighted within the report;
- A review of factors was undertaken which may have led to delays in progressing the investigation of SCIs. This had arisen from concerns over problems in some areas where difficulties were experienced in completing the process within the intended three month timescale. This had seen a reduction in the number of SCIs over the three month period.

Dr Armstrong welcomed comments on the presentation of the information, appreciating the need to balance the possible presentation of too much detailed information against ensuring that the Acute Services Committee felt it received the appropriate assurance around clinical safety within NHSGGC.

Mr Finnie indicated that he found the presentation of information very helpful and would be keen to see whether the measures put in place across a range of initiatives had been effective in future reports. In relation to the tables provided, he found them helpful but could benefit from information on the total volume of activity for each.

Councillor O'Donnell enquired about the issue of aggressive behaviour/brain injury patients and how these were handled within clinical areas. Dr Armstrong described the specialist care arrangements, appropriate care settings and the use of medication when appropriate.

Ms Brown indicated that she felt it would be useful to see comparative data with other NHS Boards. In addition, she asked if it was possible to show any actions taken outwith the protocols/guidelines and if so, flag this in future reports.

Medical Director

Ms Micklem welcomed the information and the increase in reporting trends as she was keen to ensure there were no disincentives on staff in reporting incidents and near-misses.

NOTED

30. BEATSON WEST OF SCOTLAND CANCER CENTRE (BWoSCC): UPDATE POSITION

There was submitted a report [Paper No 15/21] by the Medical Director and the Chief Officer, Acute Services on the clinical model to support deteriorating patients

at the Beatson West of Scotland Cancer Centre, including the newly opened High Acuity Unit. This paper highlighted the progress since the last meeting in June as follows:-

- Accelerated implementation of the documentation in ward B5 around early recognition of the deteriorating patient, with appropriate clinical response;
- The introduction of treatment escalation plans for deteriorating patients;
- The Hospital at Night enhancements with dedicated on-site anaesthetic support;
- Clear standard operating procedures for accessing advice from other specialities;
- Clear pathways for advice and, if required, transfer of patients needing additional levels of care or invasive monitoring to the QEUEH with a retrieval team;
- Onsite facilities at the BWoSCC for enhanced care of the ill patient.

Dr Armstrong highlighted the patient activity up to 31 July 2015 and the increase in critical care outreach activity with the average contacts per patient increasing from 2.7 in June to 4.5 in July 2015. The temporary return of the Bone Marrow Transplant Unit to the BWoSCC from the QEUEH had generated further demand for this service.

The staffing model and financial implications were noted and a formal review of the temporary measures would be undertaken in order to develop a plan for a sustainable service going forward. Discussions would continue to be held with clinical staff on the basis of maintaining patient safety as the key priority and it would be important to resolve the anaesthetic cover issue and the training experiences for junior doctors.

Medical Director

NOTED

31. HEALTHCARE ASSOCIATED INFECTION: EXCEPTION REPORT

There was submitted a paper [Paper No 15/22] by the Medical Director updating the Committee on the NHS Board's performance against HEAT and other healthcare association infection targets and performance measures. The most recent validated results for quarter one of 2015 confirmed a total of 102 SAB cases, this equating a rate of 27.1 cases per 100,000 acute occupied bed days. Early indications were that there was an increase between April and June 2015.

In relation to clostridium difficile, the validated results for the first quarter of 2015 confirmed a total of 87 cases for NHS GGC, this equating to a rate of 24.6 cases per 100,000 occupied bed days (OCBDs).

The paper also highlighted the completion rate of the infection prevention and control related training modules on LearnPro as well as the impact of the norovirus on wards and bed days lost.

NOTED

32. VALE OF LEVEN INQUIRY: UPDATE ON PROGRESS IN THE IMPLEMENTATION OF THE RECOMMENDATIONS

There was submitted a paper [Paper No 15/23] by the Medical Director and Nurse Director updating the Committee on the recommendations from the Vale of Leven Hospital Inquiry report. The National Implementation Group was in the process of developing a national plan with timescales and milestones to show progress against each recommendation by all NHS Boards. It was anticipated that the SGHD would issue their guidance during Autumn 2015 on how best to show the implementation of the report's recommendations.

The paper attached a template and gap analysis detailing progress within NHSGGC against each recommendation; ten of the recommendations required further guidance from SGHD and one required further guidance from the Crown Office/Procurator Fiscal Service. Of the remaining 64 recommendations, NHSGGC had fully implemented 47 and partially implemented 16, with good progress shown against those partially implemented. One recommendation was not applicable to NHSGGC.

A further update would be submitted to the Committee following the issue of further guidance from SGHD.

**Medical
Director/
Nurse Director**

NOTED

33. QUEEN ELIZABETH UNIVERSITY HOSPITAL CAMPUS DEVELOPMENT UPDATE

There was submitted a paper [Paper No 15/25] by the Director of Facilities and Capital Planning which updated members on the compensation events to date, commissioning of the new Adult and Children's Hospitals including the air quality issues within the Bone Marrow Transplant rooms in the Adult Hospital, and progress with the final multi-storey car park, demolitions, the ICE building and the Institute of Neurosciences entrance and overcladding.

Mr Loudon further explained the issue of air quality affecting the Bone Marrow Transplant rooms in relation to the use of suspended ceilings as opposed to a permanent ceiling and the contractors were now undertaking this work with a completion date of the end of October 2015.

Mr White highlighted the mechanism of funding in relation to the ICE building and the University of Glasgow.

NOTED

34. ACCESS POLICY

There was a verbal update by the Chief Officer, Acute Services indicating the process for the intended review of the Access Policy, in particular, in relation to a patient choosing to receive a service from a local hospital or named consultant. NHSGGC was keen to come into line with the rest of the Scottish health service. In exercising that choice, patients would defer their rights to the Waiting Time Guarantee.

Ms Micklem asked that the Equality Impact Assessment action plan be reviewed to ensure the policy was updated in relation to the points raised and further assessment be undertaken in relation to the changes proposed. Taking positive action to prioritise certain patients' access to services was raised but difficult to achieve under current arrangements.

**Chief Officer,
Acute Services**

Mr Archibald indicated that the revised policy, which clearly highlighted the key changes and implications, would be submitted to the NHS Board for consideration and approval.

**Chief Officer,
Acute Services**

NOTED

35. ACUTE STRATEGIC MANAGEMENT GROUP: MINUTES OF MEETINGS HELD ON 25 JUNE AND 23 JULY 2015

There was submitted a paper [Paper No 15/27] enclosing the Acute Strategic Management Minutes of meetings held on 25 June and 23 July 2015.

NOTED

36. MS ROSSLYN CROCKET – NURSE DIRECTOR

The Convener intimated that this would be the last meeting that Ms Rosslyn Crocket, Nurse Director, would be attending prior to her retiral at the end of the month. He wished to thank her for the contribution to the work of the Committee and her responsiveness to this and the former Quality & Performance Committee's scrutiny and questions, and wished her well for a healthy and happy retirement.

37. DATE OF NEXT MEETING

9.00am on Tuesday 17 November 2015 in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 1pm

Healthcare Associated Infection: Exception Report

Recommendation: For noting.

Purpose of Paper: Update on NHSGGC performance against HEAT and other HAI Targets and performance measures.

Key Issues to be considered: All Scottish NHS Boards are to achieve *Staphylococcus aureus* Bacteraemia (SAB) HEAT target of **24** cases or less per 100,000 Acute Occupied Bed Days (AOBDs) by 31st March 2016. For NHS Greater Glasgow & Clyde this is estimated to equal 25 patients or less each month developing a SAB.

The most recent validated results for 2015, Quarter 1 confirm a total of 102 SAB cases for NHS GGC, between January and March 2015. This equates to a SAB rate of **27.1** cases per 100,000 AOBD.

Local data for 2015 Quarter 2 indicates a 14% increase, with 116 SABs identified between April and June 2015. This equates to an estimated rate of approx. 31.5 cases per 100,000 AOBD. The validated results for Quarter 2 are expected to be published in October 2015.

Clostridium difficile (CDI) HEAT target of **32** CDI cases or less per 100,000 occupied bed days (OCBDs) in the over 15's age group, is to be achieved by 31st March 2016.

The most recent validated results for 2015, Quarter 1 confirm a total of 87 cases for NHS GGC, between January and March 2015. This equates to a rate of **24.6** cases per 100,000 OCBDs.

HAI HEAT Targets October - December 2014	GGC	National	HEAT target
SAB rate per 100,000 AOBD	27.1 (102 cases)	29.7	24.0
CDI rate per 100,000 OCBD	24.6 (87 cases)	27.1	32.0

Table 1. Progress against National HAI HEAT targets, 01/01/2015 – 31/03/2015.

Any Patient Safety /Patient Experience Issues: No

Any Financial Implications from this Paper: No

Any Staffing Implications from this Paper: No

Any Equality Implications from this Paper: No

Any Health Inequalities Implications from this Paper: No

Highlight the Corporate Plan priorities to which your paper relates: Improving quality, efficiency and effectiveness.

Author: Dr. Jennifer Armstrong

Tel No: [REDACTED]

Date: 27/08/2015

Infection Prevention & Control Service Report for Acute Services Committee, September 2015

Staphylococcus aureus Bacteraemia (SAB) Surveillance

From 1st October 2014 all NHS Scotland Boards are submitting data to Health Protection Scotland as part of the mandatory Scottish Government Enhanced SAB Surveillance process [CNO letter 24/04/2014]. This includes a standardised data form for all Boards to collect enhanced surveillance data for MSSA and MRSA bacteraemias. This process also involves more scrutiny of invasive procedures that the patient has undergone in the 30 days prior to developing a bacteraemia (e.g. IA/IM/IV/SC medication; venepuncture; biopsies; dental extraction; podiatry/ulcer care etc.). This information should assist in the identification of risk reduction strategies both locally and throughout Scotland in those cases which are amenable to improvement.

Due to the change in definition of origin used in the national programme, it is anticipated that there will be a slight rise in the reported number of "Hospital Acquired" cases within patients who receive regular haemodialysis as an out-patient or day case. Contaminated blood cultures will now also be reported as hospital acquired or healthcare associated. Continued best practice and adherence with aseptic technique must be undertaken by clinicians when obtaining blood specimens for culture in order to minimise the risk of contamination from the environment, clinician or patient's skin flora.

For the last available reporting quarter (January - March 2015), NHSGGC reported **27.1** SAB cases per 100,000 AOBs and NHS Scotland reported **29.7** per 100,000 AOBs. The existing National HEAT target which requires all Boards in Scotland to achieve a rate of **24** cases per 100,000 AOBs or lower has now been extended to 31st March 2016.

In the year ending March 2015, NHSGGC had a **statistically significant decrease** in MSSA and total *Staphylococcus aureus* bacteraemias in comparison to the previous year.

Year end	MSSA rate (per 100,000 AOBs)	SAB rate (per 100,000 AOBs)
March 2014	29.1	31.8
March 2015	24.4	26.4
Change	↓15.9%	↓17.0%

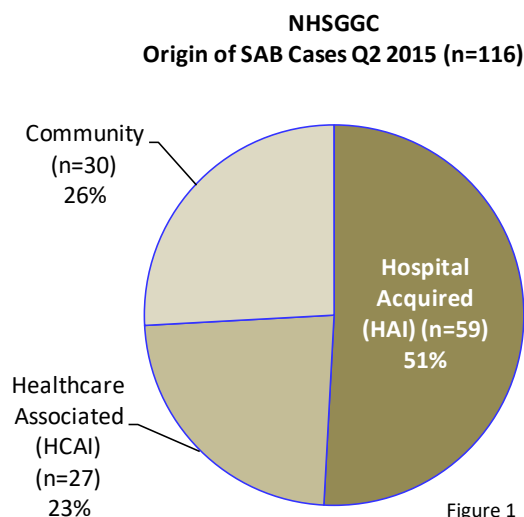
Table 2. Comparison of MSSA rates per 100,000 AOBs.

Quarter 2 (April – June) local surveillance status

Local SAB surveillance figures for April - June (Quarter 2) 2015 indicate that NHSGGC has had a total of **116** patient cases. Only eight of these cases were MRSA.

Local estimation of occupied bed day (OBD) data suggests a rate of approximately **31.5** cases per 100,000 OBDs, however it should be noted that this may vary from the final AOB rate based on ISD/HPS informatics, which will be published in early October 2015.

Over half of all cases this quarter are hospital acquired.



Twenty six patients had the source of their *Staphylococcus aureus* Bacteraemia identified as an Intravenous Access Device (CVC or PVC).

Eleven patients had no clear source identified for source of sepsis following thorough investigation by the Infection Prevention & Control Team and the local Clinical Team.

SOURCE	HAI SABs
Central Venous Catheter (CVC)	16
Not clear source (i.e. not device related)	11
Peripheral Venous Catheter (PVC)	10
Skin/Soft Tissue	7
Urinary Catheter	3
Contaminant	2
Pneumonia	2
Surgical site infection	2
Acute pancreatitis	1
Dental - poor oral hygiene	1
Discitis	1
Likely pacing wires	1
Lower urinary tract infection	1
Nephrostomy	1
Total HAI cases	59

Table 3. Sources of HAI SABs, 01/04/2015 – 30/06/2015

Actions to Address Performance

- In clinical areas that have an increased incidence of HAI SAB cases, a prospective review of all patients is undertaken by the Infection Prevention and Control Team and the Clinical team. This enables real time review, evaluation of features that may be amenable to improvement and development of local clinical action plans for improvement.
- All SAB data is sent quarterly to Health Protection Scotland as part of the National eSAB Surveillance Programme.
- Enhanced SAB data given to Antimicrobial Prescribing Team for analysis of appropriate prescribing and treatment of each case.
- Clinical Review Tools are issued to the Consultant in Charge of each patient with a Hospital Acquired SAB, or those that are Healthcare Associated and are linked to a clinical specialty or have an invasive device *in situ* to enable prospective local clinical review to identify any areas that may be amenable to improvement.
- Ward audit of IV access device care plan undertaken by Infection Prevention and Control Team in SAB cases attributed to CVC or PVC – Nurse in Charge and Chief Nurse prospectively notified of audit result. This is collectively reported in the Monthly Enhanced SAB Report.
- Patient specimen information on blood cultures deemed as 'contaminants' reported to Consultant in Charge and Chief Nurse to enable local review of Blood Culture aseptic technique.
- Continued adherence to CVC and PVC Standard Operating Procedures for all healthcare workers within NHSGG&C clinical teams remains crucial in reducing the number of hospital acquired or healthcare associated cases that are attributed to IV access devices.
- *Staphylococcus aureus* Bacteraemia is a standing agenda item at the Bi - monthly Acute Control of Infection Committee.
- Compliance with GGC SOPs for the insertion, care and maintenance of CVC and PVC will now be monitored via the Infection Prevention and Control Audit. Audit results will be returned to the Chief Nurses for the area and included in the sector/directorate monthly reports.
- Trajectories have been issued to sectors/directorates in order for them to assess their performance against the SAB HEAT target.

Clostridium difficile

The *Clostridium difficile* (CDI) HEAT target, for attainment by the 31st March 2016, now includes cases in ages 15 & over and requires boards to achieve a rate of 32 cases or less per 100,000 OCBDs.

For the last available reporting quarter (January - March 2015), NHSGGC reported 24.6 cases per 100,000 occupied bed days (OCBDs), combined rate for all ages, which remains below the national average of 27.1 per 100,000 OCBDs.

Quarter 2 (April - June) local surveillance status

Local CDI surveillance figures for April - June (Quarter 2) 2015 indicate that NHSGGC has had a total of 108 patient cases. Only 43% of these cases are hospital acquired (n=46). Monitoring continues with the intention of exploring GP and community antimicrobial prescribing practice and also analysing recurring CDI (relapse/re-infection cases).

Local estimation of occupied bed day data for April - June 2015 indicates a rate of approximately 31.2 cases per 100,000 OCBDs, for the last quarter.

Completion of LearnPro HAI related modules

The table below provides the total number of Infection Prevention & Control related LearnPro modules completed by staff members throughout NHS GGC, between June – July 2015.

LearnPro Modules	Staff Group				
	Nursing & Midwifery	Medical Staff	Allied Health Professionals	Ancillary	Total
Cleanliness Champions	12	0	0	0	12
Clostridium difficile (Clinical scenario)	165	0	2	4	171
Clostridium difficile Online Tutorial	241	0	2	6	249
HAI Mandatory Induction	310	0	5	9	324
Helping patients cope with isolation in hospital	75	1	5	0	81
Hospital Outbreak Management	86	1	0	2	89
IPC Influenza	366	4	35	30	435
Aseptic Technique	208	2	0	3	213
IPC Standard Infection Control Precautions	476	7	52	76	611
IPC Statistical process Control Charts	132	3	31	15	181
Total	2071	18	132	145	2366

Table 4. IPC LearnPro Modules, 01/06/2015 – 31/07/2015

Outbreaks/Exceptions

Norovirus

Month	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15
Ward Closures	3	0	1	7	3	2	13	9	14	4	2	6	14	7	5	5
Bed Days Lost	26	0	0	135	43	57	216	135	292	10	10	55	270	98	65	42

Table 5. Monthly total number of ward closures due to suspected/confirmed norovirus, 01/04/2014 – 31/07/2015.

Glasgow Royal Infirmary:

Case of *Corynebacterium diphtheriae* (Toxigenic) in Burns Unit, June 2015

Patient had *C. diphtheriae* isolated from a wound swab taken in OPD on 09/06/15 (incubation period can be up to 10 days, normally 2-5). This is an unusual infectious episode and required an incident review meeting, held 17/06/15. PHPU attended and carried out contact tracing for close contacts in the community. Two members of staff who are deemed as close contacts refrain from clinical work until results available. Both were commenced on antibiotics. Other staff on ward were also been screened. HPS informed. **HIAT AMBER**. Holding press statement prepared with Dr T Inkster ICD. Staff contact screens returned negative. No further action required.

ASC(M)15/03
Minutes: 38 - 53

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Acute Services Committee held at 9.00am on Tuesday, 17 November 2015 in the Board Room, J B Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH

P R E S E N T

	Mr I Lee (Convener)
Ms M Brown	Cllr J McIlwee
Dr H Cameron	Cllr A Lafferty
Cllr G Casey	Dr D Lyons
Mr I Fraser	Cllr M Macmillan (To Minute 47)
	Ms R Micklem (To Minute 47)

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

Mr R Calderwood	Mr A O Robertson OBE, DSc, LLB
Dr M McGuire	Mr M White

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

Mr G Archibald	..	Chief Officer, Acute Services
Mr A Crawford	..	Head of Clinical Governance (To Minute 42)
Mr J C Hamilton	..	Head of Board Administration
Mr D Loudon	..	Director of Facilities & Capital Planning (To Minute 41b)
Mr S McLeod	..	Head of Specialist Children's Services (To Minute 41b)
Ms S McNamee	..	Assistant Director of Nursing – Infection Control (To Minute 43)
Ms A MacPherson	..	Director of Human Resources & Organisational Development
Ms T Mullen	..	Head of Performance
Ms C Renfrew	..	Director of Planning and Policy
Ms H Russell	..	Audit Scotland
Mr G Welch	..	Chief of Medicine, South Sector (To Minute 46)
Prof C Williams	..	Consultant Microbiologist (To Minute 43)
Mr R Wright	..	Director of Health Information and Technology

38. APOLOGIES, WELCOME AND PRELIMINARIES

Apologies were intimated on behalf of Prof A Dominiczak OBE, Mr R Finnie, Cllr Kerr, Mr A Macleod, Cllr M O'Donnell and Mr D Sime.

39. DECLARATIONS OF INTEREST

There were no declarations of interest.

NOTED

40. MINUTES OF PREVIOUS MEETING

On the motion of Dr D Lyons and seconded by Dr H Cameron, the Minutes of the Acute Services Committee meeting held on 15 September 2015 [ASC(M)15/02] were approved as a correct record.

NOTED

41. MATTERS ARISING

a) Rolling Action List

Dr Lyons pointed out that there were a number intimated as “in progress” with November 2015 completion dates. He asked that each one be dealt with prior to the next meeting and that the Rolling Action List show the outcome or full explanation as to the actions being taken and timescale for completion.

**All Directors/
Chief Officer**

NOTED

b) Ward 4 – National Child Psychiatric Inpatient Service, Royal Hospital for Children: Risk Assessment Report

In relation to Minute 20a(i) – Royal Hospital for Children – Child Psychiatry Ward and Garden – there was submitted a paper [Paper No 15/29] from Mr Stephen McLeod, Head of Specialist Children’s Services, providing an overview of the clinical risk activity within Ward 4, Royal Hospital for Children in relation to:-

- Risk assessment
- DATIX and RIDDOR summary
- Work completed and outstanding
- Children and families feedback

It was acknowledged that there were outstanding issues which were impacting on the running of the service and on the patients, parents/carers’ experience of the service and where those were impacting on health and safety these were being managed by increased nurse staffing levels within the ward.

In relation to the issues identified under the risk assessment, Mr Loudon advised that where the timescale had not been identified within the paper, the intention was to complete these, subject to the delivery of specific pieces of equipment, all by the date of the next meeting of the Committee. Mr McLeod intimated that the temporary introduction of a walkie talkie system was mitigating some of the identified risks.

Mr Fraser expressed concern that one year on from the Members’ visit to the ward, discussions and actions were still ongoing in relation to the concerns raised within the risk assessments. The fault lay with the specification, design and sign-off process and Dr Lyons reiterated his concerns that the separate entrance could be seen as increasing the stigma of young people with mental health issues. He queried why the facility was on the top floor and not signposted, and believed that the roof garden should not be brought into operation.

Ms Brown was worried that Members having pursued this for so long, that it was only now that an accredited risk assessment tool was being used to assess the risks. She endorsed the suspension of use of the roof garden and remained dissatisfied with the actions to identify and remove ligature points in the hospitals and that this should be reviewed further with a plan for removal.

Mr Calderwood acknowledged the continued concerns and explained the process undertaken to bring about an improvement to the former service when the moves to the new hospital were being planned, and that this had included clinical staff, user groups and children's panels. He highlighted the formal and informal feedback arrangements being utilised to date. He would ask Officers to look again at the use or otherwise of the roof garden and, in taking forward any plans in relation to ligature points, this should be a Board-wide review. Lastly, in relation to the signage to the fourth floor and information provided to reception staff, this would be reviewed in order to improve the signage and also the information available to reception staff as well as the arrangements for access out of hours.

**Chief Officer,
Acute Services**

NOTED

42. SCOTTISH PATIENT SAFETY PROGRAMME UPDATE

There was submitted a paper [Paper No 15/38] by the Medical Director focusing on the aim of reducing hospital mortality in hospitals within the Acute Services Division.

With the service reconfiguration undertaken in spring/summer and moving to the new QEUH, future reporting for HSMR would cover the following:-

- (1) Inverclyde Royal Hospital;
- (2) Glasgow Royal Infirmary/Stobhill Hospital;
- (3) Royal Alexandra (RAH) /Vale of Leven Hospitals;
- (4) Queen Elizabeth University Hospital.

Mr Crawford reminded Members that the HSMR for the RAH/Vale of Leven Hospitals had been flagged as being relatively high in the quarter from January to March 2014 and this had led to a Healthcare Improvement Scotland (HIS) visit in order to gain an understanding of what factors might be underlying the upward trend and where improvements might be required. The HIS visiting team had indicated a sense of being encouraged by the approach and work being undertaken at the RAH and discussions covered the local action plan together with the additional measures undertaken with the medical staff, which, amongst other actions, included moving towards a review or screening process for all inpatient mortality at the RAH. HIS's formal communication to the Board indicated that it was satisfied that now was the right time to conclude their formal dialogue with the Board on this matter, recognising that the responsibility for monitoring and delivery of the action plan, and addressing any concerns, rests with NHSGGC's own clinical governance system.

Members noted the improved HSMR figures for the RAH/VOL hospitals in the most recently published data.

NOTED

43. **HEALTHCARE ASSOCIATED INFECTION: EXCEPTION REPORT**

There was submitted a paper [Paper No 15/40] by the Medical Director updating the Committee on the NHS Board's performance against HEAT and other Healthcare Associated Infection targets and performance measures. The most recently validated results for quarter two of 2015 (April to June) confirmed a total of 116 SAB cases, this equating to a rate of 33 cases per 100,000 acute occupied bed days. This was consistent with the NHS Scotland rate of 33 cases for the same quarter. Early indications from non-validated national data suggested that quarter three (covering July to September) has a similar outcome.

In relation to clostridium difficile, the validated results for the first quarter of 2015 confirmed a total of 107 cases, equating to a rate of 30.2 cases per 100,000 acute occupied bed days.

Professor Williams highlighted the steps taken in relation to the two actions which came out of the Committee's consideration of the report at the last meeting. In relation to the Renal Unit at Stobhill Hospital, performance had now returned to within normal parameters following the completion of an action plan which included additional theatre sections. In relation to the figures for Community in relation to people using IV illicit drugs, the percentage up to 46% SABs was being taken forward in discussions with the Public Health department.

Professor Williams highlighted the increased incidence of *serratia marcescens* in patients in the NICU at the Royal Hospital for Children. Weekly screening identified 13 patients, of whom 12 had been colonised and the organism was found on routine weekly screening specimens. Not all cases involved the same strain of the organism, and three different strains of the bacteria had been identified. An action plan had been developed and agreed with Health Protection Scotland and there had been no new cases since 26 October 2015.

Ms McNamee spoke about the increase in surgical site infections at the Queen Elizabeth University Hospital and Royal Alexandra Hospital orthopaedic departments. In relation to a question from the Convener, Ms McNamee advised that the bringing together of three different teams onto one site was still taking some time to come together in a single process of best practice and a consistent pathway for patients.

Lastly, the paper also highlighted the completion rate of the infection prevention and control related training modules on LearnPro as well as the impact of the novovirus on wards and bed days lost.

NOTED

44. **PATIENT'S STORY**

Dr Margaret McGuire, Nurse Director, read out a recent patient story from the Breast Cancer Unit which highlighted particular lessons in listening to the patient and taking on board their insights, evidence and thoughts on their care. Getting the balance right was important, and additionally, ensuring the provision of as much relevant information as possible to those patients who may not have access to evidence in relation to their own diagnosis/condition.

NOTED**45. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT**

There was submitted a paper [Paper No 15/30] by the Chief Officer, Acute Services setting out the integrated overview of NHSGGC Acute Services Division's performance. Of the 29 measures which had been assessed a performance status based on their variation from trajectory and/or target, 16 were assessed as green, six as amber (performance within 5% of trajectory) and seven as red (performance 5% outwith meeting trajectory). Exception reports had been provided for those measures which had been assessed as red and Mr Archibald took Members through each one in turn.

In particular, Mr Archibald highlighted the actions being taken in relation to the cancer wait times (62 day and 31 day standards), particularly in relation to urology, head & neck, and breast cancers, with an additional non-recurring resource allocation being made available to alleviate a number of ongoing pressures in these areas.

Ms Renfrew highlighted that whilst delayed discharge rates had been improving, there had been a slight increase again and discussions were ongoing with the City Council in order to seek further improved performance, and Members of Integrated Joint Boards would bring about local scrutiny of the figures at their IJB Board meetings.

In relation to the sickness absence report, Ms MacPherson highlighted the issues discussed at the last meeting of the Committee, and advised that the Resolve absence tool would be used across the NHS Board and she reported that the support teams were now in place to provide specialist advice and support to managers when managing absence within their areas. In addition, a transition advisor was also available to support discussions with staff on long term absences and staff side were engaged with this process. It was recognised that stress was a particular concern, and the stress action plan was being refreshed and made available to managers.

NOTED**(a) DISAGGREGATE DATA FOR A RANGE OF POPULATION GROUPS TO TRACK A NARROWING OF THE INEQUALITIES GAP**

There was submitted a paper [Paper No 15/31] by the Director of Planning and Policy which outlined the progress made to date in providing an overview of performance against measures with disaggregated data currently reflected within the Acute Services Integrated report alongside proposals to further disaggregate data in relation to other existing measures.

The integrated performance report currently contained performance measures where disaggregated data was used to track a narrowing of the inequalities gap. These measures comprised antenatal care (SIMD) and new outpatient Do Not Attends (sex and SIMD). In addition, 38 Equality Impact Assessments (EQIAs) had been carried out from April 2013 to 2015, in 2015/16 the focus of the EQIA programme was on the quality rather than the quantity. A total of 26 new EQIAs were planned in 2015/16 together with the 6-12 month review date of EQIA action plans.

Ms Micklem noted the start made and commented that although two targets were shown in relation to the measurement for inequalities, she had hoped more might have been identified for now and the future. New equality outcomes would be identified from April 2016 however, she was hoping that the existing ones which were possibly coming to an end could have been highlighted and measured showing the progress/outcome to date. She would welcome the Equalities Team highlighting those measures that they believe should be prioritised for the forthcoming years.

Ms Brown felt that the public health report would assist with this work, particularly in relation to age-specific death rates and how resources were allocated within NHSGGC.

Ms Renfrew indicated that this was only one piece of work within Acute Services, and it did not present a full picture of everything that was undertaken within the Equalities agenda. The Equality Annual Report would be submitted to the December NHS Board for consideration and this would cover the full range of work undertaken, although it did remain a challenge to disaggregate data in a meaningful way. She would ensure however, the paper to the Board in December would set out priorities for the future for the NHS Board and the IJBs.

**Director of
Planning &
Policy**

NOTED

(b) KSF ACTIVITY

There was a paper [Paper No 15/32] submitted by the Director of Human Resources and Organisational Development setting out, at the Committee's request from the last meeting, the position within Acute Services in meeting the compliance and quality of local activity associated with the e-Knowledge Skills Framework (e-KSF).

The target was 80% compliance and the latest monthly figures indicated a compliance rate of 67.2% (which was down from the same period last year).

The paper set out the progress and actions taken to improve compliance including the assignment of the correct manager on e-KSF following the hospital moves to the Queen Elizabeth University Hospital over the last few months; a focus on KSF compliance was part of the regular monitoring process to managers; advice, training and support to managers to be provided by the Learning & e-Support Team, KSF Staff Side Advisor, KSF Leads, Learning & Education Advisors and website resources. In relation to improving the quality of the KSFs and Performance Development Plans (PDPs), audits would be carried out to review the quality and to inform further actions to make improvements.

In addition, a series of roadshows to promote new resources and support would be held together with a series of drop in sessions and Ms MacPherson advised that a national review was underway with the key priority to make the web-based resource more user friendly and intuitive.

In relation to a question from Dr Cameron, Ms MacPherson agreed to share the outcomes of the audits with the Committee.

**Director of HR
& OD**

NOTED

(c) UNSCHEDULED CARE PLANNING: WINTER PLAN 2016/17

There was submitted a paper [Paper No 15/33] by the Chief Officer, Acute Services and Director of Planning & Policy attaching the final Winter Plan for approval by the Committee. The focus of the detailed planning had been to deliver high quality patient care throughout the pressurised period of winter and to make the national target to deliver care to 95% of Accident & Emergency attenders within four hours. The plan had been developed through a detailed review process within Acute Services Division and the Partnerships and the collective consideration by the Board Chief Executive, Chief Officers and Directors. Acute, Community, Primary Care and Social Services were interdependent and needed to operate as a coherent system to achieve the objective to deliver high quality patient care throughout the winter. The paper highlighted that additional funding of [REDACTED] had been made available from the Scottish Government in relation to delayed discharges which had been provided direct to the Partnerships, and [REDACTED] for the Six Essential Actions programme and this money had already been committed as required. In addition, a further [REDACTED] had been added to the Board Financial Plan to the already committed [REDACTED] of non-recurring winter funding.

Following the redesign of Acute Services, fewer beds would be available this winter than previously, and the Scottish Government had already agreed [REDACTED] additional funding to enable the new ways of working across the Acute Services Division to become embedded throughout the first six months of 2015. The additional funding underpinned baseline activity and capacity relevant to achieving the government's waiting time targets.

In addition, the paper provided an overview setting out the latest key performance indicators in relation to meeting the four hour A&E waiting time target. The overall weekly performance for the six week period from 4 October to 8 November 2015 ranged from 92 to 94% with the number of attendances varying between 6,447 and 6,905. Admissions ranged from 1,909 to 2,038 per week and the paper highlighted the actions which continued to be taken in order to meet the four hour A&E waiting time target. The most recent figures for the last completed week indicated that the Queen Elizabeth University Hospital was at 94.3% and the overall Board performance was at 94.8%.

Councillor Macmillan asked about the discussions with the Scottish Government and the availability of resources for winter planning and Mr Calderwood advised that monthly discussions were held with Scottish NHS Board Chief Executives and Scottish Government officials, and the NHS Board Chairs also had monthly meetings with officials and the Cabinet Secretary and a regular feature of these meetings was resources and wait times targets.

From April 2016, the Integrated Joint Boards would have responsibility for strategic planning in relation to unscheduled care and these would be important discussions/considerations for the IJBs in relation to planning unscheduled care and planning for the winter pressures. Mr Archibald and Ms Renfrew offered to provide specific and detailed information to local IJBs in relation to the services within their areas and where their population accessed services and would attend meetings to discuss these matters if it was helpful. Different IJBs would approach these matters in different ways and the role of Non-Executive Members at the discussions would be important in shaping the outcomes.

**Chief Officer,
Acute Services/
Director of
Planning &
Policy**

NOTED

46. QUEEN ELIZABETH UNIVERSITY HOSPITAL – IMMEDIATE ASSESSMENT UNIT (IAU) UPDATE

Mr Archibald and Mr George Welch, Chief of Medicine, South Sector, Acute Services, provided Members with a verbal update on the issues relating to the IAU at the QEUH following media reports of the death of an elderly person who had waited over eight hours for a medical review. Mr Welch provided the details associated with this case. He highlighted that it had been a particularly busy Monday evening with attendances at the Accident & Emergency department 11% up from the eleven week average and there had been a 15% increase in attendances at the IAU, with pressures on beds such that the ability to discharge to a bed had been 16% down. A significant clinical incident review was underway and the Procurator Fiscal had been advised of the death.

The IAU had been set up to receive referrals from GPs and to date, the number being referred in was higher than expected/planned and as this had now been sustained over a period of time, additional space was being identified within the IAU, there would be a realignment of critical care staffing, a review of junior doctor staffing and how the patient flows were handled.

The purpose of the IAU retained clinical support, however, the demand had been much greater than expected, and steps were being taken to retain the model but in a more workable and acceptable way for the staff.

Councillor Macmillan asked what timescale was proposed for dealing with the additional capacity in a way that the IAU model was seen to be working. Mr Archibald advised that it would be a challenge, but part of that challenge was also assisting patients in getting the most appropriate care and treatment in relation to their needs, and that was not always within a hospital setting. A GP telephone triage and hot clinic appointments (appointments on the same day) would be considered, and a more joined-up and aligned process would assist in achieving a better experience and outcome for patients. Mr Calderwood intimated that the Royal Alexandra Hospital pilot worked well and was successful, however, the additional resources this attracted had assisted in meeting the increased attendances. The Queen Elizabeth University Hospital still needed time to settle into new ways of working with the coming together of different teams. The bringing together of three Adult Acute hospitals which were not meeting the A&E waiting time targets was always going to be a major challenge for the new hospital to turn this performance around into a sustained high performing unit. All indications were that the elective elements of the patient experience were good but he and his fellow Directors recognised the test that lay ahead in relation to the winter pressures from now until Easter.

Ms Micklem wondered if introducing further stages of triage brought the risk of potentially missing the deteriorating patient. It was reported that the triage tool to be used was designed to be specifically sensitive to patients' needs and recognise the risk factors in listening to patients' descriptions of their symptoms.

Ms Brown intimated that the whole system approach was critical to this and that IJB members needed to be focused on unscheduled care and all parts of winter planning. She appreciated the clinical staff being keen to retain the IAU model however, recognising that clinical leadership was important, the NHS Board needed to also provide reassurance to some of those staff who remained disaffected. She mentioned that she and a few other Board Members had felt that they should have received earlier notification of the circumstances surrounding the death of the

**Director of
Corporate
Communications**

elderly patient within the IAU and she asked that this be reviewed and considered for future occasions.

Dr Lyons highlighted the anticipatory care issue for IJBs and welcomed the possible ambulatory care options for patients attending the IAU. However, he did not believe it was coincidental that the incident discussed occurred on a Monday evening. There were higher levels of attendance on Monday evenings and this needed to be planned and catered for going forward. Mr Calderwood acknowledged this point and that the expansion of the space made available to the IAU was one of the key actions in recognising the increased activity on a Monday night. Mr Archibald indicated that discussions were ongoing with the broader clinical body about the flow from the IAU, A&E, Acute Receiving and GPs, and it was important to get this aspect of the new hospital working in a way which gave greater confidence to patients and others.

It was agreed that a further update on the operation of the IAU would be submitted to the January meeting of the Committee.

**Chief Officer,
Acute Services**

NOTED

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

The Director of Finance provided a presentation to Members on the financial position within the Acute Services Division for the seven month period to 31 October 2015. Expenditure within Acute Services was overspent by [REDACTED] and this was the same figure for the overall NHS Board overspend. Mr White highlighted that the variance to date within the South and North Sectors was [REDACTED] and the primary reasons were associated with the medical staffing and nursing staffing budget overspends.

The higher levels of activity were a factor, however, it was also recognised that the higher sickness rates of staff were resulting in additional costs for locums, bank and agency staff, particularly for Glasgow Royal Infirmary and the Queen Elizabeth University Hospital.

Mr Fraser raised his concern at the high levels of overexpenditure within the South Sector and the fact that it would now need to deliver a saving of [REDACTED] per month to achieve break even. He asked if it would be possible to over-recruit numbers of staff in anticipation of vacancies and reduce the need to use bank and agency staff. Dr McGuire advised that this was already underway, especially when recruiting qualified nurses, however, the recruitment in some specialist areas was for the first time now more difficult than previously. The national workforce tool was being rerun across seven wards in order to determine the correct staffing, acuity of patients and necessary observations, and she observed that 12 hour shift absences were challenging when trying to obtain cover from bank staff.

Mr Calderwood indicated that the target was to bring an end to the [REDACTED] per month overspend, however, it remained a major challenge to deal with the cumulative overspend in a recurring way. Therefore, there would be a review of the opening budgets, the use of non-recurring funds, and a look at discretionary spends to see whether some elements could be deferred until a later date. A number of short term arrangements had to be put in place in relation to the QEUA i.e. anaesthetic cover for the Beatson West of Scotland Cancer Centre, bone marrow transplant and resolving these in a more substantive way would assist. There was also a concern

that additional funding was provided to the Glasgow Royal Infirmary however, the level of sickness absence, while remaining consistent, was now proving more costly to backfill and a further review of that whole area would be required over the coming weeks.

In relation to the Convener's question about the timing and further discussions, Mr Archibald intimated that there would be an opportunity for further discussion at the NHS Board Seminar on 1 December 2015, the planned Away Day on 22 December, and at the next Acute Services Committee meeting on 19 January 2016.

**Chief Officer,
Acute Services**

NOTED

48. PERSON-CENTRED HEALTH & CARE PROGRAMME: STRATEGIC REPORT AND WORK PLAN

There was submitted a report [Paper No 15/36] by the Nurse Director setting out the current position on the NHS Board's progress in implementing the Person-Centred Health & Care Programme. Dr McGuire drew attention to the number of prominent reporting requirements made available to the NHS Board and its Standing Committees in relation to different strands of Person-Centred Care. She advised that it was her wish to bring forward proposals on reporting to Members in a way which fully reflected the scope of feedback on patient experience, the various improvement programmes, the priority of care experience within the strategic commitment to quality, and using the information gained from complaints, feedback, comments and concerns. Members welcomed this intention and recognised that the new way of reporting would occur over the coming months.

Nurse Director

The Person-Centred Health & Care Programme reported:-

- 1) 94% of responses received from patients, relatives and carers within the Acute Services Division were indicative of a positive care experience over the three month reporting period.
- 2) 196 in-depth conversations with people had been undertaken and 7,448 responses had been gathered in relation to the themed conversations.
- 3) Recent months had shown an improvement in patients' views of the mealtime experience.
- 4) A further review of the clinical teams currently being supported by the Person-Centred Health & Care Programme had been undertaken and that the coaching and mentoring support provided to date would now be concentrated on a new cohort of clinical teams in future.

NOTED

49. QUARTERLY REPORT ON CASES CONSIDERED BY THE SCOTTISH PUBLIC SERVICES OMBUDSMAN: 1 JULY TO 30 SEPTEMBER 2015

There was submitted a report [Paper No 15/37] by the Nurse Director which set out the Acute Services Report on the actions taken against the recommendations made by the Scottish Public Services Ombudsman in relation to investigative reports and decision letters issued in the period from 1 July to 30 September 2015. Three investigative reports had been issued together with 23 decision letters. Dr

McGuire, in highlighting key points from the report, advised Members that elements of offering patients and complainants an apology was still not consistently and systematically happening, and the benefit of an apology being offered in the very early stages needed to be reinforced with frontline staff.

Ms Brown highlighted the issues drawn out from the investigative report in relation to the Community Midwife Unit at the Vale of Leven Hospital. The clinical safety of the Unit again required to be considered and Mr Calderwood intimated that this continued to be discussed with the Scottish Government Health Directorate. The Medical Director and Nurse Director were considering the issue and hoped to submit a paper to a future meeting of the Committee for review and consideration. It would need to show what was different from the previous submissions and be evidence based.

**Medical
Director/
Nurse Director**

Councillor Lafferty asked about legal claims as a result of an SPSO report and whilst it was acknowledged this was possible and did happen, the numbers were very low.

NOTED

50. BEATSON WEST OF SCOTLAND CANCER CENTRE (BWoSCC): UPDATE POSITION

There was submitted a report [Paper No 15/39] by the Chief Officer, Acute Services and the Medical Director which attached the Healthcare Improvement Scotland (HIS) report on its findings on a recent Inquiry Visit to the Beatson West of Scotland Cancer Centre (BWoSCC). Concerns had been raised by medical staff in relation to clinical support for the continuing activity and case mix managed within the oncology and blood cancer services.

The HIS Inquiry Team has asked NHSGGC to carefully consider the four recommendations and prepare an improvement plan to address these by April 2016.

The paper advised that meetings had been arranged with the medical consultant staff from the BWoSCC on 25 November, and with the wider medical staff including critical care, anaesthetics and physician/consultant colleagues on 30 November. It was important to move forward jointly in a constructive way with the medical staff at the Beatson and it was hoped that this could be achieved in taking forward the recommendations in a positive and supportive way.

Ms Brown indicated that the report had been interesting reading and she felt it was critically important that management worked with all clinicians in a facilitative and supportive way in order to ensure a trusting environment for both parties. Dr Cameron indicated that, while it was important to ensure appropriate engagement with the medical staff, it was equally important to engage with the wider clinical staffing, not just in the Beatson but within NHSGGC. Clinical teams were made up of much more than just medical staff, and working with all relevant clinical colleagues would be essential in achieving good relationships and outcomes.

In relation to the recommendation about the Area Clinical Forum, Mr Calderwood indicated that he had discussed this with Dr Armstrong, and it would be important to give further consideration as to how best the Senior Management Team engaged with the Area Clinical Forum and the professional advisory structure. The review to be undertaken would be shared with the Area Clinical Forum for its comments and views before being finalised and submitted to HIS.

**Head of Board
Administration**

NOTED**51. SURGICAL REDESIGN: VALE OF LEVEN HOSPITAL**

There was submitted a report [Paper No 15/41] by the Director of Planning & Policy asking the Committee to approve the proposal to re-provide Ward 6 activity in the Surgical Day Bed Unit for day cases and Lomond Ward for inpatients.

The Clyde Sector Management Team, in reviewing services and activity across Clyde, was aware that there was insufficient surgical activity on the Vale of Leven hospital site to justify the retention of both Ward 6 and the Surgical Day Bed Unit. To re-provide the activity on Ward 6 within the Surgical Day Bed Unit, the Unit would require to extend its opening hours. Patients requiring an inpatient stay would continue to have their care provided in the Lomond Ward and therefore the proposed redesign would have no impact on the surgical activity which was currently carried out within the Vale of Leven hospital.

From a workforce perspective, there was the opportunity to accommodate the majority of the staffing team on the site through internal redeployment while releasing savings which could be used and reinvested to support capacity elsewhere within the Clyde Sector.

DECIDED

- That, the proposal to re-provide Ward 6 activity within the Surgical Day Bed Unit for day cases, and Lomond Ward for inpatients, on the Vale of Leven hospital site, be approved.

52. ACUTE STRATEGIC MANAGEMENT GROUP: MINUTES OF MEETINGS HELD ON 27 AUGUST AND 24 SEPTEMBER 2015

There was submitted a paper [Paper No 15/42] enclosing the Acute Strategic Management Minutes of meetings held on 27 August and 24 September 2015.

NOTED**53. DATE OF NEXT MEETING**

9.00am on Tuesday 19 January 2016 in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 12:10pm

Healthcare Associated Infection: Exception Report

Recommendation: For noting.

Purpose of Paper: Update on NHSGGC performance against HEAT and other HAI Targets and performance measures.

Key Issues to be considered: All Scottish NHS Boards are to achieve *Staphylococcus aureus* Bacteraemia (SAB) HEAT target of **24** cases or less per 100,000 Acute Occupied Bed Days (AOBDs) by 31st March 2016. For NHS Greater Glasgow & Clyde this is estimated to equal 25 patients or less each month developing a SAB.

The most recent validated & published results for 2015, Quarter 2 confirm a total of 116 SAB cases for NHSGGC, between April and June 2015. This equates to a SAB rate of **33.0** cases per 100,000 AOB. This also aligns with the NHS Scotland rate of 33.0 cases for the quarter.

While validated national data is not available, local data for 2015 Quarter 3 indicates that 116 SABs were again reported between July and September 2015. Based on local bed occupancy data from NHSGGC Information Services this equates to an estimated rate of 34.4 cases per 100,000 AOB.

Clostridium difficile (CDI) HEAT target of **32** CDI cases or less per 100,000 occupied bed days (OCBDs) in the over 15's age group, is to be achieved by 31st March 2016.

Validated results for 2015, Quarter 2 confirm a total of 107 cases for NHS GGC, between April and June 2015. This equates to a rate of **30.2** cases per 100,000 OCBDs. Quarter 3 saw a slight decrease with 101 inpatient cases and local intelligence data estimates a rate of 29.7 cases per 100,000 OCBD.

The validated results from Health Protection Scotland for the Quarter are expected to be published in January 2016.

Validated HPS/ISD data April – June 2015			
HAI HEAT Targets	GGC	National	HEAT target
SAB rate per 100,000 AOB	33.0 (116 cases)	33.0	24.0
CDI rate per 100,000 OCBD	30.2 (107 cases)	32.2	32.0

Table 1. Progress against National HAI HEAT targets, 01/04/2015 – 30/06/2015.

Any Patient Safety /Patient Experience Issues: No

Any Financial Implications from this Paper: No

Any Staffing Implications from this Paper: No

Any Equality Implications from this Paper: No

Any Health Inequalities Implications from this Paper: No

Highlight the Corporate Plan priorities to which your paper relates: Improving quality, efficiency and effectiveness.

Author: Dr. Jennifer Armstrong

Tel No: [REDACTED]

Date: 06/11/2015

Infection Prevention & Control Service Report for Acute Services Committee, November 2015

Staphylococcus aureus Bacteraemia (SAB) Surveillance

For the last available reporting quarter (April – June 2015), NHSGGC reported **33.0** SAB cases per 100,000 AOBDS (116 patient cases) and NHS Scotland also reported a national SAB rate of **33.0** per 100,000 AOBDS (416 patient cases). The existing National HEAT target which requires all Boards in Scotland to achieve a rate of **24** cases per 100,000 AOBDS or lower has now been extended to 31st March 2016. This equates to 75 patient cases or less per reporting Quarter.

In the rolling year ending June 2015, NHSGGC had a **statistically significant decrease** in MSSA bacteraemias and total *Staphylococcus aureus* bacteraemias in comparison to the previous year.

Year end	Number of MSSA cases	MSSA rate (per 100,000 AOBDS)	Number of SAB	SAB rate (per 100,000 AOBDS)
June 2014	427	29.5	466	32.2
June 2015	371	25.4	398	27.3
Change		↓13.7%		↓15.2%

Table 2. Comparison of MSSA rates per 100,000 AOBDS. [To calculate rate per 1000 AOBDS divide by 100]

Quarter 3 (July-September) local surveillance status

Local SAB surveillance figures for July-September (Quarter 3) 2015 indicate no change in total cases and NHSGGC will again be reporting **116** patient cases to Health Protection Scotland. Thirteen of these cases were MRSA.

A breakdown of the cases by site is contained in the table below. All sectors are above aim for the Quarter.

Sector/Directorate	July	August	September	Total	SAB aim per quarter
North Glasgow	10	6	9	25	17
South Glasgow	9	14	5	28	25
South Clyde	7	12	14	33	17
Regional	6	2	4	12	11
Women's & Children's	3	7	7	17	5
Total GGC	36	41	39	116	75

Includes 1 SAB for MHP

Table 3. Comparison of each sector in Quarter 3

Local estimation of bed occupancy data suggests a rate of approximately **34.4** cases per 100,000 OBDs, however it should be noted that this is highly likely to vary from the final AOBDS rate based on ISD/HPS informatics, which will be published in early January 2016.

Almost half of all cases this quarter are hospital acquired (Figure 1)

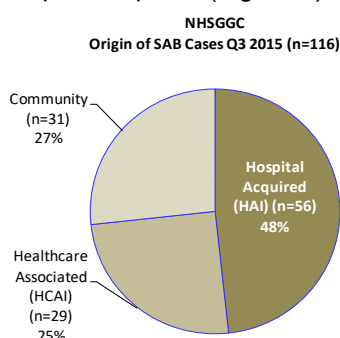


Figure 1

Source of Bacteraemia for Hospital Acquired cases is displayed in the table below. Nineteen patients (34% of HAI cases) suffered harm from a vascular access device during their care episode.

Bacteraemia by system involved or external factor	HAI SABs
Vascular access device	19
Source not known	9
Surgical site infection	7
Skin & soft tissue infection	6
Skeletal or joint infection	5
Contaminant	4
Related to medical device other than VAD	2
Respiratory infection	2
Cardiovascular infection	1
Intra abdominal infection	1
TOTAL HAI CASES	56

Table 4. Sources of HAI SABs, 01/07/2015 – 30/09/2015

Board wide Actions to Address Performance

- Compliance with GGC SOPs for the insertion, care and maintenance of CVC and PVC will now be monitored via the Infection Prevention and Control Audit. Audit results will be returned to the Chief Nurses for the area and included in the sector monthly reports.
- Trajectories have been issued to the five Acute sectors in order for them to assess their performance against the SAB HEAT target. These trajectories are challenging and include all SABs and not only hospital acquired cases. It is acknowledged that non-HAI cases may be less amenable to improvement measures which can be implemented and sustained with the Acute sector of NHS GGC.
- The cross sector SABs group is to be reconvened and the first meeting is scheduled for 11th November 2015. Chief Nurses for each sector have been invited to submit individual sector papers (e.g. improvement tools or local action plans) for shared discussion at the inaugural meeting.
- In clinical areas that have an increased incidence of HAI SAB cases, a prospective review of all patients is undertaken by the Infection Prevention and Control Team and the Clinical team. This enables real time review, evaluation of features that may be amenable to improvement and development of local clinical action plans for improvement.
- All enhanced SAB surveillance data is sent quarterly to Health Protection Scotland as part of the National eSAB Surveillance Programme.
- Enhanced SAB data given to Antimicrobial Prescribing Team for analysis of appropriate prescribing and treatment of each case.
- Clinical Review Tools are issued to the Consultant in Charge of each patient with a Hospital Acquired SAB, or those that are Healthcare Associated and are linked to a clinical specialty or have an invasive device *in situ* to enable prospective local clinical review to identify any areas that may be amenable to improvement.
- Ward audit of IV access device care plan undertaken by Infection Prevention and Control Team in SAB cases attributed to CVC or PVC – Nurse in Charge and Chief Nurse prospectively notified of audit result. This is collectively reported in the Monthly Enhanced SAB Report.
- Patient specimen information on blood cultures deemed as 'contaminants' reported to Consultant in Charge and Chief Nurse to enable local review of Blood Culture aseptic technique.
- Continued adherence to CVC and PVC Standard Operating Procedures for all healthcare workers within NHS GGC clinical teams remains crucial in reducing the number of hospital acquired or healthcare associated cases that are attributed to IV access devices.
- *Staphylococcus aureus* Bacteraemia is a standing agenda item at the Bi - monthly Acute Control of Infection Committee.

Areas for Local Quality Improvement measures

Ten clinical areas reported more than one HAI SAB case this quarter

	HAI SABs	
RHC NICU	5	Neonatology There were eight HAI cases from two Neonatal ICUs <u>Returned actions from Clinical Review Tools :</u> <ul style="list-style-type: none"> • Very premature infants so prevention may not be possible but will re stress hand washing and apron wearing at safety brief. • All actions from previous infection control action plan complete. • Continued compliance with central line care bundle and vigilance with central lines. Renal Five cases were in Renal Dialysis units. Some of the completed action plan requirements achieved were the improved provision of wall clocks with a second hand to improve drying time of TCVC sites and an increase in the number of theatre sessions at QEUH to enable more patients to change from TCVC to AV fistula
PRM NICU	3	
GRI 43	3	
NVH RDU	3	
IRH J North	2	
QEUH 10D	2	
QEUH 8B	2	
RAH CCU	2	
RHC 1D PICU	2	
STO RDU	2	

Clostridium difficile

The *Clostridium difficile* (CDI) HEAT target, for attainment by the 31st March 2016, now includes cases in ages 15 & over and requires boards to achieve a rate of **32** cases or less per 100,000 OCBs.

For the last available reporting quarter (April - June 2015), NHSGGC reported **30.2** cases per 100,000 occupied bed days (OCBDs), combined rate for all ages, which remains below the national average of **32.2** per 100,000 OCBs.

Quarter 3 (July – September) local surveillance status

Local CDI surveillance figures for July - September (Quarter 3) 2015 indicate that NHSGGC has had a total of 101 patient cases. Only 45% of these cases are hospital acquired (n=45). Monitoring continues with the intention of exploring GP and community antimicrobial prescribing practice and also analysing recurring CDI (relapse/re-infection cases).

Local estimation of bed occupancy data for July – September 2015 suggests a rate of approximately **29.7** cases per 100,000 OBDs, for the last quarter. It should be noted that this is highly likely to vary from the final OCB rate based on ISD/HPS informatics, which will be published in early January 2016.

Completion of LearnPro HAI related modules

The table below provides the total number of Infection Prevention & Control related LearnPro modules completed by staff members throughout NHS GGC, between August – September 2015.

LearnPro Modules	Staff Group				
	Nursing & Midwifery	Medical Staff	Allied Health Professionals	Ancillary	Total
Cleanliness Champions	14	0	1	1	16
Clostridium Difficile (Clinical scenario)	137	0	5	4	146
Clostridium Difficile Online tutorial	204	2	6	7	219
HAI Clinical Induction	259	8	15	23	305
Helping patients cope with isolation in hospital	79	0	5	2	86
Hospital Outbreak Management	99	1	0	2	102
IPC Influenza	364	8	48	27	447
Aseptic Technique	199	2	3	6	210
IPC Standard Infection Control Precautions	518	9	98	101	726
IPC Statistical process Control Charts	151	3	28	20	202
Total	2024	33	209	193	2459

Table 4. IPC LearnPro Modules, 01/08/2015 – 30/09/2015

Outbreaks/Exceptions

Increased incidence of *Serratia marcescens* in patients NICU, Royal Hospital for Children

13 patients have been found to have *Serratia marcescens* on routine weekly screening specimens since 20th July 2015. 12 patients have been colonised and the organism was found on routine weekly screening specimens. 1 patient, a very premature infant with complex medical problems, developed a blood stream infection and died, septicaemia is on Part 1 of the death certificate. Not all the cases involve the same strain of the organism and 3 different strains of the bacteria have currently been identified, investigations to establish any links are continuing. An action plan has been developed and agreed between Health Protection Scotland and ourselves. Progress against the plan is reported at each Incident Management Team (IMT) meeting. 9 patients have been discharged. 3 colonised patients remain in the unit (1 in NICU and 2 in SCBU). There have been no new cases since the 26th October 2015.

Norovirus

There were no ward closures reported between August – September 2015.

Month	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Ward Closures	1	7	3	2	13	9	14	4	2	6	14	7	5	5	0	0
Bed Days Lost	0	135	43	57	216	135	292	10	10	55	270	98	65	42	0	0

Table 5. Monthly total number of ward closures due to suspected/confirmed norovirus, 01/06/2014 – 30/09/2015.

Increase of Surgical Site Infections in August 2015 procedures: Queen Elizabeth University Hospital Orthopaedic Surgery

The Queen Elizabeth University Hospital undertakes surgery following the migration of Southern General Hospital, Victoria Infirmary and West Glasgow Hospitals (Western Infirmary/Gartnavel General Hospital).

In August there were six reported surgical site infections (SSI). Four of the reported SSIs had one or more NHSN risk factors and it should also be noted that the three hip arthroplasty SSIs were in revision procedures.

Local review of local theatre practice identified a requirement a standardised approach to theatre behaviours and this has been implemented by the local clinical team.

SSI surveillance is ongoing and at time of report collation, there have been no further SSI cases reported in any of the Orthopaedic procedure categories performed in October 2015 at the QEUH.

Increased Incidence of Surgical Site Infections: Royal Alexandra Hospital Orthopaedic Surgery

Since May this year, the Royal Alexandra Hospital have reported eight deep surgical site infections (SSI), six of which have been in primary hip or knee arthroplasties. It should be noted that five of these eight patients had one or more identified risk factor (NHSN).

Review meetings were held on 07/09/2015, 21/09/2015 & 23/10/2015 between IPC, Orthopaedic and Theatre clinical/managerial teams to discuss the increased incidence of SSI cases in all three procedure categories from May 2015 onwards and action plan developed.

SSI surveillance is ongoing and at time of report collation, there is one further patient who underwent a primary hip arthroplasty in October and is highly suggestive of deep surgical site infection. Further discussion with the Consultant in Charge and Infection Control Doctor is ongoing to determine SSI status.

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

NHS GREATER GLASGOW AND CLYDE

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

P R E S E N T

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

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

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

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

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

01. APOLOGIES, WELCOME AND PRELIMINARIES

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

02. DECLARATIONS OF INTEREST

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

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

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

03. MINUTES OF PREVIOUS MEETING

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

NOTED

04. MATTERS ARISING

a) Rolling Action List

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

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

Medical Director

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

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

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

(iii) Minute 50 – Beatson WoS Cancer Centre Update

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

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

**Director of HR
& OD**

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

Medical Director

NOTED

05. PATIENT'S STORY

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

NOTED

06. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT

There was submitted a paper [Paper No 16/02] by the Chief Officer, Acute Services setting out the integrated overview of NHS GGC Acute Services Division's performance. Of the 29 measures which had been assessed against a performance status based on their variation from trajectory and/or target, 16 were assessed as green, five as amber (performance within 5% of trajectory) and eight as red (performance 5% outwith meeting trajectory). Exception reports had been provided for those measures which had been assessed as red and Mr Archibald took Members through each report.

(i) Detect Cancer Early

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

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

**Chief Officer,
Acute Services**

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

**Chief Officer,
Acute Services**

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

(ii) Delayed Discharges > 14 Days

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

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

**Director of
Planning &
Policy**

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

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

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

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

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

**Director of HR
& OD – March
ASC**

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

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

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

offered appointments at their local hospital site, wherever possible.

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

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

NOTED

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

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

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

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

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

**Director of
Finance**

NOTED

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

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

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

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

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

NOTED

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

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

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

**Medical
Director/
Nurse Director**

DECIDED

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

10. CLINICAL GOVERNANCE UPDATE

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

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

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

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

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

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

NOTED**11. HEALTHCARE ASSOCIATED INFECTION: EXCEPTION REPORT**

There was submitted a paper [Paper No 16/07] by the Medical Director updating the Committee on the NHS Board's performance against HEAT and other Healthcare Associated Infection targets and performance measures. The most recently validated results for quarter 3 of 2015/16 (July to September 2015) confirmed a total of 116 SAB cases, equating to a rate of 34.3 cases per 100,000 acute occupied bed days. This was above the NHS Scotland rate of 31.6 cases for the same period.

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

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

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

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

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

Medical Director

NOTED

12. INTERNAL REVIEW OF PAEDIATRIC CARDIAC SERVICES

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

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

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

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

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

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

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

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

Medical Director

NOTED

13. ANALYSIS OF LEGAL CLAIMS

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

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

NOTED

14. NATIONAL CHILD PSYCHIATRIC UNIT – ROYAL HOSPITAL FOR CHILDREN

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

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

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

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

**Director of
Planning &
Policy**

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

NOTED

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

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

NOTED

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

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

NOTED

17. IMAGING CENTRE OF EXCELLENCE – FULL BUSINESS CASE

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

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

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

DECIDED

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

**Director of
Facilities &
Capital Planning**

18. DATE OF NEXT MEETING

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

The meeting ended at 12:25pm

Healthcare Associated Infection: Exception Report

Recommendation: For noting.

Purpose of Paper: Update on NHSGGC performance against HEAT and other HAI Targets and performance measures.

Key Issues to be considered: All Scottish NHS Boards are to achieve *Staphylococcus aureus* Bacteraemia (SAB) HEAT target of **24** cases or less per 100,000 Acute Occupied Bed Days (AOBDs) by 31st March 2016. For NHS Greater Glasgow & Clyde this is estimated to equal 25 patients or less each month developing a SAB.

The most recent validated & published results for 2015, Quarter 3 confirm a total of 116 SAB cases for NHSGGC, between July and September 2015. This equates to a SAB rate of **34.3** cases per 100,000 AOBD. This is also above the NHS Scotland rate of 31.6 cases for the quarter.

Local surveillance for October to December 2015 (Q4) indicates that NHSGGC have noted a **9.5%** increase with **127** SAB cases at time of report collation

Clostridium difficile (CDI) HEAT target of **32** CDI cases or less per 100,000 occupied bed days (OCBDs) in the over 15's age group, is to be achieved by 31st March 2016.

Validated results for 2015, Quarter 3 confirm a total of 101 cases for NHS GGC, between July and September 2015. This equates to a rate of **29.5** cases per 100,000 OCBDs and remains below HEAT target.

Local surveillance for Quarter 4 has seen a **39%** increase in reported CDI cases, with **140** reported cases.

The validated results from Health Protection Scotland for the Quarter are expected to be published in early April 2016.

Validated HPS/ISD data July - September 2015			
HAI HEAT Targets	GGC	National	HEAT target
SAB rate per 100,000 AOBD	34.3(116 cases)	31.6	24.0
CDI rate per 100,000 OCBD	29.5 (101 cases)	35.7	32.0

Table 1. Progress against National HAI HEAT targets, 01/07/2015 – 30/09/2015.

Any Patient Safety /Patient Experience Issues: Yes increase in SAB and CDI

Any Financial Implications from this Paper: Yes – Implementation of HPS SSI bundle (specifically proposed change to skin prep)

Any Staffing Implications from this Paper: No

Any Equality Implications from this Paper: No

Any Health Inequalities Implications from this Paper: No

Highlight the Corporate Plan priorities to which your paper relates: Improving quality, efficiency and effectiveness.

Author: Dr. Jennifer Armstrong

Tel No: [REDACTED]

Date: 19/01/2016

Infection Prevention & Control Service Report for Acute Services Committee, January 2016

Staphylococcus aureus Bacteraemia (SAB) Surveillance

For the last available reporting quarter (October to December 2015), NHSGGC reported **34.3** SAB cases per 100,000 AOBs (116 patient cases). This is above the NHS Scotland reported national SAB rate of **31.6** per 100,000 AOBs (388 patient cases). The existing National HEAT target which requires all Boards in Scotland to achieve a rate of **24** cases per 100,000 AOBs or lower has now been extended to 31st March 2016. This equates to 75 patient cases or less per reporting Quarter.

Quarter 3 (July-September) local surveillance review

Local SAB surveillance figures for July-September (Quarter 3) 2015 indicated no change in total cases and NHSGGC again be reported **116** patient cases to Health Protection Scotland. Fourteen of these cases were MRSA. A breakdown of the cases by site is contained in the table below. All sectors are above aim for the Quarter.

Sector/Directorate	July	August	September	Total	SAB aim per quarter
North Glasgow	10	6	9	25	17
South Glasgow	9	14	5	28	25
South Clyde	7	12	14	33	17
Regional	6	2	4	12	11
Women's & Children's	3	7	7	17	5
Total GGC	36 <i>Includes 1 SAB for MHP</i>	41	39	116	75

Table 3. Comparison of each sector in Quarter 3

Almost half of all cases for the quarter were hospital acquired (Figure 1)

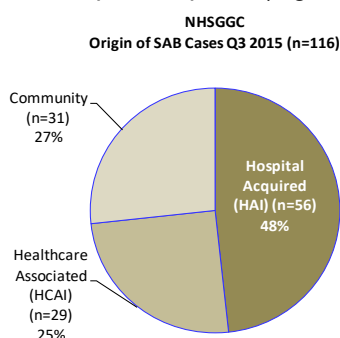


Figure 1

Source of Bacteraemia for Hospital Acquired cases is displayed in the table below. Nineteen patients (34% of HAI cases) suffered harm from a vascular access device during their care episode.

Bacteraemia by system involved or external factor	HAI SABs
Vascular access device	19
Source not known	9
Surgical site infection	7
Skin & soft tissue infection	6
Skeletal or joint infection	5
Contaminant	4
Related to medical device other than VAD	2
Respiratory infection	2
Cardiovascular infection	1
Intra abdominal infection	1
TOTAL HAI CASES	56

Table 4. Sources of HAI SABs, 01/07/2015 – 30/09/2015

Areas for Local Quality Improvement measures

Ten clinical areas reported more than one HAI SAB case this quarter

HAI SABs		Neonatology
RHC NICU	5	There were eight HAI cases from two Neonatal ICUs
PRM NICU	3	
GRI 43	3	Returned actions from Clinical Review Tools :
NVH RDU	3	<ul style="list-style-type: none"> Very premature infants so prevention may not be possible but will re stress hand washing and apron wearing at safety brief. All actions from previous infection control action plan complete. Continued compliance with central line care bundle and vigilance with central lines.
IRH J North	2	
QEUH 10D	2	
QEUH 8B	2	
RAH CCU	2	
RHC 1D PICU	2	
STO RDU	2	
		Renal
		Five cases were in Renal Dialysis units. Some of the completed action plan requirements achieved were the improved provision of wall clocks with a second hand to improve drying time of TCVC sites and an increase in the number of theatre sessions at QEUH to enable more patients to change from TCVC to AV fistula

Quarter 4 (October – December) local surveillance status

Surveillance on SAB data has not been validated by HPS; however local data indicates **127** SAB cases. This is a **9.5% increase** in patient cases upon the past two reporting quarters and continued Board wide actions are required.

The action plan will be presented at the Acute Infection Control Committee meeting on 11th January. Aims of the action plan are detailed below

Board wide Actions to Address Performance

- PVC and CVC ward sweeps to be undertaken in every sector by ward staff using IPC sweep proforma. Completed PVC and CVC sweep proforma returned to IC Data Team to enable analysis and report on results
- Validation audit February 2016: PVC and CVC ward sweeps to be undertaken in every sector by IPC staff. This will also include availability of PVC patient information leaflet for all applicable patients at time of sweep. Analysis/report produced by IPC Data Team
- Focussed Quality Improvement work :
 - 1) Neonatal units : RAH,RHC & PRM
Reduction of IV access device related SABs by standardised PVC/CVC insertion & maintenance bundles and care plans
 - 2) Royal Alexandra Hospital admission wards
Reduction of IV access device related SABs by increasing PVC care plan compliance
 - 3) Community
Reduction of non hospital acquired SAB cases (Community and Healthcare Associated Infection)
 - 4) Royal Hospital for Children: Neonatal Unit
Reduction of IV access device related SABs by increasing PVC care plan compliance
- Development and production of educational videos demonstrating adherence with aseptic technique when inserting & accessing PVCs and obtaining a blood culture. (This will be undertaken in conjunction with Practice Development).
- Increased focus on junior medical staff educational induction programme content to include information on prevention of bacteraemia and optimal practice with insertion, utilisation and maintenance of IV access devices (PVC/CVC/PICC).
- Review of PVC care plan commencement on device insertion in Emergency Departments and Theatres
- Review of incorporation of PVC and CVC careplans as eForms within Nursing Admission Documentation
- Assurance that medical staff induction & education incorporates healthcare associated infection information e.g. aseptic technique, venepuncture and cannulation
- Provide information on completed LearnPro Aseptic Technique module by staff groups for 2015
- Active promotion of antibiotic review to optimise timely IV to oral switch on all hospital sites: Daily review of all patients receiving IV antibiotic therapy with minimum standard of documented review and plan at 72hrs
- Incorporation of antibiotic IVOST indicators into PVC care plan
- Incorporation of antibiotic review / IVOST and PVC review to “ward round checklist” (in development)
- AMT to retrospectively review clinical management of patients with SAB in Q3 2015
- Promotion of SAB management guideline: ensure appropriate management of source and correct antibiotic therapy
- IPC Data Team will inform sector Antimicrobial Pharmacists of SAB patient CHIs to enable real time review of appropriate therapy, and assurance that appropriate source control had been undertaken.

Clostridium difficile

The *Clostridium difficile* (CDI) HEAT target, for attainment by the 31st March 2016, now includes cases in ages 15 & over and requires boards to achieve a rate of **32** cases or less per 100,000 OCBDs.

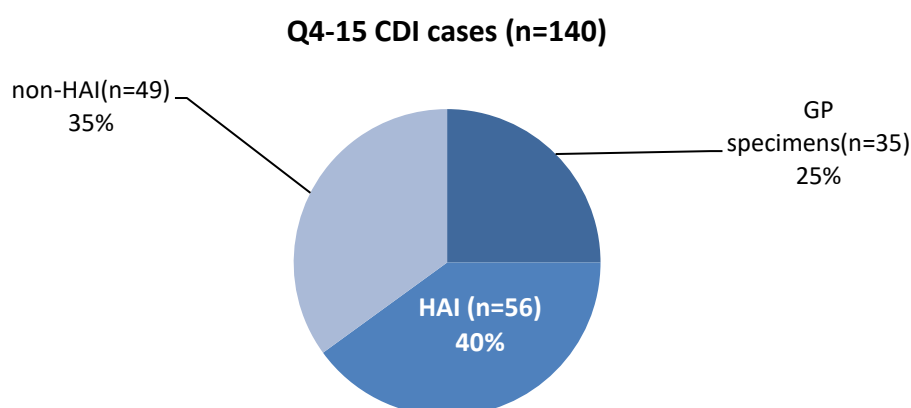
For the last available reporting quarter (July - September 2015), NHSGGC reported **29.5** cases per 100,000 occupied bed days (OCBDs), combined rate for all ages, which remains below the national average of **35.7** per 100,000 OCBDs.

Quarter 4 (October – December) local surveillance status

Local CDI surveillance figures for October - December (Quarter 4) 2015 indicate that NHSGGC has had a total of 140 patient cases. This is an **increase of 39%** upon the previous quarter. Only 40% of these cases are hospital acquired (n=56).

Monitoring continues with the intention of exploring GP and community antimicrobial prescribing practice and also analysing recurring CDI (relapse/re-infection cases).

PCR Ribotyping of October & November hospital acquired (HAI) cases has been requested to the national reference laboratory for *C.difficile* to examine whether there has been any change in PCR ribotype predominance or emergence of uncommon isolates.



Completion of LearnPro HAI related modules

The table below provides the total number of Infection Prevention & Control related LearnPro modules completed by staff members throughout NHS GGC, between October – November 2015.

LearnPro Modules	Staff Group				Total
	Nursing & Midwifery	Medical Staff	Allied Health Professionals	Ancillary	
Cleanliness Champions	12	0	1	1	14
Clostridium Difficile (Clinical scenario)	221	2	3	3	229
Clostridium Difficile Online tutorial	240	2	6	3	251
HAI Clinical Induction	380	10	18	21	429
Helping patients cope with isolation in hospital	105	0	1	3	109
Hospital Outbreak Management	117	0	1	2	120
IPC Influenza	403	8	46	58	515
Aseptic Technique	226	2	5	4	237
Recognising Surgical Site Infection (C-sec)	76	1	2	1	80
Recognising Surgical Site Infection	186	2	1	3	192
IPC Standard Infection Control Precautions	487	22	106	82	697
IPC Statistical process Control Charts	175	5	22	19	221
Total	2628	54	212	200	3094

Table 4.IPC LearnPro Modules, 01/10/2015 – 30/11/2015

Outbreaks/Exceptions

Increased incidence of *Serratia marcescens* in patients NICU, Royal Hospital for Children

17 patients have been found to have *Serratia marcescens* on routine weekly screening specimens since 20th July 2015. 16 patients have been colonised and the organism was found on routine weekly screening specimens. 1 patient, a very premature infant with complex medical problems, developed a blood stream infection and died, septicaemia is on Part 1 of the death certificate. One other patient died of causes unrelated to *Serratia*. Not all the cases involve the same strain of the organism and 4 different strains of the bacteria have currently been identified, investigations to establish any links are continuing. An action plan has been developed and agreed between Health Protection Scotland and ourselves. Progress against the plan is reported at each Incident Management Team (IMT) meeting. 12 patients have been discharged. 3 colonised patients remain in NICU. The last new case was identified from screening carried out on the 21st December 2015. This is the information known to IPC as of 10th January 2016.

Increased incidence of RSV in patients Beatson Oncology Centre,

Ward B7 is a 19 bed haemato oncology ward. The ward was closed to admissions/transfers on 9th December 2015 following report of a fourth confirmed patient case of RSV. Infection control guidance was provided and all patients and staff were screened immediately. Ward B7 was visited twice daily by an Infection Prevention & Control Nurse and four outbreak control meetings held. A total of eight patients and two staff tested positive for RSV over the course of the outbreak. The ward was initially categorised as amber on hospital infection incident assessment tool (HIIAT) before being recategorised red following death of a confirmed patient case. Two further confirmed patient cases died during the outbreak (one patient following transfer to ITU QEUEH and one patient following readmission to St John's Hospital). Ward B7 reopened 17th December 2015 when only two confirmed patient cases remained on the ward, each nursed in isolation in a single side room with precautions as advised by Infection Prevention & Control in place. HIIAT was stepped down to amber on 18th December 2015 before returning to green 21st December 2015. A full outbreak report will be produced by the Infection Prevention & Control Team. Datix reference 338026.

TB Maternity Unit QEUEH Campus NHSGCC

A 28 yr old woman who delivered at QEUEH maternity unit on 12th Dec and who, after being unwell on the post natal wards with fever, was diagnosed with smear positive miliary TB on 24th Dec. She is currently responding very well to treatment. Her baby was treated with prophylactic antibiotics and continues under the care of ID paediatric services for follow up.

A Problem Assessment Group was held on 30/12 and a follow up PAG was held 06/01/16. All staff identified as having cared for index case were referred to Occupational Health Service for further assessment. Mothers who shared the same overnight accommodation with index case were assessed as exposure equivalent to house hold contacts and have been referred to TB liaison services for follow up. Babies who had also shared overnight accommodation with index were risk assessed as equivalent to household contacts and have been referred to a specially arranged Paediatric clinic.

Norovirus

There were 4 ward closures reported between October – November 2015.

Month	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
Ward Closures	3	2	13	9	14	4	2	6	14	7	5	5	0	0	1	3
Bed Days Lost	43	57	216	135	292	10	10	55	270	98	65	42	0	0	0	19

Table 5. Monthly total number of ward closures due to suspected/confirmed Norovirus, 01/08/2014 – 30/11/2015.

Increase of Surgical Site Infections in August 2015 procedures: Queen Elizabeth University Hospital Orthopaedic Surgery

The Queen Elizabeth University Hospital undertakes surgery following the migration of Southern General Hospital, Victoria Infirmary and West Glasgow Hospitals (Western Infirmary/Gartnavel General Hospital). In August 2015 there were six reported surgical site infections (SSI). Four of the reported SSIs had one or more NHSN risk factors and it should also be noted that the three hip arthroplasty SSIs were in revision procedures. Local review of local theatre practice identified a requirement a standardised approach to theatre behaviours and this is still under implementation by the local clinical team.

Health Protection Scotland have published literature reviews, recommendations and bundles to prevent SSI. One of the key recommendations of this documentation is that 2% chlorhexidine gluconate in 70% isopropyl alcohol solution is used for skin preparation. This is not currently followed in NHSGGC and should be strongly considered for implementation throughout the board for standardised theatre skin preparation.

SSI surveillance is ongoing and at time of report collation, the following SSI cases have been reported at the QEUH. A further review meeting will be held in late January/early February.

QEUH : SSI Surveillance – reported SSIs			
Month	Hip Arthroplasty	Knee Arthroplasty	Repair of Neck of Femur
September	0	0	1
October	1	1	1
November	3	0	2

Increased Incidence of Surgical Site Infections: Royal Alexandra Hospital Orthopaedic Surgery

Since May 2015, the Royal Alexandra Hospital have reported ten deep surgical site infections (SSI), six of which have been in primary hip or knee arthroplasties. It should be noted that seven of these ten patients had one or more identified risk factor (NHSN). In addition, there have also been two superficial infections reported in September & November procedures

Review meetings were held on 07/09/2015, 21/09/2015, 23/10/2015 & 16/11/2015 between IPC, Orthopaedic and Theatre clinical/managerial teams to discuss the increased incidence of SSI cases in all three procedure categories from May 2015 onwards and action plan developed.

SSI surveillance is ongoing and at time of report collation the following SSI cases have been reported at the RAH.

RAH : SSI Surveillance – reported SSIs			
Month	Hip Arthroplasty	Knee Arthroplasty	Repair of Neck of Femur
September	0	0	1
October	1	0	0
November	0	1	1
December	0	0	1

As found at the QEUH, Local review of local theatre practice identified a requirement a standardised approach to theatre behaviours and this is still under implementation by the local clinical team. There is also a requirement for adherence theatre skin preparation requirements as per the HPS Prevention of SSI bundle.

HPS documentation can be accessed here: <http://www.documents.hps.scot.nhs.uk/hai/infection-control/evidence-for-care-bundles/key-recommendations/ssi-V2.pdf>

ASC(M)16/02
Minutes: 19 - 39

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Acute Services Committee held at 9.00am on Tuesday, 15 March 2016 in the Board Room, J B Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH

P R E S E N T

	Mr I Lee (Convener)
Ms M Brown	Dr D Lyons
Dr H Cameron	Cllr McIlwee (To Minute 27)
Mr R Finnie (To Minute 34)	Mr A Macleod
Cllr A Lafferty	Ms R Micklem
	Mr D Sime

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

Dr J Armstrong	Mr R Calderwood
Mr J Brown CBE (From Minute 25)	Dr M McGuire
	Mr M White

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

Mr G Archibald	..	Chief Officer, Acute Services
Ms J Erdman	..	Head of Inequalities (For Minute 33)
Mr J C Hamilton	..	Head of Board Administration
Mr G Jenkins	..	Director, Regional Services (For Minutes 26a and 26b)
Mr D Loudon	..	Director of Facilities & Capital Planning
Mr A McLaws	..	Director of Corporate Communications
Ms A MacPherson	..	Director of Human Resources & Organisational Development
Ms T Mullen	..	Head of Performance (To Minute 34)
Ms C Renfrew	..	Director of Planning and Policy
Mr M Simpson	..	Audit Scotland

19. APOLOGIES, WELCOME AND PRELIMINARIES

Apologies were intimated on behalf of Councillor G Casey, Professor A Dominiczak OBE, Mr I Fraser, Cllr M Kerr, Cllr M Macmillan and Cllr M O'Donnell.

20. DECLARATIONS OF INTEREST

There were no declarations of interest.

21. MINUTES OF PREVIOUS MEETING

On the motion of Mr A Macleod and seconded by Dr D Lyons the Minutes of the Acute Services Committee meeting held on 19 January 2016 [ASC(M)16/01] were approved as a correct record.

NOTED

22. REVIEW OF ACUTE SERVICES COMMITTEE REMIT

There was submitted a paper [Paper No 16/12] by the Head of Administration enclosing the remit of the committee as approved by the NHS Board in June 2015 and asking Members to review the remit as part of the annual process of reviewing standing committee remits and membership.

The Board Chair was carrying out a review of governance committees of the NHS Board and on that basis the Acute Services Committee agreed to defer any changes to its remit until after that review.

In discussing matters relating to the operation of the committee, Members raised a number of points to be considered for future meetings:-

- Further improvements needed to the executive summary produced for each paper;
- The volume of papers for committee meetings made it difficult to digest each issue to be discussed. It was agreed that, where links to reports could be made, this could be utilised together with providing separate background papers for those who wish to read the detail of specific issues.
- It was difficult to define how quality was being measured beyond outputs and there should be more emphasis on outcomes.

**Head of
Administration**

It was agreed that Members would consider this matter further and contact the Head of Administration if they had any further thoughts or ideas on how the papers should be presented to future committee meetings.

**All Members/
Head of
Administration**

NOTED

23. MATTERS ARISING

a) Rolling Action List

Minute 19 – Minutes of Previous Meeting – CAS Standards

Ms Micklem intimated that the Corporate Inequalities Team were to review the Care Assurance Standards and to submit this information to a future Acute Services Committee. The rolling action list indicated that this was on the March 2016 agenda when in fact it was not. Dr McGuire advised that the work had been completed and this would be submitted to Members in time for the next meeting of the Committee.

Nurse Director

NOTED

b) Vale of Leven Inquiry: Executive Review Short Life Working Group – Update Report

There was submitted a paper [Paper No 16/14] by the Medical Director and Nurse Director providing an update on progress in reviewing the actions taken to address the recommendations made in the Vale of Leven Public Inquiry Report.

The Short Life Working Group met for the first time on 23 February 2016. It had been noted that significant progress had been made against each of the 65 NHS Board recommendations, however, further work was required to evidence-based sustainability and to complete the outstanding recommendations.

A further report would be submitted to the NHS Board in June and the Acute Services Committee meeting in July 2016.

**Medical
Director/
Nurse Director**

NOTED

c) Internal Review of Paediatric Cardiac Services: Updated Action Plan

There was submitted a paper [Paper No 16/15] by the Medical Director providing an updated action plan which had been prepared to address the recommendations set out in the report of the external review of the Paediatric Cardiac Service.

Dr Armstrong intimated that improvements were being made however, more work was still required to be done and a further report would be provided to the Acute Services Committee in July 2016.

Medical Director

NOTED

24. PATIENT'S STORY AND REVIEW OF PROCESS

Dr Margaret McGuire, Nurse Director, read out a patient story which was based on a formal complaint and which highlighted the difficulties experienced in caring for and managing patients with complex and difficult behaviours. This was an increasing theme and included patients with alcohol-related brain damage. There was a need to ensure, in planning for such patients, that the medical, nursing and planning teams streamlined their review work around short-term issues; interface with mental health services and the role of the Physical Disability Rehabilitation Unit.

Dr McGuire asked if Members found it beneficial to receive the type of patient story she had covered at the last three meetings or whether Members were looking for a different presentation of information for future meetings. It was clear that Members found great benefit in hearing of individual patient stories and the impact they had on redesigning and realigning particular services. Dr McGuire thanked Members for their comments and would continue to ensure the stories presented were meaningful and focused on lessons learned and improvements brought about to the services as a result of patient experiences.

NOTED

25. FINANCIAL MONITORING REPORT FOR THE 10 MONTH PERIOD TO 31 JANUARY 2016

There was submitted a paper [Paper No 16/17] by the Director of Finance setting out the financial position within the Acute Services Division for the ten month period to 31 January 2016. Expenditure within Acute Services was overspent by [REDACTED], which was a rise of [REDACTED] from the previous month. The main cost pressures related to medical pay where significant expenditure on agency and locum cover had been incurred to support activity levels. Non-elective and elective inpatient activity continued to increase significantly in the year to-date, there were long-term vacancies, difficulties recruiting to particular posts and there continued to be the need to support waiting time initiatives to achieve the national targets.

Mr White advised that the overall position within the NHS Board continued to see the forecast position being one of break even at the year end. He referred to the second mid-year review meeting held with the Scottish Government Health Directorate on 14 March where the Financial Monitoring Report for 2015/16 had been discussed together with the development of a Financial Plan for 2016/17.

Mr Finnie appreciated the additional information and asked if the overspend being a consequence of increased activity was in fact increased activity across the whole NHS Board or only within particular areas/sectors. He felt it would be useful to have this better explained in the narrative of future financial monitoring reports.

**Director of
Finance**

Mr Calderwood acknowledged this point and explained that the sickness absence rate was variable across the NHS Board and there were variables with different rostering arrangements and local management initiatives. The use of double running costs in the early part of the financial year as the new Queen Elizabeth University Hospital took on the services of closing hospitals had masked some areas of overspend within the new hospital. The increase in expenditure within medical locums was a significant factor in the increased expenditure within staff costs and this was highlighted with the difficulties experienced, almost for the first time within NHSGGC, in filling particular consultant and junior doctor vacancies due to more attractive opportunities being available elsewhere in the UK or wider.

In responding to a comment by Mr Macleod about setting realistic budgets for 2016/17, Mr White acknowledged that the budgets would be reviewed in the next few weeks and that these would be set on the basis of what was considered realistic for each individual Sector/Directorate to run their services.

NOTED

26. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT

There was submitted a paper [Paper No 16/16] by the Chief Officer, Acute Services setting out the integrated overview of NHSGGC Acute Services Division's performance. Of the 29 measures which had been assessed against a performance status based on their variation from trajectory and/or target, 13 were assessed as green, five as amber (performance within 5% of trajectory) and eleven as red (performance 5% outwith meeting trajectory). Exception reports had been provided for those measures which had been assessed as red.

Members discussed the exception report which had been prepared for the

percentage of patients waiting over four hours at an Accident & Emergency Department within NHSGGC. The performance for January 2016 had improved 9.9% on the same month from the previous year however, three of the A&E and Minor Injuries Units had failed to reach the 95% target, namely Glasgow Royal Infirmary at 82.9%, Royal Alexandra Hospital at 84.1% and Queen Elizabeth University Hospital at 86%. Mr Archibald advised that while the performance target had not been reached in these three hospitals, it was in no way a reflection of the significant efforts made by staff to ensure appropriate, adequate and safe treatment to their patients. It was his intention again, to carry out a fundamental review to ensure the NHS Board was geared to meet these targets in 2016/17 and he was keen to ensure that every element of the service was reviewed and reconsidered in order that the Board could be satisfied that the services were operating as effectively as possible.

Mr Finnie wished to highlight that some 18 months ago, a fundamental review was undertaken at Glasgow Royal Infirmary A&E department in order to enact further change and embed a more effective service in order to meet the national targets. The resultant improvement seemed not to have materialised and he asked if the changes had been embedded in a consistent and sustainable way. Mr Archibald advised that the review had indeed brought about changes and improvements at the time, but there was a constant need to review and change the service based on demand and activity levels. The attendances at A&E department of Glasgow Royal Infirmary had been higher than anticipated and despite the improvements and best efforts of staff, the national targets were still not being achieved. Ms Brown also highlighted the increased activity and the impact that it had on the new redesigned service arrangements and she felt that the next review needed to identify those areas working well in order to share them across the NHS Board and then concentrate time and effort on those areas which needed greater attention/improvement.

Mr Calderwood agreed that a system-wide review was required, however this was being carried out with increased patient activity levels and a static resource. The main issue related to patients waiting for a bed and currently, NHSGGC had 16% more patients being admitted for hospital care than the Scottish average. He highlighted that the average length of stay across NHSGGC was 3.7 days, which was less than the Scottish average. He acknowledged that there were improvements with delayed discharges although more could still be done.

It was recognised by Members that the reviews undertaken to date, the involvement of Scottish Government Health Directorate officials in reviewing our arrangements and the increased attention given to this target all suggested that there were no significant deficiencies or inefficiencies within the service, however, the activity levels were being sustained at a level where the allocation of resources to this part of the service had to be considered.

Normally, the additional beds which had been funded during the winter period would come to an end at the beginning of the new financial year. However, Members were keen to ensure that the Executive Team took account of the risk factors including service delivery, meeting of national targets, patient safety issues and impact on staff, and ensured that the service remained sustainable and that any changes to services were considered and planned in a smooth, safe and effective way. The financial challenge facing the Board in 2016/17 had been fully discussed at the 29 February 2016 Board Away Day and it was acknowledged that plans were still being developed to try and ensure that a balanced budget was able to be set for 2016/17. Mr Calderwood thanked Members for debating this issue in detail and he would now consider, with his management team, what plans could be put in place

to fund the retention of these beds for a further two month period. He was conscious that this short term measure would contribute to the operational performance of the service, and minimise patient risk. He would review the contingency arrangements with the Director of Finance to deal with the issues highlighted.

**Chief Executive/
Director of
Finance**

Dr Lyons highlighted a terminology change in the A&E four hour wait exception report and reminded Members that the strategic commissioning for unscheduled care would lie with the Integrated Joint Partnership Boards for 2017/18.

NOTED

(a) DETECT CANCER EARLY: PATIENT JOURNEY

There was submitted a paper [Paper No 16/16a] by the Chief Officer, Acute Services providing the Committee with an overview of the Detect Cancer Early initiative. The Convener welcomed Gary Jenkins, Director, Regional Services, to the meeting, for this and the next item on cancer waiting times. Mr Jenkins advised that the Detect Cancer Early initiative was launched in 2012 and covered breast, colorectal and lung cancers with the aim of improving survival for people with cancer by diagnosing and treating the disease at an earlier stage. He explained the objectives of the initiative and the progress against the trajectory which had been set in July 2013 and had assumed a gradual and steady increase in cancers diagnosed at Stage 1 over time. The HEAT target was based on the combined position across the three cancer types and, in the latest reporting period of July to September 2015, the overall percentage of patients diagnosed with cancer at Stage 1 was 26.5%, which was lower than the 28.1% trajectory for that period. In breaking this down, Mr Jenkins advised that the breast cancer and colorectal cancer rates were below trajectory and the lung cancer rate, at 20.6%, remained above the trajectory figure of 19%.

Mr Jenkins referred to the national marketing campaigns aimed at encouraging early stage presentation and he acknowledged Dr Lyons' point that the summary paper, in highlighting that there were no health inequality implications, was incorrect and he would be discussing the inequalities issues with Miss Anna Baxendale, Head of Health Improvement, to ensure that both services were linked and appropriately targeted.

**Head of Health
Improvement/
D.Lyons**

Ms Brown referred to the national campaigns and the need to ensure links back to the screening programmes undertaken by the Public Health Team, and Mr Jenkins indicated that he would discuss with Dr Crighton how these could be better linked and the information presented in a more joined-up way.

**Director,
Regional
Services/Interim
Director of
Public Health**

NOTED

(b) CANCER WAITING TIMES ACTION PLAN

There was submitted a paper [Paper No 16/16b] by the Chief Officer, Acute Services which detailed the current position within the NHS Board in relation to cancer waiting times performance against both the 62 and 31 day targets.

The HEAT standards relating to cancer waiting times are that 95% of all patients diagnosed with cancer begin treatment within 31 days of a decision to treat and that 95% of those referred urgently with a suspicion of cancer begin treatment within 62

days of receipt of referral. The target related to the ten cancer types reported within the paper, which highlighted that performance against the 62 day standard continued to be challenging across a number of cancer types and that the 95% target had not been delivered in 2015.

Mr Jenkins took Members through each cancer type and its position in terms of service delivery, challenges and performance, and Mr Archibald acknowledged that the urology service continued to face a series of challenges, in particular in terms of recruitment which had been highlighted, once again, by the NHS Board being unable to fill a recent vacancy at Glasgow Royal Infirmary.

Mr Jenkins advised that non-recurring funding had been utilised to reduce the backlog of patients who had already breached the waiting times target, however, whilst the combination of measures did result in an 8.7% increase in performance, this was not expected to be sustained as the non-recurring resource allocation had been a one-off. The filling of the two consultant vacancies would be the single biggest contributor to a performance turn-around in urology.

Members thanked Mr Jenkins for his presentation on both these cancer-related issues.

NOTED

(c) KNOWLEDGE & SKILLS FRAMEWORK PERSONAL DEVELOPMENT PLANNING & REVIEW PROCESS (KSF AND PDP/R) – SURVEY 2016

There was submitted a paper [Paper No 16/16c] by the Director of Human Resources & Organisational Development which provided information on the outcome of the Knowledge & Skills Framework – Personal Development Planning and Review Process Survey which had been conducted in February 2016.

The purpose of the survey had been to identify and provide assurance from managers and employees about the quality of the personal development planning and review process; an issue which had been raised in the Staff Survey in relation to the drive to meet the KSF target which had adversely affected the quality and value of the personal development plan.

From the sample of 600 staff, the return response rate had been 10%; 36% of whom were managers/reviewers and 64% of whom were reviewees. Despite the low response rate, the feedback and data provided had been valuable in combination with the previous focus group work.

Ms MacPherson provided a summary of the key themes from the survey together with an additional analysis. She highlighted that the Learning and Education department was providing tailored support for each Acute Sector/Directorate and each HSCP in this area, and the KSF roadshows delivered in all hospital sites within dining rooms/lecture theatres on the theme of “talk don’t tick” – focusing on improving the quality of the personal development plans.

Members welcomed this report. Dr Cameron was disappointed at the response rate and enquired whether a survey would be undertaken again in the future in order to compare outcomes and progress. Ms MacPherson advised that this was indeed the case and mentioned that in this month’s Staff News the Staff Bursary Scheme was again being launched with applications open from 7 March to 22 April 2016.

NOTED

27. CLINICAL GOVERNANCE UPDATE

There was submitted a paper [Paper No 16/18] by the Medical Director which provided an overview of the clinical risk activity within Acute Services, highlighting the SPSP Falls data, Fatal Accident Inquiry update and the SPSP Medicines Reconciliation update report.

Dr Armstrong highlighted the information relating to reported patient falls between October and December 2015; the quality indicators of the Significant Clinical Incident (SCI) process and the handling of SCIs within different Directorates and the progress of the Scottish Acute Adult Patient Safety Programme Medicines Reconciliation workstream and the involvement of the internal auditors in determining whether these processes were embedded within the service. The review had indicated that, whilst a lot of good work was ongoing, improvements were still needed to embed medicines reconciliation processes within the routine admission process.

Dr Armstrong also highlighted that the key issues around deteriorating patients would form part of the 2016/17 objectives for Senior Managers and the position with delirium was that it was being tested within three wards and the outcomes would be rolled into the objectives of the Chiefs of Medicine and, hopefully, General Managers.

Lastly, Dr Armstrong asked Members for any thoughts or comments on the presentation of the information to ensure that it met their needs now and in the future.

NOTED

28. HEALTHCARE ASSOCIATED INFECTION: EXCEPTION REPORT

There was submitted a paper [Paper No 16/19] by the Medical Director updating the Committee on the NHS Board's performance against HEAT and other Healthcare Associated Infection targets and performance measures. This report covered the same quarter as the report submitted to the last committee meeting however, Dr Armstrong highlighted that the unvalidated figures for the following quarter suggested a 9.5% increase in SAB cases, and she set out the range of board-wide actions to address this dip in performance.

In relation to clostridium difficile, steps had been taken to write to all clinical staff about the prescribing of co-amoxiclav in order to tighten recommendations/restrictions on broader spectrum antibiotics. This targeted intervention had indicated that the first two months of 2016 would have a decrease in overall C-Diff rates. This would be confirmed in the next validated quarter's report.

NOTED

29. PUTTING PATIENTS FIRST: PROGRESS REPORT ON IMPLEMENTING THE PATIENT RIGHTS ACT IN NHSGGC'S ACUTE SERVICES

There was submitted a report [Paper No 16/20] by the Nurse Director providing Members with an update on the implementation of the Patient Rights Act (Scotland) 2011 and the Putting Patients First – Acute Services Development Plan 2016/17. Dr McGuire took Members through the paper, highlighting the progress in implementing the Patient Rights Act within NHSGGC, and in particular, the different routes via which the NHS Board now received feedback from patients and carers.

Members welcomed this new report and, in responding to a question from Ms Micklem about the governance responsibility of the new Patient & Carer Experience Group, Dr McGuire advised that it would report in to the Board Clinical Governance Forum as well as providing updates to the Whole System Directors Group and the Acute Strategic Management Group. The Integrated Joint Partnership Boards would form their own groups to review activities in their own areas of responsibility.

Dr Lyons referred to the patient stories covered within the report and asked that, in future, they show the outcome and improvements which came about as a result of each.

Nurse Director

Mr Finnie asked if there were other areas of legislation which covered the NHS Board's responsibilities to patients beyond the Patient Rights Act. Dr McGuire indicated that there was a whole range of additional legislation which covered the NHS Board's responsibilities to patients, however, she had brought this report in particular, to feature the new responsibility in relation to feedback, comments and concerns.

NOTED

30. SUMMARY OF HEALTHCARE ENVIRONMENT INSPECTORATE (HEI) UNANNOUNCED INSPECTIONS AND IMPROVEMENT PLANS JAN-MARCH 2016

There was submitted a report [Paper No 16/21] by the Nurse Director which provided a summary of the Healthcare Environment Inspectorate progress report for the period January to March 2016. The report highlighted that there had been one unannounced inspection to the Royal Alexandra Hospital on 13 and 14 January 2016. The inspection resulted in two requirements and an improvement plan had been developed to address the areas identified and they were discussed with the Royal Alexandra Hospital's Infection Control Committee.

NOTED

31. QUARTERLY REPORT ON CASES CONSIDERED BY THE SCOTTISH PUBLIC SERVICES OMBUDSMAN: 1 OCTOBER TO 31 DECEMBER 2015

There was submitted a report [Paper No 16/22] by the Nurse Director which set out the Acute Services Report on the actions taken against the recommendations made by the Scottish Public Services Ombudsman in relation to investigative reports and

decision letters issued in the period from 1 October to 31 December 2015. The Acute Services Committee had the responsibility to seek the necessary assurances that recommendations made by the SPSO in relation to Acute Services were implemented in the interests of delivering safe and effective care. This report covered one investigative report and nine decision letters where recommendations were identified by the SPSO and those cases carried forward from the last quarterly report that had not previously been completed.

Ms Brown was concerned that the SPSO continued to uphold a high number of issues which had previously been considered by Board Officers and had resulted in the complainant being dissatisfied with the outcome of the Board's complaints response, and had then raised the issue with the SPSO. Dr McGuire intimated that this had become an important focus for the restructuring of the complaints function and staffing, and a new Board Complaints Manager had been appointed two weeks ago to ensure a greater focus and a more patient-centred approach was taken in handling complaints and dealing with those who raised them. She was aware that the SPSO upheld complaints wherever they found fault, even if this was already upheld by the NHS Board and an apology had been given. An improvement in the quality of responses and engagement with complainants was the focus, and while she appreciated there would be a number of legacy complaints sitting with the SPSO still to be reported on, she hoped that a noticeable improvement would be forthcoming.

Dr Lyons intimated that he felt that the national NHS Complaints Procedure would benefit from having a middle stage prior to complainants being referred to the Ombudsman. In relation to the investigative report, he would want further assurance in the next report about the steps being taken and the outcomes of the actions, particularly in relation to patients transferring from another NHS Board to NHSGGC.

Nurse Director

Mr Sime stressed the need for an early apology in so many complaints and also drew attention to the legislation awaiting royal consent which would cover a duty of candour in relation to mistakes within the health services and it was hoped that the SGHD would issue guidance covering the new responsibilities of NHS Board and HSCPs.

NOTED

32. CARE ASSURANCE SYSTEM UPDATE

There was submitted a report [Paper No 16/23] by the Nurse Director providing an update and current position in relation to the progress in implementing the Care Assurance System within NHSGGC.

NHSGGC commenced work in 2014 with NHS Lanarkshire and NHS Ayrshire & Arran to develop a care assurance system with the aim of improving and assuring care consistently and sustainably for patients. The paper described the support infrastructures in relation to staff learning and development; leadership development; lead nurse/midwife development; local sector/directorates implementation; tri-board support network events; and care assurance IT dashboard development.

NOTED

33. MEETING THE REQUIREMENTS OF EQUALITY LEGISLATION: A FAIRER NHSGGC 2016-20 AND MONITORING REPORT 2015-16

There was submitted a report [Paper No 16/24] by the Director of Planning and Policy setting out the highlights of what had been achieved in 2015/16 including the actions undertaken in the Equality Scheme 2013-16 together with the Meeting the Requirements of Equality Legislation: A Fairer NHSGGC 2016/20 which set out the actions intended to be taken to meet the commitment to tackle inequality across the NHS Board's core functions.

Ms Jackie Erdman, Head of Inequalities, attended and presented the reports to Members.

Ms Micklem welcomed the reports and preferred to look at the last four years and then use that experience to shape the report to cover the next four years. She asked about the reporting responsibility of the Health Improvement and Inequalities Group, which was to oversee the governance of the actions in the 2016-20 report. Ms Renfrew advised that this group would report to the Acute Services Strategic Management Group which, in turn, saw its minutes submitted to the Acute Services Committee.

Ms Micklem had wondered why some of the measures had no figures attached to them as this would have been an easier way to see the progress made. Ms Erdman acknowledged this point and would consider this for next year's report.

**Head of
Inequalities**

Ms Brown stressed that inequalities was the business of all staff and Members, however, she would have been keen to see information on the diversity of the workforce. Ms MacPherson advised that a specific audit was being undertaken and this would be reported direct to the Staff Governance Committee. In relation to the low percentage of people recruited who had advised that they had a disability, she was keen that there was a review of the recruitment and selection process in order to highlight this and see if a better return could be achieved by giving people more confidence in answering this question.

**Director of HR
& OD**

NOTED

34. UPDATE ON QEUEH CAMPUS

There was submitted a report [Paper No 16/25] by the Director of Facilities & Capital Planning which provided a progress update on the construction works still being undertaken on the Queen Elizabeth University Hospital (QEUEH) campus.

Mr Loudon covered the Children's Play Park, the demolitions and site clearances, the overcladding of the Neurosciences Building together with the upgrade of the main entrance, the new Imaging Centre of Excellence, Horatio's Garden, the extension to the existing multi-storey car park, and the east campus road renewal project. The paper indicated the timescales for key milestones and completion, and Members welcomed the update.

NOTED

35. NATIONAL CHILD PSYCHIATRIC UNIT: ROYAL HOSPITAL FOR CHILDREN – FINAL UPDATE

There was submitted a paper [Paper No 16/26] by the Director of Planning & Policy which set out the progress against each of the outstanding issues impacting on running the service at the National Child Inpatient Psychiatry Service, Ward 4, Royal Hospital for Children.

Dr Lyons enquired about the entrance door/reception and signage and Mr Calderwood advised that this was being improved, and, as reported at the last meeting, CCTV was being provided at the entrance door/reception area.

Ms Brown was concerned that the full Mental Welfare Commission report had not been shared with Members although it had been passed to herself and Dr Lyons. It had acknowledged that the issues raised in the report issued in October 2015 had been fully responded to by officers. She also enquired about the costs of establishing a roof garden. Mr Calderwood advised that the cost for a retractable roof at the roof garden was [REDACTED], and, with the restrictions on the capital budget and no clinical support for this, it had been agreed not to proceed.

Mr Lee commented that the main concerns had been dealt with and therefore he was content that no further action was required in relation to this matter.

NOTED

36. ACUTE STRATEGIC MANAGEMENT GROUP: MINUTES OF MEETINGS HELD ON 17 DECEMBER 2015 AND 28 JANUARY 2016

The minutes of the Acute Strategic Management Group meetings held on 17 December 2015 [SMG(M)15/12] and 28 January 2016 [SMG(M)16/01] were noted.

NOTED

37. BOARD CLINICAL GOVERNANCE FORUM: MINUTES OF MEETING HELD ON 1 FEBRUARY 2016

The minutes of the Board Clinical Governance Forum meeting held on 1 February 2016 [BCGF(M)16/01] were noted.

NOTED

38. ROS MICKLEM

Mr Lee advised that Ros Micklem's term of office would come to an end on 31 May 2016 and, as she was unable to attend the May meeting, this would be her last meeting of the Acute Services Committee. Mr Lee thanked Ms Micklem for her contribution to the former Quality & Performance Committee and the Acute Services Committee, particularly in the areas of health inequalities and equalities legislation.

39. DATE OF NEXT MEETING

9.00am on Tuesday 17 May 2016 in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 12:50pm

Healthcare Associated Infection: Exception Report**Recommendation:** For noting.**Purpose of Paper:** Update on NHSGGC performance against HEAT and other HAI Targets and performance measures.**Key Issues to be considered:** All Scottish NHS Boards are to achieve *Staphylococcus aureus* Bacteraemia (SAB) HEAT target of **24** cases or less per 100,000 Acute Occupied Bed Days (AOBDs) by 31st March 2016. For NHS Greater Glasgow & Clyde this is estimated to equal 25 patients or less each month developing a SAB.

The most recent validated & published results for 2015, Quarter 3 confirm a total of 116 SAB cases for NHSGGC, between July and September 2015. This equates to a SAB rate of **34.3** cases per 100,000 AOBD. This is also above the NHS Scotland rate of 31.6 cases for the quarter.

Local surveillance for October to December 2015 (Q4) indicates that NHSGGC have noted a **9.5%** increase with **127** SAB cases at time of report collation

Clostridium difficile (CDI) HEAT target of **32** CDI cases or less per 100,000 occupied bed days (OCBDs) in the over 15's age group, is to be achieved by 31st March 2016.

Validated results for 2015, Quarter 3 confirm a total of 101 cases for NHS GGC, between July and September 2015. This equates to a rate of **29.5** cases per 100,000 OCBDs and remains below HEAT target.

Local surveillance for Quarter 4 has seen a **38%** increase in reported CDI cases, with **139** reported cases.

The validated results from Health Protection Scotland for the Quarter are expected to be published in early April 2016.

Validated HPS/ISD data July - September 2015			
HAI HEAT Targets	GGC	National	HEAT target
SAB rate per 100,000 AOBD	34.3(116 cases)	31.6	24.0
CDI rate per 100,000 OCBD	29.5 (101 cases)	35.7	32.0

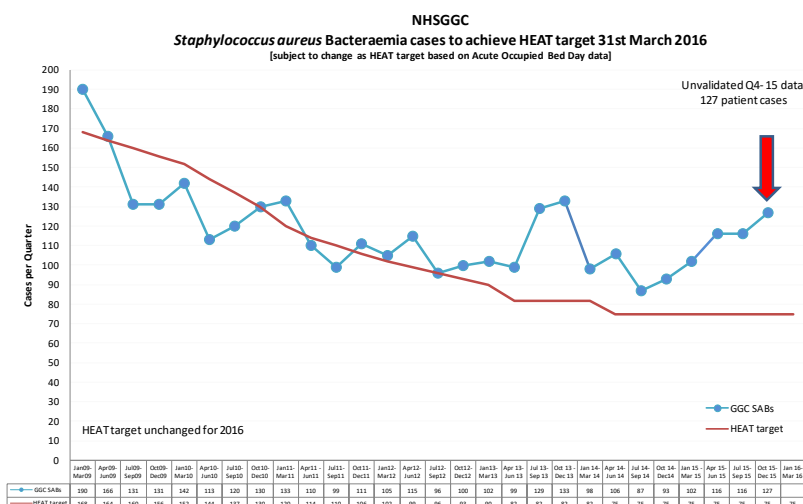
Table 1. Progress against National HAI HEAT targets, 01/07/2015 – 30/09/2015.

Any Patient Safety /Patient Experience Issues: Yes increase in SAB and CDI**Any Financial Implications from this Paper:** Yes – Implementation of HPS SSI bundle (specifically proposed change to skin prep)**Any Staffing Implications from this Paper:** No**Any Equality Implications from this Paper:** No**Any Health Inequalities Implications from this Paper:** No**Highlight the Corporate Plan priorities to which your paper relates:** Improving quality, efficiency and effectiveness.**Author:** Dr. Jennifer Armstrong**Tel No:** [REDACTED]**Date:** 29/02/2016

Infection Prevention & Control Service Report for Acute Services Committee, March 2016

Staphylococcus aureus Bacteraemia (SAB) Surveillance

For the last available reporting quarter (July - September 2015), NHSGGC reported **34.3** SAB cases per 100,000 AOBs (116 patient cases). This is above the NHS Scotland reported national SAB rate of **31.6** per 100,000 AOBs (388 patient cases). The existing National HEAT target which requires all Boards in Scotland to achieve a rate of **24** cases per 100,000 AOBs or lower has now been extended to 31st March 2016. This equates to 75 patient cases or less per reporting Quarter.



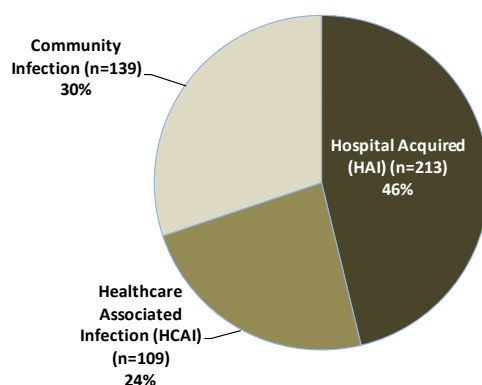
NHSGGC had demonstrated a gradual decline in *Staphylococcus aureus* bacteraemia (SAB) cases from 2009 to the second half of 2013, when there was an increase in potentially avoidable IV access device (central venous catheters, CVC) cases in the Regional Services Renal specialty and an overall increase in case numbers within Emergency Care & Medical Services. Improvement work was undertaken within Renal to improve CVC care & maintenance and increase vascular theatre time availability for haemodialysis fistula creation, thereby reducing the ratio of CVCs in this patient population.

Targeted measures within ECMS were more difficult to institute and sustain due to the high proportion of non-hospital acquired cases within this Directorate. Almost 70% of ECMS SAB blood culture specimens in this period were obtained in Emergency Departments or Acute Receiving Units.

One of the most common devices used within healthcare – Peripheral Venous Catheters (PVC) have also been a cause of **patient harm** by being identified as the primary source of bloodstream infection. In 2014, 24% of all Hospital acquired SAB cases were caused by a PVC and although there was a slight reduction in 2015 to 16% of HAI SAB cases, these should be considered **avoidable** infections.

There was a noted decrease in 2014 following these improvement measures, with 384 SAB cases reported for the year, however there has been a quarterly upward trend of SAB in 2015 and a total of 461 cases were reported. This is an increase of 20.1% upon the previous year.

2015 cases : Origin of SAB (n=461)



There has also been a noted increase in the proportion of Community SAB cases in 2015. These cases are less likely to improvement measures within Acute Hospital settings. Cases related to illicit intravenous drug use account for 29% of community SABs, followed by unknown source, skeletal/joint infections and skin/soft tissue. Targeted

awareness of SAB reduction aims within Health and Social Care Partnerships and Public Health should be strongly considered in order to reduce the burden of bloodstream infection.

Quarter 4 (October – December) local surveillance status

Surveillance on SAB data has not been validated by HPS; however local data indicates **127** SAB cases. This is a **9.5% increase** in patient cases upon the past two reporting quarters and continued Board wide actions are required.

The action plan was presented at both the Acute and Board Infection Control Committee meetings in January. Aims of the action plan are detailed below

Board wide Actions to Address Performance

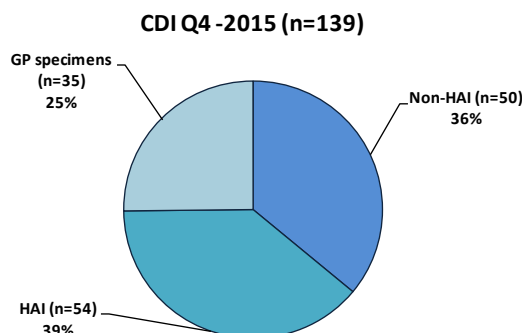
- PVC and CVC ward sweeps to be undertaken in every sector by ward staff using IPC sweep proforma. Completed PVC and CVC sweep proforma returned to IC Data Team to enable analysis and report on results
- Validation audit February 2016: PVC and CVC ward sweeps to be undertaken in every sector by IPC staff. This will also include availability of PVC patient information leaflet for all applicable patients at time of sweep. Analysis/report produced by IPC Data Team
- Focussed Quality Improvement work :
 - 1) Neonatal units : RAH, RHC & PRM
Reduction of IV access device related SABs by standardised PVC/CVC insertion & maintenance bundles and care plans
 - 2) Royal Alexandra Hospital admission wards
Reduction of IV access device related SABs by increasing PVC care plan compliance
 - 3) Community
Reduction of non hospital acquired SAB cases (Community and Healthcare Associated Infection)
 - 4) Royal Hospital for Children: Neonatal Unit
Reduction of IV access device related SABs by increasing PVC care plan compliance
- Development and production of educational videos demonstrating adherence with aseptic technique when inserting & accessing PVCs and obtaining a blood culture.
(This will be undertaken in conjunction with Practice Development).
- Increased focus on junior medical staff educational induction programme content to include information on prevention of bacteraemia and optimal practice with insertion, utilisation and maintenance of IV access devices (PVC/CVC/PICC).
- Review of PVC care plan commencement on device insertion in Emergency Departments and Theatres
- Review of incorporation of PVC and CVC careplans as eForms within Nursing Admission Documentation
- Assurance that medical staff induction & education incorporates healthcare associated infection information e.g. aseptic technique, venepuncture and cannulation
- Provide information on completed LearnPro Aseptic Technique module by staff groups for 2015
- Active promotion of antibiotic review to optimise timely IV to oral switch on all hospital sites: Daily review of all patients receiving IV antibiotic therapy with minimum standard of documented review and plan at 72hrs
- Incorporation of antibiotic IVOST indicators into PVC care plan
- Incorporation of antibiotic review / IVOST and PVC review to “ward round checklist” (in development)
- AMT to retrospectively review clinical management of patients with SAB in Q3 2015
- Promotion of SAB management guideline: ensure appropriate management of source and correct antibiotic therapy
- IPC Data Team will inform sector Antimicrobial Pharmacists of SAB patient CHIs to enable real time review of appropriate therapy, and assurance that appropriate source control had been undertaken.
- Clinical staff have a requirement to comply with guidelines published by the NHS Greater Glasgow & Clyde Antimicrobial Utilisation Committee.

January & February 2016 local surveillance status

The first two months of 2016 have not shown a substantial decrease in overall SAB cases with 78 reported cases (aim is 50). Based on AOBDR rates from the same quarter in 2015, this would suggest an estimated rate of 31.1 cases per 100,000 AOBDRs.

Clostridium difficile**Quarter 4 (October – December) local surveillance status**

Local CDI surveillance figures for October - December (Quarter 4) 2015 indicate that NHSGGC has had a total of 139 patient cases. This is an **increase of 38%** upon the previous quarter. Only 39% of these cases are hospital acquired (n=54).



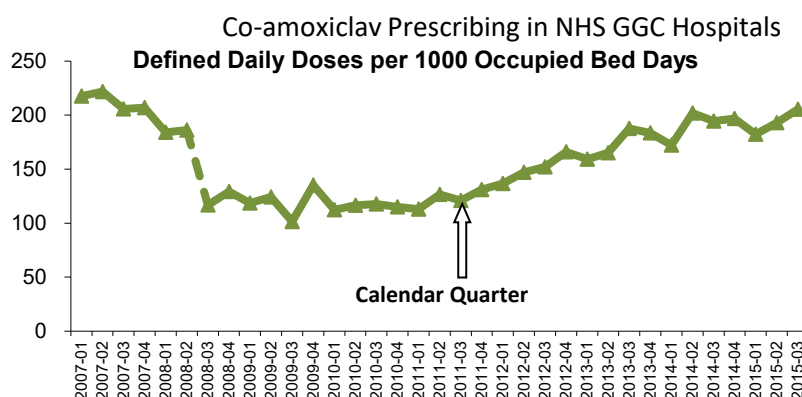
The average number of cases per month is generally between 30-35. In October of 2015 there were 36 cases of CDI reported which was within expected numbers although higher than average, however, by mid November, 30 cases had already been reported which necessitated the need for an immediate targeted investigation and thereafter intervention. Data is reviewed constantly but additional analysis was undertaken and no single site, hospital or ward was considered to be an outlier; it appeared to be a general increase across all healthcare sectors. The IPCT reviews every case of CDI for any place/time contact with other patients with CDI and if two HAI cases occur in any ward in a two week period this is considered a 'trigger' for additional action and the ward is visited daily until the cases are discharged or are well (there is a presumption until proven otherwise that two in two weeks is most likely due to cross infection). In the last quarter of 2015 three triggers were identified; two of the three were not due to cross infection – confirmed by the reference laboratory. In addition because of the increase in numbers in November all of the specimens that were available from the labs from October and November were sent for typing. Of the 29 specimen submitted 16 different types were identified. This supports the theory of a general increase in numbers across all care sectors and not cross infection in our hospitals.

One of the main risk factors associated with CDI acquisition is exposure to antimicrobial therapy (usually given for chest infections, UTI etc) specifically co-amoxiclav. Target educational sessions have been delivered by the Antimicrobial Management Team to try and reduce the amount prescribed routinely. The next section is a summary of the AMT analysis of this issue:

Co-amoxiclav prescribing

Prescribing rates of co-amoxiclav in hospitals have increased since the later part of 2011 (see below). Rates have returned to 2008 baseline. Non-guideline use of co-amoxiclav is common:

1. Suspected respiratory tract: usually **OVER TREATMENT**. Amoxicillin or Doxycycline preferred
2. Lower UTI: usually **OVER TREATMENT**. Trimethoprim or Nitrofurantoin preferred
3. Suspected urosepsis: usually **UNDER TREATMENT**. Gentamicin preferred due to resistance.



The importance of prudent use of co-amoxiclav, promotion of published infection management guidance and adherence with shorter duration of therapy has been emphasized in a joint communication from IPC and AMT. Good infection prevention practice has also been emphasized (including short duration of IV therapy and avoidance of unnecessary IV cannulation). The AMT has also raised these specific issues through clinical governance committees in South, North and Clyde sectors. Targeted surveillance of co-amoxiclav use in the medical receiving complex in QEUH is underway. Hospital based infection management guidelines have also been reviewed in February in order to tighten recommendations/ restrictions on broader spectrum antibiotics.

In summary.

Recent increase in *C. difficile* observed in GGC hospitals is likely driven by increase in broad spectrum antibiotics in general and co-amoxiclav prescribing in particular.

Targeted interventions by the AMT are ongoing.

January & February 2016 local surveillance status

The first two months of 2016 have shown a decrease in overall CDI cases with 54 reported cases. Based on OBD rates from the same quarter in 2015, this would suggest an estimated rate of 22.9 cases per 100,000 OBDs.

Completion of LearnPro HAI related modules

The table below provides the total number of Infection Prevention & Control related LearnPro modules completed by staff members throughout NHS GGC, between December 2015 & January 2016

LearnPro Modules	Staff Group				
	Nursing & Midwifery	Medical Staff	Allied Health Professionals	Ancillary	Total
Cleanliness Champions	5	0	0	0	5
Clostridium Difficile (Clinical scenario)	233	1	2	3	239
Clostridium Difficile Online tutorial	260	1	4	10	275
HAI Clinical Induction	428	1	7	19	455
Helping patients cope with isolation in hospital	90	0	1	2	93
Hospital Outbreak Management	98	0	1	2	101
IPC Influenza	431	2	29	28	490
Aseptic Technique	307	1	5	9	322
Recognising Surgical Site Infection (C-sec)	64	2	0	0	66
Recognising Surgical Site Infection	99	0	0	0	99
IPC Standard Infection Control Precautions	466	13	68	92	639
IPC Statistical process Control Charts	146	3	23	18	190
Total	2627	24	140	183	2974

Table 4. IPC LearnPro Modules, 01/12/2015 – 31/01/2016

Outbreaks/Exceptions

Increased incidence of Surgical Site Infections : Queen Elizabeth University Hospital and Royal Alexandra Hospital Orthopaedic Surgery

Both hospital sites experienced an increased incidence of Surgical Site Infections within the three Orthopaedic procedure categories included in the National SSI Surveillance programme in the latter half of 2015.

Local review of theatre practice identified a requirement to adopt a standardised approach to theatre behaviours and this was implemented by the clinical teams at both sites. There was also a requirement noted for adherence to theatre skin preparation requirements as per the HPS Prevention of SSI bundle.

One of the key recommendations of this documentation is that 2% chlorhexidine gluconate in 70% isopropyl alcohol solution is used for skin preparation. This is not current practice in NHSGGC and an SBAR report on the situation was discussed and agreed in principle at the AICC in January 2016, however further clarification is required on the MHRA licensing status of the appropriate skin preparation product. The current product which has licensed status for theatre skin preparation (ChlorPrep®) has a considerable cost implication for NHSGGC if introduced (circa. [REDACTED]/year). An alternative efficacious product which would also meet the SSI bundle requirements is also

available but is unlicensed. This requires further discussion at Board level and will be taken forward by Medicines Governance within Pharmacy Prescribing and Support Unit.

Increased incidence of *Serratia marcescens* in patients NICU, Royal Hospital for Children

18 patients have been found to have *Serratia marcescens* on routine weekly screening specimens since 20th July 2015. The last new case was identified from screening carried out on the 25th January 2016 however this was a found to be a unique type and not linked to the cluster. The last case associated with the cluster strain was identified on the 24th December, therefore this incident has been declared over. A debrief report will be submitted to the Board Infection Control Committee once complete.

Notes on *Serratia*

Serratia marcescens can be naturally occurring in the gut and its presence on or in the body (colonisation) is not harmful in healthy people.

However given the vulnerability of premature babies, *Serratia marcescens* infections, where the colonised bacteria gets into the bloodstream, can occur.

Increased incidence of *Malassezia Pachydermitis* in patients NICU, Princess Royal Maternity

8 patients have been found to have *Malassezia Pachydermitis* on routine screening specimens since 06.01.16. At present there are still 2 patients who remain colonised with *Malassezia Pachydermitis* in NICU all other patients have been discharged to SCBU or home. Weekly screening continues. At present all babies are well in relation to colonisation with this organism.

Notes on *Malassezia Pachydermitis*

Malassezia Pachydermitis is yeast normally found in animals which may transiently colonise human skin. The organism is found in moist warm areas e.g. ears and groins, and the likelihood of neonatal colonisation increases with length of stay and degree of prematurity.

Norovirus

There were 4 ward closures reported between December 2015 – January 2016

Month	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec 15	Jan 16
Ward Closures	13	9	14	4	2	6	14	7	5	5	0	0	1	3	2	2
Bed Days Lost	216	135	292	10	10	55	270	98	65	42	0	0	0	19	14	16

Table 5. Monthly total number of ward closures due to suspected/confirmed Norovirus, 01/10/2014 – 31/01/2016.

ASC(M)16/03
Minutes: 40 - 59

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Acute Services Committee held at 9.00am on Tuesday, 17 May 2016 in the Board Room, J B Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH

P R E S E N T

	Mr I Lee (Convener)	
Ms M Brown		Mr R Finnie
Dr H Cameron		Dr D Lyons
Professor A Dominiczak		Mr A Macleod
	Mr D Sime	

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

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

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

Mr P Cannon	..	Deputy Head of Administration
Mr A Gallacher	..	General Manager, Estates
Mr J C Hamilton	..	Head of Board Administration
Mr D Loudon	..	Director of Facilities & Capital Planning
Mr A McLaws	..	Director of Corporate Communications
Ms A MacPherson	..	Director of Human Resources & Organisational Development
Ms T Mullen	..	Head of Performance
Ms C Renfrew	..	Director of Planning and Policy
Ms H Russell	..	Audit Scotland
Mr M Simpson	..	Audit Scotland

40. APOLOGIES, WELCOME AND PRELIMINARIES

Apologies were intimated on behalf of Mr I Fraser, Councillor M Kerr, Councillor A Lafferty, Councillor J McIlwee, Councillor M Macmillan and Ms R Micklem.

41. DECLARATIONS OF INTEREST

There were no declarations of interest.

42. MINUTES OF PREVIOUS MEETING

On the motion of Donald Sime and seconded by Alan McLeod the Minutes of the Acute Services Committee meeting held on 15 March 2016 [ASC(M)16/02] were approved as a correct record.

NOTED

43. MATTERS ARISING**a) Rolling Action List**

In relation to dates and timescales, Ms Brown asked that the rolling action list be updated accordingly.

Mr John Brown provided an overview of a Governance Review being undertaken by Ms Renfrew and indicated that the options, in order to strengthen the Board's Governance Framework, would be brought to the June Board for approval.

In relation to the item on Winter Funding it was noted that the proposal was to extend winter beds to May/June 2016.

44. PATIENT'S STORY

Dr Margaret McGuire, Nurse Director, referred Members to the patient's story as part of item 55 and her intention to show a short video to Members instead of reflecting on the patient's story.

NOTED

45. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT

There was submitted a paper [Paper No 16/28] by the Head of Performance setting out the integrated overview of NHSGGC Acute Services Division's performance. Of the 27 measures which had been assessed against a performance status based on their variation from trajectory and/or target, 13 were assessed as green, 6 as amber (performance within 5% of trajectory) and 8 as red (performance 5% outwith meeting trajectory). Exception reports had been provided for those measures which had been assessed as red.

Ms Mullen alerted Board Members to changes to the key diagnostic test target which had been changed from the 4 weeks targets to reflect the National Waiting Time Standard of 6 weeks. In addition, the Elective and Non-Elective Inpatient episodic activity indicators had been replaced with Elective and Non-Elective admissions as this was a more accurate reflection of changes in inpatient activity.

Ms Mullen went on to confirm that there were no new red ratings and that improvements had been evidenced in relation to the A&E 4 hour wait moving from red to amber and the Stroke Care Bundle moving from red to green.

Members discussed the exceptions reports which had been prepared for those key

performance indicators at red.

Ms Mullen highlighted a number of issues not set out within the KPI matrix, namely referring to page 26 of the report where Members' attention was drawn to the bullet points on the 2 unannounced Healthcare Environment Inspectorate visits which had taken place in the reporting period, the first at the Victoria ACH on 17th and 18th February 2016 and the second at the Vale of Leven Hospital on 27th and 28th April 2016.

In relation to the 12 week Treatment Time Guarantee, Ms Mullen highlighted that detailed narrative was contained within the report at pages 27 and 28, albeit the rating attached to this indicator was amber, however the narrative detail was provided given the importance of this target in relation to patient pathways.

Mr Lee noted that the number of red ratings had fallen from 11 in the previous report to 8 in the report presented to Members and congratulated officers in reducing the number of red ratings to this level.

In relation to the cancer 62 day target, and in response to a request from Ms Brown for further information, Mr Calderwood took Members through the work being undertaken to review pathways in order to remove bottlenecks and indicated that as a result of these detailed pathways reviews an overview paper was being compiled. This paper would assist in a better understanding the consequences of doing same, and also to assess the levels of demand which were, in some specialties, greater than the available capacity. Mr Calderwood stated that early indications for the 62 day target in the most up-to-date quarter where data is available was not likely to show any significant improvement, however officers have been targeting those patients who had waited longest within the breast pathway before further improvements can be evidenced in the 62 day target itself.

In relation to a question on Learnpro and Medical Staff uptake of Aseptic techniques, Dr Armstrong re-assured Members that although this was a mandatory requirement and had been highlighted as requiring attention in the Vale of Leven Action Plan, it was being subject to random audits, as well as a national view being sought about the frequency with which this training had to be updated.

In relation to the Vale of Leven CMU and the Unannounced Visit by HEI, Dr McGuire reported that there had been 6 births this year to date and that it was unacceptable that concerns had been raised by the HEI Inspectors in relation to mattresses, which locally had been missed from the audit cycle as the unit was not regarded locally as a 24 hour unit. Members were re-assured that this had been rectified and would continue to be monitored closely. In relation to maintaining skills and expertise generally at the Vale of Leven CMU, it was noted that although the quality of care is felt to be good through any inspection regime or through patient feedback, the numbers are relatively small and maintaining skills at an appropriate level continues to be a challenge.

In response to a question posed by Dr Lyons in relation to stroke care and swallow screening in particular, Mr Calderwood reported that all instances of breaches were audited and appropriate action taken to ensure that circumstances were reviewed carefully and any remedial action taken as appropriate. However, it had been noted that a change to the Scottish Government target which would see the swallow screening take place within 4 hours of attending hospital, was a target that management felt would be difficult to achieve and clarification in relation to the changes announced by Scottish Government has been sought. Once this advice had been received and a further assessment had been completed, Members would be

updated accordingly. The inappropriateness of the stroke swallow screening indicator being changed in such a way was supported widely by fellow Board Members.

Mr Finnie thanked Dr McGuire for her detailed update in relation to the Vale of Leven CMU and the difficulties in maintaining skills and experience and enquired whether this needed to be taken more into account in relation to high quality patient care and that part of the service moved to the Royal Alexandra Hospital to create a Centre of Excellence where the appropriate skills and experience can be easily maintained. Mr Calderwood emphasised that the discussions around the Vale of Leven CMU were particularly and specifically about the birthing unit and the low number of births being experienced at the unit. He highlighted that difficulties in identifying a struggling neonate and transferring the mother and baby to the Royal Alexandra Hospital had been the subject of significant criticism by the Scottish Public Services Ombudsman recently and that officers were continuing to monitor the situation carefully from a clinical safety point of view in order to be re-assured that the birthing unit was appropriately staffed and that the appropriate skills were available for mothers locally who chose to use the Vale of Leven CMU. It was also noted that this would be subject to further consideration as part of the development of the local delivery plan for 2016/17 which would be presented to the Board on 28th June 2016.

NOTED

46. DISABILITY RECRUITMENT STATISTICS – APPLICANTS FOR JOBS DECLARING A DISABILITY

There was submitted a paper [Paper No 16/29] by the Director of Human Resources & Organisational Development setting out an analysis of the data in relation to the recruitment and selection process in respect of applicants for jobs declaring a disability.

Mrs MacPherson reminded Members that as part of the monitoring process to ensure compliance with the Equality Act, data is collected via the NHS Scotland application form for job applicants on a number of protected characteristics including disability. Candidates are asked to complete Part D (EO Monitoring Form) of the online form or on a MS Word NHS Scotland application form and submit this to the recruitment service. Job applicants are advised that the data is kept confidential and will only be used for equality monitoring purposes and is not made available at any stage of the recruitment process.

In addition, it was noted that data regarding disabilities is also collected by the recruitment service as part of the Board's commitment to an NHS Scotland Job Interview Guarantee (JIG) scheme for disabled applicants. JIG data is collected within the main body of the application form and candidates are advised that the Board offered a job interview guarantee scheme for any applicant who makes a declaration that they consider themselves to be disabled and meet the minimum selection criteria.

It was noted that there is a higher rate of disability declarations from candidates accessing the JIG in comparison to the equal opportunities monitoring form and the purpose of the questions are promoted differently.

Members noted that the data included in the report was therefore taken from two sources – the Job Interview Guarantee Scheme fields, and the Equal Opportunities

Monitoring Form.

Revised figures were provided in relation to staff who disclosed disability and those who did not and their relative chance of success, which showed that when taken together staff who disclosed a disability had a relative chance of success of 4% and staff who did not disclose a disability had a 5.4% relative chance of success.

Mrs MacPherson asked Members to note that the analysis of the additional information through the JIG process revealed a more positive success rate for applicants for jobs declaring a disability than the figures which were provided to the Staff Governance Committee which showed a relative chance of success for those who disclosed disability of only 0.625%.

It was noted that the service will continue to monitor the full set of statistics going forward.

Members welcomed the more robust set of data; however it was apparent that there was still a 1.4% gap, which had to be acknowledged. Mrs MacPherson alluded to the various measures being undertaken to ensure that this gap is closed including diversity training and support for recruitment panels and working with the disability forum to ensure that the Job Interview Guarantee Scheme is promoted and also seeking views, ideas and experiences from those who had gone through this process. It was also noted the Modern Apprentice Scheme was a very positive development in relation to this issue and Project SEARCH was also referenced as an example of good practice.

Ms Brown, in welcoming the updated data, also asked that officers continue to be vigilant in relation to this issue and although acknowledging that the measures set out by Mrs MacPherson were a constructive approach to the issue, there was also a number of other discrete groups of staff that had to be considered such as faith, LGBT, poverty and mental health.

In order to take this forward positively, Mrs MacPherson welcomed the suggestion that this issue be added to the list of 2016/17 Audit Programme topics, which will be considered in due course by the Audit Committee.

**Director of
Human
Resources &
Organisational
Development**

NOTED

47. PLANNING ACUTE SERVICES

There was submitted a paper [Paper No 16/30] by the Director of Planning & Policy which provided the Committee with information on the National Clinical Strategy and work in progress to develop planning for the Acute Services provided by NHS Greater Glasgow and Clyde.

Ms Renfrew took colleagues through the paper in detail setting out the national clinical strategy and highlighting that this was in line with the Board's Clinical Strategy and the Acute Division Plan. It was noted however that a longer-term Acute Strategy was required beyond 2016/17; however early efforts had been directed at 2016/17 and in doing so, a leadership event would be held on 20th June 2016 where a number of senior managers will come together to discuss the Divisional Delivery Plan for 2016/17, and the shape of the plan for 2017/18.

Ms Brown welcomed the paper which set out the context for planning Acute Services, the planning outputs and timelines, and the key features of the Divisional Delivery Plan, and she made a number of suggestions in relation to including

tackling inequalities as part of the context in which the Board's and Divisional Delivery Plan needed to be set, and a number of other comments in relation to the language used, which Ms Renfrew indicated would be taken on board in developing the Acute Delivery Plan.

In relation to the approach being adopted to develop the Divisional Delivery Plan it was highlighted that this was a bottom-up approach and the event on 20th June 2016 involving all senior nurses, doctors and managers would provide clinical leadership at this stage to the high level plan, although it was widely acknowledged that in taking forward the issues that required addressed in 2016/17 and 2017/18 that clinical leadership throughout the organisation was key in order to deliver the aspirations within the plan.

Mr Brown acknowledged that the paper set out the framework for the development of the 2016/17 plan, which was a very positive engagement process, culminating in the submission of the Local Delivery Plan to the Board in June 2016; however he agreed that further work was required in relation to 2017/18 and beyond.

It was also apparent that the links between the Board's Local Delivery Plan and the plans coming forward from the 6 IJB's needed to be better co-ordinated in future, although it was acknowledged that this was the first year of planning in such a way with the Acute Services Division and the IJB's, and this would be taken forward in partnership with IJB Chief Officers in due course.

Mr Sime remarked that while it was acknowledged that clinicians needed to be engaged in the process as leaders, this was not restricted to doctors and nurses, and this was echoed by Dr Cameron.

Mr Sime indicated that it would be useful for Members to have sight of an extract of the SNP election manifesto as it related to health and it was agreed that Mr Cannon would circulate this to Members in due course.

**Deputy Head of
Administration**

Members were also provided with an update by Mr Calderwood in relation to early discussions on the future configuration of NHS Boards, and therefore the challenging context within which future plans may need to be derived was acknowledged.

NOTED

48. REVIEW OF UNSCHEDULED CARE: UPDATE

Ms Renfrew provided an update in relation to Unscheduled Care and it was noted that a stock take was being undertaken by each of the Acute Division Sectors and Directorate at the end of March 2016 to inform a review of Winter Plans (for 2015/16) in order to share experiences and provide a platform for the development of the Winter Plan for 2016/17.

It was also noted that an interim response was required by the Cabinet Secretary in relation to Unscheduled Care, which was being drafted, which will set out the actions being taken and a proposal to undertake a root and branch review of the next 4 – 6 months of Unscheduled Care across key sites in Greater Glasgow and Clyde, before embarking on the revision of the Board's Winter Plan for 2016/17.

Mr Calderwood stated that he had met senior officers within the Acute Division the day before the meeting where UCC performance had been reviewed and actions

discussed and it was agreed that the additional winter beds would be in place until the end of June 2016 in order to provide a degree of short-term stability while the root and branch review and the review of last year's Winter Plan was undertaken.

Mr Calderwood also reminded colleagues that on average, the Board's UCC performance against the 4 hour target was 8 percentage points better than in 2015/16, although it was also acknowledged that more was required in order to bring about sustained improvement and achievement of the 95% target on a routine basis.

49. PROPOSED QEUEH BBC DOCUMENTARY

There was submitted a paper [Paper No 16/31] by the Director of Corporate Communications which set out a proposal for the BBC to return to film 3 new one hour programmes at the QEUEH and RHC.

Mr McLaws took Members through the background to the proposal and reminded colleagues that during the construction of the QEUEH and RHC, the BBC Science Documentary Team were selected to record the closure of the old hospitals and the migration to the new hospital, and also "fly on the wall" coverage of the opening weeks and months of the new hospitals. Filming took place over several months in 2015 and edited into 2 one hour documentary packages. Both programmes had been very well received when these were aired in 2016 and gave the public a very positive insight into both the adult and children's hospitals during this period of significant change. The BBC was delighted with the quality of the programmes, the huge public interest that was generated, and viewing figures were extremely high.

It was noted that the BBC producers had contacted NHS GG&C Communications staff in early 2016 to request a meeting to discuss filming a new series in which they proposed up to 3 one hour programmes covering a range of services and departments including the:

- Emergency Department
- The official opening of the Teenage Cancer Trust Ward
- The scale of productivity in the operating theatres equipped with the most modern equipment in the country, including precision robotic surgery
- Linkages between Maternity Services and the Neonatal Intensive Care & Special Baby Unit
- Laboratory Medicine
- Renal Dialysis; Cardiology Unit and Respiratory Medicine
- Research development and cutting-edge work on stratified medicine and how this will be the cornerstone of tomorrow's world of healthcare

Mr McLaws indicated that he had met the South Sector Acute Director and Women & Children's Director who had subsequently talked through the approach with clinical colleagues at both hospitals, and it was noted that the proposal was supported locally.

It was proposed to invite the BBC back to gain access to the ED and other designated areas of the hospital during August and September 2016, and the ICE Building, and new state-of-the-art Neuro Theatres in early 2017.

NHSGGC Communications staff would link in closely with University of Glasgow Communications colleagues to progress a partnership approach to this.

As before, the edited programme would be shared with NHSGGC senior managers, clinicians and communications professionals prior to screening, which would be expected sometime after March 2017. Colleagues discussed the associated risks and benefits in relation to the approach to return to the hospitals for a further 3 one-hour programmes and after canvassing views from each member of the Committee, the Chairman summarised the view of the Committee as being largely supportive, whilst acknowledged the risks but also the opportunities that this presented to showcase the hospitals and the cutting-edge developments being taken forward in Glasgow.

50. FINANCIAL MONITORING REPORT – 12 MONTH PERIOD TO 31 MARCH 2016

There was submitted a paper [Paper No 16/32] by the Director of Finance setting out the financial position within the Acute Services Division for the twelve months period to 31st March 2016. Expenditure within the Acute Services was overspent by [REDACTED], which was a rise of [REDACTED] from the previous month. The main cost pressures related to medical pay where significant expenditure on agency and locum cover has been incurred to support activity levels. Actual non-elective and elective inpatient activity continued to increase significantly for the year to date, together with long-term vacancies, difficulties recruiting and the requirement for waiting list initiatives to achieve TTG targets.

Mr White advised that the overall position within the NHS Board continued to see the forecast position being one of break-even at year-end and the annual accounts were currently being finalised and would be submitted to the Audit Committee and Board in June 2016 which was anticipated will show a small overall underspend.

Mr Calderwood acknowledged that this had been an extremely difficult financial year and paid tribute to Mr White and his team, and also fellow Directors across the Board, and in Acute, for delivering the overall position; however 2016/17 was equally challenging and indicative budgets have been set which have assumed the monthly overspend will be eradicated and the Acute Division's overspend trend for 2016/17 eliminated. It was noted that there were a number of invest to save schemes being put in place in order to reduce the reliance on agency and locum staff and rotational schemes to attract candidates to work in NHS Greater Glasgow & Clyde.

In relation to Nursing overspends, Dr McGuire indicated that there was significant work being undertaken in relation to sickness absence and as well as refreshing rostering skills at ward level, a new E-Rostering system was being considered to supplement the drive to reduce pressures on nursing pay.

In relation to Waiting List Initiatives, Mr Calderwood indicated that a review of the discretionary spend which is non-recurring in order to achieve the 18 week RTT target was being undertaken and a clear message sent to all budget holders not to commit expenditure unless this was within the base budget and to hold all discretionary spend in the first three months of 2016/17. A further assessment would be undertaken in June in relation to the headline rate of expenditure.

Mr White also provided an update in relation to the work being undertaken to reduce locum expenditure by not only addressing the demand but also the supply of

locum staff through national and regional efforts to cap rates, the recovery of VAT and engagement with a small number of agencies to achieve more competitive rates.

NOTED

51. CLINICAL GOVERNANCE UPDATE

There was submitted a paper [Paper No 16/33] by the Medical Director which provided an overview of the clinical governance activity within Acute Services, which described notable progress and challenges in the maintenance of clinical governance. The report was structured around 7 domains (clinical safety, clinical effectiveness, person centred care, systems and leadership, quality improvement, training and education and information technology)

Dr Armstrong, in introducing the report, highlighted that this was presented in a new format as a result of a review of the content of the information, which it was hoped would provide a fuller description of the wide scope of clinical governance issues, and support non-executive oversight and accountabilities for clinical governance, as well as informing Members on the assurance processes in place to monitor and report at corporate levels.

Dr Lyons in addressing some questions in relation to the report indicated that he thought this was a very good overview and an excellent format for Members, and suggested a number of amendments to some of the language used, particularly in relation to [REDACTED] and he also asked for further information in relation to the delirium bundle; Dr McGuire confirmed that this would be reported at the next meeting of the Acute Services Committee.

Ms Brown also commended the format of the paper and in relation to a question posed about the person-centred care report as a standalone item, was re-assured that this would be incorporated and integrated into future versions of the report.

Mr Finnie also welcomed the very positive report and welcomed the detail contained within the paper, particularly in relation to the detail provided around Fatal Accident Inquiries, although it was suggested that it would also be helpful to provide assurances in relation to processes of care in future updates.

In response to a question raised by Dr Cameron in relation to the implementation of national guidance, Dr Armstrong indicated that there was a high degree of confidence in relation to national guidance; however the same degree of assurance did not exist in relation to new clinical guidelines uploaded to the clinical guideline directory which were more local and bespoke in nature.

Mr Lee, in summarising, acknowledged the positive remarks made by fellow Members; however it was also remarked that the covering report should set out the key issues to be considered as opposed to replicating the content of the report itself, which would be helpful to Members going forward and applied equally to all reports, not just the report at hand.

52. HEALTHCARE ASSOCIATED INFECTION: EXCEPTION REPORT

There was submitted a paper [Paper No 16/34] by the Medical Director updating the Committee on the NHS Board's performance against HEAT and other

Healthcare Associated Infection targets and performance measures.

Dr Armstrong highlighted the SAB increase in quarter 4 2015 and the remedial actions undertaken in quarter 1 2016 to reduce SABS by 17% with 106 locally reported cases for the quarter.

It was also noted that there was an increase in CDI cases in quarter 4 2015 and direct action had been undertaken to reduce CDI incidents in quarter 1 2016 with 94 locally reported cases, which represented a reduction of 32%.

NOTED

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

There was submitted a paper [Paper No 16/35] by the Medical Director providing Members with a report setting out in detail the actions undertaken and progress made to date against the four key recommendations as set out by HIS in October 2015. This followed a review undertaken in relation to concerns raised with the GMC by medical staff at the Beatson West of Scotland Cancer Centre in May 2015.

Dr Armstrong invited colleagues to note the key points within the detailed papers including:-

- The establishment of a Beatson WOSCC Future Steering Group and five sub-groups, to address two of the four recommendations, and agree a sustainable future vision for the centre examining short, medium and long term strategies;
- The improvement event planned for 14th June 2016 to provide feedback on the work of the sub-groups;
- External clinical engagement in the process outlined above;
- Robust clinical governance arrangements which had been established to provide assurance of safe care;
- NHSGG&C's arrangements for the Area Clinical Forum and supporting advisory structures; and
- The internal staff survey commissioned by the Director of Human Resources and Organisational Development, the meeting with medical staff on 22nd March 2016 to discuss the outcome and the intention to develop a set of high level recommendations and action plan to progress this, and a Focus Group to explore the actions in more detail planned for 20th May 2016.

Ms Brown acknowledged the significant work being undertaken already, in particular around the staff survey and the changes to the Area Clinical Forum structure.

Members welcomed the depth and breadth of work being undertaken and it was noted that regular updates will be provided to Members on the progress of work being taken forward.

54. VALE OF LEVEN INQUIRY: EXECUTIVE SHORT LIFE WORKING GROUP UPDATE REPORT

There was submitted a paper [Paper No 16/36] from the Medical Director and Nurse Director setting out an update on the action plan which contained recommendations for NHS Boards, and the action plan agreed by NHSGG&C against the recommendations within the report, which were submitted to Scottish Government in January 2015.

The paper provided a further update in preparation for a final report by July 2016. It was noted in NHSGG&C 62 recommendations had been completed and 3 were ongoing. The ongoing actions related to the mainstreaming or rollout of wider areas of work across the organisation and were not specific to events at the Vale of Leven, the hospital which gave rise to the inquiry.

NOTED

55. PUTTING PATIENTS FIRST: PROGRESS REPORT ON IMPLEMENTING THE PATIENT RIGHTS ACT IN NHSGGC'S ACUTE SERVICES

There was submitted a report [Paper No 16/37] by the Nurse Director providing Members with an update on the implementation of the Patient Rights Act (Scotland) 2011 and the Putting Patients First – Acute Services Development Plan 2016/17.

As part of the update, Dr McGuire provided Members with early sight of a short video which was on YouTube in relation to one ward at the Royal Alexandra Hospital and although it was acknowledged that there was some further work to be undertaken, Dr McGuire stressed that this had come from the ward staff themselves who had undertaken this as part of a project locally and it was to be very welcomed as a local initiative to be built on.

In response to a question from Dr Lyons in relation to Appendix 1 of the report, and the questionnaire methodology, Dr McGuire indicated that the methodology had been validated nationally and was providing a very useful benchmark across services in the Scottish NHS.

56. QUARTERLY REPORT ON CASES CONSIDERED BY THE SCOTTISH PUBLIC SERVICES OMBUDSMAN: 1 JANUARY TO 31 MARCH 2016

There was submitted a report [Paper No 16/38] by the Nurse Director which set out the Acute Services Report on the actions taken against the recommendations made by the Scottish Public Services Ombudsman in relation to investigative reports and decision letters issued in the period from 1 January to 31 March 2016. The Acute Services Committee had the responsibility to seek the necessary assurances that recommendations made by the SPSO in relation to Acute Services were implemented in the interests of delivering safe and effective care.

The report covered one investigation report and eleven decision letters with recommendations were identified by the SPSO in those cases carried forward from the last quarterly report that had not previously been completed.

In relation to the investigation report carried forward from the last meeting as set out in Appendix B, Dr Lyons sought further information in relation to the recommendations listed and it was agreed that this would be provided to Dr Lyons separately.

**Deputy Head of
Administration**

NOTED

57. UPDATE ON SUSTAINABILITY

There was submitted a paper [Paper No 16/39] by the Director of Facilities & Capital Planning which set out the key issues and substantial challenges in relation to the delivery of energy and carbon reduction targets agreed between NHSGG&C and Scottish Government and the significant challenges imposed on NHSGG&C around the Scottish Government's sustainability agenda.

Mr Gallacher attended along with Mr Loudon to take colleagues through the paper in detail and highlighted the key issues in relation to resource usage, energy saving proposals to mitigate cost pressures and ongoing energy projects.

In relation to the carbon and energy fund (CEF), Members were disappointed to note that the Board had received confirmation from Scottish Government that after further investigation, they were unwilling to support the CEF route to fund large scale projects which have significant energy and carbon reduction, which impacted on schemes being considered at the Inverclyde Royal Hospital, Glasgow Royal Infirmary and possibly Gartnavel campuses where boilerhouse schemes were being taken forward to Full Business Case status.

It was noted however that this was being taken up by the Director of Facilities and Capital Planning at a meeting involving Scottish Government. As a consequence of not having the carbon and energy fund support for the Glasgow Royal Infirmary scheme in particular, this was being assessed further as the assets involved were over 40 years old.

Mr Brown welcomed the detailed report and the breadth of actions being taken across the Board to meet the various savings and energy targets and asked that a greater degree of clarity be brought to the targets to make it easier for Members and colleagues to monitor progress in relation to these important initiatives.

Mr Loudon in response to a question from Mr Brown, indicated that as well as targeting supply side savings, local behaviour change was being addressed through an energy awareness campaign which would be launched this year, and also indicated that in order to achieve these targets, large-scale schemes were required and offered the introduction of electric cars as an example of a large-scale scheme which may deliver significant benefits.

Mr Finnie in acknowledging the positive comments made by Mr Brown and Mr Loudon highlighted that this was a key issue for the Board as a public authority and reminded colleagues that the obligations contained within the initiatives arose during the period 2002 – 2006 and the Board had to be more proactive in addressing these. He also urged the Board to take up concerns around the Scottish Government decision not to support the carbon and energy fund route to fund large scale projects as this was a significant disappointment.

58. CHAIR'S LAST MEETING

Mr Brown reminded colleagues that this was the last meeting to be chaired by Mr Ian Lee before stepping down as a Board Member on 30th June 2016. He paid tribute to the work that Ian had undertaken as a Board Member over the past 8 years and the significance of the contribution made, not only as a member, but also as Chair of what used to be the Quality and Performance Committee, and now was the Acute Services Committee, and also as Vice-Chairman of the Board. Mr Brown also added his personal thanks to Mr Lee for the support that he had provided to him as Chairman, in his role as Vice-Chairman, and all Members joined Mr Brown in wishing Mr Lee all very best wishes for the future.

59. DATE OF NEXT MEETING

9.00am on Tuesday 5 July 2016 in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 1.00pm

Healthcare Associated Infection: Exception Report**Recommendation:** - For noting.**Purpose of Paper:** - Update on NHSGGC performance against HEAT and other HAI Targets and performance measures.**Key Issues to be considered:-**

Validated HPS/ISD data : Quarter 4 (October – December) 2015			
HEAT Targets	GGC	National	HEAT target
SAB rate per 100,000 AOB	36.6 (127cases)	32.6	24.0
CDI rate per 100,000 OCB	38.5 (139 cases)	38.0	32.0

Table 1. Progress against National HAI HEAT targets, 01/10/2015 – 31/12/2015

- *Staphylococcus aureus* Bacteraemia (SAB) increase in Q4-2015 and remedial actions undertaken in Q1-2016 to decrease SABs by 17% with 106 locally reported cases for the quarter.
- There was a noted increase in CDI cases in Q4-2015. Direct action undertaken to reduce CDI in Q1-2016 with 94 locally reported cases. This is a reduction of 32%.

Any Patient Safety /Patient Experience Issues: - Yes, increase in SAB and CDI in Q4-2015.NHSGGC are taking relevant actions to remedy the situation.**Any Financial Implications from this Paper:** - No**Any Staffing Implications from this Paper:** - No**Any Equality Implications from this Paper:** - No**Any Health Inequalities Implications from this Paper:** - No**Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome:** - No**Highlight the Corporate Plan priorities to which your paper relates:** - Improving quality, efficiency and effectiveness and patient safety.**Author:** Dr. Jennifer Armstrong**Tel No:** [REDACTED]**Date:** 17/05/2016

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Infection Prevention & Control Service
Report for Acute Services Committee, May 2016

Staphylococcus aureus Bacteraemia Surveillance

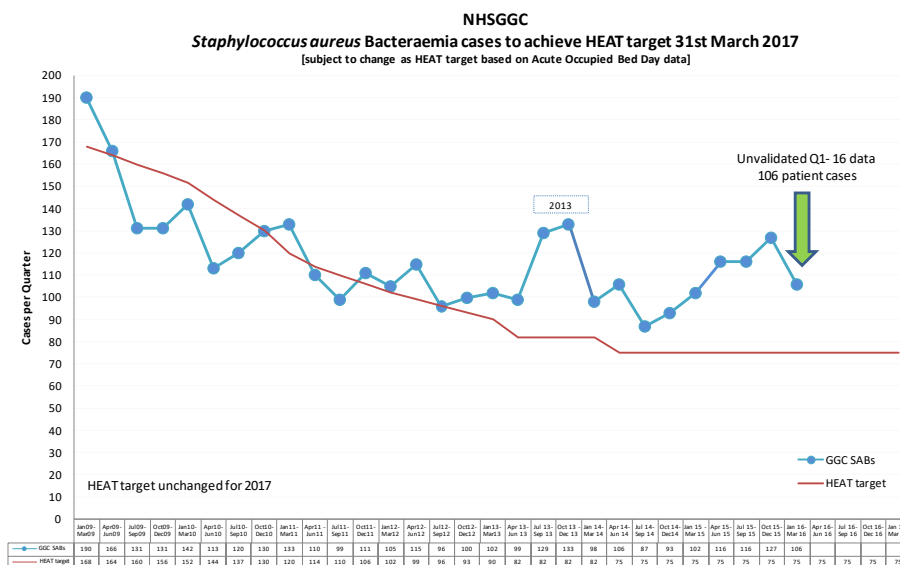


Figure 1. *Staphylococcus aureus* Bacteraemia cases by reporting quarter

The graph above demonstrates a gradual decrease in *Staphylococcus aureus* bacteraemia (SAB) cases from 2009 to the second half of 2013, when there was a noted increase. A series of measures were implemented mainly surrounding intravenous access device care and maintenance.

There was a reduction in 2014 following these improvement measures with 384 SAB cases reported for the year, however there has been a quarterly upward trend of SAB in 2015 and a total of 461 cases were reported. This is an increase of 20.1% upon the previous year.

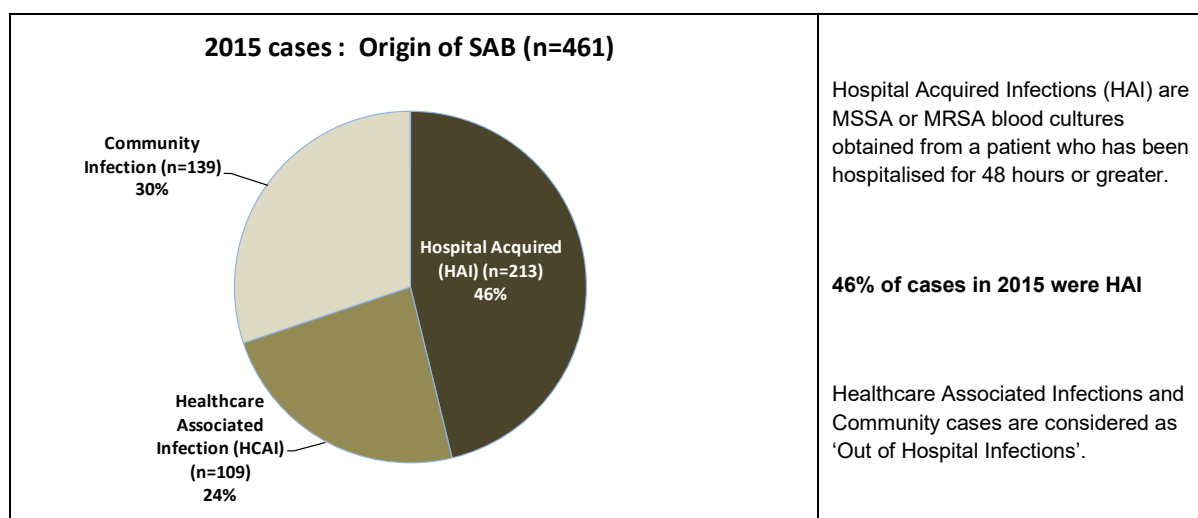


Figure 2. Origin of SAB cases in 2015

Within the 54% of out of hospital SABs in 2015, there has been a noted increase in the proportion of community cases which are much less likely to be reduced using traditional improvement methodology. Cases related to illicit intravenous drug use account for 29% of community SABs, followed by unknown source, skeletal/joint infections and skin/soft tissue. Health and Social Care Partnerships, the Public Health Protection Unit and IPCT are currently exploring possible interventions to try to reduce SABs in these specific groups e.g. work is ongoing to identify patient pathway interaction within community addiction teams and patients with chronic infection known to community services.

Quarter 4 (October – December) Results from HPS Q4 Report

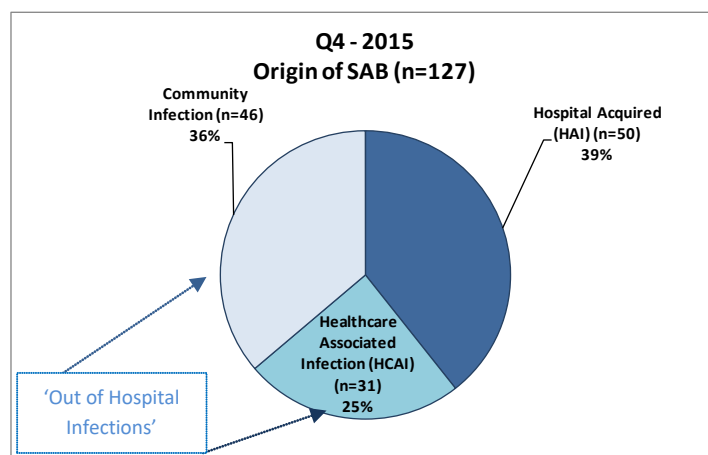


Figure 3. Origin of SAB cases Q4-2015

For the last available reporting quarter (October - December 2015), NHSGGC reported **36.6** SAB cases per 100,000 AOBs (127 patient cases). This is higher than the same quarter in 2014 where 93 cases were reported.

This is above the NHS Scotland reported national SAB rate of **32.6** per 100,000 AOBs (407 patient cases). The existing National HEAT target which requires all Boards in Scotland to achieve a rate of **24** cases per 100,000 AOBs or lower was extended to 31st March 2017. This equates to 75 patient cases or less per reporting Quarter.

Quarter 1 (January – March 2016) local surveillance status

The pie chart below shows the breakdown of origin of SAB i.e. whether it was obtained in hospital (HAI) or whether it was an out of hospital infection (Healthcare associated and/or Community). 61% are of Out of Hospital/community onset infections.

Fifty patients developed a HAI SAB during their in-patient stay and the highest proportion (40%; n=20) of these were caused by an IV access device.

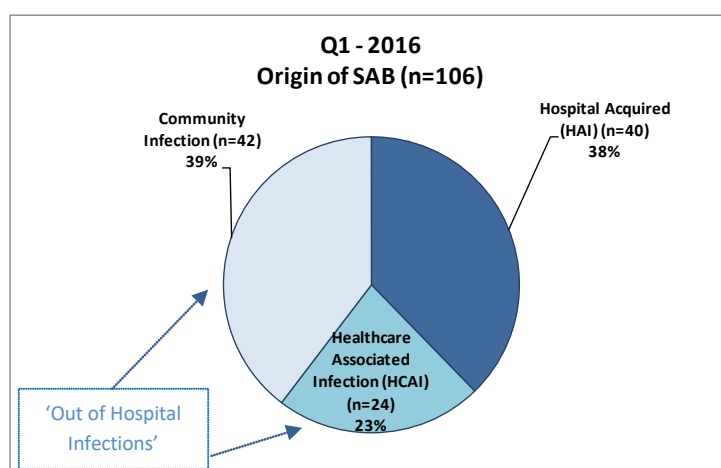


Figure 4. Origin of SAB cases Q1-2016

Local surveillance data indicates **106** SAB cases reported at 31/03/2016. This is a 17% decrease upon the last reporting quarter however will not meet HEAT target requirements

Analysis of NHSGGC bed occupancy data between January to March 2016 suggests an estimated rate of **29.4** cases per 100,000 AOB

It should also be noted that the proportions of 'Hospital Acquired' and 'Out of Hospital' infections have remained static at 38% and 62% respectively. The action plan to reduce hospital acquired SABs continues to be presented at both the Acute and Board Infection Control Committee meetings and has been summarised previously.

Clostridium difficile

Quarter 4 (October – December) Results from HPS Q4 Report

For the last available reporting quarter (October - December 2015), NHSGGC reported **38.8** cases per 100,000 occupied bed days (OCBDs), combined rate for all ages, which was also marginally above the national average of **38.0** per 100,000 OCBDs.

IPCT surveillance within NHS GGC comprises prospective data collection which provides daily case numbers on alert organisms such as *Clostridium difficile*. As well as providing early identification of increasing or decreasing patient cases, CDI information is also shared with Antimicrobial Pharmacist colleagues to assist real time local antimicrobial prescribing review of in-patient CDI cases, whether they are hospital acquired or whether the patient has been admitted to hospital already with CDI.

The importance of prudent use of co-amoxiclav, promotion of published infection management guidance and adherence with shorter duration of therapy has been emphasized in a joint communication from IPC and AMT. The AMT has also raised these specific issues through clinical governance committees in South, North and Clyde sectors. Targeted surveillance of co-amoxiclav use in the medical receiving complex in QEUP and Urology in GRI is underway. Hospital based infection management guidelines have also been reviewed in February in order to strengthen recommendations/ restrictions on broader spectrum antibiotics.

Clinical teams are reminded to adhere to the Management of Suspected *Clostridium Difficile* Infection (CDI) in Adults algorithm.

Quarter 1 (January – March 2016) local surveillance status

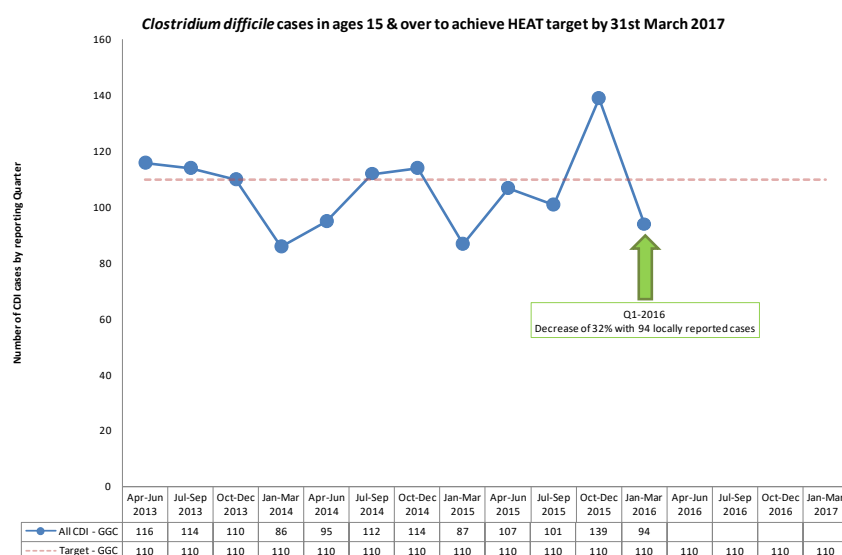


Figure 5 *Clostridium difficile* cases by reporting quarter

Local surveillance data for Q1-2016 demonstrates a 32% reduction in CDI with 94 cases reported. Analysis of NHSGGC bed occupancy data between January to March 2016 suggests an estimated rate of **25.3** cases per 100,000 OBD. This is below the HEAT target.

Completion of LearnPro HAI related modules

The table below provides the total number of Infection Prevention & Control related LearnPro modules completed by staff members throughout NHS GGC, between February & March 2016

LearnPro Modules	Staff Group				
	Nursing & Midwifery	Medical Staff	Allied Health Professionals	Ancillary	Total
Cleanliness Champions	5	0	0	0	5
Clostridium Difficile (Clinical scenario)	222	1	8	8	239
Clostridium Difficile Online tutorial	345	1	12	8	366
HAI Clinical Induction	408	6	19	31	464
Helping patients cope with isolation in hospital	138	0	0	1	139
Hospital Outbreak Management	129	0	0	1	130
IPC Influenza	420	4	34	27	485
Aseptic Technique	329	4	2	8	343
Recognising Surgical Site Infection (C-sec)	80	2	0	4	86
Recognising Surgical Site Infection	122	3	0	3	128
IPC Standard Infection Control Precautions	524	23	67	108	722
IPC Statistical process Control Charts	153	2	15	16	186
Total	2875	46	157	215	3293

Table 2. IPC LearnPro Modules, 01/02/2016 – 31/03/2016

Outbreaks/Exceptions

Sector/ Directorate	Site	Ward	Trigger / Organism	Date Reported	Action / Update
South Clyde	RAH	ITU	2 cases of VRE	14.04.16	PAG undertaken by ICD and Lead IPCN 14/04/16. Two IMT meetings held. Patients in unit screened for VRE 14/04/16 (all negative). Environmental screens obtained 15/04/16 (all negative). Terminal clean of unit undertaken 15/04/16. Update: 20/04/16 - no new cases identified. HIIAT GREEN reported to HPS 18/04/16.

Commencement of Surgical Site Infection Surveillance within QEUH Institute of Neurological Sciences.

The IPC Surveillance team have commenced surgical site infection (SSI) surveillance on cranial surgery procedures and specified spinal surgery procedures undertaken by the service.

This includes in-patient surveillance and readmission to day 30 post surgery and commenced on 1st March 2016. A surveillance nurse funded by Regional Services will continue this process in the coming months for a period of one year.

March 2016	Cranial and Spinal Surgery in INS QEUH	
	Procedures	SSIs
Cranial	55	2
Spinal	11	0

Table 3. Monthly total of cranial and spinal procedures and SSIs detected at INS

The table above contains the total number of procedures undertaken and any SSIs detected. Due to the small amount of surgical procedures this data should be viewed with caution. It should also be noted that SSI surveillance of these procedures is not undertaken elsewhere in Scotland and is therefore unable to be benchmarked nationally.

Norovirus

There were 5 ward closures reported between February – March 2016

Month	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec 15	Jan 16	Feb-16	Mar-16
Ward Closures	14	4	2	6	14	7	5	5	0	0	1	3	2	2	2	3
Bed Days Lost	292	10	10	55	270	98	65	42	0	0	0	19	14	16	15	45

Table 4. Monthly total number of ward closures due to suspected/confirmed Norovirus, 01/12/2014 – 31/03/2016.

DRAFT

ASC(M)16/04
Minutes: 60 - 73

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Acute Services Committee held at
9.00am on Tuesday, 5 July 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 (Convener)
Ms M Brown	Dr D Lyons
Mr I Fraser	Mr A Macleod
Dr H Cameron	Councillor A Lafferty
Professor A Dominiczak	Mr D Sime

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

Dr J Armstrong	Mr R Calderwood
Mr J Brown CBE (Item 11 only)	Dr M McGuire
	Mr M White

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

Mr P Cannon	..	Deputy Head of Administration
Mr D Loudon	..	Director of Facilities & Capital Planning
Mr G Love	..	Property Manager
Ms A MacPherson	..	Director of Human Resources & Organisational Development
Ms T Mullen	..	Head of Performance
Mr D MacConnell	..	Audit Scotland

60. APOLOGIES, WELCOME AND PRELIMINARIES

Apologies were intimated on behalf of Councillor G Casey, Councillor M Kerr, Councillor J McIlwee, Councillor M Macmillan and Councillor M O'Donnell.

61. DECLARATIONS OF INTEREST

There were no declarations of interest.

62. MINUTES OF PREVIOUS MEETING

Ms Brown asked that a correction be made to Minute 46, where the penultimate paragraph should read “ ... there was also a number of other discrete groups of staff (not patients) that had to be considered such as faith, LGBT, poverty and mental health...” which was endorsed by members. With this correction, on the motion of

Mr A Macleod, seconded by Professor A Dominiczak, the minutes of the Acute Services Committee meeting held on 17 May 2016 [ASC(M)16/03] were approved as a correct record.

NOTED

63. 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.

64. PATIENT'S STORY

Dr Margaret McGuire, Nurse Director, read out a recent patient story which focussed on the need to ensure that carers and families are intimately involved in the care and treatment provided to their family member, in this case the carers mother, who was admitted to Hospital in a comatose state and was discharged having made a full recovery. The importance of engaging with and involving family members was widely acknowledged by those present.

NOTED

65. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT

There was submitted a paper [Paper No 16/41] by the Head of Performance setting out the integrated overview of NHSGGC Acute Services Division's performance. Of the 27 measures which had been assessed against a performance status based on their variation from trajectory and/or target, 11 were assessed as green, 5 as amber (performance within 5% of trajectory) and 11 as red (performance 5% outwith meeting trajectory). Exception reports had been provided for those measures which had been assessed as red.

Ms Mullen reminded colleagues that an earlier version of this report had been discussed at the June Board meeting, and she therefore highlighted 3 specific exception reports which were all new in terms of this version of the Performance Report. These were, the 12 Week Treatment Time Guarantee (TTG) performance (moving from amber to red), performance against Stroke Care Bundle (which had moved from green to red) and performance in relation to the percentage of complaints responded to within 20 working days (which had moved from green to red).

In relation to the 12 Week TTG, it was noted that there were a total of 430 people waiting over 12 weeks for inpatient treatment, at May 2016. Ms Mullen took members through actions being taken to address performance within Trauma and Orthopaedics (122 patients), Urology (104 patients), General Surgery (78 patients), Neurosurgery (89 patients) and Oral Maxillofacial Surgery 33 patients). Detailed updates were also provided on the status of each of the patients waiting over 12 weeks.

In relation to the Stroke Care Bundle, it was noted that current performance in

relation to the bundle was below target in May 2016 at 53%, against a target of 80%. It was highlighted that the current Stroke Care Bundle position is driven by performance in relation to the swallow screening test, the percentage of fast track patients seen within 4 days of receipt of referral, and the percentage of patients admitted to an Acute Stroke Unit on the day of admission or day following presentation. Members were provided with a detailed exception report in relation to the measures being taken at specific hospital sites to address each of the component parts of the bundle.

In relation to complaints, it was noted that for the quarter ending March 2016 58% of complaints received were responded to within 20 working days when compared to the target of 70%. Members were advised that the 2 of the 3 complaints teams had moved sites during this period (to the West ACH) and there was a further move of one of the teams from one floor to another within the ACH, which caused significant disruption to the service. At the same time, the Complaints Department experienced significant sickness absence with circa 30% of the entire team being absent at one point. This, coupled with annual leave due at the end of the financial year, had a negative impact on performance, however the newly appointed Board Complaints Manager has started in post, to provide leadership and direction, and it was anticipated that performance would improve in the next quarter.

Mr Fraser indicated that he was concerned about Detect Cancer Early and Suspicion of Cancer Referrals (62 days) as performance measures, and this was echoed by a number of members including Dr Lyons and Ms Brown. In response to a question posed by Dr Lyons, it was agreed that further detail in relation to the Colorectal Cancer Pathway be provided to Mr Lyons separately. Ms Brown, in addition to those areas already highlighted, raised a concern about the Urology performance in relation to suspicion of cancer.

Medical Director

In relation to the Urology pathway, Mr Calderwood indicated that there had been no applicants coming forward to apply for senior medical posts, and this, coupled with a rise in demand, had meant that the Urology service was under considerable pressure. In order to match current capacity with rising demand Service Managers were reviewing job plans to ensure that there was as little variability across sites as possible, which it was hoped would have an impact on the 62 day performance. It was also noted that late tertiary referrals coming to the Board from outwith NHS GGC had an adverse impact in meeting the 62 day target.

In relation to Head and Neck Cancer Services, in response to a question raised by Mr Macleod, Mr Calderwood indicated that Board staff were working with Regional Network colleagues to look at the issue of high referrals but relatively low diagnostic yield in order to ensure that the services are as efficient and effective as possible.

In relation to general pressures within clinical services, Mr Calderwood indicated that the Neurosurgery and Oral & Maxillofacial Surgery services would begin to recover following the difficulties experienced in Theatres; the backlog of patients should be treated by September 2016. In relation to Orthopaedics, the cancellation of elective cases caused by the current, significant, demand being experienced in unscheduled care, particularly in the South, was being addressed. In relation to General Surgery, TTG impacts were inevitable as a result of the decision taken by Scottish Government to ask NHS GGC to cease offering patient advised unavailability codes, and this will inevitably lead to the number of patients breaching the guarantee increasing over the coming months. The impact of these changes was being assessed and an update would be provided at the September Acute Services Committee meeting.

Chief Executive

In relation to delayed discharges, Mr Calderwood reported that the overall position was relatively static and that the Scottish Government target of no patients waiting 14 days beyond the date of discharge was being focused on by local authority colleagues, which was having an impact on the number of patients who were waiting over 72 hours. The overall number of patients delayed, particularly in the Queen Elizabeth University Hospital and Glasgow Royal Infirmary was continuing to present challenges to local bed managers.

NOTED

66. SAFER USE OF MEDICINES IN NHS GG&C

There was submitted a paper [Paper No 16/42] from the Medical Director which provided the Committee with an overview of the structures and processes in place to safely and effectively manage the use of medicines in NHS GG&C. The paper provided an overview of the key stages in the system of medicines use and information from Healthcare Improvement Scotland on the safer use of medicines in an average 500 bed Acute Hospital was shown in a diagrammatical format.

Dr Armstrong took colleagues through the Medicines Governance Framework which was described as an integrated single system providing clinical advice on safe and effective use of medicines, the management of advice on affordability and service delivery. The Medicines Advisory Structure underpinning the framework was provided in Appendix 1, and Dr Armstrong highlighted the key role of the Pharmacy and Prescribing Support Unit, led by Professor Norman Lannigan. This unit provided strategic co-ordination and service support in delivering the arrangements along with the work of the Area Drug and Therapeutics Committees who provide advocacy and perspective on the needs of patients.

Dr Armstrong went on to provide a short case history involving learning from a near-miss involving a 35 year-old patient with a suspected DVT, who had come in to the Queen Elizabeth University Hospital and members were guided through the detailed clinical pathway and the issues which arose in relation to recording and acting upon a Penicillin allergy. It was noted that the patient had made a full recovery and Dr Armstrong provided an overview of the lessons learned in reviewing each stage of the patient's journey.

Members also welcomed sight of the Medication Incident Learning Report Template which invited staff to reflect on issues, by prompting fields to be completed including *what happened, what went well, what if anything could be improved and what have we learned in reviewing adverse events*.

The Convenor commented that the Committee could only “note” the advice of the Medical Director that the medicines governance priorities were strategically aligned with other clinical priorities, rather than “confirm the position” as set out in the paper.

NOTED

67. INTERNAL REVIEW OF PAEDIATRIC CARDIAC SERVICES

There was submitted a paper [Paper No 16/43] by the Medical Director which provided an updated Action Plan which had been established to address the recommendations set out in the report of the external review of the Paediatric Cardiac Service. Dr Armstrong reminded colleagues that the external review of the Paediatric Cardiac service was commissioned, and commenced, in August 2015. The external review team report and draft action plan were considered and noted by the Acute Services Committee in January 2016 and a further update provided in March 2016. The paper presented to members provided a further update on the Action Plan.

It was noted that the external review group would be re-visiting the Action Plan in August to review progress and Dr Armstrong, in presenting the updated Action Plan, focused on the amber rated status items and took members through each of these in detail.

It was noted that significant progress was being made, although it was also acknowledged that more required to be done, and members thanked Dr Armstrong and Mrs MacPherson for their leadership in relation to the clinical and organisational development aspects of the Action Plan and looked forward to receiving a further update in due course.

In relation to the organisational development programme and in response to a question by Ms M Brown, Mrs MacPherson agreed to share the detail behind the organisational development efforts separately.

**Director of
Human
Resources &
Organisational
Development**

NOTED

68. PUTTING PATIENTS FIRST: PATIENT RIGHTS ACT IN NHSGG&C

There was submitted a report [Paper No 16/44] by the Nurse Director providing members with an update on the implementation of the Patient Rights Act (Scotland) 2012 and an overview of patient and carer feedback received between April and May 2016.

Members noted the update and in particular the positive results flowing from the National Maternity Survey (Having a Baby in Scotland 2015: Listening to Mothers) which had been sent to over 1,000 women who had given birth in NHSGG&C in February and March 2015.

Members also noted a summary of feedback provided via universal feedback, NHSGG&C feedback or Patient Opinion. Members were also provided with examples of feedback from each of these sources.

NOTED

69. FINANCIAL PLANNING – ACUTE ACTIVITY TO 31ST MAY 2016

There was submitted a paper [Paper No 16/45] by the Director of Finance setting out the financial position within the Acute Services Division for the two months period to 31st May 2016. Mr White reminded members that the first financial monitoring report would normally cover the first three months of the financial year; however

given the significant financial challenges being faced by the Board, and as the Month 2 results demonstrated a significant overspend, an early sight of the Month 2 position had been brought forward for consideration by the Acute Services Committee. It was noted therefore that the out-turn positions had not been balanced with any non-recurring input, nor reflected any achieved/unachieved savings, however the trends were still applicable.

Mr White took members through the report in detail which it was noted was showing an adverse variance of [REDACTED] at the end of May 2016. It was noted that the main cost pressures were in Medical Pay, Nursing Pay, surgical sundries and CSSD supplies.

The Director of Finance was keen to stress to the Committee that the Acute Division has continued the pattern of overspending into 2016/17, a position which is clearly unsustainable. There is now an urgent need for tangible progress with the Cost Containment Programme, the implementation of the savings schemes already identified, and identification of additional schemes to close the financial gap outlined in the Financial Plan.

Mr Calderwood reported that in Mr Archibald's absence he had held 3 Performance Review meetings with Directors, and three were scheduled for the next week. It was however becoming clear that there was limited room for manoeuvre in terms of additional cash releasing schemes to be brought forward to address the continuing overspend in the Division and, therefore, all Directors were looking at services line by line to set out what choices might be open to the Board, should expenditure continue to exceed the budget. Mr Calderwood reiterated the message delivered to Directors that the Acute Divisional budget had to be in balance by the end of January 2017 in order to ensure that the Board returned a break even outturn for 2016/17.

Finance Director

In relation to a further detailed update on the cost containment programme and a projection for the year end position, Mr White indicated that this would be brought to the September Acute Services Committee Meeting for consideration.

NOTED

70. FINANCIAL CHALLENGES – ACUTE PLANNING

There was submitted a paper [Paper No 16/46] by the Finance Director which sought members views on the priority and pattern of spend for non recurring Scottish Government income received in 2016/17 in relation to Unscheduled Care and Waiting Times Delivery.

It was noted that [REDACTED] had been allocated by Scottish Government, but [REDACTED] had already been committed to begin to treat patients who had expressed a desire to be treated by a specific consultant or in a specific Hospital location (patient advised unavailability). This was required because Scottish Government colleagues had asked the Board to discontinue the use of this option and these patients were now being added to service waiting lists.

Mr White reminded members that the Board Chairman had provided assurances to the Cabinet Secretary that an internal review of unscheduled care would be undertaken over the course of the summer months, and that the Board would retain winter beds for a further period in order to allow this review to continue in a stable environment.

The additional (181) beds in place were summarised as:-

- 71 beds at Gartnavel General Hospital and Glasgow Royal Infirmary
- 110 beds across the remainder of the Acute Division

It was noted that the Committee had already agreed to the continuation of the 181 beds until the end of June 2016. This has cost the Board [REDACTED] and was achieved by using the revenue receipt from the sale of the Mansionhouse Unit, albeit as another call on the diminishing reserves and non-recurrent funds of the Board.

It was reported that some of the 110 beds had already been wound down and removed from the services, mostly in the Clyde Sector, due to lack of demand, and the overall number of additional beds was now 60. This did not appear to have had not had any adverse impact on local unscheduled care performance.

Following detailed discussion it was agreed that;

- The Board allocate [REDACTED] to trying to clear the new wait pressures from the ceasing of patient choice unavailability;
- The Board approve the allocation of [REDACTED] to provide at least the additional 71 winter beds, and that the number of additional beds over and above the 71 beds already agreed should be reviewed and non-recurrent funding identified to keep them open until the end of October 2016, as determined optimal by the relevant medical teams. This should coincide with the completion of the internal Unscheduled Care Review.

The Director of Finance drew the Committee's attention to both the Financial Plan as presented at the Board on 28 June 2016 which outlined that the continued rate of spending would create a significant risk to achieving break-even, and the Month 2 Acute report. Both reports alluded to the unsustainability of continued use of non-recurring monies to fund day-to-day business.

It was noted that the Acute Services Committee will be updated at the September meeting on the configuration of winter beds that remain open, and the costs incurred, and the Board will be provided with a further update at the October meeting, by which time the main conclusions of the UCC Review being undertaken will be known and can be factored into further discussion around unscheduled care and the provision of winter beds going forward.

DECIDED

- To approve the allocation of up to [REDACTED] for unscheduled care winter beds until the end of October 2016
- To review the configuration of beds, impacts and the costs at the next meeting

Chief Executive

Chief Executive

71. DISPOSAL OF THE FORMER VICTORIA INFIRMARY

There was submitted a paper [Paper No 16/47] by the Director of Facilities and Capital Planning which sought approval to accept the unconditional offer received from Sanctuary Group for the purchase of the former Victoria Infirmary site.

As part of the Acute Services Strategy which resulted in the opening of the Queen Elizabeth University Hospital campus, members were reminded that the former Victoria Infirmary was closed for the delivery of services in May 2015. The site was then marketed by Savills, a property adviser and marketing agent to progress with the disposal of the site and a full and comprehensive marketing campaign was commenced on 22nd October 2015.

Following the marketing campaign, a number of parties expressed interest and a closing date set for 10th March 2016. Thereafter an assessment process was undertaken by Savills and at the closing date the Board received 4 offers. This was reduced to 2 prospective bidders following a further round of interviews with Savills and representatives from the Board to clarify the bids in more detail.

As a result of the review of best and final bids on 17th May 2016, it was recommended that the Sanctuary Group bid be accepted. It was also noted that the legally binding clawback provision in place would allow 50% recovery of the net upturn in value created from the sale, which would apply for 10 years from the purchase date.

It was noted that missives were being concluded and that the target date for handover of the site was 1st August 2016.

DECIDED

- To accept the unconditional offer from Sanctuary Group for the sale of the old Victoria Infirmary site

**Director of
Facilities and
Capital Planning**

Members noted that the Board would release a public statement confirming that Sanctuary Group had been selected as preferred bidder.

72. ACUTE STRATEGIC MANAGEMENT GROUP MINUTES OF MEETING HELD ON 26 MAY 2016

NOTED

73. DATE OF NEXT MEETING

9.00am on Tuesday 20 September 2016 in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 1.00pm

ASC(M)16/05
Minutes: 74 - 96

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Acute Services Committee held at 9.00am on Tuesday, 20 September 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 S Carr (Committee Vice Chair)
Ms S Brimelow	Mr I Fraser
Ms M Brown	Councillor M Kerr
Dr H Cameron	Mr J Legg
Councillor G Casey	Dr D Lyons
Councillor M Devlin	Dr R Reid
Ms J Donnelly	Mr D Sime

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

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

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

Ms S Canavan	..	Depute Director of Human Resources
Mr P Cannon	..	Deputy Head of Administration
Mr D Loudon	..	Director of Facilities & Capital Planning (Minute Nos 90–92)
Ms P Mullen	..	Head of Performance
Ms C Renfrew	..	Director of Planning & Policy
Dr D Stewart	..	Deputy Medical Director
Mr C Whyte	..	Team Leader, Property Disposals (Minute Nos 90–92)

74. APOLOGIES, WELCOME AND PRELIMINARIES

Apologies were intimated on behalf of Mr R Finnie, Mrs D McErlean, Councillor M Macmillan and Mr I Ritchie. Mr Carr welcomed members to the meeting, which he had been asked to chair in Mr Finnie's absence.

75. DECLARATIONS OF INTEREST

There were no declarations of interest.

76. MINUTES OF PREVIOUS MEETING

On the motion of Mr Fraser and seconded by Mr Sime, the Minutes of the Acute Services Committee meeting held on 5 July 2016 [ASC(M)16/04] were approved as a correct record subject to the age details of the patient referred to in Dr Armstrong's update on the Safer Use of Medicines (Page 4, Minute No. 66, 3rd paragraph) being deleted.

NOTED

77. 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.

All

78. PATIENT'S STORY

Dr Margaret McGuire, Nurse Director, read out a recent patient story which focused on the experience of a mother and daughter while the daughter was a patient in the Queen Elizabeth University Hospital and Gartnavel General Hospital over a number of episodes of care.

While it was noted that many aspects of the care provided were reported as positive, some concerns about how the family was made aware of the impact of delirium on the patient were raised and a number of positive suggestions made by the family about how general awareness might be improved were being taken forward, at individual ward level and as part of the Scottish Patient Safety Programme workstream on delirium. Dr McGuire referred to the paper on the agenda on this issue which provided further detail on actions being taken.

NOTED

79. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT

There was submitted a paper [Paper No 16/49] by the Head of Performance setting out the integrated overview of NHSGGC Acute Services Division's performance. Of the 27 measures which had been assessed against a performance status based on their variation from trajectory and/or target, 10 were assessed as green, 5 as amber (performance within 5% of trajectory) and 12 as red (performance 5% outwith meeting trajectory). Exception reports had been provided for those measures which had been assessed as red.

Ms Mullen highlighted that a change in the way that data was collected and reported in relation to Delayed Discharges (not a monthly census snapshot but at points in time throughout the month) was having an impact on the way that this could be compared with previous monthly reported positions.

It was also noted that since the last meeting there had been 2 inspections by the Healthcare Inspectorate. The first was an unannounced Older Peoples inspection

follow up visit in September 2016 to the Langlands Unit on the QEUH Campus, (which will report in October 2016) and an unannounced Healthcare Environment Inspection to the Royal Hospital for Children (which would report in November 2016).

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 Cancer (62 day target), 12 week Treatment Time Guarantee and the Stroke Care Bundle.

In relation to the Detect Cancer Early programme, it was highlighted that screening programmes were having an impact on detection rates and Mr Calderwood stated that nationally this impact was being discussed with a view to revising the trajectories to reflect the positive impact of screening programmes.

Dr Armstrong described in detail the successful lung cancer outpatient pilot that was underway at Glasgow Royal Infirmary which had been successful in reducing the number of patients who needed to attend after being triaged and telephoned following Consultant review of their results. This was freeing up appointment slots for other patients and reducing unnecessary attendances at clinics.

In relation to Delayed Discharges, Ms Renfrew stated that Board Officers were working closely with HSCP counterparts to drive down the number of patients waiting to be discharged from Acute Hospitals and that the number of patients waiting was significantly better than in previous years. However, it was acknowledged that further improvement would require significant, focussed, effort. It was noted that efforts were being focussed on a small number of patients in Glasgow City HSCP where further improvements were anticipated could be made to the overall position.

In relation to waiting times in general, Mr Calderwood reminded the Committee that the Board RTT performance was 92% and contrasted this with the Scottish position of 84%. The 12 week TTG position had, until January 2016, been consistently met by the Board but the position had deteriorated in the current calendar year and there were now 1,200 patients who had breached the guarantee. The impact of removing the facility for patients to opt to choose a particular hospital location for out-patient treatment, following an instruction by Scottish Government, had a negative impact on the size of the waiting list and while the initial impact had been to add around 6,000 patients to the waiting list, this had been reduced by rebooking patients to other hospitals and was currently standing at 1,000 patients.

It was acknowledged that the financial challenges being reported to the Board were undoubtedly having an impact on the Boards ability to continue to maintain compliance across a wide of rage of targets and this was evident in the trends that were emerging, particularly in relation to patient facing targets. However, Mr Calderwood alluded to a series of data summaries that were being produced with the assistance of Business Intelligence to establish a template for a comparison of specialties against key performance metrics and reported that this was already showing that there were productivity gains that were achievable and which would in turn inform and direct managerial action. It was noted that this was the focus of the corporate team in identifying how productivity could be increased in 2017/18 onwards. In the longer term, Officers were engaged with Dr de Caestecker in looking at how the demands on acute care could be described, understood, contained and reduced.

In relation to ongoing risk and the governance of issues identified as operational challenges, Mr Brown reported that he had asked Mr McLeod, as Audit Committee chair, to discuss with that Committee how best to identify and manage risks in the widest sense of the operating environment, particularly recognising the balance between unscheduled and scheduled care.

NOTED

79a ACUTE SERVICES KNOWLEDGE & SKILLS FRAMEWORK PERSONAL DEVELOPMENT PLANNING & REVIEW PROCESS (KSF PDP&R) – PROGRESS UPDATE

There was submitted a paper [Paper No 16/49a] from the Director of Human Resources & Organisational Development which provided the Committee with an update on the programme of work which supports the KSF Personal Development Planning and Review target of 80% of reviews being recorded and signed off on the electronic system.

It was also noted that the current programme of work was focussed not only on the target but also the quality of staff interaction.

NOTED

80. PERFORMANCE REVIEWS FEEDBACK REPORT

There was submitted a paper [Paper No 16/50] by the Director of Planning & Policy which provided an overview of the key actions and themes arising from the round of Performance Review meetings with Acute Directors during the period June - July 2016, chaired by the Chief Executive, which was noted

NOTED

81. FINANCIAL MONITORING REPORT

There was submitted a report [Paper No 16/51] by the Director of Finance setting out the financial position within the Acute Services Division for the four month period to 31st July 2016.

Mr White took members through the report in detail which it was noted was showing an adverse variance of [REDACTED] at the end of July 2016 after taking account of non recurring relief. It was noted that the main cost pressures continued to be in Medical Pay, Nursing Pay, 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.

Mr Calderwood reported that in Mr Archibald's absence he continued to hold Performance Review meetings with Directors, and that Directors has been tasked with ensuring that the Divisional budget had to be in balance by the end of January 2017 in order to ensure that the Board returned a break even outturn for 2016/17.

NOTED

82. ACUTE COST CONTAINMENT PROGRAMME

There was submitted a paper [Paper No 16/52] by the Director of Finance setting out an update on the position with the main elements of the Acute Cost Containment Programme.

Throughout the 2015/16 financial year, members were reminded that the Acute Division overspent by approximately [REDACTED] per month. The Division was allocated non-recurrent funding towards the end of the financial year to offset the total deficit and recorded a [REDACTED] overspend.

At the December 2015 Board Seminar, the Acute Chief Operating Officer and Assistant Director of Finance presented a high level Cost Containment Programme designed to address the overspends in operational budgets and ensure operational financial balance.

Overall the Acute Cost Containment Programme, as presented to the Board in December 2015, was not having the required impact and the Division continued to overspend at an unsustainable rate.

A range of work-streams and initiatives were set out in the paper to support the Programme. These were summarised in the report covering Nursing overspends (in particular the impact of sickness absence, rota management, and premium rate agency nursing), Medical spend (agency cover) and Waiting List Initiatives. Each issue was subject to detailed analysis and the paper described the measures taken to date, progress, on-going initiatives and actions.

It was noted that further work on the range of measures and the consequences and impact assessments was being undertaken to present a package of measures for the Board to discuss at the 1 / 2 November 2016 Away Days.

NOTED

83. HOSPITAL STANDARDISED MORTALITY RATIO (HSMR)

There was submitted a paper [Paper No 16/53] by the Medical Director which set out an update on the:-

- change to the calculation model for HSMR;
- variance in the reported levels for HSMR;
- engagement with Healthcare Improvement Scotland (HIS) on HSMR at the Royal Alexandra/Vale of Leven Hospitals (RAH/VoL); and
- follow up processes instigated.

It was noted that the HSMR for the RAH/VoL was statistically above the national average but that the Acute Clyde team and the Board were continuing to use HSMR as an opportunity to improve the safety and quality of care.

It was also reported that despite this variance HIS had reported that they were content the NHS GG&C had responded appropriately to the emerging HSMR data at RAH/VoL.

HIS was also assured that there was ongoing work to understand the HSMR as it applied to RAH/VoL and to consider how to further augment the existing quality improvement programmes at both hospitals.

NOTED

84. HEALTHCARE ASSOCIATED INFECTION: EXCEPTION REPORT

There was submitted a paper [Paper No 16/54] by the Medical Director which provided an update on NHSGGC performance against HEAT and other HAI targets and performance measures covering the period January 2016 - March 2016.

Members noted the update and Dr Armstrong highlighted that SAB increases were being reported in the unvalidated data reported for the quarter April - June 2016 and described the efforts being deployed to understand why this had occurred and measures being taken to support local staff in addressing this increase.

NOTED

85. ENGAGEMENT ON SERVICE CHANGES - UPDATE

The Director of Planning & Policy provided the Committee with a verbal update on the service engagement efforts being directed towards the service changes described at the August 2016 Board meeting, highlighting the specific engagement efforts being undertaken in supporting the Ward 15, RAH proposals.

It was noted that the October Board discussed the outcome of the engagement process in relation to the Community Midwifery Units and the Centre for Integrative Care and that the proposals around the changes envisaged at Lightburn Hospital were scheduled to be discussed in December 2016.

Members noted the significant public, staff, service user and clinical engagement efforts being taken forward.

NOTED

86. ACUTE DIVISIONAL DELIVERY PLAN

There was submitted a paper [Paper No 16/55] by the Director of Planning & Policy which provided an updated version of the Acute Division Delivery Plan (ADDP).

It was noted that the overall purpose of the ADDP was to ensure that the Acute Division was able to deliver safe, high quality and effective clinical services within the agreed financial allocation by identifying and resolving challenges to the provision of services. The ADDP was also an important part of the architecture to ensure that the Division functioned as a single, coherent entity and provide a basis for performance management across the Division ensuring delivery of key commitments and enabled the Divisional Leadership team to exercise collective oversight of the wide range of planning activity which was required to underpin effective delivery by

shaping reporting to Strategic Management Group (SMG).

Ms Renfrew provided an overview of the plan and highlighted that a detailed reporting grid underpinned the Plan, thus enabling scrutiny and collective oversight at the Division's SMG monthly meetings.

It was also emphasised that this was an internal document and was not intended to be viewed as a Plan that would be disseminated widely outwith the Acute Division or the Board. The Board's Delivery Plan for 17/18 was being developed separately in a more appropriate format and would be ready for the Board to endorse before the end of the calendar year.

NOTED

87. QUARTERLY REPORT ON CASES CONSIDERED BY THE SCOTTISH PUBLIC SERVICES OMBUDSMAN: 1 APRIL – 30 JUNE 2016

There was submitted a paper [Paper No 16/56] by the Nurse Director which set out a summary of those Ombudsman cases that required the Board to respond to a recommendation contained within the Investigation Report or Decision Letter covering the period 1 April 2016 to 30 June 2016.

It was noted that during the period covered by the report no Investigation Reports had been received. The Ombudsman had also advised the Board that during the period covered they had decided not to take forward 12 complaints. A total of 15 Decision Letters had however been received.

Within the 15 Decision Letters received, a total of 30 recommendations had been made and the report set out the complaint(s) investigated by the Ombudsman, each recommendation and the date by which a response was required, the response made by the Board to each recommendation, and the date on which the response had been submitted to the Ombudsman.

Mrs Brimelow remarked that she thought the report was excellent and demonstrated the Board's approach to addressing positively the recommendations made by the Ombudsman to improve services and review processes.

The report was noted.

NOTED

88. PUTTING PATIENTS FIRST – PATIENT RIGHTS ACT IN NHS GGC

There was submitted a paper [Paper No 16/57] by the Nurse Director which provided an update on the development in implementing the Patients Rights Act (2012), and a detailed overview of patient and carer feedback received during the months of June and July 2016.

The paper described the progress and outputs of Patient Audits, where a member of the Patient Engagement Team spent a week in one ward at a time and for 2 hours each day engaged with visitors and patients to ask them about their experiences on the ward. The paper also set out the results of the National In-Patient Experience Survey in 2016 drawing out the highlights and challenges and comparing results across all NHS GGC hospitals. Further detail was also provided in relation to known

feedback systems such as Patient Opinion, and Universal Feedback, and members noted an update on the Person Centred Health and Care Programme.

Members noted the range and depth of work being undertaken to elicit patient and carer feedback within the Board and outwith the Board.

NOTED

89. UPDATE ON THE IMPLEMENTATION OF A PROGRAMME FOR PREVENTION, DIAGNOSIS AND MANAGEMENT OF DELIRIUM

There was submitted a paper [Paper No 16/58] by the Nurse Director which provided an update on specific areas of work implemented to ensure that patients at risk of delirium were identified by early assessment and robust prevention management.

Dr McGuire outlined the current position and the nature of the care provided using the nationally validated tool (4AT) which had been rolled out across NHSGGC in July 2016. The paper described the measures in place in all hospitals to identify and assess patients at risk of delirium which members noted and positively welcomed.

NOTED

90. 2016/17 CAPITAL PLAN UPDATE

There was submitted a paper [Paper No 16/60] by the Director of Property, Procurement & Facilities Management which provided an update on the changes made to the Capital Plan and new proposed initiatives since formal approval of the Plan in June 2016. These new initiatives were provided in detail and covered the:-

- Institute of Neurological Surgery - ward accommodation and potential theatre upgrading;
- Queen Elizabeth University Hospital - Acute Medical Block and Central Medical Block;
- Victoria Infirmary disposal;
- Queen Elizabeth University Hospital - campus developments and Section 75 payments to Glasgow City Council;
- Forecasted overspends;
- Capital Stimulus Award; and
- Additional Medical Equipment funding

Members noted the update and the various changes made to the Capital Plan in the light of emerging requirements, the progress of existing schemes, and additional allocations from Scottish Government.

NOTED

91. UPDATE ON DISPOSAL OF YORKHILL CAMPUS

There was submitted a paper [Paper No 16/61] by the Director of Property, Procurement & Facilities Management which set out the options available to the Board in considering how best to market and dispose of the assets within the Yorkhill campus.

It was noted that the Board was being supported in this process by Mr Whyte, who was working with the Board on a secondment basis from the Scottish Futures Trust, as an expert on large and complex public sector property disposals.

Mr Whyte took members through the background to the campus, the limitations in terms of the assets therein and the range of options that were being actively considered to maximise the return to the Board in realising these assets. In addition Mr Whyte and Mr Calderwood took members through some of the options being discussed in relocating the clinical and non clinical staff who were currently occupying the site and associated research materials and equipment still stored on the site.

Members discussed the potential timescales and the options being explored, and noted that Board Officers were working towards concluding the various considerations and setting out a disposal strategy for the site in early 2017.

NOTED

92. UPDATE ON THE DEVELOPMENT OF THE QEUH CAMPUS

There was submitted a paper [Paper No 16/62] by the Director of Property, Procurement & Facilities Management which detailed the progress of developments on the Queen Elizabeth University Hospital campus of the:-

- Phase 3A works;
- Construction of the new Imaging Centre for Excellence;
- Improvements being made to existing buildings on the campus (highlighting the works to upgrade the Institute of Neurosurgical building);
- Car parking: and
- Site infrastructure generally

which was noted.

In relation to car parking facilities, it was noted that over 4,000 car parking spaces were available at the new campus, compared to only 3,000 on the demitting sites. While not being complacent about the difficulties that staff without a permit could face in securing a car parking space because of the restrictions imposed by the Council on surrounding on street parking, it was highlighted that the permit allocation process and the number of permits issued already to staff was being reviewed in the light of the way the site functioned in the light of more experience of managing facilities at the Queen Elizabeth University Hospital campus.

Members also noted the significant improvements made to create Horatio's Garden at the rear of the National Spinal Injuries Unit. It was noted that the charity had designed and created accessible spaces for patients with spinal injuries which was formally opened on 2 September 2016, and Dr Reid asked that the role of the Endowments Committee in funding this development be noted.

NOTED

93. ACUTE STRATEGIC MANAGEMENT GROUP MINUTES OF MEETINGS HELD ON 23 JUNE & 28 JULY 2016

NOTED

**94. BOARD CLINICAL GOVERNANCE FORUM MINUTES OF MEETING
HELD ON 13 JUNE 2016**

NOTED

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

NOTED

96. DATE OF NEXT MEETING

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

The meeting ended at 1.00pm

20 September 2016

Dr. J. Armstrong
Board Medical Director

Paper No: 16/

Healthcare Associated Infection: Exception Report**Recommendation:** - For noting.**Purpose of Paper:** - Update on NHSGGC performance against HEAT and other HAI Targets and performance measures.**Key Issues to be considered:-**

Validated HPS/ISD data : Quarter 1 (January – March) 2016			
HEAT Targets	GGC	National	HEAT target
SAB rate per 100,000 AOB	29.4 (106 cases)	32.6	24.0
CDI rate per 100,000 OCB	25.8 (92 cases)	26.8	32.0

Table 1. Progress against National HAI HEAT targets, 01/01/2016 – 31/03/2016

Please note that Q2-2016 data has not been validated by Health Protection Scotland at time of report collation. Validated national data will be reported in early October.

- *Staphylococcus aureus* Bacteraemia (SAB) decreased by 17% in Q1-2016 with 106 locally reported cases however increased by 4% in Q2-2016 with 110 cases reported locally.
- There was a noted 5% decrease in CDI cases between Q1-2016 (92 cases) and Q2-2016 (87 cases) reported locally.

Any Patient Safety /Patient Experience Issues: -

Yes, further increase in SAB in Q2-2016. NHSGGC continue to prioritise the implementation of a comprehensive action plan to improve NHSGGC performance to achieve this target.

Increase in Surgical Site Infections (SSI) in Caesarean section procedures. A clinical review group meeting was held to discuss any issues identified and any improvements that could be made to reduce the rates of SSI in this patient group. Improvement actions identified with surgical antibiotic prophylaxis administration and will be monitored by Antimicrobial Pharmacist colleagues.

Any Financial Implications from this Paper: - No**Any Staffing Implications from this Paper: -** No**Any Equality Implications from this Paper: -** No**Any Health Inequalities Implications from this Paper: -** No**Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome: -** No

Highlight the Corporate Plan priorities to which your paper relates: - Improving quality, efficiency and effectiveness.

Author: Dr. Jennifer Armstrong**Tel No:** [REDACTED]**Date:** 20/09/2016

A51786194

Infection Prevention & Control Service Report for Acute Services Committee, September 2016

Staphylococcus aureus Bacteraemia Surveillance

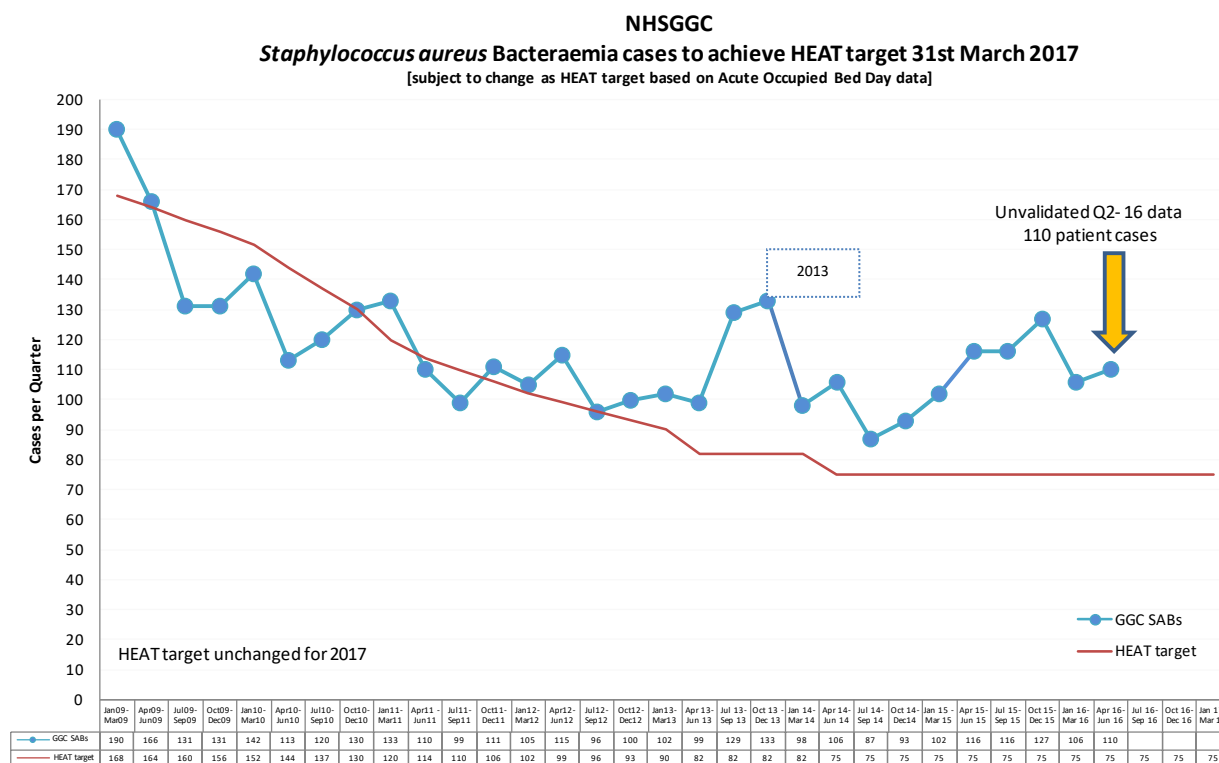


Figure 1. *Staphylococcus aureus* Bacteraemia cases by reporting quarter

The graph above demonstrates a steadily decreasing trend in *Staphylococcus aureus* bacteraemia (SAB) cases from 2009 to the second half of 2013 when a peak in cases occurred. Since this peak a series of measures have been implemented, mainly around the insertion and maintenance of intravenous access devices. Implemented actions appear to be having a slow impact in reducing the number of avoidable SAB cases, particularly related to these invasive devices. Targeted improvement work continues through a series of education and audit initiatives, supported by a Quality Improvement Facilitator who is currently applying improvement methodology at one Acute site to test, measure and improve how we manage these devices. At present the QIF is testing a new care plan and education package in two wards in Glasgow Royal Infirmary, The aim of this is to increase compliance with PVC and CVC care bundles. Compliance is critical to ensure that these devices are managed appropriately and removed as soon as possible. During April to September 114 audits assessing compliance with these bundles have been undertaken across GGC and 56 of these scored red i.e. compliance of less than 66%. Clinical reviews are also requested to elucidate lessons learned or areas for improvement in SABs that are considered to be hospital acquired; 74 have been issued in the same time period and 50 have been returned by clinicians. Compliance with these bundles is reported to each Division/Directorate monthly and to the SCN at the time of the audit. The Acute Infection Control Committee also has oversight of this and this issue was discussed extensively at the last meeting on the 5th September 2016 as was the status of the

GGC SAB Action Plan. AICC also recommended that progress with the SAB action plan be an agenda item on all local Clinical Governance Groups.

In addition, sub groups have been established in Paediatrics and Community to review current guidelines and practices and to identify any areas for improvement. At this time the community group are awaiting data which is being collected by the Community Addictions Team which will we hope assist in identifying interventions. The IPC Data Team provide a update on new SAB cases to the Antimicrobial Pharmacists, which enables real time review of appropriate therapy, and assurance that appropriate source control had been undertaken.

Quarter 1 (January – March 2016) Results from HPS Q1 Report

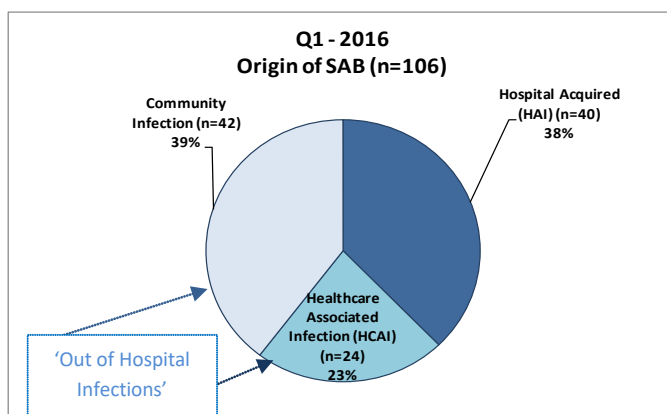


Figure 3. Origin of SAB cases Q1-2016

For the last published reporting quarter (January - March 2016), NHSGGC reported **29.4** SAB cases per 100,000 AOBs (106 patient cases). This is a 17% decrease from the previous quarter (October – December 2015) when 127 patient cases were reported.

The Q1 rate is **below** the NHS Scotland reported national SAB rate of **32.6** per 100,000 AOBs (407 patient cases). The existing National HEAT target which requires all Boards in Scotland to achieve a rate of **24** cases per 100,000 AOBs or lower was extended to 31st March 2017. This equates to 75 patient cases or less per reporting Quarter in NHSGGC.

Quarter 2 (April – June 2016) local surveillance status

Local surveillance data indicates **110** SAB cases reported at 30/06/2016. This is a 4% increase upon the last reporting quarter and above HEAT target requirements.

The pie chart below shows the breakdown of origin of SAB i.e. whether it was acquired in hospital (HAI) or whether it was an out of hospital infection (Healthcare associated and/or Community). Sixty percent of patient cases meet the 'out of hospital' definition and are therefore less amenable to improvement measures within our Acute hospitals.

Forty-four patients developed a Hospital acquired SAB during their in-patient stay and the highest proportion (59%; n=26) of these were caused by an IV access device. Some of these cases are potentially avoidable and these are now reported via the NHSGGC incident management system for further review. This should support the cascade of information (lessons learned or potential improvements to the existing systems) across all services.

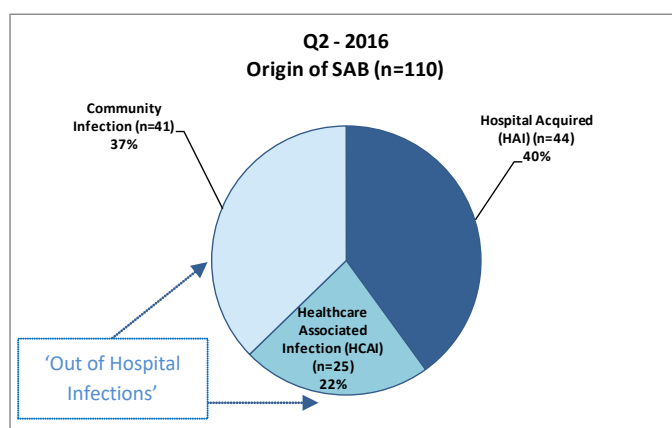


Figure 4. Origin of SAB cases Q2-2016

It should also be noted that the proportions of 'Hospital Acquired' and 'Out of Hospital' infections have remained relatively static this quarter at 40% and 60% respectively. The action plan to reduce avoidable SABs continues to be reviewed at both the Acute and Board Infection Control Committee meetings and has been summarised previously.

Quarter 3 (July – September 2016) local surveillance status at 31st August 2016

Surveillance is not yet complete for the current Quarter. There are currently **70** cases reported for the first two months of Quarter 3.

Clostridium difficile

Quarter 1 (January – March 2016) Results from HPS Q1 Report

For the last published reporting quarter (January – March 2016), NHSGGC reported **25.8** CDI cases per 100,000 AOBs (92 patient cases). This is a 34% reduction in the number of cases since the last quarter of 2015. NHS Greater Glasgow & Clyde are **below** the NHS Scotland reported national CDI rate of **26.8** per 100,000 and also below the 2017 HEAT requirement of **32** cases or less per 100,000 AOBs in ages 15 and over.

IPCT surveillance within NHS GGC comprises prospective data collection which provides daily case numbers on alert organisms such as *Clostridium difficile*. As well as providing early identification of increasing or decreasing patient cases, CDI information is also shared with Antimicrobial Pharmacist colleagues to assist real time local antimicrobial prescribing review of in-patient CDI cases, whether they are hospital acquired or whether the patient has been admitted to hospital already with CDI.

The importance of prudent use of co-amoxiclav, promotion of published infection management guidance and adherence with shorter duration of therapy has been emphasized in a joint communication from IPC and AMT. The AMT has also raised these specific issues through clinical governance committees in South, North and Clyde sectors. Targeted surveillance of co-amoxiclav use in the medical receiving complex in QEUG and Urology in GRI is underway. Hospital based infection management guidelines have also been reviewed in February in order to strengthen recommendations/ restrictions on broader spectrum antibiotics.

Clinical teams are reminded to adhere to the Management of Suspected *Clostridium Difficile* Infection (CDI) in Adults algorithm.

Quarter 2 (April – June 2016) local surveillance status

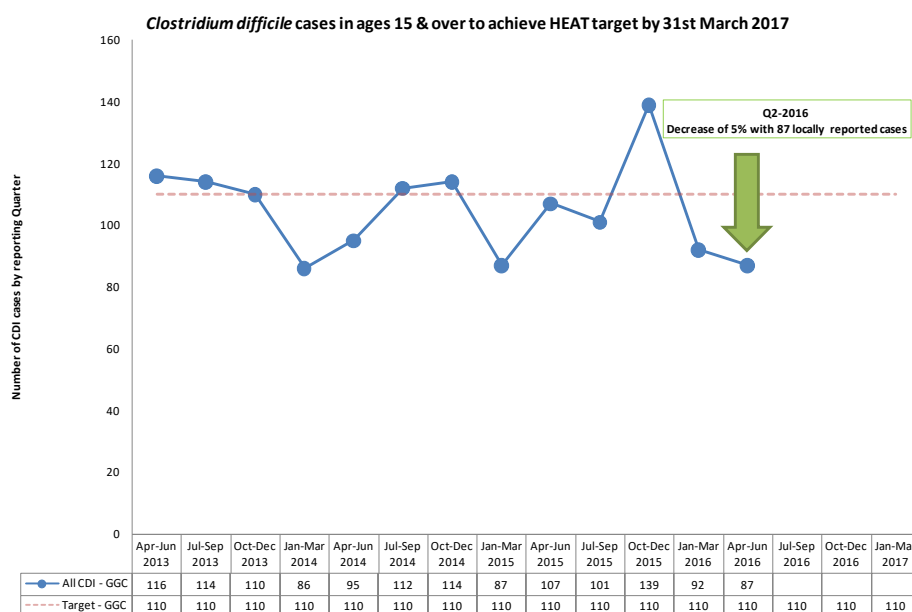


Figure 5 *Clostridium difficile* cases by reporting quarter

The graph above displays quarterly variation of CDI cases in ages 15 & over. Local surveillance data for Q2-2016 demonstrates a 5.4% reduction in CDI cases with 87 cases reported.

Trends are continuously being monitored and an increase was noted in October and November of 2015. An immediate additional targeted review of cases was undertaken in November. This review concluded that no single site, hospital or ward was considered to be an outlier; it appeared to be a general increase across all healthcare sectors. In addition to this review, in November all available specimens from NHSGGC were sent to the National Reference Laboratory for typing. Of the 29 specimen submitted 16 different types were identified. This supports the theory of a general increase in numbers across all care sectors and not cross infection in hospital. Antibiotics can cause CDI, so additional educational sessions were delivered by the Antimicrobial Management Team within NHSGGC.

Quarter 3 (July - September 2016) local surveillance status at 31st August 2016

Surveillance is not yet complete for Quarter 3 at time of report collation. There are currently **80** cases reported.

Completion of LearnPro HAI related modules

The table below provides the total number of Infection Prevention & Control related LearnPro modules completed by staff members throughout NHS GGC, between June & July 2016.

LearnPro Modules	Staff Group Module Completions for June & July 2016 combined				
	Nursing & Midwifery	Medical Staff	Allied Health Professionals	Ancillary	Total
Cleanliness Champions	3	1	0	0	4
Clostridium Difficile (Clinical scenario)	325	3	4	5	337
Clostridium Difficile Online tutorial	251	1	4	7	263
HAI Clinical Induction	358	17	16	11	402
Helping patients cope with isolation in hospital	197	0	2	2	201
Hospital Outbreak Management	120	0	0	4	124
IPC Influenza	274	1	8	46	329
Aseptic Technique	244	2	1	3	250
Recognising Surgical Site Infection (C-sec)	47	0	0	5	52
Recognising Surgical Site Infection	96	1	1	1	99
IPC Standard Infection Control Precautions	370	19	41	79	509
IPC Statistical process Control Charts	158	0	6	19	183
Total	2443	45	83	182	2753

Table 2. IPC LearnPro Modules, 01/06/2016 – 31/07/2016

Outbreaks/Exceptions: June & July 2016

Sector/ Directorate	Site	Ward	Trigger / Organism	Date Reported	Action / Update
South Clyde	RAH	4	Norovirus outbreak	03/06/16	Opened 06/06/16. Total 6 patients and 1 staff.
South Clyde	RAH	26	Two cases of HAI CDI in two days	08/06/16	HPS Trigger Tool implemented. One patient was asymptomatic at time of referral. The other patient was isolated in a side room with transmission based precautions in place. There have been no new cases reported since 08/06/16.
W&C	RHC QEUH Campus	NICU	5 cases of HAI Serratia from screening specimens	21/06/16	This incident is ongoing with 11 cases as of 31/08/16 Highest HIIAT score to date is GREEN.
South Glasgow	QEUH	ITU	Increase in the number of cases of Aspergillosis. Two confirmed and two possible cases.	Increase noted since 01/01/16	IMT held 21/06/16 - may be associated with water ingress into the unit. Full action plan agreed with Service Director. Highest HIIAT score was GREEN.
W&C	RAH/ QEUH /PRM	Maternity	Increase in C-section Surgical Site Infections (SSI) for Quarter 2 (April – June) 2016. 5 post op SSI.	11/07/16	This incident is ongoing. Clinical and Management Team informed of increase. Meetings held with IPCT and Obstetric team in July & August. Action plan from PRM and QEUH meeting shared with RAH team and board wide actions agreed. Following a review by the Antimicrobial Pharmacists at two Obstetric sites further improvements are required with antibiotic prophylaxis administration in high BMI patients. This will be monitored by the AMT.

Sector/ Directorate	Site	Ward	Trigger / Organism	Date Reported	Action / Update
South Glasgow	QEUH	ITU-1	2 cases of HAI CDI in 2 weeks	12/07/16	HPS Trigger tool implemented. The patient in ITU is asymptomatic; the 2 nd patient has been transferred to a downstream ward and is clinically improving. Samples have been sent to the Reference Lab for typing – confirmed to be different types.
Regional	GRI	Burns Unit Ward 45	Two cases of HAI Gp A Strep infection	19/07/16	All patients on the wards have had a throat swab taken for screening purposes. Positive patients have been isolated. Terminal clean of the ward is in progress. Hand hygiene audit carried out by Board HH Co-ordinator score 100% opportunities and 85% technique. HIIAT to be done.
Regional	BWoSCC	Haematology	Increase in the number of BC with Vancomycin Resistant Enterococcus - 6 cases in 5 weeks	Reported between 07/06/16 to 11/07/16	PAG held 15/07/16 Highest HIIAT score was GREEN. Reported to HPS. All patients screened and managed appropriately.

Surgical Site Infection (SSI) Surveillance

NHSGGC participates in the Surgical Site Infection (SSI) surveillance programme that is mandatory in all NHS boards in Scotland. All NHS boards are required to undertake surveillance for hip arthroplasty and caesarean section procedures as per the mandatory requirements of HDL (2006) 38 and CEL (11) 2009. Post discharge surveillance until day 10 post operation is also carried out for all caesarean sections performed, with the assistance of our Community Midwifery colleagues.

HPS last available quarter (January-March 2016)

Category of procedure	Operations	Infections	NHSGGC SSI rate (%)	NHSGGC 95% CI	National dataset SSI rate (%)	National 95% CI
Caesarean section	1265	12	0.9	(0.5, 1.6)	1.4	(1.1, 1.8)
Hip arthroplasty	365	2	0.5	(0.1, 1.9)	0.3	(0.1, 0.6)

The table above shows the SSI rates for Caesarean section (inpatient and PDS to day 10), Hip arthroplasty (inpatient and readmission to day 30) procedures within NHS Greater Glasgow & Clyde, 01/01/2016 – 31/03/2016.

For the last available reporting quarter (January – March 2016), the Surgical Site Infection rate for hip arthroplasty was just above the national average. It should be noted that overall infection numbers are very low and are within local and national confidence intervals. A collaborative local review of these cases has been undertaken and a local improvement action plan has been instigated and is ongoing.

SSI rates for Caesarean section procedure category are also slightly above the national average, but remain within national and local confidence intervals, however it should be noted that the majority of SSIs in this procedure category were superficial and were detected by community midwives following the patient's discharge home.

Q2-2016 Local surveillance Status

Quarter 2 (April – June 2016)					
Category of procedure		Operations	Infections*	National Reporting NHSGGC SSI rate (%)	NHSGGC 95% CI
Mandatory	Caesarean section	1424	22	1.5	(1.0, 2.3)
	Hip arthroplasty	426	4	0.9	(0.4, 2.4)
Recommended	Knee arthroplasty (in-patient SSI only)	379	1	0.3	(0.1, 1.5)
	Repair of neck of femur (in-patient SSI only)	404	7	1.7	(0.9, 3.6)

The table above shows the SSI rates for Caesarean section (inpatient and PDS to day 10), Hip arthroplasty (inpatient and readmission to day 30), Knee arthroplasty (inpatient) and Repair of neck of femur (inpatient) procedures within NHS Greater Glasgow & Clyde, 01/04/2016 – 30/06/2016.

Surveillance is now complete for the Quarter, and in April 2016 there was an increase in SSI cases within the caesarean section procedure category in two obstetric sites. Local prospective review of all cases was undertaken and local action plans were commenced. There was also a slight increase in cases in the repair of neck of femur procedure category. It should be noted that many patients requiring this type of surgery have other existing co-morbidities at time of surgery. National data for comparison in the two mandatory procedure categories will be available in early October 2016.

New surgical procedure categories included in the NHSGGC Surveillance programme

The IPC Surveillance team commenced surgical site infection (SSI) surveillance in July 2016 on Major Vascular surgery procedures undertaken at the Queen Elizabeth University Hospital and also on Large Bowel (Colorectal) procedures undertaken across the four main hospital sites in the Board. Surveillance methodology will be based on existing processes and future reports will provide an update on progress.

Surgical Site Infection Surveillance within QEUH Institute of Neurological Sciences.

The IPC Surveillance team commenced surgical site infection (SSI) surveillance in March 2016 on cranial surgery procedures and specified spinal surgery procedures undertaken by the service.

This includes in-patient surveillance and readmission to day 30 post surgery. A surveillance nurse funded by Regional Services commenced post in July and will continue this process for a period of one year.

June & July 2016	Cranial and Spinal Surgery in INS QEUH	
	Procedures	SSIs
Cranial	126	4
Spinal	99	2

Table 3. Total of cranial and spinal procedures and SSIs detected at INS in June & July 2016

The table above contains the total number of procedures undertaken and any SSIs detected. Due to the small amount of surgical procedures this data should be viewed with caution. It should also be noted that SSI surveillance of these procedures is not undertaken elsewhere in Scotland and is therefore unable to be benchmarked nationally. We will monitor locally any increase in infections within these procedure categories.

A monthly meeting is chaired by the Director of Regional Services with representation from Neurosurgical Consultants, Nursing Staff, Managerial staff, Lead Infection Control Doctor and Lead Nurse Surveillance. This sub group has developed a rolling action plan to address issues raised monitor progress with improvements proposed.

Norovirus

There were 3 ward closures reported in June and July 2016.

Month	Aug-15	Sep-15	Oct-15	Nov-15	Dec 15	Jan 16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Ward Closures	0	0	1	3	2	2	2	3	6	13	3	0
Bed Days Lost	0	0	0	19	14	16	15	45	155	250	76	0

Table 4. Monthly total number of ward closures due to suspected/confirmed Norovirus, 01/08/2015– 31/07/2016.

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 BWoSCC 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 [REDACTED] 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 co-ordinates 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. NHSGGC'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, QEUIH 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 [REDACTED] 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 [REDACTED] 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

ASC(M)17/01
Minutes: 01 - 17

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Acute Services Committee held at
9.00am on Tuesday, 17 January 2017 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 M Brown	Mr J Legg
Dr H Cameron	Dr D Lyons
Councillor G Casey	Mrs A M Monaghan
Mrs J Donnelly	Dr R Reid
Mr I Fraser	Mr I Ritchie

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

Mr Brown	Dr M McGuire
	Mr M White

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

Mr J Best	..	Interim Chief Officer, Acute
Mr P Cannon	..	Deputy Head of Administration
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
Mr C Whyte	..	Team Leader, Property Disposals (Minute 11 to 13)
Ms H Dorrance	..	Consultant Colorectal Surgeon (Minute 1 to 4)
Mr D Loudon	..	Director of Property, Procurement & Facilities Management

01. APOLOGIES, WELCOME AND PRELIMINARIES

Apologies were intimated on behalf of Dr Armstrong, Mr Calderwood, Mr Carr, Mrs S Brimelow and Cllr MacMillan. Mr Finnie welcomed Ms Dorrance to the meeting.

02. DECLARATIONS OF INTEREST

There were no declarations of interest.

03. 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 15 November 2016 [ASC(M)16/06] were approved as a correct record.

NOTED

04. 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 [Paper No 17/01] and officers were asked to liaise with Mr Cannon to update the list accordingly.

b) Colorectal Cancer Pathways

Ms Dorrance attended the meeting to provide members with a presentation setting out an overview of the colorectal cancer pathway. Members were reminded that this was first raised at the July 2016 meeting.

It was highlighted that Colorectal Cancer is the third most common cancer in Scotland. In the West of Scotland there were around 1,600 new cases diagnosed annually. A significant proportion of patients present as emergencies, with a poorer immediate and long-term outcome compared to those who present electively.

The purpose of the presentation to the Committee was to detail the pathway of both elective & emergency patients, from initial contact to definitive management.

Ms Dorrance covered in detail

- emergency presentations;
- the elective pathway;
- screening;
- colorectal referrals;
- investigations;
- staging & the multi disciplinary team;
- tertiary referral pathways; and
- current capacity issues.

Ms Dorrance highlighted the disparity between sectors in waiting times for endoscopy investigations, clinic capacity (especially seeing return patients) and the time required to undertake full and detailed patient consent. It was also noted that operating time could also be limited.

Ms Renfrew noted the disparity in endoscopy waiting times across sectors and highlighted the need to move towards a single waiting list for specialties to ensure that there was equity of access for patients across NHSGG&C.

Mrs Brown noted that capacity was highlighted as a general issue and encouraged the use of Nurse Practitioners, and others, to free up Consultant input if return patients did not require this level of clinical supervision, and to review the appropriateness of the range of tests undertaken.

In relation to consent issues, Ms Dorrance highlighted that this can take up to 1 hour and the service was looking at ways of accommodating this time and focus at an earlier part in the patient journey, rather than at the pre operative assessment stage.

Mr Best acknowledged that the service was under pressure and highlighted that, together with Directors and Chiefs of Medicine, this was being addressed from the point of view of capacity and demand, productivity benchmarking, and better use of the Ambulatory Hospitals to provide additional capacity, including weekend clinics / theatre lists. He added that the establishment of a single waiting list was also being assessed.

Mr Finnie thanked Ms Dorrance for her detailed and informative presentation, and he noted that Mr Best and others were seeking to address the issues raised. He looked forward to seeing improvements in performance being evidenced through the regular Integrated Performance Report which is presented to the Committee at each meeting.

NOTED

05. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT

There was submitted a paper [Paper No 17/02] by the Interim Chief Officer setting out the integrated overview of NHSGGC Acute Services Division's performance. Of the 23 measures which had been assessed against a performance status based on their variation from trajectory and/or target, 10 were assessed as green, 6 as amber (performance within 5% of trajectory) and 7 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 12 week Treatment Time Guarantee (TTG), new outpatient waiting >12 weeks for a new outpatient appointment, and the number of patients waiting >6 weeks for a key diagnostic test.

In relation to unscheduled care it was noted that the Programme Board was continuing to finalise a report of the range of activities being undertaken and their assessment of the future steps required. It was also noted that the Programme Board would be reporting their findings in April 2017, with the intention to share this with Board Members at a Board Finance Workshop in April 2017. Dr Stewart also reported that the post of Deputy Director in the South Sector had been established as part of this ongoing review of capacity within the Sector, and that candidates were being interviewed shortly.

In response to a question from Dr Cameron, Dr Stewart highlighted the analysis of the numbers of patient being admitted at GG&C Hospitals, when compared to national benchmarks. It was evident that a higher proportion of patients were being admitted in GG&C Hospitals when compared with other similar organisations.

Dr Stewart emphasised that the first phase of the work of the Unscheduled Care Programme Board was coming to an end and that this had necessarily focussed on a root and branch review of local patient flow and procedures underpinning unscheduled care, and efficiencies that could be put in place. Mr Best underlined this point stating that the Programme Board had tried to identify and distil best practice, both locally and nationally.

In relation to sickness absence, Mrs MacPherson reported that this was subject to a deep dive assessment and that short term and long term hot spots were being identified and addressed. It was noted that the focus of efforts was on ensuring that the Board's Attendance Management Policy was followed and staff were supported

and encouraged to return to work as quickly as possible. Occupational Health Managers were working closely with local Managers to streamline the process of review so that there were no delays in dealing with individual cases.

Mr Finnie highlighted the significant cost being incurred by the Board and commended the targeted approach being adopted.

In response to a question from Mrs Brown, Dr McGuire highlighted that there were differences in sickness absence rates between Registered and Unregistered Nurses, and that the approach by the Board needed to be sensitive, and address work life balance and shift patterns. It was also noted that Paid As If At Work also had an impact on sickness rates.

Mr Fraser commended the approach adopted and asked that long term absence should be prioritised. Members noted the range of measures being adopted and the role of the Staff Governance Committee in monitoring these trends in greater detail.

In relation to Delayed Discharges, it was noted that discussion were being taken forward between the Board and the Glasgow City Health & Social Care Partnership to deliver the anticipated reductions in the number of patients experiencing a delayed transfer of care. It was also noted that discussions were also being taken forward with neighbouring NHS Boards.

Mr Best highlighted the Detect Cancer Early project, which Scottish Government had brought to a close in December 2016, the steps being taken to continue to record and manage local performance going forward, and the impact of the forthcoming National Cancer Plan on local service provision. Mr Best also reported that a detailed analysis of the 62 day cancer pathway was underway, and the result of this analysis would be shared with the Committee in March 2017.

**Interim Chief
Officer, Acute**

A specific update was provided on the Urology Cancer pathway, and the improvement plan in place to improve this service. It was noted that 2 Consultants had been recruited and one would be deployed in the South Sector in January 2017, the second in the North Sector in February 2017. In relation to Breast Cancer it was noted that pathway redesign was underway to increase the available number of clinics.

Mrs Mullen referred members to the TTG exception report which showed that the Orthopaedic, General Surgery and Urology services were all under significant pressure and inpatients were being seen outwith the 12 week target. The recent changes to cease the use of locational unavailability codes had also had an impact on the number of patients on the waiting lists in these specialties.

NOTED

06. NATIONAL WAITING TIMES

There was submitted a paper [Paper No 17/03] by the Interim Chief Officer setting out a report comparing NHS Greater Glasgow & Clyde's (NHS GG&C) performance with that of NHS Scotland and other comparable Health Boards in relation to a number of key national waiting times standards, to provide a wider context to NHS GG&C's performance.

The report provided that comparison and demonstrated NHS GG&C's contribution to Scotland's overall performance using the latest published data relating to September

2016. The measures included in the report covered 18 week Referral To Treatment, New outpatients waiting >12 weeks for a new outpatient appointment, the 12 Week Treatment Time Guarantee, the Cancer 62 day wait, the Cancer 31 day wait, and the A&E 4 hour waiting time.

Members welcomed the report and the useful data that was presented to contextualise the NHS GG&C performance data.

NOTED

07. QUARTERLY REPORT ON CASES CONSIDERED BY THE SCOTTISH PUBLIC SERVICES OMBUDSMAN (1 JULY 2016 – 30 SEPTEMBER 2016)

There was submitted a paper [Paper No 17/04] from the Nurse Director which set out a summary of those Ombudsman cases that required the Board to respond to a recommendation contained within the Investigation Report or Decision Letter covering the period 1 July 2016 to 30 September 2016.

It was noted that during the period covered by the report no Investigation Reports had been received. The Ombudsman had also advised the Board that during the period covered they had decided not to take forward 5 complaints. A total of 15 Decision Letters had however been received.

Within the 15 Decision Letters received, a total of 27 recommendations had been made and the report set out the complaint(s) investigated by the Ombudsman, each recommendation and the date by which a response was required, the response made by the Board to each recommendation, and the date on which the response had been submitted to the Ombudsman.

Dr McGuire highlighted developments in complaint handling, including a new Complaints Procedure from 1 April 2017, which will introduce an obligation on NHS Boards to try to resolve complaints within 5 working days, and also the legislation expected to be in force from 1 April 2018 around the Duty of Candour, both of which were noted.

Mr Ritchie acknowledged that it was regrettable that patients and their families had cause to complain to the Ombudsman about the handling of their complaint, but he noted that within the wider context of the number of complaints received, and the number of discrete patient interactions every day, the number of Decision Letters received had to be set in that context.

NOTED

08. TRANSFORMING ACUTE SERVICES

There was submitted a paper [Paper No 17/05] by the Director of Planning & Policy which provided a revised draft of the paper to establish the detailed programmes of clinical service planning required to deliver the transformation described and reshape the delivery of acute services across NHS Greater Glasgow and Clyde. The intentions to deliver extensive internal communication, and the plans to develop external communications were also noted.

Ms Renfrew took Members through the report in detail, which was still being developed, with a view to being discussed again at the February 2017 Board Seminar

and the February 2017 Board meeting.

Members made a number of detailed contributions to improve the tone and language used and it was agreed that the draft had been a useful and positive contribution to the development of a final paper.

It was also acknowledged that a public facing version of the paper would be required and that the Board's Communications Team were working on this separately.

NOTED

09. UPDATE ON DELIVERY PLAN

There was submitted a paper [Paper No 17/06] from the Director of Policy & Planning which set out an update on the progress being made in respect of the Acute Division Delivery Plan. Ms Renfrew reminded Members that the Committee last reviewed the Plan in September 2016.

Ms Renfrew reported that the purpose of the Plan was to ensure that the Division was able to deliver safe, high quality and effective clinical services within the agreed financial allocation, by identifying and resolving challenges to the provision of services.

The Plan also played an important part of the architecture to ensure that the Division functioned as a single, coherent entity and it provided a basis for performance management across the Division, ensuring delivery of key commitments, and enabled the Divisional Leadership team to exercise collective oversight of the wide range of planning activity which is required to underpin effective delivery by shaping reporting to the Strategic Management Group.

The grid attached to the paper showed progress on the key components of the 16/17 plan. In a number of these areas it was noted that the Board was working with HSCPs as changes to acute services need to be driven by the reshaping and redesign of community services led by HSCPs, and changes to community services need to be driven by the need to reshape acute services.

In addition to this activity, the Division also had a series of programmes of work to look at productivity and efficiency to assess how proposals can be brought forward to address the financial challenge which the Division needs to meet from the start of the new financial year.

NOTED

10. FINAL OUTPUT OF DIVISIONAL LEADERSHIP EVENT

There was submitted a paper [Paper No 17/07] from the Director of Policy & Planning which summarised the output of the Acute Division Leadership Event held at the end of October 2016, to discuss the unprecedented challenges which the Division is facing through this year, and into 2017/18.

Ms Renfrew reminded Members that the Acute Services Committee received the draft report of the Divisional Leadership Event in November 2016, and the report attached to the paper provided the detailed final report.

It was acknowledged that the event had been a very worthwhile endeavour and would

be repeated in March 2017.

NOTED

11. QEUEH CAMPUS DEVELOPMENT UPDATE

There was submitted a paper [Paper No 17/08] by the Director of Property, Procurement and Facilities Management which set out the progress achieved on the QEUEH campus of the Phase 3A works, the construction of the new Imaging Centre of Excellence, the improvements being made to older buildings to be retained on the campus such as the Institute of Neurosurgical which is being transformed with the addition of a new entrance and over-cladding, and improvements to the site infrastructure.

Mr Loudon took Members through the paper in detail illustrated by updated photographs of the site campus, and the developments highlighted, which included:-

- Central Park
- Formation of the SUDS (Sustainable Drainage System) pond
- New roadway between the old and new Govan Road entrances
- Demolitions
- Extension to existing surface car park at Govan Road Entrance
- Imaging Centre of Excellence
- Institute of Neurosurgical (INS) - Over-cladding project
- Institute of Neurosurgical - New Entrance
- Pedestrianisation of area between Multi Storey Care Park and Office Block
- Covered walkway on Arrival Square
- Surface Car Park at the rear of the Central Medical Block

NOTED

12. QEUEH CAMPUS: THE PROVISION OF FACILITIES MANAGEMENT SERVICES AT THE IMAGING CENTRE OF EXCELLENCE (ICE) BUILDING

There was submitted a paper [Paper No 17/09] by the Director of Property, Procurement and Facilities Management which sought approval to the proposal that the Property, Procurement and Facilities Management Directorate provide facilities management services in accordance with agreed specifications and prices to the University of Glasgow for the Imaging Centre of Excellence (ICE) building.

It was noted that the Property, Procurement & Facilities Management Directorate was proposing to enter into a formal contract with the University Court of the University of Glasgow to provide a range of facilities management services over an initial period of two years with an option to extend on a yearly basis.

It was highlighted that the Board would be required to recruit additional Facilities Management (FM) staff to provide the services specified in the contract, if successful. The costs of any additional staff required to deliver the FM services will be recharged to the University as a result of service provision.

Mr Loudon explained that the University of Glasgow is a significant strategic partner of NHS Greater Glasgow & Clyde with a demonstrable track record of delivering high standards of research and development, and that the ICE will be a world class

facility that incorporates a new neurosurgical theatre suite to be utilised by NHS Greater Glasgow & Clyde.

Mr Loudon highlighted that the Property, Procurement & Facilities Management Directorate already provided a range of FM services to the University in the Stratified Medicine floor of the Teaching and Learning Building. The proposal contained in the paper built upon this arrangement albeit, in a more commercial and formal contractual structure.

Members acknowledged the attendant risks in establishing a commercial contract, but commended the approach.

APPROVED

- That the Property, Procurement and Facilities Management Directorate should provide facilities management services in accordance with agreed specifications and prices to the University of Glasgow for the Imaging Centre of Excellence (ICE) building.

13. YORKHILL DISPOSAL PLAN UPDATE

There was submitted a paper [Paper No 17/10] by the Director of Property, Procurement and Facilities Management which asked Members to note that the Property Disposal Team were progressing with the review of options for relocating the temporary clinical and non-clinical facilities and staff currently based on site to permanent locations, seeking an appropriate disposal strategy that addresses the conflicting needs of, an early disposal, best value and risks. Mr Whyte attended the meeting to take Members through the progress report in detail.

It was noted that as well as staff and facilities, there was a requirement to relocate a significant amount of storage required (e.g. blocks and slides / historic artefacts), but that limited work had been done on this so far.

It was noted that two options being considered, these being sale and leaseback, and joint venture. The advantages and disadvantages of each approach were discussed with Members.

It was noted that the Property Disposals team will report back in due course to the Committee on the preferred procurement vehicle and associated risks to optimise receipts from the disposal of the site.

**Director of
Property,
Procurement
and Facilities
Management**

NOTED

14. FINANCIAL MONITORING REPORT

There was submitted a report [Paper No 17/11] by the Director of Finance setting out the financial position within the Board for the 8 month period to 30 November 2016.

Mr White took members through the report in detail which it was noted was showing an adverse variance of [REDACTED] at the end of November 2016 after taking account of non recurring relief. The pressures being experienced in the Acute Services Division continued to be in Medical Pay, Nursing Pay, prescribing costs, surgical sundries and CSSD supplies.

Members acknowledged that the Board's financial position had been discussed in

great detail at the recent Board Away Day, at Board Seminars, and at the December 2016 Board meeting.

NOTED

**15. ACUTE STRATEGIC MANAGEMENT GROUP MINUTES OF MEETINGS
HELD ON 27 OCTOBER 2016 & 24 NOVEMBER 2016**

NOTED

**16. AREA PARTNERSHIP FORUM MINUTES OF MEETING HELD ON 3
OCTOBER 2016**

NOTED

17. DATE OF NEXT MEETING

9.00am on Tuesday 21 March 2017 in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 1.30pm

NHS Greater Glasgow & Clyde

Acute Services Committee

Gary Jenkins
Director, Regional Services



Paper No: 17/??

BONE MARROW TRANSPLANTATION

Recommendation

The Acute Services Committee is asked to note the content of this paper.

Purpose of Paper

To provide an update on arrangements for BMT Services and further actions to be taken.

Key Issues to be considered

There are risks with the BMT service remaining at BWoSCC in the longer term, and potential environmental infection control risks associated with a move to QEUEH. Further information regarding air quality in 4B at QEUEH is required to make a proper risk assessment of options available.

Following a detailed option appraisal process, involving clinical teams, infection control and Health Protection Scotland, it is proposed that a six month monitoring period of the ward 4b environment is undertaken to assess the environmental suitability of transferring the BMT service to QEUEH.

To support the monitoring period, it is proposed that the existing Haematology ward (4c) is relocated into ward 4b. This will enable the positive air pressure to be activated and the environmental sampling measure to occur. The vacated ward (4c) will be used for older people although this will be a reduction of 14 beds on the site.

Any Patient Safety /Patient Experience Issues

Yes

Any Financial Implications from this Paper

Minor capital expenditure is associated with a move to 4B.

Any Staffing Implications from this Paper

Yes

Any Equality Implications from this Paper

No

Any Health Inequalities Implications from this Paper

No

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome.

Inconclusive with further information required.

Highlight the Corporate Plan priorities to which your paper relates

BMT Services are specifically highlighted in the corporate plan.

Author Gary Jenkins

Contact gary.jenkins [REDACTED]

Date 17th March, 2017

1. Introduction

This paper outlines the background to the current situation within BMT services. The paper details the risks associated with the options to retain the service at Beatson West of Scotland Cancer Centre (BWoSCC) or relocate to ward 4B, Queen Elizabeth Hospital (QEUH).

The paper concludes that further information is required to inform an assessment of the balance of risk and the actions required to provide this.

The Acute Services Committee is asked to note the content of this paper.

2. Background

NHS Greater Glasgow and Clyde is commissioned by National Services Division to provide all adult allogeneic donor stem cell transplantation for the population of Scotland. The national service covers both stem cell donation from family members and unrelated donors. The SLA value in 2016/17 was [REDACTED] for 70 transplants. This is proposed to increase to [REDACTED] for 73 in 2017/18.

In 2013, a decision was taken to move the BMT service from wards B8/B9 at the BWoSCC to the new QEUH. This was to address concerns that the planned level of support for acutely unwell patients on the Gartnavel General Hospital (GGH) site would be insufficient for such a high intensity speciality as BMT and would not meet the JACIE accreditation standards. The move also allowed for an increase of beds from 19 to 24 to support the agreed increase in the national transplant programme.

Capital funding of [REDACTED] was invested to support enabling works to 4B, such as upgrade air filtration plant, and the BMT service moved to the QEUH in May 2015.

Following the identification of air quality issues in the new transplant unit, the service was, however, returned to B8/9, BWoSCC in July 2015. This return was predicated on it being short-term, with further remedial works to be undertaken to improve the air quality in ward 4B, QEUH to acceptable levels. Remedial works were completed by October 2015 and at this time the service began to make plans to move back to QEUH.

The Infection Control Team raised concerns regarding the specification of works that had been completed and requested input from Health Protection Scotland (HPS) at this time. Following the receipt of recommendations from HPS with regard to the required specification, the Infection Control Team advised that the specification did not meet the required environmental standards for a BMT Unit and therefore, they were unable to support return to the QEUH. The BMT service has remained at BWoSCC since this time.

3. Feasibility Exercise

Further detailed studies have been undertaken into the technical feasibility of configuring ward 4B to meet the required environmental standards, as well as exploring alternative options on the QEUH site.

With regard to 4B, the work concluded that, whilst further improvements could be made to facilities, due to limitations of the current plant and lack of space to expand, the fourth floor QEUH could not be configured to meet the full specification of requirements as detailed by HPS/Infection Control.

In the autumn of 2016, a further feasibility study commenced into potential options utilising retained estate on the QEUH site. A report was produced in January 2017 and a multi professional option appraisal was undertaken. From this, the conclusion drawn was that further options on the QEUH site at this stage were neither technically, clinically nor financially viable.

Therefore, the two options that remain for consideration are the existing location on B8/9 in BWoSCC or relocation to 4B at QEUH as per the current specification.

4. Balance of Risk

It is not possible to recommend either option based on the balance of risk with the information currently available. Further works were undertaken in ward 4B in 2015 following the temporary relocation of the service back to BWoSCC. The ward has been used for medical patients since this time and therefore, it has not been possible to robustly measure air quality following completion of this work.

Air quality check, pressure monitoring and air change monitoring will not provide conclusive evidence of the environmental risks associated with 4B, but will provide meaningful data to help inform a discussion on probability against the clinical risk associated with remaining at BWoSCC. Monitoring for a period of up to six months would be required to enable this assessment to be made.

5. Conclusions

Further information regarding air quality and specification in 4B is required to inform a decision on the clinical risk of remaining in B8/9 in BWoSCC compared with the environmental risk of moving to 4B at QEUH. It is therefore, concluded that a period of monitoring of up to six months be undertaken. This is supported by clinical teams, Infection Control and Health Protection Scotland.

To enable this, the ward should be vacated of older people to enable the positive pressure to be turned back on. To minimise the loss of beds to medicine, it is proposed that the 10 Haemato-Oncology beds on 4C should be relocated to 4B and that medicine move into 4C. Prior to the commencement of monitoring, work to seal the ceilings in the ensuite bathrooms must be completed.

The proposed ward changes and bed reductions have been discussed and agreed in principle by the interim Chief Operating Office and with the Directors of both the South and Regional Directorates. Mitigating actions to offset the risks of the impact of this reduction of beds on the QEUH site will be identified prior to any final agreement

This monitoring period will be used to determine a number of infection control measures including air sampling, fungal counts and air exchange rates over a sustained period. The outcome of this process will enable a final decision to be reached on the suitability of the clinical environment. .

6. Recommendations

The Acute Services Committee is therefore, asked to note the contents of this paper.

DRAFT

ASC(M)17/02
Minutes: 18 - 36

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Acute Services Committee held at
9.00am on Tuesday, 21 March 2017 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	Councillor J Clocherty
Ms M Brown	Mrs T McAuley
Dr H Cameron	Mrs D McErlean
Mr S Carr	Dr R Reid (To Minute 30)
	Mr I Ritchie

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
Mr Brown	Dr M McGuire
	Mr M White

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

Mr G Archibald	..	Chief Officer, Acute Services
Mr J Best	..	Interim Chief Officer, Acute Services
Mr P Cannon	..	Deputy Head of Administration
Mrs J Grant	..	Chief Executive (Designate)
Mr D Loudon	..	Director of Property, Procurement & Facilities Management
Mrs A MacPherson	..	Director of Human Resources & Organisational Development
Ms M McColgan	..	General Manager, Regional Services
Ms P Mullen	..	Head of Performance
Ms C Renfrew	..	Director of Planning & Policy

18. APOLOGIES, WELCOME AND PRELIMINARIES

Apologies were intimated on behalf of Councillors Casey, Kerr and McMillan and Mrs Monaghan. Mr Finnie also welcomed Mr Archibald to the meeting after his recent ill health and Mrs Grant on her appointment as Chief Executive from 1 April 2017.

19. DECLARATIONS OF INTEREST

There were no declarations of interest.

20. MINUTES OF PREVIOUS MEETING

On the motion of Dr Reid, and seconded by Dr Cameron, the Minutes of the Acute

Services Committee meeting held on 17 January 2017 [ASC(M)17/01] were approved as a correct record.

NOTED

21. 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 [Paper No 17/12] and officers were asked to liaise with Mr Cannon to update the list accordingly.

It was noted that staff engagement was underway to promote and raise awareness of the Transforming Acute Services initiative, and Mr Calderwood referred to the staff communication efforts to promote this. He also added that the Board was working closely with Scottish Government to ensure that there was alignment with the National Clinical Strategy. It was also noted that Regional Planning guidance, which would impact on the approach, was anticipated to be issued by Scottish Government in May 2017 and the Board's overall approach would need to be consistent with that guidance.

Ms Brown asked for an update on the water drainage scheme at the front of the Queen Elizabeth University Hospital, and Mr Calderwood reported that the temporary fencing was to be replaced with more robust fencing. He further explained that the drainage scheme was a condition within the planning consent for the Hospital, rather than an aesthetic feature.

NOTED

22. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT

There was submitted a paper [Paper No 17/13] by the Interim Chief Officer setting out the integrated overview of NHSGGC Acute Services Division's performance. Of the 23 measures which had been assessed against a performance status based on their variation from trajectory and/or target, 11 were assessed as green, 4 as amber (performance within 5% of trajectory) and 8 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, including alcohol brief interventions, antenatal care, and DNA rate reductions, there were key measures where the trend was showing reduced compliance with targets in areas including the 12 week Treatment Time Guarantee (TTG), new outpatient waiting >12 weeks for a new outpatient appointment, and the number of patients waiting >6 weeks for a key diagnostic test. Members were also presented with a list of other red rated metrics.

In relation to targets generally, Mr Calderwood remarked that cancer services were being prioritised in relation to performance, and that Mr Best would cover cancer issues arising from the Integrated Report in the next agenda item. It was also noted that Delayed Discharges had been discussed in some detail at a recent Board Seminar.

In relation to the treatment time guarantee (TTG), Mr Best referred to the number of Consultant level posts that were unfilled, despite attempts to fill these by traditional

recruitment means. However, the Division was looking to redesign a number of Consultant posts to make these more attractive to prospective candidates. In terms of services specifically, Mr Best provided a sector by sector update highlighting Orthopaedics, Urology and General Surgery challenges across all three sectors, and the described the local actions being taken forward to address these challenges. He also highlighted that the Division was taking action to reduce reliance on locum agency doctors, and that while this was having a positive impact on the financial position; it was impacting on service delivery.

In terms of stroke services, it was noted that swallow screening was the key challenge and that significant focus had been deployed to improving this metric, which was anticipated to be demonstrated in future reports.

In relation to Human Resources performance metrics, Mrs MacPherson highlighted that the service was focussing on long term sickness absence and looking at a range of supportive measures to reduce the periods of absence, and the frequency and quality of contact with staff who were absent from work on a long term basis. Mr Best was chairing a short life working group to drive this forward. There had also been a dip in e-KSF performance which was being actively addressed.

Mr Finnie noted that the Board Members had discussed the delayed discharge data at the recent Seminar but made a further comment that colleagues were still reporting that the data presented to them at Integrated Joint Boards (IJBs) was sometimes not consistent with the data presented at an aggregate level at Seminars or in Integrated Performance Reports. Ms Renfrew explained that the data was derived from the same data source for both bodies so these should be consistent, and added that the IJBs were clearly responsible for reducing delayed discharges, and that this may need to be linked more firmly with financial allocations so that expectations were clearly articulated and measured. Mr Calderwood also reported on the meetings being taken forward with neighbouring Boards as there were a significant number of delayed patients who were not NHS GG&C residents.

Ms Brimelow referred to the paper later on the agenda on performance monitoring and reporting and highlighted her concerns that the Integrated Performance Report was not clear enough about improvement actions and timescales. Ms Mullen stated that this was being addressed.

Mr Ritchie noted that the number of patients waiting over 12 weeks was significantly worse than in the previous year, and Mr Calderwood acknowledged that this was the case, however much of the Board's efforts in the past year had been targeted on unscheduled care, and that the impact of this focus, and the conversion of some Orthopaedic beds to Medicine had had an impact on patients waiting over 12 weeks. Mr Calderwood also referred to recent changes in national waiting list rules with the removal of the option of patient advised unavailability, which also had an adverse impact on the waiting lists, although this was being addressed and the long waiting patients targeted and treated. Mr Calderwood also referred to the RTT position across Scotland which was reported as 83%, whereas the NHS GG&C position was 90%.

In response to a question from Mr Finnie about the use of the Golden Jubilee National Hospital, Mr Best described the arrangements in place covering Orthopaedic surgery (Hips & Knees, and Foot & Ankle), General Surgery and Cataract Surgery cases.

In relation to infection control issues, Dr Armstrong explained that SABS measurements fluctuate because of the community acquired aspect, but that the

measure that was of more concern to address was MSSA, and she explained the range of measures being taken to ensure that staff were addressing this issue. It was noted that rapid audits were being conducted by Infection Control colleagues where hot spots emerged through data monitoring. McGuire also added that staff education was important and that this was also being taken forward pro actively.

NOTED

23. CANCER PERFORMANCE REPORT

There was submitted a paper [Paper No 17/14] by the Interim Chief Officer setting out a summary overview of the improvement initiatives and financial investment that has occurred within the Acute Division over the last six month period in relation to cancer services. Members were reminded that this was sought at the January 2017 meeting, with particular focus on the 62 day pathway.

Mr Best took members through the paper in detail and reminded the Committee that as a consequence of continued performance challenges against cancer access standards, a number of non-recurring and recurring investments were agreed with the Cancer Access Team at Scottish Government to tackle the following tumour types:

- Breast Cancer;
- Colorectal Cancer;
- Upper GI Cancer;
- Urology Cancer;
- Head and Neck Cancer;
- Lung Cancer

Performance improvement plans were agreed and implementation began in July 2016, and a summary of the actions being taken forward and current performance was set out in detail in the report presented.

In response to an observation from Mrs McAuley that the plans appeared to be reactive in nature, relying on non recurring investments to address performance issues, Mr Best acknowledged this and reassured the Committee that the Division was working on a revised Cancer Plan which seek to address this, and which will be brought to the future Acute Services Committee for discussion.

**Chief Officer,
Acute**

Mr Carr asked if Consultant availability was an issue, and Mr Best confirmed that there were UK shortages of Consultants in key specialties, such as Urology, which was hampering efforts to improve the position. Mr Best added that the Division was looking at the expansion of non Consultant tasks and roles. Mrs MacPherson added that these challenges, and the efforts to address these, will be set out in the Medical Workforce Plan which will come to the Committee in due course.

**Director of
Human
Resources &
Organisational
Change**

NOTED

24. UPDATE ON LOCAL DELIVERY PLAN CHANGES

There was submitted a paper [Paper No 17/15] from the Director of Planning & Policy which set out a summary of the progress on delivering the service changes included in the Board's approved LDP and confirmed in subsequent Board decisions, including the North East Rehabilitation Services, the transfer of paediatric services from RAH to RHC, birthing services in Vale of Leven Hospital and Inverclyde Royal

Hospital CMUs and at the Centre for Integrative Care.

NOTED

25. MINOR INJURIES SERVICES IN WEST GLASGOW: PROPOSED PROCESS

There was submitted a paper [Paper No 17/16] by the Director of Planning & Policy which recommended that the Committee approve the proposed process to consider future options for minor injuries services for West Glasgow and agree that the temporary closure of the Yorkhill service remains in place pending the outcome of that review.

The paper set out the background to the issue, the impact of the temporary transfer of services in December 2016, attendances by catchment population, access and travel time, demand, and the views of the HSCP. Ms Brown asked if the relative efficiency of other Minor Injuries Units could be included and reported in the appraisal of the services in the West of Glasgow.

It was recommended that the options which needed to be considered included:

- reopening the service at Yorkhill;
- assessing the potential to reprovide the service at Gartnavel;

It was also noted that the appraisal process would be carried out over the next 3 months and the outcome reported to the July 2017 Acute Services Committee meeting.

AGREED

26. TRANSITION TO HOSPITAL BASED COMPLEX CARE: UPDATE

There was submitted a paper [Paper No 17/17] from the Director of Policy & Planning on the transition to Hospital Based Complex Care. The paper provided an update on progress with that transition.

It was noted that the Board established a joint planning process with Health and Social Care Partnerships to plan the services to replace NHS Continuing Care, and that process had been overseen by a Joint Group with representatives of each HSCP, the Director of Planning and Policy (Board lead for this work programme), clinical leads from each of the three sectors and financial and planning support.

It was also noted that the Group had reached a number of conclusions in relation to the way forward and these were set out in the paper. These were being implemented through the transfer of the responsibility and resources associated with previously commissioned beds to the HSCPs, with the aim of reducing levels of institutional care across HSCP responsibilities.

In relation to commissioned beds, Ms Renfrew reported that negotiations with previous continuing care providers had proceeded smoothly to agree transitional arrangements which ensured that beds were appropriately used for HSCP patients while agreeing the longer term configuration, although these were ongoing for a small number of beds.

Members were reassured by the progress made to date and the steps being taken to conclude this exercise.

NOTED

27. BONE MARROW TRANSPLANTATION SERVICE

There was submitted a paper [Paper No 17/18] from the Director of Regional Services which provided an update on arrangements for BMT Services and further actions to be taken.

Dr Armstrong introduced the paper on the Director's behalf and reminded members that the service was assessing the relative risks with the BMT service remaining at BWoSsC in the longer term, and potential environmental infection control risks associated with a move to QEUH. Further information regarding air quality in ward 4B at QEUH was required to make a proper risk assessment of options available.

Following a detailed option appraisal process, involving clinical teams, infection control and Health Protection Scotland, it was proposed that a six month monitoring period of the ward 4B environment is undertaken to assess the environmental suitability of transferring the BMT service to QEUH.

To support the monitoring period, it was also proposed that the existing Haematology ward (4c) is relocated into ward 4b. This will enable the positive air pressure to be activated and the environmental sampling measurement to occur. The vacated ward (4c) will be used for older people, although this will be a reduction of 14 beds on the site.

It was emphasised that the proposed ward changes and bed reductions had been discussed and agreed in principle by the Interim Chief Officer and with the Directors of both the South Sector and Regional Directorate. Mitigating actions to offset the risks of the impact of this reduction of beds on the QEUH site will be taken.

Dr Armstrong reassured members that the monitoring period would be used to determine a number of infection control measures including air sampling, fungal counts and air exchange rates over a sustained period. The outcome of this process will enable a final decision to be reached on the suitability of the clinical environment.

NOTED

28. AUDIT OF PERFORMANCE MONITORING AND REPORTING - PwC

There was submitted a paper [Paper No 17/19] by the Director of Policy & Planning which outlined the findings of the Price Waterhouse Cooper (PwC) audit of performance monitoring and reporting across Acute Services published in November 2016. The report also provided the Acute Services Committee with an update on how the recommended actions were being addressed.

The overall rating of the audit was classified as low risk suggesting it may have a minor risk to the organisations operational performance. Ms Mullen highlighted that the review found a number of areas of good practice, however, the review also identified two medium risk actions relating to the effectiveness of information reported and accountability and timescales for change management. The two

medium risk actions were set out in the report along with local action being taken to address these.

Mr Carr commented that while he was reassured that processes had been reviewed, he remained concerned about ensuring that performance metrics were improving.

NOTED

29. PERFORMANCE REVIEW GROUP (PRG) - FEEDBACK REPORT

There was submitted a paper [Paper No 17/20] by the Director of Policy & Planning which provided the Acute Services Committee with an overview of key actions and themes which emerged from the January 2017 round of the Acute Division PRGs.

Members welcomed the detail presented, and were reassured by the information that linked strategic and operational issues in the summary report.

NOTED

30. FINANCIAL MONITORING REPORT

There was submitted a report [Paper No 17/21] by the Director of Finance setting out the financial position within the Board for the 10 month period to 31 January 2017.

Mr White took members through the report in detail and highlighted that the Corporate and Partnerships were largely in operational balance, and the Acute Cost Containment Programme had started to demonstrate progress through Months 9 and 10. However, whilst the Cost Containment Programme had focused on pay pressures, non-pay spend had emerged as a significant area of overspend and plans were being developed to identify the underlying reasons and actions to address.

Mr Finnie stated that as the Finance Workshop was following the Committee meeting in the afternoon, it was appropriate to defer discussion about the financial position until the afternoon session, when all Board Members could participate in that debate.

NOTED

31. SCOTTISH INHERITED METABOLIC DISEASE SERVICE

There was submitted a paper [Paper No 17/22] by the Interim Chief Officer, Acute Services which asked the Committee to note that NHS Greater Glasgow and Clyde had been invited by the National Specialist and Screening Services Directorate (NSD) of NHS National Services Scotland to become the lead Board for the above service and to apply for national designation.

This process will take place during 2017/18 with a view to national designation in 2018/19 if agreed by the relevant groups and NHS Board Chief Executives.

Members noted the approach and the way forward.

NOTED

**32. ACUTE STRATEGIC MANAGEMENT GROUP MINUTES OF MEETINGS
HELD ON 22 DECEMBER 2016 & 26 JANUARY 2017**

NOTED

**33. AREA PARTNERSHIP FORUM MINUTES OF MEETING HELD ON 7
NOVEMBER 2016 & 23 JANUARY 2017**

NOTED

**34. BOARD CLINICAL GOVERNANCE FORUM MINUTES: 12 DECEMBER
2016**

NOTED

35. CLOSING REMARKS

Mr Finnie reported that this was the last meeting attended by Dr Reid, as he had come to the end of his term of office at 31 March 2017, and on behalf of fellow Board Members and Executives he wished to record, in Dr Reid's absence (as he had to leave the meeting early), the Board's gratitude to Dr Reid for the significant contribution he had made to the work of the Board as a Non Executive Board Member.

36. DATE OF NEXT MEETING

9.00am on Tuesday 18 April 2017 in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 12.00pm

ASC(M)17/03
Minutes: 37 - 49

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Acute Services Committee held at 9.00am on Tuesday, 18 April 2017 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	Cllr J Clocherty
Ms M Brown	Mrs A M Monaghan
Dr H Cameron	Mrs T McAuley
Mr S Carr	Mrs D McErlean
	Mr I Ritchie

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	Mrs J Grant
Dr M McGuire	

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

Mr G Archibald	..	Chief Officer, Acute Services
Mr J Best	..	Interim Chief Officer, Acute Services
Mr P Cannon	..	Deputy Head of Administration
Ms J Erdman	..	Head of Equality and Human Rights (to minute 42)
Mrs A MacPherson	..	Director of Human Resources & Organisational Development
Ms P Mullen	..	Head of Performance
Mr C Neil	..	Assistant Director of Finance
Ms C Renfrew	..	Director of Planning & Policy

37. APOLOGIES, WELCOME AND PRELIMINARIES

Apologies were intimated on behalf of Mr Loudon, Mrs Monaghan and Mr White.

38. DECLARATIONS OF INTEREST

There were no declarations of interest.

39. MINUTES OF PREVIOUS MEETING

On the motion of Mrs McAuley, and seconded by Dr Ritchie, the Minutes of the Acute Services Committee meeting held on 21 March 2017 [ASC(M)17/02] were approved as a correct record.

NOTED

40. MATTERS ARISING

a) Rolling Action List

It was noted that there were a number of items which would be brought to future Committee meetings and one paper on the agenda for the April meeting as outlined.

NOTED

41. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT

There was submitted a paper [Paper No 17/24] by the Interim Chief Officer setting out the integrated overview of NHSGGC Acute Services Division's performance. Of the 23 measures which had been assessed against a performance status based on their variation from trajectory and/or target, 11 were assessed as green, 4 as amber (performance within 5% of trajectory) and 8 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, including alcohol brief interventions, antenatal care, and outpatient DNA rate reductions, there were key measures where the trend was showing reduced compliance with targets in meeting national waiting times standards. Members were also presented with a list of other red rated metrics.

In relation to targets generally, Mr Best stated that in the short to medium term the provision of additional non recurring support from the Scottish Government was being discussed in order to target resources effectively. In addition it was also noted that since the last meeting an additional Consultant Urologist had been recruited and this too will bring about improvements in the pathway performance metrics.

In relation to the Stroke Bundle, Mr Best reported that the full stroke pathway was being reviewed and this would be completed by the end of April 2017, with a particular emphasis on swallow screening.

In relation to waiting times standards and the Treatment Time Guarantee specifically, Mr Best stated that there were a range of measures in place to bring about improvements across a number of specialties and discussions were continuing with the Scottish Government Access Team to support the Board. It was also noted that the Division was establishing capacity and demand plans for each specialty to inform future planning.

Mr Finnie thanked Mr Best for his overview and asked why NHS GG&C did not submit any projects in relation to the Detect Cancer Early Programme. Mr Best explained that Scottish Government wrote to all NHS Boards in November 2016 inviting applications for funding of further projects aimed at enhancing current or introducing novel referral methods, which he reassured the Committee that Directors had considered carefully, but decided to concentrate on the volume of patients already waiting, than directing resources to establish novel referral pathways, describing the approach as concentrating on business as usual.

Mr Finnie invited comments from members, in particular, focussing on the exceptions reports.

Ms Brown asked that in future reports improvement projects should be described,

with timescales and impacts, or if any additional funding was applied whether this was from within NHSGGC or from other sources, recurring or non recurring.

Mr Carr stated that it would be helpful to include in exception reports whether the issues being faced were local or national, as this context was helpful to Committee members to have when reading the reports. In addition, Mr Carr asked about sickness absence rates and welcomed the improvements made in reducing long term sickness absence. Mrs MacPherson stated that the Directors and Heads of People and Change had targeted long term sickness absence across Sectors and Directorates, which had yielded positive results, and that the focus was shifting to identifying the top 10 areas of absence in each Directorate to make similar targeted progress. Mrs MacPherson offered to provide further information in relation to this deep dive exercise at the next meeting.

Mr Carr also asked about DNA rates and highlighted the disparity of the rates across SIMD male and female cohorts, as described on page 37 of the report. Mr Best advised that targeting DNA rates was part of the work being taken forward in conjunction with the revised Access Policy, to be discussed later on the agenda.

Cllr Clocherty highlighted that he was concerned about the number of red rated metrics and Mrs Grant reported that the management team was focussed on reducing the red rated metrics as quickly as possible. The issues emerging were multifaceted, and Scottish Government colleagues were being kept apprised of the efforts being deployed within the Board to address these issues, in particular the work being taken forward around establishing service and specialty capacity plans.

Mrs McAuley asked about paediatric surgery waiting times and was reassured that the patients awaiting surgery were for a specific non urgent procedure.

Mrs Monaghan asked for further information about the additional capacity established at Stobhill ACH, and Mr Best described the additional sessions put in place to treat patients who had waited beyond the TTG target, which was positive, and supported as a pilot by Scottish Government support. The potential to roll out this pilot was being taken forward with Scottish Government.

In relation to the Local Delivery Plan (LDP), Ms Renfrew stated that the Board will be asked to agree the draft LDP for submission to Scottish Government in June 2017.

In response to a question from Ms Brimelow around the review of targets being conducted by Sir Harry Burns, Dr McGuire reported that this had discussed at a recent Board Chief Executives meeting and it was noted that a report was expected in the next few months.

NOTED

42. A FAIRER NHS GG&C 2016-17 & MONITORING REPORT

There was submitted a paper [Paper No 17/25] by the Head of Equality & Human Rights setting out an update of the range of work underway across NHSGGC to meet the mainstreaming and equality actions which the Board set at the beginning of 2016.

Ms Erdman took the Committee through the report in detail, and highlighted at the outset that in 2017-18 there were some additional priorities driven by new legislation and the Public Sector Equality Duty set out in the Equality Act 2010. These included:

- Ensuring NHSGGC Equality Impact Assess (EQIA) financial decisions and continue to EQIA service changes;
- Publishing an Equal Pay Statement and implementing actions;
- Fulfilling requirements of new duties set out in:-
 - BSL (Scotland) Act
 - The Equality Act 2010 (Specific Duties) (Scotland) Amendment Regulations 2016 6a in relation to board diversity
 - Child Poverty (Scotland) Act
 - Community Empowerment (Scotland) Act, in particular public participation requests.

Ms Erdman took the Committee through the detailed sections of the report.

It was noted that NHSGGC had improved services for Deaf people and people whose first language is not English to ensure that interpreters were always available for health appointments. The Board provided approximately 500 interpreter assisted appointments per day for patients whose first language is not English, or who use British Sign Language; between April 2016 and February 2017 this equated to 101,036 face to face appointments.

In relation to Deaf Blind Patients, Deafblind Scotland had provided professional guide communicators for 459 patients at GP visits, hospital appointments, specialist assessments, nurse appointments, Optician, Audiology and Podiatry appointments, day surgery and hospital admissions to Accident and Emergency.

Gender Based Violence was targeted in 2016-17 and maternity services audited 268 sets of notes from 2016-17 to monitor discussions on Gender Based Violence. 260 enquiries were made and 5 women disclosed and were offered support. Pathways on Female Genital Mutilation have been developed and circulated to all staff in maternity services supported by staff training.

In relation to poverty issues, since January 2015 until December 2016, NHSGGC Acute staff have made over 4,852 referrals to Money Advice Services. The Royal Hospital for Children's (inpatients and outpatients) Money and Debt Advice Service received 469 referrals between January 2016 and December 2016 with an additional 452 midwifery referrals into Healthier Wealthier Children. Financial gains from the Royal Hospital for Children service were over [REDACTED] and a further [REDACTED] of debt management. Healthier Wealthier Children has now been acknowledged as an approach which will be rolled out nationally. Since 2011 Healthier Wealthier Children referrals from children and families services have generated over [REDACTED] for NHSGGC's most vulnerable residents.

Ms Erdman referred to training and induction for new staff which covers all the protected characteristics and key messages relating to the Equality Act, as well as training on specific equality issues, work on Gender, Disability and Ethnicity Pay Gaps, Disability, Transgender Staff, the Black and Minority Ethnic Health and Wellbeing Survey, Lone Parents, and Human Rights.

Members welcomed the range and depth of initiatives in place and being developed not only to meet the requirements of the legislation, but noted the significant efforts being made to exceed the requirements of the legislation in many cases across NHSGGC.

Ms Brown thanked Ms Erdman for her comprehensive report and her very detailed overview and commended the efforts made to address poverty and disability issues in particular. Ms Brown asked that the Board should also concentrate efforts on

supporting patients with Learning Disabilities and in Mental Health, without detracting from the excellent work undertake thus far.

Ms Erdman advised that there were initiatives underway with patients within Mental Health, and in Learning Disabilities and this would be highlighted in future reports. It was also noted that a scorecard was being developed in conjunction with the Health Inequalities Group to show how the Board was performing at a glance.

Mr Ritchie in welcoming the report highlighted the excellent work being taken forward in relation to Healthier Wealthier Children and across Health Visiting and Midwifery Services.

NOTED

43. ACCESS POLICY

There was submitted a paper [Paper No 17/26] from the Interim Chief Officer which sought approval of the revised NHSGG&C Access Policy.

It was noted that the NHSGG&C Access Policy had been developed to provide a common vision, direction and understanding of how the Board would ensure equitable, safe, clinically effective and efficient access to services for their patients. The Policy set out the principles that will help to ensure systems are in place to optimise the use of facilities and available capacity in order to deliver high quality, safe patient care in a timely manner.

The Policy will act as an operational guide for staff involved in the management of patients on an 18 Week RTT pathway. It outlines roles, responsibilities and processes to be followed to ensure the effective management of patients who need to attend hospital as an outpatient, inpatient, day case or to access diagnostic services.

Mr Best stated that the revised policy is underpinned by the NHS Scotland Waiting Times Guidance and maintained the same overarching principles set out in the original policy in 2013.

This revised Policy had been expanded to include more detail on waiting list management, including additional specific guidance on the management of reasonable offers of appointment/admission, Did Not Attends (DNAs), and patient unavailability, as well as some minor drafting issues as identified on page 2 (Version and Document Control) of the revised Policy.

Mr Best, in seeking approval of the revised Access Policy, highlighted that in relation to the wider issue of patients who do not attend, and the earlier remarks made by Mr Carr, a programme of work to ensure the impact on inequalities is mitigated was being undertaken. This programme of work is based on the EQIA work that had been carried out in supporting the revised Policy and will be conducted alongside the implementation of the Access Policy. The progress of this work will be reported back to the Acute Services Committee.

**Interim Chief
Officer, Acute**

In relation to Did Not Attend patients, Ms Brown highlighted the important role of link workers in ensuring that patients are encouraged to attend. Mr Carr reiterated his concern that patients who do not attend were from lower social economic groups. Mr Best reassured Mr Carr and Committee members that the Directors within the Division also shared these concerns and were working actively with GPs and other stakeholders to address this. However, Mr Best assured members that the approval of

the Access Policy would not have any impact on the work being taken forward on reducing DNA rates or making clinic appointments more accessible.

In order to ensure that staff were able to operate with the most up to date guidance, and taking account of reservations expressed by Committee members, it was agreed to approve the revised Access Policy, as an interim document, and await further information in relation to DNAs, before the Access Policy is fully approved.

APPROVED

44. QUARTERLY REPORT ON CASES CONSIDERED BY THE SCOTTISH PUBLIC SERVICES OMBUDSMAN (1 OCTOBER 2016 – 31 DECEMBER 2016)

There was submitted a paper [Paper No 17/27] from the Nurse Director which set out a summary of those Ombudsman cases that required the Board to respond to a recommendation contained within the Investigation Report or Decision Letter covering the period 1 October 2016 to 31 December 2016.

It was noted that during the period covered by the report no Investigation Reports had been received. The Ombudsman had also advised the Board that during the period covered they had decided not to take forward 4 complaints. A total of 19 Decision Letters had however been received.

Within the 19 Decision Letters received, a total of 36 recommendations had been made and the report set out the complaint(s) investigated by the Ombudsman, each recommendation and the date by which a response was required, the response made by the Board to each recommendation, and the date on which the response had been submitted to the Ombudsman.

Mr Ritchie drew attention to a repeated theme in two particular cases (para 4.4 and para 4.5) of communication, and Dr Armstrong referred to the significant efforts in place to highlight the importance of good communicating to doctors in training. This will also be covered in preparing the Board for the Duty of Candour requirements, anticipated from April 2018.

Mr Finnie suggested that it would be useful to see some trend information about cases going back previous quarters, and the date of the original complaint made. He added that it would also be helpful to see whether, in cases where the Ombudsman had asked the Board to make an apology, the Board had made such an apology in the complaint response. It was agreed to develop the report further and review this information at the next meeting.

Nurse Director

NOTED

45. PLANNING UPDATE

There was submitted a paper [Paper No 17/28] from the Director of Planning & Policy which set out a draft 2017/18 Acute Division Delivery Plan (ADDP).

It was noted that the Divisional Delivery Planning process was introduced in 2016/17 to ensure that the Division had a coherent approach to identifying and resolving challenges to the provision of services so that safe, high quality and effective clinical care is delivered within the agreed financial allocation. The ADDP is also an

important part of the architecture to make sure the Division functions as a single, coherent entity and has clear performance metrics and that the Board has coherent planning with Health & Social Care Partnerships (HSCPs).

Ms Renfrew took colleagues through the draft, which was intended to underpin the Boards Local Delivery Plan, and it was highlighted that a matrix of actions timescales and action owners was in place to support the ADDP. It was also noted that a small group, led by Mrs MacPherson, was looking at how best to communicate and cascade the ADDP to secure wide staff engagement.

Mrs Grant highlighted that the ADDP and the Local Delivery Plan were by nature focussed on 2017/18, but the Board required a longer term Strategic Plan to cover a 5 year horizon, which encompassed Acute, HSCP and emerging Regional issues.

In relation to the service review section it was agreed that it would be helpful to add timescales to each item listed in the Plan.

**Director of
Planning &
Policy**

NOTED

46. FINANCIAL MONITORING REPORT

There was submitted a report [Paper No 17/29] by the Director of Finance setting out the financial position within the Board for the 11 month period to 28 February 2017.

Mr White took members through the report in detail and highlighted that the Corporate and Partnerships were largely in operational balance, and that the Acute Cost Containment Programme had demonstrated progress through months 9 to 11, culminating in an in-month operational underspend of [REDACTED], albeit recorded with sustained non-recurring funding.

However, while it was noted that the Cost Containment Programme had focused on pay pressures, non-pay spend had also been an area of overspend. Mr White reported that plans were in place to address this and the February in month position was reported at break-even for non-pay.

As reported previously, Mr White reiterated that the National Workstreams identified in the Financial Plan will not contribute any savings in 2016/17.

It was noted that the CRES programme was still anticipated to deliver the [REDACTED] target savings; however current estimates indicated that [REDACTED] may be non-recurrent. In addition, further non-recurring funding may be required in-year as some projects have not realised the savings identified at the outset.

Mr White emphasised that reductions in monthly spend were required for 2017/18 as there were limited non recurring reserves to support the Board's overall revenue position.

Dr McGuire highlighted the significant efforts in engaging with other West of Scotland Boards to address and reduce premium rate nurse agency spend, and the ongoing nature of this initiative. Dr Armstrong highlighted the Retinue initiative to reduce medical agency spend, and the efforts locally to reduce reliance on locum doctors wherever possible.

Mr Carr stated his view that the figures within the tables should make it clearer that the Board achieved a balanced position only after the application of significant non

recurring reserves, and that the underlying position needed to be highlighted.

NOTED

47. FACILITIES UPDATE

It was agreed to defer this item as Mr Loudon was unable to attend.

NOTED

**48. ACUTE STRATEGIC MANAGEMENT GROUP MINUTES OF MEETINGS
HELD ON 23 FEBRUARY 2017**

NOTED

49. DATE OF NEXT MEETING

9.00am on Tuesday 4 July 2017 in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 12.30pm

DRAFT

ASC(M)17/04
Minutes: 50 - 62

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Acute Services Committee held at
9.00am on Tuesday, 4 July 2017 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	Mrs T McAuley
Ms M Brown	Mrs D McErlean
Mrs A M Monaghan	Mr I Ritchie

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

Dr J Armstrong	Mr J Brown
Mrs J Grant	Mr M White

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

Mr P Cannon	..	Deputy Head of Administration
Ms M Farrell	..	Director, Clyde Sector
Mr D Loudon	..	Director of Procurement, Property & Facilities Management
Mr A McLaws	..	Director of Communications
Mrs A MacPherson	..	Director of Human Resources & Organisational Development
Ms P Mullen	..	Head of Performance
Mr C Whyte	..	Team Leader, Property Disposals (for item 58 only)

50. APOLOGIES, WELCOME AND PRELIMINARIES

Apologies were intimated on behalf of Mr Carr, Mrs Thompson, Dr McGuire and Mr Best. Mr Finnie welcomed Ms Farrell who was representing Mr Best.

51. DECLARATIONS OF INTEREST

There were no declarations of interest.

52. MINUTES OF PREVIOUS MEETING

On the motion of Mrs Monaghan, and seconded by Mrs McAuley, the Minutes of the Acute Services Committee meeting held on 18 April 2017 [ASC(M)17/03] were approved as a correct record.

NOTED

53. MATTERS ARISING**a) Rolling Action List**

It was noted that there were a number of items which would be brought to future Committee meetings, and one paper on the agenda for the July April meeting as outlined.

In relation to the Acute Division Delivery Plan, it was noted that this was being developed in line with the Local Delivery Plan and the Corporate Objectives of the Board. Dr Armstrong highlighted that a series of system wide reviews were being completed to inform the further development of the Acute Division Plan and the outcome of these reviews would be brought back to the Committee in September 2017.

**Medical
Director**

Mrs Grant took the opportunity to alert the Committee to a letter from the Cabinet Secretary that had been received in the past few days and outlined the content, which related to performance issues and, in particular, waiting times. The letter indicated that additional funding was to be made available in two tranches and was in part contingent on meeting the delivery of targets, which would be aligned to reflect the March 2017 position.

Members discussed the implications of the letter and noted that the Executive Team were working through a series of scheduled capacity and demand plans to identify gaps in performance and opportunities for productivity gain. Mrs Grant stated that it was clear from the analysis already undertaken that performance across the Division could be different across the same specialties, and Directors were reviewing local working practices to bring about a consistent level of service delivery and performance.

Mr Ritchie commended the work already underway to review capacity and demand, but highlighted the need to influence the clinical community who drive activity and performance.

Dr Armstrong provided a detailed update of the range of work being undertaken, using Orthopaedics as an example of the way in which pre hospital, elective and trauma activity and service delivery was being analysed, alongside the resources used.

Ms Brown in also welcoming the initiatives outlined, asked that if services were to be aligned in different delivery models that patient transport be included in the assessments undertaken of impacts.

Mr Brown stated that he was reassured by the detailed analysis being undertaken to determine the assets available to the Board and the better management of demand. He asked that these assessments also consider the role to be played by IJBs in delivery these new models, and importantly in being aligned with the Acute Division's delivery plan.

NOTED

54. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT

There was submitted a paper [Paper No 17/31] by the Head of Performance setting out the integrated overview of NHSGGC Acute Services Division's performance.

Of the 23 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 8 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, including delayed discharges, alcohol brief interventions, antenatal care, and e-KSF completion rates, there were key measures where the trend was showing reduced compliance with targets in financial performance and in meeting national waiting times standards. Members were also presented with a list of other red rated metrics.

In relation to Delayed Discharges, Ms Mullen stated that the data presented to IJBs and within the Board reports were drawn from the same system, so there should be no inconsistency in the data. Ms Mullen suggested that the Board reports were showing all delays in Acute but it may be that IJB data was showing only patients above 65 years of age. Ms Grant agreed to take this up with IJB colleagues to remove any potential for data being presented differently.

**Chief
Executive**

Ms Grant took Members through the productivity reviews being undertaken to address demand and capacity management, and this involved all out patient and in patient activity. In terms of business analytics, Mr Brown encouraged officers to build this capacity, and Ms Grant reassured Members that this was being addressed.

In relation to the Stroke Care Bundle, it was noted that the review was complete and there were early signs of improvement.

In relation to sickness absence, Mrs MacPherson highlighted the successes in reducing long term absences.

NOTED

55. DNA REPORT

There was submitted a paper [Paper No 17/32] by the Interim Chief Officer, Acute which set out a report on new and return outpatient Do Not Attend (DNA) rates across Acute Services. In particular, the report disaggregated DNA rates by different population groups and protected characteristics where reportable to identify the differentials in the risk of different groups of patients not attending outpatient appointments. Ms Farrell introduced the report in Mr Best's absence.

This report provided a profile of new and return outpatient DNAs in the context of age, sex, deprivation and ethnicity and outlined the work in place to help reduce the variation.

Ms Farrell reminded Members that the Board's Access Policy stated that patients must be provided with clear, accurate and timely information on the processes that will be followed for arranging for patients to be seen for consultation or to be admitted to hospital. This included accessible information (a format people can understand) as defined in our Clear to All policy. The Access Policy also stated that patients will be made aware that they are required to attend their agreed appointment and where the appointment is no longer required or the patient is unable to attend, they should inform the hospital at the earliest available opportunity. A new or return outpatient DNA was therefore defined as a patient that did not attend a booked appointment and gave no prior warning. The Access Policy also clearly stated that a

patient who DNAs would not be offered a further appointment, however, if clinical priorities override the procedure not to rebook a patient that DNAs, the clinician will advise booking staff. The process currently in operation for managing patients that DNA was outlined in Appendix 1.

Ms Farrell went on to explain that often appointments are over-booked to take account of the likelihood of patients not attending an outpatient appointment, however this is not universally applied across each specialty. So whilst patients are recorded as a DNA if they fail to attend without prior warning, their clinic slot may have been used if overbooked.

However, despite the process in place to try to mitigate DNAs, NHSGG&C continued to report an overall new and return outpatient DNA rate of between 10 - 13% each year. This overall rate had remained fairly static for a number of years and masked the variation that existed across the system between different population groups.

Members noted that the analysis of new and return outpatient DNAs showed that for every appointment, the risk of DNA is highest among patients living in more deprived areas, males, young adults and in general psychiatry settings. Research showed that the pattern of DNA has remained fairly stable during the past 10 years and reflected DNA patterns nationally in terms of age, sex and deprivation. The analysis also shows that patients from different ethnic groups are more likely to DNA than their White Scottish counterparts.

Ms Farrell drew Members attention to the further work which was required to examine why there is variation in the risk of DNA between groups, including potential differences in the barriers they face and differences in their needs to help the Board reduce DNAs in the future. Both patient and service factors can contribute to DNAs and there were a number of practical steps that were being taken to improve patient attendance and ultimately, retention across the patient care pathway.

The range of practical steps being taken by the Board were also detailed in the report which included an equality impact assessment of the Access Policy; a secondary data analysis and a review of DNA statistics in agreed NHSGGC specialties using the methodology adopted in the 2015 report to provide an updated picture of trends since 2011/12; a scoping exercise of existing efforts to improve DNA rates across NHS GGC and elsewhere to help inform debates on best practice; a monthly review of patients who DNA their appointment retrospectively to establish the reasons for the DNA; a Waiting List Review; a review of Patient Focused Booking; a restructuring of the Referral Management Centres; and a review of the Transforming Outpatients Programme.

Mrs McAuley commended the report and the approach to a very difficult area of patient flow management.

Ms Brown also welcomed the report and the rigorous approach adopted. She added that it was important to understand the barriers preventing patients from attending.

Mr Brown commended the NetCall approach to reminding patients of forthcoming appointments but asked if there was any way of patients notifying that they no longer needed or were able to attend, as part of that process. Ms Farrell agreed to pass this back to the referral management team.

Mr Finnie thanked Ms Farrell for the comprehensive and helpful report.

NOTED

56. QUARTERLY REPORT ON CASES CONSIDERED BY THE SCOTTISH PUBLIC SERVICES OMBUDSMAN (1 JANUARY 2017 – 31 MARCH 2017)

There was submitted a paper [Paper No 17/33] from the Nurse Director which set out a summary of those Ombudsman cases that required the Board to respond to a recommendation contained within the Investigation Report or Decision Letter covering the period 1 January 2017 to 31 March 2017.

It was noted that during the period covered by the report no Investigation Reports had been received. The Ombudsman had also advised the Board that during the period covered they had decided not to take forward 14 complaints. A total of 30 Decision Letters had however been received.

Within the 30 Decision Letters received, a total of 53 recommendations had been made and the report set out the date the complaint had been received by the Board, the complaint(s) investigated by the Ombudsman, each recommendation and the date by which a response was required, the response made by the Board to each recommendation, and the date on which the response had been submitted to the Ombudsman.

Mr Cannon highlighted that at last Acute Services Committee meeting Members asked that the report be developed to indicate where possible if the Board had provided an apology in the original complaint response. It was noted that this information was included in each of the case summaries. Members also asked if trend information could be provided and this was shown at Appendix 1 to the report. This additional information was welcomed by Members.

Mr Finnie thanked Mr Cannon for his report.

NOTED

57. FINANCIAL MONITORING REPORT

There was submitted a report [Paper No 17/34] by the Director of Finance setting out the financial position within the Board for the 2 month period to 31 May 2017.

Mr White took members through the report in detail and highlighted that the overall Board position at the end of month 2 was a [REDACTED] overspend, and that the Acute Division's position at Month 2 was an overspend of [REDACTED]. Overall, there were pressures within pays and the CRES position on a YTD basis reported a deficit. It was noted that the pay overspend was driven by medical and nursing.

Mr White highlighted that the 2017/18 Financial Plan was approved by the Board on the 15th June 2017. The Plan highlighted a gap, significant risk in identified savings schemes and an in-year cash issue as a number of schemes will not crystallise until later in the financial year.

Mr White highlighted the work being taken forward to reduce the cost base and efforts in reducing expenditure in key areas such as vacancy management, recruitment, medical locums, and premium rate agency nursing.

In relation to medical locums, Dr Armstrong reported that the service had reviewed each and every appointment, and were looking to staffing alternatives, and different patient pathways, to reduce reliance on these locum doctors. Members noted the local actions being taken and Mrs MacPherson provided an update on the national initiatives being taken forward.

Ms Grant stressed the need for the Board to operate from a stable and sustainable recurrently funded base budget, and to have robust controls in place.

Mr White also provided an update on the progress of discussion with IJB Chief Officers in relation to financial allocations.

NOTED

58. FORMER YORKHILL CAMPUS - DISPOSAL STRATEGY - PROGRESS REPORT

There was submitted a report [Paper No 17/35] by the Director of Procurement, Property and Facilities Management, which highlighted the key issues under consideration to allow the Yorkhill Campus site to be disposed of. Mr Loudon introduced Mr Campbell Whyte to the meeting and asked him to take Members through the update.

Mr Whyte stated that the most significant challenge remains the relocation of the clinical and non-clinical services to permanent locations elsewhere. It was noted that the Short Life Working Group established to co-ordinate these efforts had continued to focus on understanding the different teams working from the former Yorkhill Campus and assessing their potential requirements.

Members noted the detailed assessments being taken forward of the requirements of the clinical and non clinical staff currently based at the old Yorkhill Campus and the need to relocate these staff and services as part of the disposal programme.

It was also noted that the intention was to align the disposal strategy with the relocations, and that the Disposals Team were working on a timetable that would see the site being marketed in March 2018, and a preferred bidder/partner secured by the end of 2018, with a view to vacating the entire site by the end of 2019.

However, following discussion, it was acknowledged that this timetable needed to be accelerated and Mr Loudon and Mr (Mark) White agreed to work to bring forward the timetable as far as possible. Mr Loudon stated that clinical and non clinical accommodation requirements should be finalised by the end of September 2017.

**Director of
Procurement,
Property and
Facilities
Management**

Mrs Monaghan asked that in any assessment of the relocation of clinical services the analysis should include a review of the postcodes of patients currently using these services on the West ACAD site.

Mr Whyte stated that the Board would be presented with a range of options for relocating clinical and non clinical staff.

Mr Finnie reminded Members that the Board had decided to vacate the site and dispose of the campus in its entirety and cautioned against any suggestion that certain parts of the site be retained for accommodation purposes.

Mr Finnie thanked Mr Whyte for attending and providing the update.

NOTED

59. LEGAL CLAIMS MONITORING REPORT 2016/17

There was submitted a report [Paper No 17/36] by the Deputy Head of Administration setting out the Annual Monitoring Report on the handling and settlement of legal claims within NHS Greater Glasgow and Clyde for the period 2016/17.

The report summarised how claims are handled and comparative data was provided showing the previous year's data to demonstrate trends and highlight issues arising in both years.

Mr Cannon took Members through the report in detail, highlighting the numbers of claims received in the past two years, where these claims originated, by service area and specialty, the number of claims settled in the year, the values of those settled claims, and the number and potential value of open high value claims.

Members noted the relationship between the Board and CNORIS (Clinical Negligence and Other Risks Scheme) and Mr White explained how this risk sharing process benefited the Board in reducing any exposure to high value claims that may be required to be settled in any one year.

Mr Finnie thanked Mr Cannon for his detailed report.

NOTED

60. COMMITTEE REMIT – UPDATE

There was submitted a report [Paper No 17/37] by the Deputy Head of Administration setting out changes to the Committee remit.

It was noted that in March 2017, the Audit Committee reviewed the Board's Standing Financial Instructions (SFIs), and in light of this review of SFIs the remit of the Committee required to be updated. The changes recommended following the review of the Committee remit will bring the remit in line with the revised SFIs. It was noted that the remits of the Finance & Planning Committee and the Property Committee were also being reviewed in the light of these changes.

The changes were agreed and it was also noted that revised Standing Committee remits will be reflected in the paper to the August 2017 NHS Board meeting on the Annual Review of Corporate Governance.

AGREED

61. ACUTE STRATEGIC MANAGEMENT GROUP MINUTES OF MEETINGS HELD ON 27 MARCH, 27 APRIL AND 25 MAY 2017

NOTED

62. DATE OF NEXT MEETING

9.00am on Tuesday 19 September 2017 in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 12.45pm

DRAFT

ASC(M)17/04
Minutes: 50 - 62

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Acute Services Committee held at
9.00am on Tuesday, 4 July 2017 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	Mrs T McAuley
Ms M Brown	Mrs D McErlean
Mrs A M Monaghan	Mr I Ritchie

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

Dr J Armstrong	Mr J Brown
Mrs J Grant	Mr M White

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

Mr P Cannon	..	Deputy Head of Administration
Ms M Farrell	..	Director, Clyde Sector
Mr D Loudon	..	Director of Procurement, Property & Facilities Management
Mr A McLaws	..	Director of Communications
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50. APOLOGIES, WELCOME AND PRELIMINARIES

Apologies were intimated on behalf of Mr Carr, Mrs Thompson, Dr McGuire and Mr Best. Mr Finnie welcomed Ms Farrell who was representing Mr Best.

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53. MATTERS ARISING

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It was noted that there were a number of items which would be brought to future Committee meetings, and one paper on the agenda for the July April meeting as outlined.

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**Medical
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**Chief
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Mr Finnie thanked Mr Cannon for his report.

NOTED

57. FINANCIAL MONITORING REPORT

There was submitted a report [Paper No 17/34] by the Director of Finance setting out the financial position within the Board for the 2 month period to 31 May 2017.

Mr White took members through the report in detail and highlighted that the overall Board position at the end of month 2 was a [REDACTED] overspend, and that the Acute Division's position at Month 2 was an overspend of [REDACTED]. Overall, there were pressures within pays and the CRES position on a YTD basis reported a deficit. It was noted that the pay overspend was driven by medical and nursing.

Mr White highlighted that the 2017/18 Financial Plan was approved by the Board on the 15th June 2017. The Plan highlighted a gap, significant risk in identified savings schemes and an in-year cash issue as a number of schemes will not crystallise until later in the financial year.

Mr White highlighted the work being taken forward to reduce the cost base and efforts in reducing expenditure in key areas such as vacancy management, recruitment, medical locums, and premium rate agency nursing.

In relation to medical locums, Dr Armstrong reported that the service had reviewed each and every appointment, and were looking to staffing alternatives, and different patient pathways, to reduce reliance on these locum doctors. Members noted the local actions being taken and Mrs MacPherson provided an update on the national initiatives being taken forward.

Ms Grant stressed the need for the Board to operate from a stable and sustainable recurrently funded base budget, and to have robust controls in place.

Mr White also provided an update on the progress of discussion with IJB Chief Officers in relation to financial allocations.

NOTED

58. FORMER YORKHILL CAMPUS - DISPOSAL STRATEGY - PROGRESS REPORT

There was submitted a report [Paper No 17/35] by the Director of Procurement, Property and Facilities Management, which highlighted the key issues under consideration to allow the Yorkhill Campus site to be disposed of. Mr Loudon introduced Mr Campbell Whyte to the meeting and asked him to take Members through the update.

Mr Whyte stated that the most significant challenge remains the relocation of the clinical and non-clinical services to permanent locations elsewhere. It was noted that the Short Life Working Group established to co-ordinate these efforts had continued to focus on understanding the different teams working from the former Yorkhill Campus and assessing their potential requirements.

Members noted the detailed assessments being taken forward of the requirements of the clinical and non clinical staff currently based at the old Yorkhill Campus and the need to relocate these staff and services as part of the disposal programme.

It was also noted that the intention was to align the disposal strategy with the relocations, and that the Disposals Team were working on a timetable that would see the site being marketed in March 2018, and a preferred bidder/partner secured by the end of 2018, with a view to vacating the entire site by the end of 2019.

However, following discussion, it was acknowledged that this timetable needed to be accelerated and Mr Loudon and Mr (Mark) White agreed to work to bring forward the timetable as far as possible. Mr Loudon stated that clinical and non clinical accommodation requirements should be finalised by the end of September 2017.

Mrs Monaghan asked that in any assessment of the relocation of clinical services the analysis should include a review of the postcodes of patients currently using these services on the West ACAD site.

Mr Whyte stated that the Board would be presented with a range of options for relocating clinical and non clinical staff.

Mr Finnie reminded Members that the Board had decided to vacate the site and dispose of the campus in its entirety and cautioned against any suggestion that certain parts of the site be retained for accommodation purposes.

Mr Finnie thanked Mr Whyte for attending and providing the update.

NOTED

59. LEGAL CLAIMS MONITORING REPORT 2016/17

**Director of
Procurement,
Property and
Facilities
Management**

There was submitted a report [Paper No 17/36] by the Deputy Head of Administration setting out the Annual Monitoring Report on the handling and settlement of legal claims within NHS Greater Glasgow and Clyde for the period 2016/17.

The report summarised how claims are handled and comparative data was provided showing the previous year's data to demonstrate trends and highlight issues arising in both years.

Mr Cannon took Members through the report in detail, highlighting the numbers of claims received in the past two years, where these claims originated, by service area and specialty, the number of claims settled in the year, the values of those settled claims, and the number and potential value of open high value claims.

Members noted the relationship between the Board and CNORIS (Clinical Negligence and Other Risks Scheme) and Mr White explained how this risk sharing process benefited the Board in reducing any exposure to high value claims that may be required to be settled in any one year.

Mr Finnie thanked Mr Cannon for his detailed report.

NOTED

60. COMMITTEE REMIT – UPDATE

There was submitted a report [Paper No 17/37] by the Deputy Head of Administration setting out changes to the Committee remit.

It was noted that in March 2017, the Audit Committee reviewed the Board's Standing Financial Instructions (SFIs), and in light of this review of SFIs the remit of the Committee required to be updated. The changes recommended following the review of the Committee remit will bring the remit in line with the revised SFIs. It was noted that the remits of the Finance & Planning Committee and the Property Committee were also being reviewed in the light of these changes.

The changes were agreed and it was also noted that revised Standing Committee remits will be reflected in the paper to the August 2017 NHS Board meeting on the Annual Review of Corporate Governance.

AGREED

61. ACUTE STRATEGIC MANAGEMENT GROUP MINUTES OF MEETINGS HELD ON 27 MARCH, 27 APRIL AND 25 MAY 2017

NOTED

62. DATE OF NEXT MEETING

9.00am on Tuesday 19 September 2017 in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 12.45pm

ASC(M)17/05
Minutes: 63 - 75

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Acute Services Committee held at 9.00am on Tuesday, 19 September 2017 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 S Carr (in the Chair)

Ms S Brimelow OBE	Mrs A M Monaghan
Ms M Brown	Mrs D McErlean
Cllr J Clocherty	Mr I Ritchie

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

Mr J Brown CBE	Dr J Armstrong (To Minute 72)
Mrs J Grant	Mr M White

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

Mr J Best	..	Interim Chief Officer, Acute Services
Mr A McLaws	..	Director of Corporate Communications
Mrs A MacPherson	..	Director of Human Resources & Organisational Development
Ms P Mullen	..	Head of Performance (To Minute 67)
Mrs E Love	..	Chief Nurse for Professional Governance & Regulation
Mr G Archibald	..	Chief Officer, Acute Services
Mrs L McGrath	..	Interim Deputy Head of Administration
Ms L Yule	..	Audit Scotland
Ms L Maconachie	..	Audit Scotland

63. APOLOGIES, WELCOME AND PRELIMINARIES

Apologies were intimated on behalf of Mr R Finnie, Cllr M Hunter, Mrs T McAuley OBE and Ms A Thomson. Mr Carr welcomed Mrs Love who was representing Dr Mcguire.

64. DECLARATIONS OF INTEREST

There were no declarations of interest.

65. MINUTES OF PREVIOUS MEETING

On the motion of Mrs McErlean, and seconded by Ms Brimelow, the Minutes of the Acute Services Committee meeting held on 4 July 2017 [ASC(M)17/04] were approved as a correct record subject to the following change:

- Minute 58, Former Yorkhill Campus – Disposal Strategy – Progress Report, paragraph five; delete ‘clinical’ from last sentence.

NOTED

66. MATTERS ARISING

a) Rolling Action List

The Committee noted the Yorkhill Disposal Strategy Update; a further report will be brought to the November meeting.

**Director of
Procurement,
Property and
Facilities
Management**

NOTED

67. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT

There was submitted a paper [Paper No 17/39] by the Interim Chief Officer of Acute Services setting out the integrated overview of NHSGGC Acute Services Division’s performance.

Of the 22 measures which had been assessed against a performance status based on their variation from trajectory and/or target, 8 were assessed as green, 4 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.

Mr Best noted that the Integrated Performance Report metric for complaints had been updated in line with the new Complaints Policy. The new arrangements now report complaints closed within five and 20 working days and focus on early resolution. Mr Best also advised that the Detect Cancer Early metrics have been removed from this report as the Scottish Government no longer reported on these statistics, however, NHSGGC will continue to collect and monitor this data and a trend report will be brought back to the Committee in due course.

It was noted that steady progress continued to be made in overall Stroke Care Bundle performance. The Stroke Care Implementation Group has been established to take forward the recommendations from the Stroke Review; the main area for immediate focus was the water swallow test element of the bundle which required improvement.

Members were presented with an overview of other red rated metrics including performance against national waiting time standards. Mr Best advised that work was being targeted in a number of areas and that growth in the number of patients waiting longer than the national standards has stabilised in recent weeks. Performance against the six week Diagnostic Test target remained challenging, a service redesign project has commenced and a project manager was working towards bringing the three Sectors scope waiting lists together. This work will ensure consistency across the Heath Board. Additionally, discussions with the Scottish Government regarding the use of additional non-recurring access funding to support extra capacity were ongoing.

The Committee discussed the current challenge of reducing Delayed Discharges, Dr

Mcguire has established weekly telephone conference calls with Local Authorities to ensure patients were moved to the most appropriate accommodation in a timely manner. Ms Brown noted that Delayed Discharges had a big impact on mental health beds and also stated that intermediate beds were not the solution. A paper would be submitted to the October Board meeting on this issue.

Nurse Director

Dr Armstrong noted that a short term solution pre Winter may be required, with a longer term focus on establishing the best model for managing delays. The Committee discussed the issue of moving patients multiple times rather than to one therapeutic environment. Mr Best advised that Frailty units were being expanded in Acute sites.

Dr Armstrong advised that Day of Care Audits will be commissioned across Glasgow City IJB, this will identify exactly what issues were delaying patients discharge and Dr de Casestecker is taking this forward.

In relation to sickness absence, Mrs MacPherson highlighted the overall reduction in absence rates, with the majority of Directorates reporting sickness absence of less than 5%. To mitigate against increased absences during winter, the Staff Health Strategy had been launched, this had a significant focus on stress management.

Mrs MacPherson also noted the improving eKSF performance, advising that performance of over 71% was achieved in August 2017. Individual trajectories for each Directorate had been agreed to maintain the focus on this key metric. A new National tool is anticipated to be launched in the near future; discussions with the Scottish Government regarding this tool were ongoing. Members discussed the current eKSF system, noting particular challenges, and welcomed the prospective change to this software at a national level.

Mr Brown stated that in order to maximise the potential of the organisation every member of staff should have a Personal Development Plan (PDP). Mrs Grant noted the need for sustained improvement in this area and agreed that the completion of eKSF and the separate PDP process should be part of routine business. Mrs MacPherson confirmed that audits on PDP completeness have been carried out previously and will undertake a further audit to focus on the quality of staff and line manager discussions. An update will be given to the Committee when completed.

**Director of HR
and OD**

A separate paper on cancer performance is on the Committee agenda.

In relation to Staphylococcus aureus Bacteraemias (SABs), Dr Armstrong noted the ongoing effort to control SABs, Infection Control investigations were conducted on occurrences and action was taken if any linkage was found. NHSGGC's SAB rate is in line with the Scottish average; however it is above the HEAT target. Dr Armstrong explained that the SAB rate is currently measured as a whole, including both Community and Hospital acquired SABs, which were then considered with Acute Beds Days to calculate performance. This may not be the most effective measure to monitor SABs and a national group are reviewing the target. An update would be provided to the Committee on progress with this when available.

**Medical
Director**

Ms Brown noted that it would be helpful to see trajectories in the performance report in future to indicate when any improvement may be seen.

Mr Best advised that the Scottish Government has launched the Elective Access Collaborative Programme; more detail on this would be presented to the Committee in due course. The current waiting times position was highlighted, noting that the number of patients waiting over 12 weeks for an Outpatient appointment or

**Interim Chief
Officer, Acute**

Inpatient/Daycase treatment had stabilised. Challenges with diagnostic reporting times were also noted, additional internal and external capacity has been secured to assist with reporting. The wider issue of increases in diagnostic test requests will be further reviewed as part of the Transformation Work programme.

NHSGGC waiting time performance remained in line with NHS Scotland averages. Patient waiting times remained a significant challenge and a programme of work to review base capacity was ongoing. Mr Carr noted that it would be helpful to see the detail of the demand increases referenced in the Integrated Performance Report. Mrs Grant agreed to bring this back to the next Committee meeting.

**Interim Chief
Officer, Acute**

Mrs Grant also advised that a detailed review of productivity at a Sector/Specialty level is underway; this will allow a year end trajectory to be calculated. An update will be provided to the Committee when available.

**Interim Chief
Officer, Acute**

Mr Brown stated that he was impressed by the effort, energy and commitment of staff to improve Scheduled and Unscheduled Care performance. However, it was recognised that despite this performance needed to improve. Staff are key to this and Mr Brown encouraged Members to proactively promote health and well being among staff. The Committee agreed that it would be beneficial to report sickness absence in a more meaningful way, therefore the next report will include additional information and the average working days lost. This format will be piloted at the Corporate Directors Group.

**Director of HR
and OD**

NOTED

68. CANCER ACCESS PLAN

There was submitted a paper [Paper No 17/40] by the Interim Chief Officer of Acute Services outlining the key actions being taken forward to improve cancer access target performance.

Mr Best advised that performance against the 31 day target was back at 95%, however, performance against the 62 day target remained a significant challenge.

Three specific cancer performance meetings were scheduled for October, November and December 2017 to maintain focus on improved compliance with the cancer access standards across the organisation. A set of key trajectories have been agreed:

- No patient waiting over 35 days for first appointment by 29 September 2017
- No patient waiting over 29 days for first appointment by 13 October 2017
- No patient waiting over 22 days for first appointment by 27 October 2017
- No patient waiting over 14 days for diagnostic imaging on a cancer pathway by 29 September 2017

These trajectories will disperse pressure from the end of patient journeys where some pathways become complex.

The first step in the process was to ensure patients with a suspicion of cancer were seen at an outpatient appointment within 14 days. Following this, access to diagnostic tests will be reviewed with a view to achieving diagnostic testing within 7 days.

Mr Best advised that improvements were also being made to individual cancer modality pathways, however it was recognised that this needed to be expanded.

Urology services were discussed and Mr Best confirmed that one additional surgeon was now trained in robotic prostatectomy, one surgeon was currently undergoing training and a further new appointment of a surgeon in January 2018 will provide the level of service agreed by the West of Scotland Boards.

With regard to the Breast Service, non-recurring funding from the National Access Support Team was being used to run additional Breast clinics while the Breast Strategy is finalised. In addition to this, NHSGGC will reopen discussions with NHS Lanarkshire on the referral pathway for screened positive breast cancer cases. Sixty patients from the South East of Glasgow were referred to NHS Lanarkshire for treatment in the first six months of 2017. Mr Best confirmed that these were NHS Lanarkshire patients from a stratified group that had been initially referred into NHSGGC as part of the Service Level Agreement; however, patients were repatriated for treatment following the establishment of the NHS Lanarkshire Breast Surgery Service.

Ms Brown welcomed the update but noted the challenges in improving performance. Mrs Grant advised that early booking and diagnosis was critical, the dedicated meetings to focus on this will be key in ensuring pathways were moving at an appropriate pace.

NOTED

69. MEDICAL WORKFORCE PLAN

There was submitted a report [Paper No 17/41] by the Director of Human Resources and Organisational Development setting out the Medical Workforce Plan 2017/18.

Mrs MacPherson delivered a presentation on the Acute Medical Workforce Plan 2017-18 noting that the sign off document for the plan was developed at the end of 2016/start of 2017 and much of the work will merge with the Transformational Plan.

Mrs MacPherson outlined the workforce planning actions taken to date for Medical Staff, highlighting that:

- Doctors in training will have a shared service HR process from August 2017;
- All Medical Staff attendance will be recorded through the Board's electronic tool SSTS;
- All consultant job plans to be agreed and on the ALLOCATE electronic tool by end September 2017;
- The Board will work to ensure no junior doctor was rostered to work more than 7 consecutive shifts; and
- Work is ongoing to reduce Band 3 Rotas.

Additionally, a new Medical Staff induction portal had been introduced and the associated induction programme was under review.

The next steps will involve the development of Dental and Mental Health Workforce Plans, supporting the West of Scotland Care Delivery Plan, reducing the Board's agency spend and supporting the Transformational Plan.

Mrs MacPherson advised that the Audit Scotland report on workforce planning referenced the requirement to link National, Regional and Local priorities in the short term. Specific workforce tools have been developed for Nursing and were under development for Allied Health Professionals, however there was currently no

comparable tool for the Medical workforce. It was recognised that current workforce planning will have a short term focus of 2-3 years, going forward this will link to specific service plans and a national delivery plan.

Mr Brown expressed concern that the plan required a large degree of updating, with particular reference to service changes. Many of these changes had moved on significantly and as such the plan should reflect this. Mr Brown advised that the governance arrangements for such reports needed to be stringent to ensure Committee papers give an accurate overview of the Board's current state. Mrs Grant noted that a review of governance arrangements had commenced and that going forward a rigorous process will be in place to prepare Committee papers for submission.

Dr Armstrong advised Members that Medical Workforce planning needed to cover three timeframes; immediate plans to ensure staff are working to the top of their licence, a 2-3 year plan to take account of training posts and a longer term plan to build on innovation and new ways of working.

Members discussed the challenges of workforce planning, recognising the role of Universities and attaining trainees at a national level.

It was agreed that the Workforce Plan be updated reflecting Member comments and brought back to the Committee; a work plan will also accompany this update to advise Members of progress.

**Director of HR
and OD**

NOTED

70. LOCAL DELIVERY PLAN UPDATE

Dr Armstrong delivered a presentation which provided a detailed update of the range of work being undertaken as part of the Local Delivery Plan (LDP). In relation to the Transformational Plan, a cross system team had been convened to represent Acute Services, Primary Care and HSCPs. A work plan was under development and a paper will be presented to the Board in October 2017.

A financial bid has been made to the Scottish Government to support the Transformational programme. This funding will be used to backfill posts allowing staff to focus on taking this work forward. Progress with this bid will be discussed with the Scottish Government at the forthcoming Quarter 1 Review Meeting.

Members noted the challenges of developing services for the future and the particular issue of population growth and changes to the working population profile.

Dr Armstrong took the opportunity to present a number of service review examples including the proposal for a Major Trauma Centre at the Queen Elizabeth University Hospital (QEUP). This proposal will have an impact on elective activity at the QEUP and options for redirecting this activity needed to be considered.

Winter Planning was also a current focus and a triage model will be implemented across all Sectors, ensuring patients were triaged by a Doctor on arrival. Additionally, work continued on a programme of service reviews in various areas including Gynaecology, Breast Surgery, Acute Stroke and Orthopaedics.

Mr Ritchie commended the work currently underway and noted the potential benefits for staff if elective and non-elective activity streams were largely separated.

Mr Brown stated that he was reassured by the level of work that was being undertaken and stated that plans must make the most effective use of the Board's estate to protect elective care activity.

Dr Armstrong agreed to further develop the LDP template to include timescales and Red/Amber/Green status.

**Medical
Director**

NOTED

71. QUARTERLY REPORT ON CASES CONSIDERED BY THE SCOTTISH PUBLIC SERVICES IMBUDSMAN (1 APRIL 2017 – 30 JUNE 2017)

There was submitted a paper [Paper No 17/43] from the Nurse Director which set out a summary of those Ombudsman cases that required the Board to respond to a recommendation contained within the Investigation Report or Decision Letter covering the period 1 April 2017 to 30 June 2017.

Mrs Love noted that during the period covered by the report two Investigation Reports had been received. Based on recommendations from these reports, a number of actions had been implemented and the SPSO advised of these actions.

The Ombudsman had also advised the Board that during the period covered they had decided not to take forward 13 complaints. A total of 25 Decision Letters had however been received.

Within the 25 Decision Letters received, 61 issues had been investigated with 31 being upheld. The SPSO had made a total of 59 recommendations and the report set out the date the complaint had been received by the Board, the complaint(s) investigated by the Ombudsman, each recommendation and the date by which a response was required, the response made by the Board to each recommendation, and the date on which the response had been submitted to the Ombudsman.

Mrs Love advised Members that the main themes within the SPSO recommendations focused on communication and standards of clinical treatment.

Mrs Monaghan welcomed this report and highlighted that small changes to processes would make significant improvements to patient experience, for example providing complaint responses in additional formats such as video. Ms Brown agreed with this point, noting that apology responses needed to be genuine and personal. Mrs Love agreed with these points and advised that work was ongoing to provide early resolution to complaints in a way that suited patient needs.

Mr Carr asked that trend information be included in future reports to assist in analysing performance.

Nurse Director

NOTED

72. FINANCIAL MONITORING REPORT

There was submitted a report [Paper No 17/44] by the Director of Finance setting out the financial position within the Board for the 4 month period to 31 July 2017.

Mr White delivered a presentation on the current position and took members through the report in detail. Mr White highlighted that the overall Board position at the end of month 4 was a [REDACTED] overspend, and that the Acute Division's position at Month 4 was an overspend of [REDACTED]. Overall, there were pressures within pay and the Cash Releasing Efficiency Savings (CRES) position on a year to date (YTD) basis reported a deficit. It was noted that the pay overspend was driven by medical and nursing staffing. A number of targeted schemes were being addressed, for example reducing the number of high cost Locums and premium rate nursing spend. Fortnightly meetings were taking place with the Director of Finance / Chief Executive, the Medical and/or Nursing Director, Chief Operating Officer and relevant Acute Director to monitor this area.

Mr White noted that although the current overall position was in deficit there were some areas performing well with the prescribing and supplies & sundries budgets remaining largely in balance.

Mr White updated Members on the CRES position, advising that of the [REDACTED] annual target, [REDACTED] has been phased into Month 4 which had an achieved level of [REDACTED] FYE, hence the [REDACTED] net deficit in CRES achievement at Month 4.

A new initiative had also been launched titled 'Small Change Matters', this campaign encourages staff members to identify schemes that may assist in making changes that may lead to a more efficient use of resources.

The Sustainability and Value Action Group (S&V) has been set up and will be overseen by Mr Archibald. Mr Archibald advised that the group will focus on reviewing best practice from a range of external sources as well as driving new and innovative ways to address the financial challenge. The group also aimed to energise staff input into small initiatives, in addition to supporting reduction in high cost areas.

Mr Brown welcomed the implementation of the S&V Group and noted reassurance at the group's focus on three main areas; use of analytics, use of benchmarking and best practice and embedding a culture of continuous improvement.

Mrs Brimelow asked if strong enough controls were in place to manage the medical spend. Mr White advised that this was being monitored at the fortnightly financial meetings as it did require a high level of focus. Members discussed the previous role of National Education Scotland (NES) in junior doctor funding, highlighting that this creates additional pressure on individual Boards.

Ms Grant noted the need for the Board to operate from a recurrently funded base budget and to have robust controls in place to manage this. Mrs Grant advised that a new 'Commitment Accounting' method was being piloted to draw attention to spending commitments over the coming weeks and encourage a more proactive approach to budget management across Acute Services.

Members discussed the role of HSCTs in the overall Board financial position, recognising challenges with demand management and delayed discharges. HSCT reserve levels were noted, Mr White will submit a paper to the Committee on this issue.

**Director of
Finance**

Mr Brown summarised the discussions noting confidence in the plans to reduce overspends in the coming months, and that robust control systems are in place to monitor and manage the financial challenge.

NOTED

73. REVIEW OF FIRE PRECAUTIONS AND CLADDING

There was submitted a report [Paper No 17/45] by the Director of Procurement, Property and Facilities Management updating Members on progress with actions in relation to the review of fire precautions and cladding.

Mr Archibald presented the pertinent points from the update, noting that this was a UK wide issue. In August 2017 the NHSGGC Board agreed that the cladding product used at QEUH be removed. Detailed technical work was ongoing to establish the best way to remove and replace the identified cladding on the QEUH.

Mr Archibald advised that the Scottish Government have indicated that they will provide funding support for the replacement of this cladding and discussions will continue as the final costs evolve.

The main hospital contractor Multiplex has confirmed that cladding on the Royal Hospital for Children would also require to be replaced.

Mr Ritchie asked if assurances have been given on the suitability of replacement products that will be used. Mr Archibald confirmed that the relative agencies will be required to sign off any products prior to their installation.

Mr Archibald confirmed that the safety of staff, patients and the provision of services was at the centre of this review. Members will continue to be updated on progress.

**Director of
Procurement,
Property and
Facilities
Management**

NOTED

74. ACUTE STRATEGIC MANAGEMENT GROUP MINUTES OF MEETINGS HELD ON 22 JUNE 2017 AND 27 JULY 2017

NOTED

75. DATE OF NEXT MEETING

9.00am on Tuesday 21 November 2017 in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 1.15pm

DRAFT

ASC(M)17/06
Minutes: 76-86

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Acute Services Committee held at
9.00am on Tuesday, 21 November 2017 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 (in the Chair)

Ms S Brimelow OBE	Mrs T McAuley OBE
Mr S Carr	Mrs A M Monaghan
Cllr J Clocherty	Ms A Thomson

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

Mr J Brown CBE	Mr M White
Mrs J Grant	

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

Mr J Best	..	Interim Chief Officer, Acute Services
Mr D Loudon	..	Director of Procurement, Property and Facilities Management
Mrs A MacPherson	..	Director of Human Resources & Organisational Development
Ms P Mullen	..	Head of Performance
Mr G Archibald	..	Chief Officer, Acute Services
Mrs L McGrath	..	Interim Deputy Head of Administration
Ms L Yule	..	Audit Scotland
Ms L Maconachie	..	Audit Scotland

76. APOLOGIES, WELCOME AND PRELIMINARIES

Apologies were intimated on behalf of Ms M Brown, Cllr M Hunter, Mrs D McErlean and Mr I Ritchie

77. DECLARATIONS OF INTEREST

There were no declarations of interest.

78. MINUTES OF PREVIOUS MEETING

On the motion of Ms Brimelow, and seconded by Ms Thomson, the Minutes of the

Acute Services Committee meeting held on 19 September 2017 [ASC(M)17/05] were approved as a correct record subject to the following change:

- Minute 72, Financial Monitoring Report, paragraph nine; add 'in relation to the nursing budget' to the second sentence.

NOTED

79. MATTERS ARISING

a) Rolling Action List

There was a submitted paper [Paper No 17/46] by the Director of Finance which detailed the financial reserve position for each Integrated Joint Board (IJB). Mr Finnie welcomed this update and noted that it would be helpful to indicate the percentage of the overall budget that the reserves account for.

Director of Finance

With reference to the Demand and Capacity review, Mr White noted that an overview of demand had been collated; this would be shared with the Committee.

Director of Finance

NOTED

80. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT

There was submitted a paper [Paper No 17/47] by the Interim Chief Officer of Acute Services setting out the integrated overview of NHSGGC Acute Services Division's performance.

Of the 22 measures which had been assessed against a performance status based on their variation from trajectory and/or target, 8 were assessed as green, 4 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.

Mr Best presented an overview of the report noting the red rated metrics and corresponding exception reports.

With reference to Cancer performance, the Board had met the 31 day target and a number of work streams were running to ensure this level of performance was maintained. The 62 day target remained challenging and a planned programme was in place to address performance. This included setting incremental local waiting time targets for individual cancer types. A number of improvement actions were underway including a pilot which allowed patients to be referred straight to test for a colonoscopy, thus avoiding an outpatient appointment.

Mr Finnie noted a question that had been posed via email from Mr Ritchie regarding cancer patients being sent to NHS Lanarkshire for treatment. Mr Best confirmed that as part of the Breast Cancer Service re-design work, breast screening patients that lived within the NHS Lanarkshire area were being repatriated back to their local Health Board for treatment. Dialogue with the Consultants in NHS Lanarkshire was ongoing to monitor this process.

Work was underway to improve new outpatient waiting times and the number of patients waiting over 12 weeks was reducing. Mr Best outlined some of the work that was progressing including the roll out of new patient focused booking processes. The Modern Outpatient Programme Board continued to oversee a number of improvement work streams and monthly meetings with the Scottish Government Access team were taking place to monitor waiting times.

Ongoing work to reduce Endoscopy waiting times was highlighted and Mr Best advised that a small team was working on a productivity review of this service. The Directors Access Targets Group was overseeing this piece of work. Mrs Monaghan noted the previous positive performance against this target and asked if improvement was anticipated in the coming months. Mr Best confirmed that a number of factors had impacted the service but waiting list management had been re-designed and workforce plans were under review to ensure capacity was used to its maximum.

Mr Best advised Members that performance against the Treatment Time Guarantee (TTG) for Inpatients was challenging. Additional capacity was being sought both internally and externally. The demand for spinal surgery was particularly challenging and additional external capacity was being arranged to address some of this demand. Non-recurring funding from the Scottish Government was being used to fund this additional activity. The service was also undertaking re-design work and reviewing patient pathways to reduce waiting times where possible.

The Committee discussed the current challenge of reducing Delayed Discharges, Mr Brown noted that Dr McGuire was leading the dialogue with Glasgow City Health and Social Care Partnership (HSCP). This was particularly important to assist with the preparations for Winter. Glasgow City HSCP have agreed that a team would be deployed to the QEUH and GRI Emergency departments during the Winter months to assist with patient flow and to ensure patients were seen in the most appropriate setting.

In relation to sickness absence, Mrs MacPherson confirmed that each Acute Sector/Directorate was reviewing their absence figures in conjunction with feedback from iMatters, stress management data and other information sources. Local teams were leading this and the Heads of People and Change were updating Mrs MacPherson on progress and findings. Mr Finnie noted that a regular update to the Committee on this process would be helpful. Mrs MacPherson agreed to provide 6 monthly updates going forward.

**Director of
Human Resources
and
Organisational
Development**

Mrs Monaghan noted the importance of managing sickness absence during the Winter period. Mrs MacPherson agreed with this and confirmed that contingency plans were in place should they be required. The Chiefs of Nursing had agreed these plans and additional staff had also been recruited to the staff bank to provide further support if necessary.

In summary, Mr Finnie noted that it was challenging to embed performance improvement in a way that was sustainable; improvements must become part of everyday processes. Cllr Clocherty made reference to the use of non-recurring funding to drive improvement and the importance of sustaining increased performance levels. Mrs Grant noted the ongoing work to re-design services, increase productivity and review models of care that was underway in conjunction with the use of non-recurring funding. These work streams were being implemented to ensure improved performance was sustained.

Mr Carr was encouraged with the report and noted that a fundamental change in the approach to this challenge was evident. He requested that a timeline for

Interim Chief

improvement be included in future reports to ensure robust monitoring arrangements were in place which allowed Committee Members to track progress.

Officer, Acute

NOTED

81. LOCAL DELIVERY PLAN UPDATE

Mr White presented a paper [Paper No 17/48] which asked Members to note the evolving systematic approach to providing Acute-related Local Delivery Plan (LDP) commitment updates to the Acute Services Committee. Members were also asked to note the progress made to date in implementing each of the Acute related commitments outlined in the 2017/18 LDP.

Mr White highlighted the revised summary reporting format which now included progress updates, timelines and named leads. The commitments were also rated using a Red/Amber/Green and Grey status.

Members welcomed the reporting format and systematic approach being used to monitor progress and were reassured by the update provided.

NOTED

82. FINANCIAL MONITORING REPORT

There was submitted a report [Paper No 17/49] by the Director of Finance setting out the financial position within the Board for the six month period to 30 September 2017.

Mr White noted key details from the report and advised that the overall Board position at the end of Month 6 highlights a [REDACTED] overspend. Mr White noted that as part of the mid-year process, a review of the initial Financial Plan assumptions had taken place and as such, the year-end deficit projection had been revised to [REDACTED].

Mr White updated Members on the Acute Division's financial position, noting that at Month 6 there was an overspend of [REDACTED], the largest proportion of this was due to unachieved savings. Challenges were also evident in relation to the pay budget and changes to Junior Doctor funding.

Mr White advised Members that the Scottish Government had allocated [REDACTED] of non recurring Access funding in-year. These funds were under close control and were being deployed to fund additional Outpatient capacity, additional beds and to facilitate improved patient flow. Discussions with the Scottish Government remained ongoing relating to the potential release of further funds to specifically assist with performance targets.

Members discussed the Acute Division's financial position and the variances between Acute Sectors/Directorates. Mr Best highlighted some of the complex differences between areas however agreed that rigorous financial management must be in place across all areas. Fortnightly financial meetings were in place to ensure stringent monitoring of Sector/Directorate budgets.

The Board had also now invoiced neighbouring Health Boards for delayed

discharges, Mrs Grant noted that patients must be treated and cared for in the most appropriate setting and therefore timely discharge when required was important. The Committee discussed this course of action and Mr White confirmed that although this had not yet yielded a high return the process would continue.

Mr White updated Members on the Acute Cash Releasing Efficiency Savings (CRES) position, advising that challenging targets had been set this year. At Month 6 an estimated [REDACTED] was anticipated to be achieved on a FYE basis, this was 38% of total target and 71% of the identified opportunities. This indicated that the Acute Division would carry forward a [REDACTED] deficit into 2018/19.

Mr Finnie thanked Mr White for the update and welcomed the report format. The narrative was helpful to detail the relationship between performance and finance.

NOTED

83. REVIEW OF FIRE PRECAUTIONS AND CLADDING

There was submitted a report [Paper No 17/50] by the Director of Procurement, Property and Facilities Management updating Members on progress with actions in relation to the review of fire precautions and cladding.

Mr Loudon noted that following Board support for the proposal to replace Aluminium Composite Materials (ACM's) from the Queen Elizabeth University Hospital (QEUH), the Scottish Government had confirmed that they will provide funding support for this replacement.

Mr Loudon stated that further investigations were continuing with the Board's external advisers, Health Facilities Scotland (HFS) and the main hospital contractor Multiplex. Multiplex had confirmed that a further cladding issue on the Royal Hospital for Children (RHC) had emerged, it was intended to replace the affected panels as a precautionary measure. HFS had conducted an interim risk assessment of the RHC and advised that they consider the level of risk from the external cladding to be extremely low.

Members discussed the current situation and the level of confidence in the building works that had been completed elsewhere on the QEUH campus. Mr Loudon advised that an independent report had been prepared by Currie and Brown; this report noted their considered view that there were no cladding issues in other areas. Mrs Grant confirmed that this issue was under close monitoring and all strands of the process were being overseen by senior managers to provide assurance.

Members further discussed the assurance processes that were used during building works and the need to ensure that they are duly followed. Mr Loudon described the multi-layer approach to quality assurance that is implemented and agreed that the role of the Board's advisors must be prominent in any future work.

Mr Archibald noted that the assurances had been given on the suitability of replacement products that will be used and confirmed that multi-agency sign off would be required for all products prior to their installation.

Mr Loudon also gave an update on the QEUH roof. During an annual maintenance visit to check the smoke dispersal system on the roof, the maintenance contractor accidentally activated the system resulting in ETFE pillows being compromised as designed. A temporary solution had been deployed to make the area wind and water

tight and replacement roof products had been ordered from the manufacturer. It was anticipated that the repair work would be completed in December 2017.

A contingency arrangement had been put into place for helicopter landings; this allowed helicopters to land at Glasgow Airport and this process has been used during the building phase of the QEUH. This was also the established procedure which was used during times of inclement weather.

NOTED

84. YORKHILL DISPOSAL STRATEGY

There was submitted a report [Paper No 17/51] by the Director of Procurement, Property and Facilities Management updating Members on the process to vacate the Yorkhill campus.

Mr Loudon noted the governance processes that had been put into place to manage staff and service relocation from the site. The Project Board would provide direction and oversee decision making to achieve the relocation of all services and staff. A phased vacation process was being agreed and the key objective was to relocate on to existing NHSGGC estate. This was a challenging project and would require close management.

Mr Loudon advised Members that the initial focus was on non-clinical staff, a number of key tasks had been carried out to date including completion of a space utilisation survey and scoping of existing capacity within NHSGGC estate. A cost analysis was being worked through. Once this preparatory work was completed the various options would be analysed and prioritised.

Mrs Monaghan noted the opportunity to review service provision and the potential to deliver services from other settings. Mr White agreed and noted that vacating from the Yorkhill site raised the opportunity to think innovatively and consider all options for the delivery of care.

Members welcomed the report and the inclusion of timelines. Mr Loudon agreed to bring a further update on progress to the next Committee meeting.

**Director of
PPFM**

NOTED

85. ACUTE STRATEGIC MANAGEMENT GROUP MINUTES OF MEETINGS HELD ON 24 AUGUST 2017 AND 28 SEPTEMBER 2017

NOTED

86. DATE OF NEXT MEETING

9.00am on Tuesday 16 January 2018 in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 11.00am

DRAFT

ASC(M)18/01
Minutes: 01-13

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Acute Services Committee held at
9.00am on Tuesday, 16 January 2018 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

Ms M Brown (in the Chair)

Cllr M Hunter
Mrs D McErlean

Mrs A M Monaghan
Mrs A Thomson

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

Mr J Brown CBE (Item 04b) Mr M White
Ms J Grant

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

Mr J Best	..	Interim Chief Officer, Acute Services
Mr D Loudon	..	Director of Property, Procurement and Facilities Management
Mrs A MacPherson	..	Director of Human Resources & Organisational Development
Ms P Mullen	..	Head of Performance
Ms M A Kane	..	Associate Director of Facilities
Mr J Hamilton	..	Head of Administration
Ms J Rodgers	..	Chief Nurse, Paediatrics and Neonates
Mr G Forrester	..	Deputy Head of Administration

01. APOLOGIES, WELCOME AND PRELIMINARIES

Apologies were intimated on behalf of Mr R Finnie, Mr S Carr, Mr I Ritchie, Ms S Brimelow OBE, Cllr J Clocherty, Ms T McAuley OBE.

Mr J Hamilton spoke to the Committee regarding governance arrangements, advising that having received apologies at short notice from the Chair and from the Vice Chair, Ms M Brown had been asked to Chair the meeting. Mr Hamilton sought and received from those members present affirmation that Ms Brown would Chair the meeting.

Mr Hamilton further advised that the Committee was inquorate at the calling of the meeting. Those Chair proposed and those present agreed to adjourn the meeting until 9.25am.

The meeting re-convened at 9.25am. Mr Hamilton advised that in the absence of a quorum, those present could consider items for noting, and upon a quorum being reached, any decisions could be affirmed. A quorum was reached upon the attendance of Mrs Monaghan at 9.43am, with items already considered being

affirmed.

Mr Loudon and Ms Kane provided a brief update for members on the collapse of Carillion, noting that Carillion were a sub-contractor for the Board's PFI services provider at Langland House. The Committee were advised that the main contractor had formed a company to take forward the role played by Carillion, that all staff have been retained and that services continue to be provided.

02. DECLARATIONS OF INTEREST

There were no declarations of interest.

03. MINUTES OF PREVIOUS MEETING

On the motion of Ms McErlean, and seconded by Ms Thomson, the Minutes of the Acute Services Committee meeting held on 21 November 2017 [ASC(M)17/06] were approved as a correct record subject to the following change:

- Minute 83, Review of Fire Precautions and Cladding, paragraph three; delete 'the affected panels' and add 'panels, of the wrong type which were fitted by Multiplex,' to the second sentence.

APPROVED

04. MATTERS ARISING

a) Rolling Action List

With reference to the Rolling Action List, the Committee were advised:

- an audit of PDPs would be carried out in the Autumn once the new Turas Appraisal system is in place;
- an update on SABs will be presented once the national position is determined;
- the Elective Access Collaborative Programme will be the subject of a report for the next meeting of the Committee; and
- the Medical Workforce Plan would be presented to the Committee in the Autumn.

**Director of HR
& OD**

**Medical
Director
Interim Chief
Officer, Acute
Services
Director of HR
& OD**

NOTED

b) Update on QEUH Cladding

There was submitted a paper [Paper No 18/02] by the Director of Property, Procurement and Facilities Management updating the Committee on progress and recommended options for replacement of cladding at the Queen Elizabeth University Hospital and the Royal Hospital for Children.

Tom Steele, of Health Facilities Scotland (HFS), provided advice for the Committee, and, along with Mr Loudon, received the thanks of the Committee for the work which has been undertaken to get to this point.

Mr Loudon outlined the update contained within the paper, advising that consideration had been given by senior management of the Board and by Health

Facilities Scotland to the most appropriate options available, noting that HFS viewed the risk posed by the cladding on the RCH as extremely low. It was further noted that risk workshops had taken place to consider the risks, and consideration has been given there to the results of large scale fire tests.

Mr Steele advised the Committee that national technical standards remain under review, but that the proposed Alucobond A2 non combustible cladding passed large scale fire tests and is a very stable product.

In relation to the Royal Hospital for Children, the Committee were advised that all options except Option 1 would have costs associated, and that with technical regulations under review, Option 2 would carry risks due to large scale fire test failures. Mr Steele advised the Committee that it is likely the proposed Option 3A would satisfy future technical regulations, and that Option 3B would require replacement of the existing carrier rail and Option 4 replacement of the existing carrier rail and submission of a planning application. It was noted that Multiplex had accepted their responsibility to replace the wrong boards they had sited.

Mr Steele advised the Committee that assurance as to the appropriateness of Option 3A should be taken from the support for this option HFS, Glasgow Caledonian University and the Scottish Fire and Rescue Service. The Committee considered the potential risks associated with choosing an option while national technical standards remain under review. Mr Brown advised the Committee that their consideration of the options should include the risk associated with each option, including operational risks relating to undertaking works, and also the requirement on the Board to make prudent use of public funds, and members were provided with further assurance by Mr Steele's provision of detailed technical information.

AGREED:

1. QEUH: to replace the existing Alucobond PE cladding with Alucobond A2 non combustible cladding;
2. RHC: to proceed with Option 3A which is to replace the existing cladding panels with Trespa Meteon FR low combustible cladding panels and replace the existing thermal insulation with a 75mm thickness non combustible type of thermal insulation.

05. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT

There was submitted a paper [Paper No 18/03] by the Interim Chief Officer of Acute Services setting out the integrated overview of NHS GGC Acute Services Division's performance.

Of the 22 measures which had been assessed against a performance status based on their variation from trajectory and/or target, 8 were assessed as green, 3 as amber (performance within 5% of trajectory) and 11 as red (performance 5% outwith meeting trajectory). Exception reports had been provided for those measures which had been assessed as red.

Mr Best presented an overview of the report noting the red rated metrics and corresponding exception reports.

In relation to suspicion of cancer referrals, Mr Best advised that 300 endoscopy slots had been commissioned at the Golden Jubilee, that colorectal bookings had been restructured to allow patients to take the first possible appointment across the Board area, and that a full complement of robotic prostatectomy surgeons are in place.

In relation to 4-hour wait compliance, Mr Best advised that recent pressures showed a 12% increase in A&E attendances with a particular spike within the Royal Hospital for Children, that attendance at the QEUH assessment unit had exceeded 100 daily, and that the West MIU was now seeing 30 to 35 people each day.

In relation to the stroke care bundle, Mr Best advised the Committee that it remained a challenge to undertake swallow screen tests within 4 hours.

In relation to delayed discharges, Mr Best advised the Committee that daily telephone calls took place with HSCP staff to manage delays. Mr Best noted that some patients are to be discharged to external partnerships, and that incapacity in adults can cause difficulties in discharging. Mr Best advised the Committee of ongoing work to reduce demand and to assess care package need at time of admission, but recognised delays can occur due to personal or familial choice of care provision.

In relation to sickness absence, the Committee were advised of a seasonal spike but in the context of a general downward trend from 2016-17 to 2017-18, and of the need to focus on staff as well as the data. Ms MacPherson advised the Committee of the introduction of new self-help guides for staff, and that sickness absence would remain a particular focus.

In relation to performance appraisal, Ms Macpherson advised the Committee of a 3.3% increase across Acute Services, and the Committee recognised this performance in the context of other pressures on teams.

In relation to SABs, the Committee were advised of an increase in rates, with a particular focus on the QEUH. The Committee were advised of possible increases in SABs coming in from the community, and of further interrogation of data when available, and also of the Improvement Group with four workstreams which are underway.

NOTED

06. PwC WAITING TIMES REPORT

The Director of Finance and the Interim Chief Officer, Acute Services, presented a waiting times audit report provided by PwC [Paper No. 18/04].

Consideration of the content of this report was undertaken in conjunction with item 07, below.

The Committee were advised that the audit of waiting times was designed to consider governance arrangements relating to reporting of waiting times management, and that the audit had recorded one high-, three medium-, and one low-rated finding, and that timelines for completion of actions remained outstanding.

It was recognised that the outcome of the audit was disappointing, but that the outcomes would benefit the development of a plan to manage waiting times, which would be reported to the next meeting of the Committee.

**Interim Chief
Officer, Acute
Services /
Director of
Finance**

NOTED

08. DEMAND AND CAPACITY REVIEW

There was submitted a report [Paper No 18/05] by the Interim Chief Officer, Acute Services, providing the Committee with an update on the programme of work which is ongoing to improve the Access position for patients. This report was considered along with item 06, above.

The Committee were advised that a Board Access Team would be created, with staff seconded to provide a plan for assessment of capacity. The Committee were further advised of ongoing work to increase access, including providing appointments first to those waiting longest, and increasing capacity through commissioning.

The Committee were advised that a national policy on access will be introduced and that local guidance will then come to the Board for consideration, and that continuing monitoring of trajectories will come to the Board through regular performance reporting.

**Interim
Officer,
Services** **Chief
Acute**

Mr Best advised the Committee that a range of tools were available to staff, and that consideration had been given to pursuing this project within existing staffing arrangements before forming the seconded team to focus on the project, though it was recognised that management of capacity must remain a matter for consideration by all staff.

AGREED:

- to note that the Board's Acute Access Team will oversee the delivery of the Access Improvement Programme;
- to note the improvement work and actions taken to date in 2017/18 to endeavour to manage patient access; and
- to note the productivity work which is ongoing to maximise the use of current capacity through a robust and comprehensive programme of improvement and redesign.

08. SPSO QUARTERLY REPORT

There was submitted a report [Paper No 18/06] by the Nursing Director providing the Committee with information on cases considered by the Scottish Public Services Ombudsman in the period 1st July 2017 to 30th September 2017, and asking members to note the learning and actions which have taken place as a result of SPSO consideration.

It was noted that the main themes of the matters considered by the SPSO were diagnostic and clinical treatment. The Committee were advised that all recommendations made by the SPSO have been progressed.

Consideration was given to the learning from SPSO recommendations, and it was confirmed that the recommendations are considered by professional meetings in the sector concerned and also beyond, and Mr Best advised the Committee that cross-sector clinical governance structures are in place to ensure learning from these matters becomes part of practise.

NOTED

09. FINANCIAL MONITORING REPORT

There was a report [Paper No. 18/07] by the Director of Finance providing a report

on the financial position for the month 8 period to 30 November 2017.

Mr White noted key details from the report and advised that recent pressures had brought some uncertainty around costs in the preceding weeks. Mr White further advised that short supply drugs may result in a pressure for the Board of between [REDACTED] and [REDACTED], though noted that Acute Services prescribing remained in financial balance. Mr White updated the Committee on work to ensure neighbouring Boards recognise their financial duties in relation to delayed discharge patients remaining in the Board's area, and further advised the Committee of a reduction in non-pay overspend to [REDACTED] with the equivalent figure in the previous financial year being in excess of [REDACTED].

Mr White confirmed to the Committee that better use of staff and active management on wards was resulting in reduced agency nurse usage, and Dr Armstrong advised the Committee of work being undertaken by leaders across the professions to raise awareness nationally of the high cost of some treatments and the opportunity cost of providing some drugs.

It was recognised that the Acute Service CRES saving is a key challenge and noted that the movement towards making these savings would be presented to a further meeting of the Committee.

**Director of
Finance**

NOTED

10. STATUTORY AND MANDATORY TRAINING – UPDATE ON FIRE SAFETY TRAINING REPORTING

There was a report [Paper No. 18/08] by the Interim Chief Officer, Acute Services, providing the Committee with an update on progress with improving General Awareness Fire Safety training compliance.

The Committee were advised that fire evacuation training required to be reported separately due to ongoing work with the Scottish Fire and Rescue Service to ensure that those who require to be trained are enabled to do so.

Mr Best advised the Committee that action had been taken to improve online learning numbers and monitoring of uptake by registering of payroll numbers on LearnPro, and advised that steady improvement had been made with 90% compliance forecast for 31st March 2018. It was noted that the target of 90% had been set to take account of Junior Doctor rotation and leave requirements.

The increase in current and forecast compliance was recognised, and Mr Best advised the Committee further of additional work to ensure that those without access to a computer receive notification of training needs or receive face-to-face training.

NOTED

11. YORKHILL DISPOSAL UPDATE

There was a report [Paper No. 19/09] by the Director of Property, Procurement and Facilities Management providing for the Committee an update on progress of the project to vacate the Yorkhill Campus since the last meeting of the Committee.

Mr Loudon advised that since the last meeting of the Committee work had been undertaken to complete assessment of space utilisation and desk usage, and that lessons learned from the QEUH project and guidance from the Scottish Futures Trust

would influence the Yorkhill project.

Mr Loudon further advised that work was underway to consider options within the Board's current estate including the costs of works which would be required for buildings to be refurbished or re-occupied, and further advised that work had been undertaken to understand clinical services, patient throughput and current space occupied to influence any clinical moves. Mr Loudon also noted that where existing Board properties may be re-purposed, consideration would need to be given to setting out reasons for the refreshed need for the property.

AGREED:

- to note the update on the work to date and progress made since the last Acute Services Committee; and
- to note that further updates to the Committee will continue through the course of the project.

12. ACUTE STRATEGIC MANAGEMENT GROUP: MINUTE OF THE MEETING HELD ON 24TH NOVEMBER 2017

NOTED

13. DATE OF NEXT MEETING

9.00am on Tuesday 20 March 2018 in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

ASC(M)18/02
Minutes: 14-25

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Acute Services Committee held at 9.30am on Tuesday, 20 March 2018 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 (in the Chair)

Ms M Brown	Mr S Carr
Cllr J Clocherty	Cllr M Hunter
Mrs T McAuley OBE	Mrs A M Monaghan
Mr I Ritchie	Mrs A Thomson

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	Ms J Grant
Dr M McGuire	Mr M White

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

Mr J Best	..	Interim Chief Officer, Acute Services
Mr G Forrester	..	Deputy Head of Administration
Ms MA Kane	..	Interim Director of Property, Procurement and Facilities Management
Dr I Kennedy	..	Consultant in Public Health Medicine
Mrs A MacPherson	..	Director of Human Resources & Organisational Development
Ms P Mullen	..	Head of Performance

14. APOLOGIES, WELCOME AND PRELIMINARIES

Apologies were intimated on behalf of Ms S Brimelow OBE and Mrs D McErlean.

The Chair sought and received the Committee's agreement to receive updates on ongoing business presented as a matter of urgency. These update items provided information for members on the water supply at the Royal Hospital for Children, an assault by a member of the public upon a patient receiving treatment at the QEUH, the planned closure of the West Glasgow Minor Injuries Unit, and service options for interventional radiology provision. These items were considered as part 'b' of Matters Arising at item 04 on the agenda.

The Chair further sought and received the agreement of the Committee to take a report on the Operational Plan for 2018-19 on grounds of urgency. This item was considered as item 06 on the agenda.

15. DECLARATIONS OF INTEREST

There were no declarations of interest.

16. MINUTES OF PREVIOUS MEETING

The Minutes of the Acute Services Committee meeting held on 16th January [ASC(M)18/01] were approved as a correct record.

APPROVED

17. MATTERS ARISING**a) Rolling Action List**

With reference to the Rolling Action List, the Committee were advised:

- The Elective Access Collaborative Programme was launched in Edinburgh on 12th March, that the Scottish Government has asked the Board to nominate people to take part in this, and that the Committee would be updated further once the programme is underway.

**Interim Chief
Officer, Acute
Services**

With reference to item 09 on the minute of the Committee's meeting of 16th January 2018, the Committee were advised that neighbouring Boards have been invoiced for sums due relating to delayed discharges from hospital, and that the Chief Executive has raised payment of these invoices with other Chief Executives.

NOTED

b) Update Items**Alleged Assault on Patient**

Members were advised of an ongoing Police investigation into an alleged assault on a female patient at the QEUH. Dr McGuire informed members of actions taken immediately after the incident and more recently. It was noted that as an ongoing Police investigation, little detail could be provided to members.

West Glasgow Minor Injuries Unit

Mr Best advised the Committee that the West Glasgow MIU had been opened as part of the Winter Plan, and had reported lower than expected attendances, even with wide advertising of the services provided. The Committee were advised of plans to close the MIU on 6th April 2018. It was noted that this would continue the service over the Easter weekend, and that the matter would be taken to the Finance and Planning Committee in early April.

Neurosurgery

Dr Armstrong advised the Committee of recruitment difficulties in interventional radiology, noting an international shortage of relevant staff. It was noted that interventional radiology is part of a Managed Service Network along with equivalent services in Edinburgh and Aberdeen, and that previously NHSGGC has assisted others in the Network when staffing issues have arisen. Dr Armstrong advised members that the service provides both elective and emergency treatment, and that discussion would be had within

the Network to identify the most suitable long-term solution.

Royal Hospital for Children Water Supply

Ms Kane advised members of ongoing work in discussion with Health Protection Scotland to manage water contamination at the RHC which had been identified in January. It was noted that treatment of the water supply had been carried out. Three cases of children showing effects of infection had been identified, but all had likely contracted in advance of the implementation of full infection control mechanisms. It was noted that taps would likely need to be replaced and sterilisation carried out.

It was noted that dealing with this outbreak would be disruptive to normal ward routine, but that water testing additional to that required by national guidance would look to identify the affected part of the supply. It was noted that a second round of filter testing would be carried out, and that risk assessments of the taps in use had been carried out.

18. REVIEW OF REMIT OF ACUTE SERVICES COMMITTEE

There was submitted a report [paper no. 18/11] by the Deputy Head of Administration setting out the Committee's terms of reference and asking members to consider any amendment to these. It was noted that collated terms of reference from each of the Board's standing committees would be presented to the Board on 17th April 2018 as part of the Annual Review of Corporate Governance.

Members noted that the formation of the Clinical and Care Governance Committee had presented significant changes for the work of this Committee when the terms of reference had last been considered in August 2017.

The Committee considered the terms of reference and identified no amendment required at this time.

AGREED

19. OPERATIONAL PLAN 2018-19

The Director of Finance presented report [Paper No. 18/16] setting out an initial draft of the Board's Operational Plan for 2018-19, noting that the requirement to submit an Operational Plan to the Scottish Government had only been advised of recently. It was noted that this Operational Plan for 2018-19 was a replacement for the Local Development Plan for 2018-19 and would be discussed with the Scottish Government.

Mr White advised that the Operational Plan was required to provide commitments from the Board regarding levels of performance, financial planning, access performance, working with Integration Joint Boards, and public health. It was further advised that the Operational Plan 2018-19 sets out a plan to achieve performance levels in line with those achieved in 2017, and forecast resource requirements to do so.

It was noted that the Operational Plan 2018-19 sets targets in some areas of Board work, but that other local expectations and targets may remain in addition to those in the Plan, and that the Plan is intended to enable balance

between the needs of all areas of the Board and the allocation of finite resource amongst all areas.

It was noted that the first meeting with the Scottish Government to discuss the plan submitted for the Board would take place on the afternoon of 20th March.

AGREED

20. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT

There was submitted a paper [Paper No 18/12] by the Interim Chief Officer of Acute Services setting out the integrated overview of NHSGGC Acute Services Division's performance.

Of the 22 measures which had been assessed against a performance status based on their variation from trajectory and/or target, 9 were assessed as green, 2 as amber (performance within 5% of trajectory) and 11 as red (performance 5% outwith meeting trajectory). Exception reports had been provided for those measures which had been assessed as red.

Mr Best presented an overview of the report noting the red rated metrics and corresponding exception reports.

Mr Best advised that context for the performance set out in the report is seen in the Annual Operational Plan discussed previously, and in the experience of the last two months. He noted that by the end of March winter additionality would need to be scaled back. It was noted that performance across sectors and themes is varied, though areas of significant deprivation are identified across the Board area.

In relation to suspicion of cancer referrals, Mr Best advised that focussing on inpatient CT scans during the winter period to benefit patient flow had seen some impact on performance, but that outpatient scanning was now catching up. He noted that bowel screening referrals had increased significantly, and that this would be monitored to identify reasons.

In relation to 4-hour wait compliance, Mr Best advised that work was underway to understand an identified 18% increase in attendance at the Royal Hospital for Children, and that across the service a 5% increase in attendance at ED and MIU sites, along with 2% additional attendance at assessment units.

In relation to delayed discharges, Mr Best advised the Committee that numbers were reducing overall, but that around 100 patients were delayed. It was noted that delayed discharges should be considered from a 'whole system' point of view, recognising the role of Integration Joint Boards in managing patient flow, and including consideration of patients treated on Board sites but being resident outside of the Board area.

In relation to outpatients appointments, Mr Best advised the Committee that during recent extreme weather around 5,000 patient slots had required to be cancelled, but that all were now reassigned and those affected had generally expressed understanding of the challenges faced.

**Chief
Operating
Officer, Acute
Services**

Consideration was given by the Committee to the ability to consider performance in the context of performance across Scotland, with members noting that information on relevant Scotland-wide performance would be beneficial in assessing local performance. Further consideration was given by members to the timelines for improvement set out within exception reports, and the level of information provided on forecast trajectories for improvement.

NOTED

21. PWC WAITING TIMES REPORT

Mr Best spoke to a report [Paper No. 18/13] and provided the Committee with an update on progress of actions in response to internal audit findings, noting that a project management team has been formed and objectives have been agreed, that analysis is being carried out on data regarding access, and that a waiting times tracker is being developed and will be presented to the Directors Access Meeting.

NOTED

22. SPSO QUARTERLY REPORT

There was submitted a report [Paper No 18/14] by the Nursing Director providing the Committee with information on cases considered by the Scottish Public Services Ombudsman in the period 1st October 2017 to 31st December 2017, and asking members to note the learning and actions which have taken place as a result of SPSO consideration.

It was noted that significant themes of the matters considered by the SPSO related to communication with patients and the ways in which apologies are expressed when corresponding with patients or families, and it was noted that consideration must be given to explanations provided to patients or families when matters are treated as adverse events. The Committee were advised that all recommendations made by the SPSO have been progressed, and that two cases noted in the report which remain outstanding will be reported to the Committee at a later date once finalised.

NOTED

23. FINANCIAL MONITORING REPORT

There was a report [Paper No. 18/15] by the Director of Finance providing a report on the financial position for the month 10 period to 31st January 2018.

Mr White noted key details from the report including that the Acute Division reported an overspend at month 10 of [REDACTED] against a year-to-date budget of [REDACTED], and within this pay reported an overspend of [REDACTED]. Non-pay overspend was reported as [REDACTED], down from [REDACTED] in the previous year.

In relation to short supply prescribing, Mr White advised that primary care budgets faced significant challenges due to the uses of drugs which are currently on short supply, in particular those prescribed for mental health conditions, and that Acute Division budgets are not affected to the same degree, but risk sharing for prescribing costs in 2017-18 placed a responsibility on the Board to fund primary care drugs on short supply.

Mr White further provided an update on the IJB budget-setting process, advising that good progress had been made and that the main challenges had been dealt with, including legacy debt, risk sharing and pay uplifts.

NOTED

24.a) ACUTE STRATEGIC MANAGEMENT GROUP: MINUTE OF THE MEETING HELD ON 21st DECEMBER 2017

NOTED

24.b) ACUTE STRATEGIC MANAGEMENT GROUP: MINUTE OF THE MEETING HELD ON 25th JANUARY 2018

NOTED

25. DATE OF NEXT MEETING

9.30am on Tuesday 15th May 2018 in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

DRAFT

ASC(M)18/03
Minutes: 26-35

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Acute Services Committee held at
9.30am on Tuesday, 15 May 2018 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 (in the Chair)

Ms M Brown	Mr S Carr
Cllr J Clocherty	Mrs D McErlean
Mrs T McAuley OBE	Mrs A M Monaghan
Mr I Ritchie	Mrs A Thomson
Mrs S Brimelow OBE	

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	Ms J Grant
Dr M McGuire	

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

Mr J Best	..	Interim Chief Officer, Acute Services
Mr G Forrester	..	Deputy Head of Administration
Ms MA Kane	..	Interim Director of Property, Procurement and Facilities Management
Dr I Kennedy	..	Consultant in Public Health Medicine
Mrs A MacPherson	..	Director of Human Resources & Organisational Development
Ms P Mullen	..	Head of Performance
Mr C Neil	..	Assistant Director of Finance, Acute Services
Mr A McLaws	..	Director of Communications
Mr M Gillman	..	Financial Governance Manager

26. APOLOGIES, WELCOME AND PRELIMINARIES

Apologies were intimated on behalf of Cllr Mhairi Hunter, Mr John Brown CBE and Mr M White.

The Chair sought and received the Committee's agreement to receive updates on ongoing business presented as a matter of urgency. These update items provided information for members on the water supply at the Royal Hospital for Children, and recently available Hospital Standardised Mortality Rate (HSMR) statistics. These items were considered as part 'b' of Matters Arising at item 04 on the agenda.

27. DECLARATIONS OF INTEREST

There were no declarations of interest.

28. MINUTES OF PREVIOUS MEETING

The Minutes of the Acute Services Committee meeting held on 16th January [ASC(M)18/01] were approved as a correct record, subject to amendment of items 18, Review of Remit of Acute Services Committee, to delete 'NOTED' and replace with 'AGREED', and of item 19, Operational Plan 2018-19 to delete 'NOTED' and replace with 'AGREED to be presented to the Board'.

General discussion of the content of the minute of the previous meeting noted that minutes should record discussion and challenge of non-Executive Board members.

Deputy Head of Administration

An update was provided regarding Neurosurgery as discussed at item 17b of the minute, with Dr Armstrong advising the Committee that a multi-disciplinary team has been set up with NHS Lothian, to ensure a sustainable service continues while national staffing shortages are considered and while arrangements are reviewed.

APPROVED

29. MATTERS ARISING

a) Rolling Action List

With reference to the Rolling Action List, the Committee determined that the items on SABs and the Elective Access Collaborative Programme were not actions for the Committee and so should be removed from the Rolling Action List, but that papers could be presented as required.

Interim Chief Officer, Acute Services

NOTED

b) Update Items

Royal Hospital for Children Water Supply

Ms Kane advised members that a 'lessons learned' meeting was taking place on 15th May 2018, and that it was thought likely that a high-level report being prepared by Health Protection Scotland (HPS) would be presented to the Scottish Parliament around the beginning of June and a detailed report would follow. Ms Kane advised that a briefing note would be issued to Board members once the HPS report had been finalised.

In response to a question, Ms Kane advised that a written report on the matter would be presented once HPS had finalised its reporting, and that the Board's Clinical and Care Governance Committee would be updated on the matter at its meeting on 12th June 2018.

Director of PPFM

Hospital Standardised Mortality Rate

Dr Armstrong advised the Committee that NHS Information Services Division (ISD) would publish Hospital Standardised Mortality Rate (HSMR) statistics on 15th May 2018 showing an increase across Scotland in the Rate, and noting that within the Board area the Royal Alexandra Hospital would be above the Scottish level in the published data. Dr Armstrong advised the Committee that consideration would be given to the coding of cases to ensure that accurate data is used by the Board when considering whether there is a clinical care issue. Dr Armstrong advised that there is evidence that recent changes to clinical pathways may have had an effect on coding, and that correcting coding may improve the accuracy of data and improve the HSMR. Dr

Armstrong further advised that the team had been asked to scrutinise the clinical care and all metrics to ensure the quality of care is thoroughly reviewed.

Board members queried the actions which would be taken to manage the HSMR and to ensure coding is accurately undertaken, noting that staff must recognise the importance of accurate coding, and proposed that clinicians could beneficially speak to coders to ensure understanding of the process.

It was noted that work was ongoing to promote quality of care as well as to ensure accurate coding, and noted that Health Improvement Scotland are content with actions proposed by NHSGGC to manage the HSMR.

The matter will be discussed at the meeting of the Board's Clinical and Care Governance Committee on 12th June 2018.

30. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT

There was submitted a report [paper no. 18/18] by the Interim Chief Operating Officer, Acute Services, setting out the integrated overview of NHSGGC Acute Services Division's performance.

Of the 22 measures which had been assessed against a performance status based on their variation from trajectory and/or target, 11 were assessed as green, 2 as amber (performance within 5% of trajectory) and 9 as red (performance 5% outwith meeting trajectory). Exception reports had been provided for those measures which had been assessed as red.

Mr Best presented an overview of the report noting the red rated metrics and corresponding exception reports, advising members that trajectories had been included in exception reports showing planned improvement against timescales submitted to the Scottish Government as part of the Annual Operational Plan process.

In respect of suspicion of cancer referrals, Mr Best advised the committee that performance against the 62-day target had been validated at 82.1% against a target of 95%. He advised that the Director of Regional Services had met with himself and the Chief Executive to discuss improvement, and that the Director of Regional Services would meet weekly with each sectoral Director to manage improvement. Mr Best further advised that improved bowel screening tests had led to significantly increased referrals for endoscopy.

In respect of 4-hour A&E performance, Mr Best advised that performance was 90% for the previous year, but that the service was continuing to see increasing numbers attending, and to manage this flow at the QEUH is being considered. He noted that the West Glasgow Minor Injuries Unit had now closed after the Easter break, and that staff who had been assigned to this service would now return to their substantive roles. Members noted the importance of transformational work on the capacity to manage flow and to reduce demand on emergency departments, and that emergency attendance was one part of an interconnected system. Members advised that consideration should be given to understanding of demand profiles, in particular to the increasing demand for emergency services at the RHC, and of changes in demand profiles. Members further advised that consideration should be given to those who wait more than 4-hours for attention at emergency departments to understand whether there would be patient safety implications.

In respect of Delayed Discharge, Dr McGuire advised the committee that while NHSGGC equates to around 24% of the NHS in Scotland, only 11% of delayed

discharges are within the area, but reminded members that delayed discharges must continue to improve as all are patients who do not need to remain in the hospital environment. Members commended the focus on the individual in managing delayed discharge, and agreed the reducing delays further should remain a priority. The impact of patients from other Boards was noted by members, and the requirement to understand a baseline for delayed discharges was raised. Members further raised the need to understand differing views on the impact on care and value of using intermediate care beds, and challenged Directors to ensure learning from positive management of delays was shared across sectors.

In respect of Diagnostic Tests, Mr Best advised there are currently just over 6,000 patients waiting over 6 weeks for a key diagnostic test, but that the department are catching up on slots which were lost over the winter period and that most of these patients have been seen. He noted the trajectories have been set for CT, MRI and ultrasound scans. In response to member questions on equipment and staffing, Mr Best advised that work is ongoing with radiologists to continue with the imaging replacement programme to renew equipment, and that 9 vacant radiologist posts have been filled although there remains a challenge in recruiting breast radiologists.

In respect of the Stroke Care Bundle, Mr Best advised that performance remained below target but that there has been improvement since ring-fenced beds have been identified at the RAH. He further advised the Committee that Marie Farrell, Director for the Clyde Sector, is leading a review of stroke services.

In respect of MRSA and MSSA cases, Dr Armstrong advised the Committee that analysis of rates showed that though short of target, rates remained steady over the preceding 18 months. She informed the Committee that staff from NHS Ayrshire and Arran had been invited to meet with NHSGGC staff to investigate what lessons could be learned from their experience which has led to consistently good returns.

In respect of Sickness Absence, Mrs MacPherson advised the Committee that while a 0.5% reduction in absence could be identified across the Acute Division, work required to be undertaken to more fully understand patterns of absence. Mrs MacPherson advised that more work would be done to promote the flu vaccine offered to staff, and that an absence working group had been re-established and additional services provided including relating to stress management, counselling, and mindfulness and resilience. Members queried continuing levels of absence while additional services were provided. Members further queried support from professional organisations to ensure staff take the flu vaccination, with Dr McGuire advising that while professional bodies may not compel members to take the vaccination, they can beneficially promote its use.

NOTED

31. CORPORATE RISK REGISTER

The Financial Governance Manager presented a report [Paper No. 18/19] setting out elements of the Corporate Risk Register considered to be relevant to the Acute Services Committee, noting that the Audit and Risk Committee had instituted a process to seek assurance from relevant standing committees of the Board that risks are being appropriately managed. He asked that the Committee consider the descriptions of risks as set out in the Corporate Risk Register, consider the terms of any proposed mitigating actions, and consider the appropriateness of the risk scores applied.

Consideration was given by members to the content of the presented risk register, with questions being asked regarding the value of mitigation actions which were listed but

where risk scores remained at the initial level. Mr Gillman advised that mitigation actions may have an impact which would not reduce total risk but may impact on trajectories. Members noted that it would be beneficial to understand the methodology for selecting risks which would be reported to this Committee, and that timescales for mitigating actions would beneficially be included in the Register presented.

**Financial
Governance
Manager**

NOTED

32. SICKNESS ABSENCE

There was submitted a paper [Paper No 18/20] by the Director of HR and OD advising the Committee of levels of absence in the Acute Division over the preceding 12 months. Mrs MacPherson noted that the report contained some information which had already been discussed by the Committee at item 30, above, but that she would present additional information. Mrs MacPherson further advised the Committee that her department were aiming to focus on managing attendance rather than considering absence. The inclusion of absence trajectories in the report was commended by members, though it was noted that there was a lack of consistency across sectors as trajectories were not set out by all.

**Director of HR
and OD**

NOTED

33. FINANCIAL MONITORING REPORT

There was submitted a report [Paper No. 18/21] setting out the Acute Division financial position to month 11 of 2017-18, covering the period to 28th February 2018. Mr Neil presented the report to the Committee, noting key details from the report including that the Acute Division reported an overspend at month 11 of [REDACTED] against a year-to-date budget of [REDACTED], and within this pay reported an overspend of [REDACTED]. Non-pay overspend was reported as [REDACTED], with [REDACTED] relating to unachieved savings.

Mr Neil noted significant impacts in the second half of the year, noting that premium rate nursing agency spend was now half of that seen in the previous year, but also noting that the Acute Division has been significantly affected by short supply drug costs. He further advised that unachieved CRES savings of [REDACTED] would be carried forward into 2018-19. Mr Neil further advised the Committee that month 12 figures were being collated, and that it was forecast that the Board would break even over the year.

Members queried the necessity of using non-recurring income to break even, with Ms Grant advising that the Scottish Government provide non-recurring funds to all Boards to assist Boards in the management of increased and increasing demand for services.

NOTED

34. MINUTES FOR NOTING

34.a) ACUTE STRATEGIC MANAGEMENT GROUP: MINUTE OF THE MEETING HELD ON 22nd FEBRUARY 2018

NOTED

34.b) ACUTE STRATEGIC MANAGEMENT GROUP: MINUTE OF THE MEETING HELD ON 29th MARCH 2018

Assurance was sought as to actions being taken to meet the expectations of the Health and Safety Executive. Members were advised that the Strategic Management Group were updated monthly on progress in meeting the requirements of improvement notices, and that the Operational Management Group oversaw actions being taken within the Acute Division. Members were further advised that the Board's Corporate Management Team ensured that all services were acting to meet the requirements, and that the Staff Governance Committee provided member-level oversight of actions taken and attainment against expected trajectories for meeting the terms of the notices.

NOTED

35. DATE OF NEXT MEETING

9.30am on Tuesday 17th July 2018 in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

ASC(M)18/04
Minutes: 36-47

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Acute Services Committee held at
9.30am on Tuesday, 17th July 2018 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 (in the Chair)

Ms M Brown	Mr S Carr
Clr J Clocherty	Mrs D McErlean
Mrs T McAuley OBE	Mrs A M Monaghan
Mrs S Brimelow OBE	Mrs A Thomson

OTHER BOARD MEMBERS IN ATTENDANCE

Dr J Armstrong

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

Mr J Best	..	Interim Chief Officer, Acute Services
Mr G Forrester	..	Deputy Head of Administration
Ms E Love	..	Chief Nurse for Professional Governance & Regulation
Mrs A MacPherson	..	Director of Human Resources & Organisational Development
Mr C Neil	..	Assistant Director of Finance, Acute Services

36. APOLOGIES, WELCOME AND PRELIMINARIES

Apologies were intimated on behalf of I Ritchie, J Brown, J Grant, M White, M McGuire, M A Kane & A McLaws.

NOTED

37. DECLARATIONS OF INTEREST

There were no declarations of interest.

NOTED

38. MINUTES OF PREVIOUS MEETING

The Minutes of the Acute Services Committee meeting held on 15th May 2018 were approved as a complete and accurate record.

APPROVED

39. MATTERS ARISING

The Chair asked for updates on items from the previous minute regarding Neurology & HSMR.

Dr Armstrong advised that a locum has been arranged and would take up post at the end of this week and would work in partnership with NHS Lothian. Dr Armstrong further advised that she had set up an external review to be held by George Youngson which would include experts from England. A number of slots in August have been set aside for clinical teams to meet with reviewers to discuss strengths & challenges. A Clinical Reference Group has been set up which would report to Dr Armstrong and her counterpart at NHS Lothian. It is intended that this group would report by October. Dr Armstrong finally noted that ongoing recruitment was required within NHSGGC, but acknowledged that there are challenges nationally with recruitment to Neurology posts.

In discussion Members sought clarity regarding the national and regional position and it was noted that a managed service network on a pan-Scotland basis with two centres for interventional Neurosurgery would be located in Edinburgh & Glasgow. It was further clarified in response to questions that there was no current impact on quality. Skills are utilised in Edinburgh & Glasgow although currently emergency out of hours can't be provided in Glasgow.

In relation to the Hospital Standardised Mortality Rate (HSMR), Dr Armstrong advised the Committee that the coding issue had been looked into with ISD and numbers resubmitted in early July. She advised that the revised coding resulted in additional predicted deaths between October and December with the result that recorded deaths at the RAH fall out with the highest risk area. Dr Armstrong advised the Committee that she intended to take an approach modelled on that adopted by NHS Lanarkshire, and has asked both NHS Lanarkshire and NHS Ayrshire & Arran for benchmarking numbers to allow assessment of medical staffing. She finally confirmed that a report would be submitted to Healthcare Improvement Scotland by 31st July and it was expected that she would meet with HIS in mid August.

NOTED

Rolling Action List

Members considered the rolling action list and approved the closure of 3 items marked as closed.

NOTED

40. URGENT UPDATES

WATER

Mr Best advised the Committee that an action plan was in place and that there had been no further confirmed cases. The water group meets weekly to monitor the situation and work is ongoing with Health Protection Scotland and Health Facilities

Scotland with the Chief Executive having hosted a meeting last week. Mr Best further advised that he was meeting twice weekly with relevant members of the organisation and his expectation was that all issues on the action plan would be resolved within 7 to 10 days. He further advised that HPS were due to report to the Scottish Government and it is expected that this would take place in August.

NOTED

41. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT

The Committee considered the paper 'Acute Services Integrated Performance Report' [Paper No. 18/23] presented by Mr Best, which set out the integrated overview of NHSGGC Acute Services divisions performance of the 22 measures which has been assessed against our performance status based on the variation from trajectory or target.

10 were passed as green, 5 as amber (performance within 5% of trajectory) and 7 as red (performance 5% out with meeting trajectory). Exception reports had been provided for those measures which had been assessed as red. Mr Best presented an overview of the report noting that the red rated matrix and corresponding exception reports and reminded Members that trajectories had been included in each of the exception reports. He further reminded Members that there was a two year process for Outpatient targets. Mr Best advised the Committee that the Acute Services Division are sustaining the 31 day cancer wait at between 95% and 96% and that the A&E four hour waits was expected to be almost 94% according to June figures. He further advised the Committee that numbers of patients attending A&E were almost at winter levels with A&E departments receiving 1336 visits on Monday 16th July and a further 164 at Assessment Units.

In respect of the 12 week Treatment Time Guarantee, Mr Best advised the Committee that actual performance of 5236 should be measured against a trajectory of 4624. Mr Best advised that recruitment and demand issues in Paediatric ENT were posing some challenges, noting in particular Paediatric Surgery relating to cultural and religious circumcision. Mr Best advised the Committee of action underway to address this performance challenge and noted work with the Scottish Government Access Team to review Urology; carry out a clinical and administrative review; and to target usage of theatres with a focus on consistency of process.

In response to questions Mr Best reported that robotic services are in place to assist with prostatectomy in Urology however there were issues related to recruitment of specialists and noted a view that planning for more than one year at a time would be beneficial. The Scottish Government Access Team had acknowledged this view point.

In relation to the 6 week target for key diagnostics tests, Mr Best said that current performance was at 6249 at the end of May against a trajectory of 4484. He further advised that the team were prioritising cancer related scopes and Mr Archibald advised that he had met with the Scottish Government Cancer Team to consider a revised plan.

Regarding actions to deal with performance, Mr Archibald advised of the

recruitment of 3 cytology nurses which would enable a further 7 lists to be undertaken, 2 additional locum consultant posts being advertised, and the introduction of the QFit system into the community in September, noting an expected additional 1,800 cases due to the new bowel screening process and that, while positive, this may present a challenge. Mr Best went on to advise that steady progress had been made in Radiology to return to the 6 week target position and that CT, MRI and NOU had now returned to trajectory.

In response to questions Mr Best & Mr Archibald advised the Committee of conversations with the Scottish Government about the 3 year or longer planning rather than year by year but noted that it was important that the Board dealt with its own productivity at the initial stages and that continuing reliance upon non-recurring funding would be inconsistent and unreliable.

Regarding delayed discharges, Mr Best advised the Committee of continuing work with Integrated Joint Boards (IJBs) and that at present there were 131 delayed discharges in Acute plus a further 66 in Mental Health and that IJBs are working closely with Acute colleagues to improve the number of discharges..

In response to questions from Members, Mr Best advised that there had been some difficulties recently in identifying intermediate beds and that there was increasing pressure on the system due to rising number of under 65 year old adults with incapacity. He advised the Committee of a number of processes in place to ensure capacity was maximised across the system including the sharing of best practice through the Corporate CMT approach and discussions with neighbouring NHS Boards. Work is underway on the application of trigger points if numbers of delayed discharges increase above specified levels. Committee Members asked that commentary for the exception report on delayed discharge be provided also from Chief Officers from Health and Social Care Partnerships to enhance understanding of capacity and discussed methods to ensure a full understanding of the roles of the Acute Division and the HSCPs. Mr Best advised that he would bring the report to the Acute Services Committee along with Chief Officers to provide analysis of the issues which were faced.

**Nurse Director;
Chief Officers,
HSCPs**

Regarding MRSA MSSA bacteraemia, Dr Armstrong advised that the QEUH and the GRI experienced most SAAB cases and that quarter 2 figures had reduced from 122 cases to 110. She advised of actions in place to reduce rates including focus on the QEUH & the GRI for the Acute side and signalled the identification of some progress.

Regarding sickness absence Mrs MacPherson advised the Committee of an increase of 0.6% in sickness absence and identified that this primarily relates to an increase in long term sickness. She noted that the Clyde and Regional Sectors reported an increase of 1%. Mrs MacPherson advised the Committee of a number of actions being taken to support the management of attendance at work. The Financial Improvement Programme had identified a number of actions including the promotion of case conferences for addressing individual cases, stress interventions, and a new approach to managing stress. She further advised that there would be consistency across the trajectories for sickness absence for all sectors. In recognising some improvements and processes in place, Members of the Committee noted an increase in musculoskeletal conditions and queried whether the structural environment could impact upon sickness levels. Mrs McPherson advised the Committee that there were some areas within the organisation where

individuals may require assistance in managing attendance.

In relation to TURAS appraisal Mrs MacPherson advised the Committee that there had been some issues with access to the newly launched TURAS system including those relating to transfer of KSF data from the previous system not being complete, which had led to some challenges for local management teams. She advised the Committee that she hoped to be able to provide further information for the next meeting of the Committee but added that there had been good feedback on the TURAS system. Members discussed the launch of TURAS and hoped that there would not be any evidence of the system being tainted by difficulties at the outset.

**Director of HR
and OD**

In relation to performance and statistics within the table on pages 23 & 24 of the report, Members queried the significant increase in A&E attendance numbers from 2016/17 – 2018/19. It was noted that these numbers include both Assessment Units and Minor Injury Units but noted that there had been significant increases and growth continues.

NOTED

42. COMPLAINTS REPORT

Ms Love presented a report [Paper No. 18/24] which provided a report on cases considered by the Scottish Public Services Ombudsman for quarter 4 being the period 1st January 2018 to 31st March 2018. She advised the Committee that there was one investigation report and 15 decision letters, with 25 issues upheld and 2 not upheld. She directed members of the Committee to the individual actions which have been taken in response to complaints in the report and asked that the Committee note the actions which had been taken forward. In discussion of the content of the report Members queried the lack of information on the effect of issues upon the patient noting that the severity of incidents and the impact upon patients is not part of the reported information.

Members further queried the reasoning for individuals to feel that they need to go to the Ombudsman to have complaints reviewed. Dr Armstrong reminded Members that approximately 1/3 of a million patients were treated in NHSGGC every year therefore it was essential to bear this in mind when considering the context in which complaints are managed. Members in discussing the complaints process, gave consideration to the role of Acute Services Committee and the terms of its remit noting a role for the IJBs in overseeing complaints in mental health, prisons and primary care settings. Members discussed the potential for the Acute Services Committee to analyse complaints performance with a view to service improvement. Mr Forrester advised that he would consider the Terms of Reference for the Committee and investigate possible changes to clarify the role of the Committee and the other Committees of the Board in overseeing the complaints process. Members considered the content of some of the complaints responses which were issued on behalf of the Board and noted some areas where a lack of communication and compassion could be identified, though there was general recognition of an increased quality of responses since Dr McGuire assumed the role as Director responsible for Board complaints management.

**Deputy Head of
Board Admin**

NOTED

43. CORPORATE RISK REGISTER

The Committee considered the Corporate Risk Register [Paper No. 18/25], presented by the Assistant Director of Finance, Acute Service Division.

The paper set out the elements of the Corporate Risk Register for the which the Acute Services Committee was considered to be the most appropriate Committee to exercise oversight & monitoring. Mr Neil recognised that the Committee had at a previous meeting critiqued the content of the Corporate Risk Register and noted that the new version presented today was more fulsome in its content. Members of the Committee queried the division of elements of the Corporate Risk Register between Standing Committees. Mr Best advised the Committee that he would need to consider the content of other elements of the Corporate Risk Register to identify any gaps. Mr Best went on to describe the mechanism within the Acute Service Division for the creation of Risk Registers and noted that Risk Registers were created from team level upward and in turn influenced the final inclusions in the Corporate Risk Register. Mrs MacPherson advised that the Risk Steering Group, chaired by Mr White the Board Finance Director, was responsible for identifying which risks were placed onto the Corporate Risk Register. The Committee were further advised that the Audit & Risk Committee were currently reviewing the Risk Framework however it was agreed that work would be undertaken on the cover sheet for the Acute Services Committee to ensure that it sets out appropriately the whole system of registering risk.

NOTED

44. BREAST STRATEGY

The Chair in introducing the Breast Strategy paper [Paper No. 18/26] to the Committee cited difficulty with the number and the range of persons consulted and suggested further information would be required. He also suggested that more context on the alignment and fit with regional developments would be helpful in providing a cohesive argument, and proposed that the paper be continued to a later meeting.

In considering the proposal put forward by the Chair, Members of the Committee raised concerns regarding the link between the Breast Services Review and the Moving Forward Together Transformational Programme, the reference to a public engagement process, the lack of information as to the numbers of impacted patients in the Inverclyde area and the lack of clarity regarding the view of the Scottish Health Council on the proposals being considered. Dr Armstrong agreed that the proposal would require more work before being presented for determination however reminded Members of the context and the principles of the strategy to develop a “one-stop-shop” provision with specialist services. Mr Best welcomed the input from Members of the Committee and advised that the paper would be refined and submitted in a revised format for further scrutiny.

**Chief Operating
Officer, Acute
Services**

CONTINUED TO A LATER MEETING

45. FINANCIAL MONITORING REPORT

The Committee considered the paper 'Financial Monitoring Report' [Paper No. 18/27] presented by the Assistant Director of Finance, Acute Services Division. The paper sets out the Acute Division financial position to month 2 of financial year 2018/19 and covering the period up to 31st May 2018. Mr Neil presented the report to the Committee and noted details from the report including that the Acute Division reported an overspend at the end of month 2 of [REDACTED] based on a year to date budget of around [REDACTED]. Within this, Mr Neil noted that there was [REDACTED] related to unachieved savings, [REDACTED] relating to pay, [REDACTED] relating to non-pay and an income under recovery of [REDACTED].

In breaking down the pay overspend, Mr Neil noted a medical overspend of [REDACTED] and a nursing overspend of [REDACTED]. Mr Neil went on to note that with regard to the Acute Division, a target of [REDACTED] has been agreed for the Financial Improvement Programme. Mr Neil explained that the Scottish Government has allocated just over [REDACTED] of non-recurring access funding to the Board for the financial year 2018/19 and that a further share of money given to other Health Boards in proportion to NRAC funding will also be received. Mr Neil explained the nursing budget overspend and described the [REDACTED] overspend at month 2 as a deterioration and reminded Members that in the later months of the 2017/18 financial year, there was significantly better performance in this area.

NOTED

46. MINUTES FOR NOTING

46.a) ACUTE STRATEGIC MANAGEMENT GROUP: MINUTE OF THE MEETING HELD ON 26th April 2018

The Committee considered the minute of the Acute Strategic Management Group Meeting of 26th April 2018.

NOTED

46.b) ACUTE STRATEGIC MANAGEMENT GROUP: MINUTE OF THE MEETING HELD ON 31st May 2018

The Committee considered the minute of the Acute Strategic Management Group Meeting of 31st May 2018. Assurance was sought as to actions being taken to meet the expectations of the Health and Safety Executive. Members were advised that the Strategic Management Group were updated monthly on progress in meeting the requirements of improvement notices, and that the Operational Management Group oversaw actions being taken within the Acute Division. Members were further advised that the Board's Corporate Management Team ensured that all services were acting to meet the requirements, and that the Staff Governance Committee provided member-level oversight of actions taken and attainment against expected trajectories for meeting the terms of the notices.

NOTED

47. DATE OF NEXT MEETING

9.30am on Tuesday 18th September 2018 in the Board Room, JB Russell House,
Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

ASC(M)18/05
Minutes: 48-57

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Acute Services Committee held at
9.30am on Tuesday, 18th September 2018 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 (in the Chair)

Mrs S Brimelow OBE	Ms M Brown
Mr S Carr	Cllr J Clocherty
Mrs A M Monaghan	Mrs A Thomson

OTHER BOARD MEMBERS IN ATTENDANCE

Ms J Grant	Dr J Armstrong
Mr M White	

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

Mr G Archibald	..	Chief Operating Officer, Acute Services
Mr J Best	..	Interim Chief Officer, Acute Services
Mrs A MacPherson	..	Director of Human Resources & Organisational Development
Ms MA Kane	..	Interim Director of Property, Procurement and Facilities Management
Mr A McLaws	..	Director of Corporate Communications
Ms E Vanhegan	..	Head of Corporate Governance and Administration
Ms E Love	..	Chief Nurse for Professional Governance & Regulation
Mr G Forrester	..	Deputy Head of Administration
Ms L McConnachie	..	Audit Scotland
Ms L Yuill	..	Audit Scotland

48. APOLOGIES, WELCOME AND PRELIMINARIES

Apologies were intimated on behalf of I Ritchie, D McErlean, M Hunter, J Brown, and M McGuire.

NOTED

49. DECLARATIONS OF INTEREST

There were no declarations of interest.

NOTED

50. MINUTES OF PREVIOUS MEETING

The Chair advised the Committee that due to an administrative error an early and incomplete version of the draft minute of the previous meeting had been circulated with the Committee papers. The Chair, having advised of a number of amendments which had been made to the minute in advance of his confirmation of the content, allowed the members of the Committee time to consider the content of the draft. The Chair, having reminded the Committee of the content of discussion regarding the Breast Service Review paper presented at the last meeting and in particular that the Committee had considered that the report contained a number of omissions, and needed further work before it would be ready to be considered by a Board committee, asked the Committee to confirm that the presented minute represented a complete and accurate record of the meeting of the Committee on 17th July 2018.

The Minutes of the Acute Services Committee meeting held on 17th July 2018 were approved as a complete and accurate record.

APPROVED

51. MATTERS ARISING

a) Rolling Action List

Members considered the rolling action list and approved the closure of 2 items marked as closed.

It was agreed to include items on the Breast Service Review and Delayed Discharge on Rolling Action List, and noted that Ms Vanhegan is reviewing the use of Rolling Action Lists to ensure that all items of business relevant to Board committees are recorded in a manner which enables member oversight of actions.

NOTED

40. URGENT UPDATES

WATER

Dr. Armstrong advised the Committee that three further cases had occurred in August and September which could possibly be related to issues with water and drains at the Royal Hospital for Children, and that these cases had come about subsequent to significant work undertaken by the Board in response to earlier cases. She further advised that an Incident Management Team had been instituted as per policy, and that children required to be transferred from current wards to enable investigation of the environment. In response to questions from members, Dr Armstrong, Ms Grant and Mr Archibald advised that a report providing an overview of issues identified at the QEUH and RHC site would be prepared and would be presented to the appropriate governance committee, and that the clinical safety of children would determine the arrangements for transfer from wards.

**Chief Executive,
Medical
Director, Chief
Operating
Officer Acute
Services
Division**

NOTED

51. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT

In introducing the paper 'Acute Services Integrated Performance Report' [Paper No. 18/29], the Chair remarked upon a difficult number of weeks during which throughput at acute facilities had been higher than had been expected, and noted that a positive outlook must be retained albeit members would rigorously scrutinise performance figures. The Chair further remarked that he expected each of the exception reports to be considered by the Committee to be accompanied by a timeline for improving performance or reasoning for this not being possible.

The Committee thereafter considered the paper presented by Mr Archibald, which set out the integrated overview of NHSGGC Acute Services division's performance of the 22 measures which has been assessed against our performance status based on the variation from trajectory or target.

13 were passed as green, 0 as amber (performance within 5% of trajectory) and 9 as red (performance 5% out with meeting trajectory). Exception reports had been provided for those measures which had been assessed as red. Mr Archibald advised the Committee that the Acute Services Division are sustaining the 31 day cancer wait at 94.2%, that the 18-week Referral to Treatment Time perf is currently exceeding target, that stroke bundle performance is currently exceeding target, and that Alcohol Brief Interventions, C.Diff infections and access to IVF treatment are all exceeding target.

In respect of the 62-day target for suspicion of cancer referrals, Mr Archibald advised the Committee that while the 31-day target for cancer treatments was being exceeded, the 62-day performance measure was unacceptably below target and declining against recent performance and against the national average. He advised of consideration at the Directors Access Meeting of proposals to introduce a 7-day process for access to radiology, and of a test of concept which will be tested within urology. In response to member questions, Mr White advised that consideration is given to all opportunities to improve services, and that cost increases are only acceptable where service improvement is identified. Ms Grant advised of a need to ensure that all elements of the patient pathway work appropriately, recognising that no one alteration will singly raise performance to expected levels, and Mr Archibald advised that the proposed test of concept would allow improvement to be trialled before changes made.

In respect of the 12-week new outpatient waiting times exception report, Mr Archibald advised members that the Board's performance level of 72.2% was better than that seen in some other Boards but significantly below expectations. Mr Archibald advised the Committee that there are currently three consultant vacancies in the ENT department, but that returning to trajectory for this measure was intended over the coming months. He advised of actions being taken including capacity and demand analysis, learning from other Boards, and through the FIP process providing additional capacity. In response to member questions, Mr Archibald noted the value of inclusion of trajectories for returning to target and provision of analysis of causes of decreased performance.

In respect of the 12-week treatment time guarantee exception report, Mr Archibald noted an increased number of patients waiting in excess of twelve weeks, but advised that as a percentage of eligible patients performance had increased. He noted ongoing work on capacity and demand, relating to both inpatients and outpatients, and advised of the need to return to expected performance and also ensure individual

patients are treated within appropriate timescales. J Armstrong provided the Committee with further detail on a process adopted within orthopaedics in which increased information is given to patients along with telephone access to clinics which has seen reduced requirement for appointments, and noted that there may be areas where this mechanism could be expanded to other areas.

In respect of the 6-week target for access to key diagnostic tests target, Mr Archibald advised of 6,933 patients waiting against a target of 4,067. He noted possible unintended consequences of improved screening methods increasing numbers of referrals, and advised of ongoing work to assess relative rates of referral to understand demand.

In respect of delayed discharge performance, Ms Love noted that July figures showed 125 delayed discharges providing 3,910 bed days, and advised the Committee of continuing work with Integrated Joint Boards (IJBs) to improve the number of discharges. Mr Best advised the Committee that a session with Acute Directors, IJB Chief Officers and planners had been arranged to begin preparations for the winter period and to build upon identified areas of success. Mr Archibald, in recognising members' concerns regarding the effect of challenging social care budgets and some local difficulties with private care provision, reminded the Committee that the number of delayed discharges equated to more than five full acute wards.

Regarding MRSA MSSA bacteraemia, Dr Armstrong advised that the SAB rate has decreased in the most recent figures, and that work has been undertaken to learn from the experiences of NHS Lanarkshire and NHS Lothian and to make changes to processes for the removal of IVs. Dr Armstrong further advised of the introduction of microbiologist ward walkrounds when issues are raised. In response to questions regarding timescales for proposed actions, Dr Armstrong advised that the content of exception reports on this measure would be considered to ensure that the Committee is fully advised of intended performance trajectories.

**Medical
Director**

Regarding sickness absence Mrs MacPherson advised the Committee that this year had seen the highest summer absence recorded, and that Heads of People and Change have been tasked with analysing the data to ascertain any reasons for this. She further advised that all Acute Division areas have seen increases in absence, and noted that three members of the HR and OD team have been assigned to work with local teams to support understanding of absence, and that Internal Audit have been asked to carry out work to provide assurance on the application of policy and processes at a local level. In response to member questions regarding increased levels of absence, Mrs MacPherson advised the Committee that cultural factors would be considered in understanding absence, with a focus on the use of the iMatters process and stress surveying to understand reasons why staff are absent and to help promote attendance.

In relation to TURAS appraisal Mrs MacPherson advised the Committee that Turas had been in place since April 2018 and that some issues in the introduction of this national system had contributed to a 30.6% drop in compliance. Mrs MacPherson advised the Committee that 80% compliance was expected by the end of March, and that feedback on the Turas system identified that this system is easier to use than the previous eKSF system.

NOTED

52. CORPORATE RISK REGISTER

The Committee considered the Corporate Risk Register [Paper No. 18/30], presented by the Director of Finance.

The paper set out the elements of the Corporate Risk Register for which the Acute Services Committee was considered to be the most appropriate Committee to exercise oversight & monitoring. Mr White advised members that the Risk Management Steering Group oversees the Corporate Risk Register, and agrees additions and removals. Mr White further advised members that the Acute Services Committee element of the Corporate Risk Register included items on waiting lists, delayed discharge, civil contingencies and water safety.

The Committee raised a number of matters to be developed in managing the Corporate Risk Register, including recognising the content of the Register when compiling reports, ensuring Register content is kept up-to-date, ensuring appropriate explanation of risks is provided.

**Director of
Finance**

It was noted that risk registers are increasingly used as a management tool, but that there is scope for increased usage. In response to questions from members regarding inclusion of items of the Register, Mr White advised the Committee that the Audit and Risk Committee had asked the Board's governance committees to consider the elements of the Corporate Risk Register in order to comment on their registration, and he advised that some items were registered as risks for other Committees as they extend beyond the remit of any individual committee. He noted that some items relevant to the Acute Division, including risks relating to Brexit and water, feature on risk registers which are overseen by other groups. Ms Vanhegan advised that she would look to add actions being undertaken to the content of the covering report accompanying the Corporate Risk Register for the Committee.

**Head of
Corporate
Governance
and
Administration**

NOTED

53. PERSONAL DEVELOPMENT PLANS

The Committee considered a report on Personal Development Plans (PDPs) [Paper No. 18/31], presented by the Director of HR and OD. Mrs MacPherson advised the Committee that the report presented a 'stock take', reflecting that concerns had been raised previously regarding the quality of completed PDPs and that future reporting on this matter would be undertaken using functionality within the Turas system but which is not currently available. Mrs MacPherson further advised of a focus on quality of conversation within the PDP process, and noted that the survey outcomes presented in the paper show 83% of respondents considered their PDP was given sufficient time, 71% felt supported to develop, and 71% considered they had been given sufficient feedback.

Responding to member questions on perception of importance and providing suitable time for PDPs, Mrs MacPherson advised of her intention that PDPs should be seen as a standard part of operational business and suitably prioritised.

NOTED

54. FINANCIAL MONITORING REPORT

The Committee considered the paper 'Financial Monitoring Report' [Paper No. 18/32] presented by the Director of Finance. The paper sets out the Acute Division financial position to month 4 of financial year 2018/19 and covering the period up to the end of July 2018. Mr White presented the report to the Committee and noted details from the report including that the Acute Division reported an overspend at the end of month 4 of [REDACTED] based on a year to date budget of around [REDACTED]. Within this, Mr Neil noted that there was [REDACTED] related to unachieved savings, [REDACTED] relating to pay, [REDACTED] relating to non-pay and an income under recovery of [REDACTED].

Mr White reminded the Committee of the continuing focus on financial management, noting that while NHS Scotland forecasts a national overspend of around [REDACTED], the Board is required to manage spending, pursue savings through the Financial Improvement Programme (FIP), and maximise non-recurring sources of funding. Mr White advised that significant increased scrutiny was placed on medical and nursing spend, that senior medical agency spend was reduced, and that the Board are alone in Scotland at the moment in managing prescribing spend within set budget. Ms Grant advised members that increased demand could be identified within current figures, and that increased pressure in winter months would make this even more challenging.

In responding to questions regarding the FIP, Mr White advised that external support has assisted in developing a methodology for savings and ensuring discipline, and that this has assisted in developing internal expertise also. Responding to questions on the financial challenge, Mr White reminded members of the adoption of a [REDACTED] starting point, and advised that reaching the mid-year point will allow more detailed projection to be submitted to the Scottish Government.

NOTED

46. MINUTES FOR NOTING

46.a) ACUTE STRATEGIC MANAGEMENT GROUP: MINUTE OF THE MEETING HELD ON 28th JUNE 2018

The Committee considered the minute of the Acute Strategic Management Group Meeting of 28th June 2018.

NOTED

46.b) ACUTE STRATEGIC MANAGEMENT GROUP: MINUTE OF THE MEETING HELD ON 26th JULY 2018

The Committee considered the minute of the Acute Strategic Management Group Meeting of 26th July 2018.

NOTED

57. DATE OF NEXT MEETING

9.30am on Tuesday 20th November 2018 in the Board Room, JB Russell House,
Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

ASC(M)18/06
Minutes: 58-68

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Acute Services Committee held at
9.30am on Tuesday, 20th November 2018 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 (in the Chair)

Ms M Brown
Ms D McErlean

Mr S Carr
Mr I Ritchie

OTHER BOARD MEMBERS IN ATTENDANCE

Ms J Grant
Mr M White

Dr M McGuire

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

Mr G Archibald	..	Chief Operating Officer, Acute Services
Mr J Best	..	Interim Chief Officer, Acute Services
Mrs A MacPherson	..	Director of Human Resources & Organisational Development
Mr T Steele	..	Director of Estates and Facilities
Ms A Muir	..	Head of Pharmacy
Mr C Neil	..	Assistant Director of Finance Acute
Ms E Vanhegan	..	Head of Corporate Governance and Administration
Mr G Forrester	..	Deputy Head of Administration

58. APOLOGIES, WELCOME AND PRELIMINARIES

Apologies were intimated on behalf of Cllr M Hunter, Mrs S Brimelow OBE, Mrs A M Monaghan, Mrs A Thomson, Cllr J Clocherty, and Mr J Brown.

The Chair advised the Committee that two additional items of business had been proposed for consideration, and received the agreement of the Committee for these items to be included for the meeting. The Chair advised that the additional item Presentation on the Access to New Medicines Policy would be considered as part of item 5 – Urgent Updates , which would also include an update for the Committee on actions to return the Cowlaire Decontamination Unit to normal service, and that the additional item Quarter 1 Report on Cases Considered by the Scottish Public Services Ombudsman would be taken after item 8 – Financial Monitoring Report.

NOTED

59. DECLARATIONS OF INTEREST

There were no declarations of interest.

NOTED

60. MINUTES OF PREVIOUS MEETING

Subject to amendment at page 2 – Urgent Updates, Water, to note that ventilation would comprise part of the work of the Group as had been agreed by the Committee, the Minutes of the Acute Services Committee meeting held on 18th September 2018 were approved as a complete and accurate record.

APPROVED

61. MATTERS ARISING

a) Rolling Action List

Members considered the rolling action list and discussed in detail the item on Delayed Discharge, with a focus on ensuring that management structures in place are designed to effectively manage delayed discharge on a whole-system basis. Ms Grant advised the Committee of proposed changes to the management structure which would provide additional capacity, and that both the Acute Division and the HSCPs have work to do to ensure that best use is made of the capacity which is within the system. The Chair advised that it would be beneficial for the Committee to see the whole picture of the system in order to fully understand where support is required.

In response to questions regarding waiting times performance, Ms Grant advised that the Director of Access would consider base capacity in line with the 30-month plan for waiting times.

Regarding Complaints Analysis, Ms Vanhegan advised the Committee that Terms of Reference were being considered for all Committees to ensure that these remained appropriate for the business of the Committee.

NOTED

62. URGENT UPDATES

COWLAIRS DECONTAMINATION UNIT

Mr Steele advised the Committee that following a site inspection, the auditors Lloyd's Register Quality Assurance, had suspended the accreditation certificate of the Decontamination Unit at Cowlairs. Remedial work had begun to take steps which would enable re-accreditation of the Unit. Mr Steele advised the Committee that HFS Technical staff were on-site to work on elements required for re-accreditation and that thorough cleaning including HPV had been undertaken. Mr Steele further advised that as the Cowlairs Unit is the largest single decontamination unit in Europe, this suspension of operations was impacting on provision of surgical equipment, but that support was being provided by the Unit in Inverclyde and from other Boards and the private sector. Ms Grant advised the Committee that the Board's focus was on patient safety and that investigation of the causes of the issue would follow from focussing on returning to normal

operation with as little impact on patients as possible, although it was recognised that some cancellation of patient operations would be required until the Unit was back to normal operation. It was noted that staff from across the Board had contributed to managing the issue, and the Committee asked that their thanks be extended to all staff, the management team, and those engaged from other Boards and organisations who have been involved in assisting to provide services.

ACCESS TO NEW DRUGS POLICY

Aileen Muir, Head of Pharmacy, presented to the Committee on the Access to New Drugs Policy, advising members of the stages involved in the introduction of new medicines. Ms Muir advised of new policies adopted nationally, and focussed upon arrangements for access to Ultraorphan drugs, noting that a funding pathway for these drugs has not yet been identified.

In responding to the presentation, Committee members raised points regarding public health and individual responsibility, as well as the ethical issues raised, and Mr White advised the Committee that Finance Directors nationally had raised the need to fully understand the financial implications of the policy to enable service and financial planning.

NOTED

63. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT

Mr Archibald, Chief Operating Officer, presented to the Committee the 'Acute Services Integrated Performance Report' [Paper No. 18/34], setting out the integrated overview of NHSGGC Acute Services division's performance of the 22 measures which has been assessed against our performance status based on the variation from trajectory or target. 9 were passed as green, 2 as amber (performance within 5% of trajectory) and 11 as red (performance 5% out with meeting trajectory).

Exception reports had been provided for those measures which had been assessed as red. Mr Archibald advised the Committee that the Acute Services Division are sustaining the 31 day cancer wait which has been above trajectory for five consecutive months, and performance in relation to the delivery of Alcohol Brief Interventions, C Diff. infections and access to IVF treatment exceed target. He further advised that new outpatient Do Not Attends (DNAs) continues to meet the target and is improved over previous years. Mr Archibald and Ms Grant, in response to points raised on the actions taken to improve performance across all reports, advised that the style of report would be refined to more effectively present information.

In respect of the 62-day target for suspicion of cancer referrals, Mr Archibald advised the Committee that while the 31-day target for cancer treatments was being exceeded, the 62-day performance measure remained below target and was declining against recent performance. He advised of considerable variation in performance across themes, with Urology in particular posing problems relating to national recruitment difficulties. He advised the Committee that the 7-day pilot process was underway, and that Directors consider individual patient journeys. He further advised that a cancer expert from the Scottish Government had recently

visited the service and provided complimentary feedback as well as some suggestions. Members questioned the recruitment challenges and ways of working amongst clinicians, and Mr Archibald advised that there remained a need to recruit two consultants in Urology, and that ways in which to address sub-specialist work were being investigated.

In respect of the 12-week new outpatient waiting times exception report, Mr Archibald advised members that the Board's performance level of 69.6% was better than that seen in some other Boards. Mr Archibald advised the Committee that there remained an expectation that performance would return to the planned trajectory, but it was noted that this would pose a significant challenge. Committee members discussed the actions to meet the target and gave consideration to how current expectations would be met. Mr Archibald reassured the Committee that reasons for failing to meet the required trajectory were considered in detail.

In respect of the 12-week treatment time guarantee exception report, Mr Archibald noted an increased number of patients (5,505) waiting in excess of twelve weeks, but advised that demand is up 2% in inpatient / day-case admissions compared to 2017-18.

In respect of the 6-week target for access to key diagnostic tests target, Mr Archibald advised of 6,188 patients waiting over 6-weeks against a target of 3,651. He noted possible unintended consequences of improved screening methods. He advised that a focus had been taken on the most urgent cases, and that waiting lists had reduced 8% over the previous month and 11% over the last 2 months.

In respect of delayed discharge performance, Dr McGuire noted that the July figures showed 131 delayed discharges occupying 3,965 bed days, and advised the Committee of continuing work with Partnerships to improve the number of discharges, with each having a target of 10% reduction in occupied bed days.

In respect of complaints responded to within 20 working days, Ms Vanhegan advised the Committee of July to September 2018 performance of 59% against a target of 70%. It was noted that there have been some staffing and absence difficulties in the team in recent months, and that the complaints team provide a mechanism for all departments across the Board to appropriately manage complaints received.

Regarding sickness absence Mrs MacPherson advised the Committee that absence rates as at September 2018 are 5.46% against the national target of 4%, but advised the Committee also that the national average for August 2018 was 5.36%. She further advised that there is variability in absence rates across the organisation, but that recent internal audit work has provided some helpful recommendations, and that while some local ownership of absence issues needs improvement, overall the controls in place for the organisation are good.

NOTED

64. CORPORATE RISK REGISTER

The Committee considered the Corporate Risk Register [Paper No. 18/35], presented by the Director of Finance.

The paper set out the four elements of the Corporate Risk Register for which the Acute Services Committee was considered to be the most appropriate Committee to exercise oversight & monitoring. Mr White advised members that the Risk Management Steering Group oversees the Corporate Risk Register, and advises additions and removals. Mr White further advised members that the Acute Services Committee element of the Corporate Risk Register included items on waiting lists, delayed discharge, civil contingencies and water safety.

The Committee raised a number of matters to be developed in managing the Corporate Risk Register, including ensuring that, where possible, an appropriate timescale for actions set out in the mitigation column is included. Mr White further advised the Committee that, with particular reference to the waiting times risk, the Risk Management Steering Group had considered in detail the achievability of reduced waiting times.

**Director of
Finance**

NOTED

65. FINANCIAL MONITORING REPORT

The Committee considered the paper 'Financial Monitoring Report' [Paper No. 18/36] presented by the Director of Finance. The paper sets out the Acute Division's financial position to month 6 of financial year 2018/19 and covers the period up to the end of September 2018. Mr White presented the report to the Committee and noted details from the report including that the Acute Division reported an overspend at the end of month 4 of [REDACTED] based on a year to date budget of around [REDACTED]. Within this, Mr White noted that there was [REDACTED] related to unachieved savings, [REDACTED] relating to pay, [REDACTED] relating to non-pay and an income under recovery of [REDACTED]. Mr White advised that within this picture, pay lines in the South Sector are significantly reduced and that this relates to considering individual costs and ward costs in detail, and that learning from this was being shared with other sectors and departments.

Mr White went on to describe the current situation of the Financial Improvement Programme, noting that a full year effect of [REDACTED] would leave a gap of around [REDACTED], but that he was reasonably confident of achieving [REDACTED] for the current year within the Acute Division, albeit only [REDACTED] had been realised at the half-year point.

Mr White further described actions to access the required [REDACTED] of non-recurring finance, noting that [REDACTED] had been received already, and advising that if a shortfall in this area became forecast, plans to deal with this would be taken to the Finance and Planning Committee.

NOTED

66. QUARTER 1: REPORT ON CASES CONSIDERED BY THE SCOTTISH PUBLIC SERVICES OMBUDSMAN (1 APRIL 2018 – 30 JUNE 2018)

The Committee considered the paper 'Quarter 1: Report on Cases Considered by

the Scottish Public Services Ombudsman (1 April 2018 – 30 June 2018)' [Paper No. 18/37] presented by the Nursing Director and the Head of Corporate Governance and Administration. It was noted that 16 decision letters had been issued by the SPSO, identifying 32 issues and making 37 recommendations, and that in all cases the SPSO had noted the expectation that the Board would write to the individual to apologise.

The Committee were advised that all points of learning are taken to local clinical and care governance forums, and that shared learning had a focus on communication and interaction with patients.

Issues relating to communication were noted by the Nursing Director as having reduced as compared to previous periods, but it was noted that complaints had been dealt with which related to almost all hospital sites. In recognition of the time of issuing the report, and to allow full consideration of its content, it was agreed that the report would again be presented to the next meeting of the Committee along with the next quarter's report.

**Head of
Corporate
Governance
and
Administration**

NOTED

67. MINUTES FOR NOTING

67.a) ACUTE STRATEGIC MANAGEMENT GROUP: MINUTE OF THE MEETING HELD ON 30th AUGUST 2018

The Committee considered the minute of the Acute Strategic Management Group Meeting of 30th August 2018.

NOTED

67.b) ACUTE STRATEGIC MANAGEMENT GROUP: MINUTE OF THE MEETING HELD ON 27th SEPTEMBER 2018

The Committee considered the minute of the Acute Strategic Management Group Meeting of 27th September 2018.

NOTED

68. DATE OF NEXT MEETING

9.30am on Tuesday 15th January 2019 in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

ASC(M)19/01
Minutes: 01-15

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Acute Services Committee held at
9.30am on Tuesday, 15th January 2019 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 (in the Chair)

Ms M Brown	Mrs S Brimelow OBE
Cllr J Clocherty	Mr I Ritchie
Mrs A Thomson – to item 10	

OTHER BOARD MEMBERS IN ATTENDANCE

Ms J Grant	Dr J Armstrong
Mr M White	Dr L de Caestecker

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

Mr J Best	..	Interim Chief Operating Officer, Acute Services
Mrs A MacPherson	..	Director of Human Resources & Organisational Development
Mr T Steele	..	Director of Estates and Facilities
Mr A Hunter	..	Director of Access
Mr A McLaws	..	Director of Corporate Communications
Mr C Neil	..	Assistant Director of Finance Acute
Ms E Vanhegan	..	Head of Corporate Governance and Administration
Mr G Forrester	..	Deputy Head of Administration
Ms L Yule	..	Audit Scotland
Ms R Weir	..	Scott-Moncrieff

01. APOLOGIES, WELCOME AND PRELIMINARIES

Apologies were intimated on behalf of Mr S Carr, Ms AM Monaghan, Cllr M Hunter, and Mr J Brown.

NOTED

02. DECLARATIONS OF INTEREST

There were no declarations of interest.

NOTED

03. MINUTES OF PREVIOUS MEETING

The Minutes of the Acute Services Committee meeting held on 20th November 2018

were approved as a complete and accurate record.

Mrs M Brown advised that the previous minutes did not fully record comments from committee members and adopted a passive style. Ms Vanhegan advised that consistency of minuting style across committees would be considered.

**Head of
Corporate
Governance
and
Administration**

APPROVED

04. MATTERS ARISING

a) Rolling Action List

Members considered the rolling action list [Paper No. 19/01] and agreed to close the two items recommended for closure.

NOTED

05. URGENT UPDATES

Dr Armstrong provided an update for committee members on actions underway at Ward 6A in the QEUH in response to identification of Cryptococcus infection. Dr Armstrong advised that contact had been made with parents of children currently on the Ward, that investigation was underway into potential issues, prophylactic medicines had been provided, and that monitoring of infection rates would continue, though they remained as would be expected. Dr Armstrong advised members that the regular Healthcare Associated Infection report presented to the Board would report on the issue.

NOTED

06. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT

Mr Best, Interim Chief Operating Officer, presented to the Committee the 'Acute Services Integrated Performance Report' [Paper No. 19/02], setting out the integrated overview of NHSGGC Acute Services Division's performance of the 22 measures which has been assessed against our performance status based on the variation from trajectory or target. 8 were passed as green, 3 as amber (performance within 5% of trajectory) and 11 as red (performance 5% out with meeting trajectory). Mr Best advised the Committee that changes had been made to the report style to take into account feedback from members, and to provide context for performance measures, including the numbers of outpatients, inpatients and ED attendees compared with the preceding year. Committee members welcomed the inclusion of context within the report, but noted concerns that evidence of understanding of underlying issues, which would help members understand the challenges faced and potential impact of planned actions, were inconsistent across exception reports. Committee members further queried the potential challenges associated with making transformational change within the Moving Forward Together programme while also aiming to tackle increasing demands upon services. Ms Grant advised the Committee that action was required to deal with the fact that patients were currently waiting too long to access services, and that this would be appropriately undertaken through improving productivity and efficiency, providing additionality, and redesigning services, both through small

changes locally and through strategic transformational change. Dr de Caestecker advised the Committee that initial work on understanding increasing demand had been undertaken, and would be reported upon later in the meeting, but reassured the Committee that wider research is also underway.

Exception reports had been provided for those measures which had been assessed as red, and advised the Committee that a full update on the Stroke Care Bundle would be provided to the next meeting of the Committee. Mr Best advised the Committee that performance in Alcohol Brief Interventions, C. Diff infections and IVF treatment continue to meet or exceed target, and that performance for access to key diagnostic tests, access to new outpatient appointments, and new outpatient 'Do Not Attends', shows improvement against recent periods.

In respect of the 62-day target for suspicion of cancer referrals, Mr Best advised the Committee that performance remained below target and had declined slightly against recent performance. He advised of considerable variation in performance across cancer modalities, with Urology and Colorectal in particular proving challenging. He did, however, advise the Committee that while Breast, Head and Neck, and Upper GI measures remained below target, five types – Lung, Cervical, Lymphoma, Ovarian and Melanoma – showed performance in excess of target. He advised the Committee that two areas were the focus for management: Breast, where an additional locum had been appointed; and the implementation of 7-day waiting times for some types.

In respect of the 12-week new outpatient waiting times and the 12-week treatment time guarantee exception reports, Mr Best advised members that work was being done to review capacity and demand, and that weekly booking targets for each speciality had been introduced. Mr Best further advised that suspension of operations at the Cowllairs Decontamination Unit had led to some delays and challenges, but that all patients affected had now been rebooked or had been seen already, and that the return to regular business should help in achieving performance targets, along with contracts for 25 spinal operations per month to be carried out in the independent sector and for some additional work to be undertaken at the Golden Jubilee.

In respect of the 6-week target for access to key diagnostic tests target, Mr Best advised of 5,174 patients waiting over 6-weeks against a target of 3,234, but noted that steady improvement could be seen in performance, and highlighted that numbers waiting in November 2018 were down 20% on September 2018 figures. He further noted a 42% reduction in numbers waiting for a radiology test since October 2018 figures. In response to questions from the Committee, Mr Best advised that he hoped performance on these targets would remain stable over coming months, though a number of posts remained vacant, as a locum endoscopist had been appointed, the Golden Jubilee were now taking 100 patients per month for scopes, and additional weekend scopes had been contracted at the QEUH site.

In respect of delayed discharge performance, Mr Best advised of a focus on daily monitoring of patients to increase opportunities for patients to be discharged including considering ways in which to start homecare earlier or undertake assessments in the home rather than in hospital. Ms Grant advised the Committee that it was important to ensure that beds remained available in Acute for those who required them, but also that the needs of the delayed patient must be kept in mind

as remaining on an Acute ward when unnecessary is not beneficial for the patient who requires a more homely environment. The Acute Services Division and the Health and Social Care Partnerships will review their systems and processes in order to increase opportunities for patients to be discharged in a timely manner, and the outcome of this work will be reported to the Committee.

Nurse Director

In respect of 18-week Referral to Treatment, Mr Best advised that recent focus on tackling long waits had led to an increase the percentage of patients waiting in excess of 18-weeks, but that he hoped that numbers would re-stabilise.

In respect of MRSA/MSSA Bacteraemia, Dr Armstrong advised that SAB cases per 100,000 patients were significantly below national performance, and had fallen 17% on figures for the previous quarter.

In respect of complaints responded to within 20 working days, the Committee agreed to consider performance along with item 13 on the agenda, Patient Experience Report – Summary Report Questers 1 & 2.

Regarding sickness absence Mrs MacPherson advised the Committee that absence rates had spiked earlier than had been anticipated, and were 6% against a target of 4%, with national performance being 5.53%. Mrs MacPherson advised the Committee that the Audit and Risk Committee had considered an internal audit report on sickness absence and a related action plan. She further advised that support for addictions and mental health had been increased with dedicated staff appointed in some areas, and that the main reasons for absence were stress and musculo-skeletal. In response to questions, Mrs MacPherson advised that the Staff Governance Committee would have oversight of planned actions, and that activity would continue into March or April.

NOTED

07. FINANCIAL MONITORING REPORT – MONTH 8

The Committee considered the paper 'Financial Monitoring Report' [Paper No. 19/03] presented by the Director of Finance. The paper sets out the Acute Division's financial position to month 8 of financial year 2018/19 and covers the period up to the end of November 2018. Mr White presented the report to the Committee and noted details from the report including that the Acute Division reported an overspend at the end of month 8 of [REDACTED] based on a year to date budget of around [REDACTED]. Within this, Mr White noted that there was [REDACTED] related to unachieved savings, [REDACTED] relating to pay, [REDACTED] relating to non-pay and an income under recovery of [REDACTED]. Mr White advised that within this picture, nursing and senior medical pays were positive over the period from month 5, with salary underspends in the South sector and Regional Directorate, though Mr White reminded members that focus had to be maintained on keeping costs down and on realising savings made. Mr White further advised that NHSGGC's Acute Division is one of only a small number in Scotland currently maintaining drug spend within allocated budgets.

Mr White went on to describe the current situation of the Financial Improvement Programme, noting a currently forecast full year effect of [REDACTED], and advising

that realisation of savings was forecast to continue in the final quarter of the year with current achievement totalling [REDACTED] within Acute. In response to questions from the Committee, Mr White advised that significant savings had been identified early in the FIP process and realised from within Prescribing and Income budgets, but that as the programme developed finding new savings had become more challenging, and noted that some of the more complex schemes identified, particularly around efficiency and productivity, already required time to realise. However, good progress had been made in year as regards improving data and systems and processes and Mr White further advised the Committee that the external consultants had introduced a methodology for the project and a rigour which has been taken on by the internal Project Management Office, and it is anticipated that the focus and profile of the FIP would continue into the next financial year.

NOTED

08. WAITING TIMES IMPROVEMENT PLAN

The Committee considered the paper 'Waiting Times Improvement Plan' [Paper No. 19/04] presented by the Director of Finance. Mr White advised that the Scottish Government's Waiting Times Improvement Plan had been published in October 2018 and prioritised three areas for action: i. Increasing capacity across the system; ii. Increasing clinical effectiveness and efficiency; and, iii. Designing and implementing new models of care. Mr White advised that [REDACTED] in funding had been brought forward into 2018-19, and that NHSGGC had made funding bids for [REDACTED], which had been approved, and for [REDACTED] which would be considered as part a the second tranche of funding.

Committee members raised queries regarding the use of currently available funds in building sustainable services in the face of increasing demand, and linkages with the Moving Forward Together transformational programme. Mr White advised the Committee that a comprehensive update on the Waiting Times Improvement Plan would be presented to the March 2019 meeting of the Committee.

**Director of
Finance**

NOTED

09. CORPORATE RISK REGISTER

The Committee considered the Corporate Risk Register [Paper No. 19/05], presented by the Director of Finance.

Committee members queried the inclusion of items relating to water safety and clinical waste on the Corporate Risk Register, with Mr White advising that he would confirm whether they appeared on sections of the Register presented to other Governance Committees. Mr White further advised that consideration would need to be given to the development of the Scottish Government's 30-month Plan in considering how to most appropriately record risks associated with waiting times within the risk management structures in place.

**Director of
Finance**

NOTED

10. COWLAIRS DECONTAMINATION UNIT UPDATE REPORT

The Committee considered a report Cowlaire Decontamination Unit Update [Paper No. 19/06], presented by the Director of Estates and Facilities, providing background to the suspension of activities at the Cowlaire Decontamination Unit, advising of the work undertaken to manage the situation and minimise the impact on patients, and advising that an internal investigation is underway. Mr Steele further advised that a report on the conclusion of the internal investigation would be presented to the Committee at its next meeting, and that a debrief session for staff involved in managing the situation would be held later in January.

In response to questions from the Committee, Mr Steele advised that issues which had been raised by the auditors prior to the licence being suspended had been rectified, enabling the re-opening of the Unit, and that at the current time it was hoped that the report as presented would provide assurance for the Committee that actions were being taken which would enable further assurance for the Committee that the Unit was functioning appropriately. Committee members queried the level of information which had been included within the report, with Ms Grant advising that fuller information would be provided through the presentation of a further report on the issue, but noted the important contribution made by staff within the Decontamination Team and beyond in maintaining services for patients and in rescheduling appointments where necessary.

NOTED

11. TRENDS IN ACCIDENT AND EMERGENCY ACTIVITY – UNDERSTANDING INCREASING DEMAND

The Committee considered a report Trends in Accident and Emergency Activity – Understanding Increasing Demand [Paper No. 19/07], presented by the Director of Public Health. Dr de Caestecker advised the Committee that Accident and Emergency included Emergency Departments and Minor Injury Units, and in presenting slides to accompany the report, set out for the Committee work which had been undertaken to provide an initial analysis of increasing demand and to identify next steps for further detailed work.

Dr de Caestecker described associations between the types of patients seen in EDs and the capacity to comply with the 4-hour waiting time, and in particular set out associations between lower levels of compliance with the 4-hour target and numbers of very elderly patients attending from affluent areas. Committee members commented on the quality of work set out within the report, the importance of working alongside HSCP partners, and the value of this initial report in identifying further detailed analysis which is required. Mr Best reminded the Committee of work which has been undertaken to help patients identify the most appropriate services within the Board area to meet their needs.

NOTED

12. MEDICAL AND DENTAL WORKFORCE UPDATE

The Committee considered a report Medical and Dental Workforce Update [Paper No. 19/08], presented by the Director of Human Resources and Organisational Development. Mrs MacPherson set out for the Committee an update on the

position of the medical workforce which would provide a baseline for work to be undertaken through the Moving Forward Together transformational programme, and advised the Committee of workforce challenges which are faced within the Board.

Committee members queried the forecast impact of Brexit upon the workforce and the level of challenge which this may bring, and Mrs Vanhegan reminded members that a focussed Steering Group within the Board is considering the potential impact of Brexit on all aspects of the Board's functions, and advised that this Group has now increased the frequency of meetings to ensure that potential impacts are fully considered. She further advised that discussion at a Board seminar will focus on Brexit preparations.

**Head of
Corporate
Governance
and Board
Administration**

Committee members raised issues regarding organisational culture and reputation and their potential effect upon the workforce, the role of trainees in complementing medical staffing of departments, and the potential impact on other states of attracting doctors to work within NHS Greater Glasgow and Clyde. Mrs MacPherson advised that a number of the challenges which are faced are similar to those faced by other Boards, but that there is a focus on identifying creative solutions and also on ensuring that services are provided to patients by appropriate staff.

NOTED

13. PATIENT EXPERIENCE REPORT – SUMMARY QUARTERS 1 & 2

The Committee considered a report Patient Experience Report – Summary Report Quarters 1 & 2 [Paper No. 19/09], presented by the Head of Corporate Governance and Board Administration, which sets out a summary of the information relevant to the Acute Services Division from within the Patient Experience Report which is presented to the Board's Clinical Care and Governance Committee, noting that as requested at the previous meeting of the Committee the information relevant to Quarter 1 had been re-presented to accompany the information for Quarter 2.

Ms Vanhegan advised the Committee that the formulation of the Patient Experience Report is part of the consideration as to the most appropriate governance mechanism to ensure oversight of patient experience reporting. She went on to advise that performance against target for Stage 2 complaints remained below expectations, and that analysis will be undertaken to understand the reasons for falling below target and to understand trends in complaints. Committee members thanked Ms Vanhegan for presenting the information in the report, and agreed that analysis of complaints and trends would be beneficial.

NOTED

14. MINUTES FOR NOTING

14.a) ACUTE STRATEGIC MANAGEMENT GROUP: MINUTE OF THE MEETING HELD ON 25th OCTOBER 2018

The Committee considered the minute of the Acute Strategic Management Group Meeting of 25th October 2018.

NOTED

14.b) ACUTE STRATEGIC MANAGEMENT GROUP: MINUTE OF THE MEETING HELD ON 29th NOVEMBER 2018

The Committee considered the minute of the Acute Strategic Management Group Meeting of 29th November 2018.

NOTED

15. DATE OF NEXT MEETING

9.30am on Tuesday 19th March 2019 in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

ASC(M)19/02
Minutes: 16 - 28

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Acute Services Committee held at
10.00am on Tuesday, 19th March 2019 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 (in the Chair)

Ms M Brown
Cllr J Clocherty
Mr S Carr

Ms S Brimelow OBE
Mr I Ritchie
Mrs D McErlean

OTHER BOARD MEMBERS IN ATTENDANCE

Ms J Grant
Mr M White

Mr J Brown CBE
Dr M McGuire

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

Mr J Best	..	Chief Operating Officer, Acute Services
Mrs A MacPherson	..	Director of Human Resources & Organisational Development
Mr T Steele	..	Director of Estates and Facilities
Mr D Leese	..	Chief Officer, Renfrewshire HSCP (Until item 21)
Mr D Williams	..	Chief Officer, Glasgow City HSCP (Until item 21)
Mr C Neil	..	Assistant Director of Finance Acute
Ms E Vanhegan	..	Head of Corporate Governance and Administration
Ms L Yule	..	Audit Scotland
Mrs G Mathew	..	Secretariat Manager (Minutes)

16. APOLOGIES, WELCOME AND PRELIMINARIES

Apologies were intimated on behalf of Cllr Mhairi Hunter, Ms Anne Marie Monaghan and Dr Jennifer Armstrong.

NOTED

DECLARATIONS OF INTEREST

There were no declarations of interest.

NOTED

17. MINUTES OF PREVIOUS MEETING

The Minutes of the Acute Services Committee meeting held on 15th January 2019 were approved as a complete and accurate record, subject to the following amendments:

Page 1 – Item 01 – Apologies, Welcome and Preliminaries – Mrs Dorothy McErlean’s apologies were noted.

Page 2 – Item 05 – Urgent Updates – Paragraph amended to:-

“Dr Armstrong provided an update for committee members on actions underway at Ward 6A and other areas within the QEUH/RHC in response to identification of Cryptococcus infection. Dr Armstrong advised that contact had been made with parents of children currently on the Ward, that investigation was underway into potential sources, prophylactic medicines and hepafilters had been provided, and that ongoing monitoring of these unusual types of infection was in place.

Dr Armstrong also reported that key infection parameters for the QEUH and RHC remain within expected levels. Dr Armstrong advised members that the regular Healthcare Associated Infection report presented to the Board would report on the issue.”

APPROVED

18. MATTERS ARISING

a) Rolling Action List

Members considered the rolling action list [Paper No. 19/10] and agreed to close the five items recommended for closure.

The Committee agreed to the closure of Minute No. 03 of the Rolling Action List – Committee Minutes.

In addition, Mr Carr noted that there was an outstanding action in relation to the analysis of increased demand, and Dr de Caestecker advised that further work was underway and would be presented to a future meeting in due course. The Committee agreed to add this item to the rolling action list.

**Dr de
Caestecker**

NOTED

19. URGENT UPDATES

There were no items of urgent business noted.

20. DELAYED DISCHARGE PERFORMANCE IN THE ACUTE HOSPITAL SYSTEM IN NHSGG&C

The Committee considered a paper ‘Delayed Discharge Performance in the Acute Hospital System in NHSGG&C’ [Paper No. 19/15] presented by Mr Williams, Chief Officer, Glasgow City HSCP, and Mr Leese, Chief Officer, Renfrewshire HSCP.

The paper provided a comprehensive description of the current position regarding delayed discharge performance within NHSGG&C and identified ways in which outcomes could be improved.

The paper included a short explanation of each of the HSCPs activities and three case studies, which represented the characteristics frequently seen when discharge is delayed. Mr Williams noted the areas for improvement and highlighted the management activities being progressed to address those delays which were more complex.

Mr Finnie thanked Mr Williams and Mr Leese for the update and invited questions from Committee members.

Committee members were pleased to receive the report and noted that it also would be useful to discuss this report at IJB meetings. Further information in relation to preventative measures such as different models being considered; additional assistance that could be offered over the winter months; and prevention of hospital admissions was requested by members. Members would like to receive an update report which included these areas.

**Mr
Williams/Mr
Leese**

In response to questions from Committee members in relation to the legal aspects of delayed discharge, Mr Williams assured the Committee that the Head of Corporate Governance & Administration along with the Legal Team continue to work closely with the Central Legal Office to ensure legal compliance.

In response to questions from Committee members in relation to work with the Mental Welfare Commission, Mr Williams noted that ensuring the welfare and protection of patients rights remained the highest priority. The Legal Team continued to work closely with the Central Legal Office to ensure this.

In response to questions from Committee members in relation to the provision of support for adults with incapacity; specialised services for patients with alcohol related brain damage and what type of support can be offered within the community, Mr Leese advised that the work of the Primary Care Improvement Plan would allow more flexibility to develop wider skills sets within the community, which would allow a greater opportunity to provide more care within a community setting.

In response to questions from members in relation to the direction and next steps, Mr Leese advised that there were three key elements being progressed. These were:

- Moving Forward Together Programme
- Proactive approach to adopt successful pilot schemes such as the COPD pilot undertaken in NHS Forth Valley.
- Investment to create transitional capacity to shift the balance of care.

In response to questions from Committee members about the availability of resource, Mr Williams felt that consideration needed to be given to investment which was already available through funding streams and how resource could be used more effectively.

In response to comments from Committee members in relation to comparative performance; quantifying the impact of delayed discharge; and to what extent earmarked reserves would have on delayed discharge, Mr Williams advised that he would be happy to develop and provide this information.

Mr Williams

In response to questions from Committee members in relation to those with complex needs, Mr Williams noted that a paper in relation to Mental Health and Learning Disability Services would be provided to the next Committee meeting.

Mr Williams

Committee members requested that a graph be included on page 2 of the report to detail information for those over 65 years of age, in addition to those over 75 years of age.

Mr Williams

Mr Best assured Committee Members that there was a commitment to work together with HSCPs and Acute colleagues to address delayed discharge as a priority.

Mr Finnie thanked Mr Williams and Mr Leese for the update. The Committee were content to note the paper and would expect an update in due course.

Mr Williams

NOTED

21. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT

Mr Finnie raised an issue in respect of the information contained within the report in its current format and felt that work was required to explore other reporting formats, more appropriate for the Committee. Mr Finnie suggested that he convene a meeting with Mr Best, Ms Vanhegan, Mr White and non-executive board member representatives, to consider alternative formats and flow of information to satisfy Board requirements. Committee members were in agreement with the proposed actions.

**Mr Best/Ms
Vanhegan**

The Committee considered the Acute Services Integrated Performance Report [Paper No. 19/11] presented by the Director of Finance, Mr Mark White.

The report sets out the integrated overview of NHSGGC Acute Services Division's performance of the 22 measures which have been assessed against performance status based on the variation from trajectory or target. 8 were passed as green, 1 as amber (performance within 5% of trajectory) and 13 as red (performance 5% out with meeting trajectory). Performance in relation to the number of Alcohol Brief Interventions delivered; the number of C.Difficile infections; and access to IVF Treatment continued to meet or exceed target/trajectory. Compliance with the overall stroke care bundle has improved when compared to the same period of the previous year. Whilst performance remains below target in relation to the number of patients waiting >6 weeks to access a key diagnostic test, current performance represents a reduction (6.8%) on the number of patients waiting over six weeks in January 2019 compared to December 2018. The new outpatient appointment 'Did Not Attend's' (DNA) continued to meet trajectory and was showing an improvement when compared to the same period of the previous two years.

Mr Best noted the areas which had provided an exception report and began with the Suspicion of Cancer Referrals. As at January 2019, 75.5% of patients with an urgent referral for suspicion of cancer started their treatment within 62 days of referral. Mr Best noted a number of actions underway to address performance within specific areas and advised that a workshop session with Chiefs of Medicine, Directors and Managers took place on Tuesday 12th March, to identify key

challenges. A number of actions were identified and have been implemented.

As at January 2019, 67.4% of available new outpatients were waiting 12 weeks or less for a new outpatient appointment. Mr Best reported a number of initiatives underway to address performance in this area, including greater focus on maximising productivity; the roll out of Patient Focussed Booking; referral triage to ensure patients are directed into the most appropriate pathway from the outset; and daily reviews by the Referral Management Centre of all cancelled appointments to ensure full utilisation of capacity.

As at January 2019, a total of 7,482 patients were waiting > 12 weeks TTG for an inpatient/day case procedure. This was above the trajectory of 3,292. The closure of the Cowlares Decontamination Unit has had an impact on this area of performance. The trajectory for the end of March 2019 is 2,809. Many actions were being taken forward including the Waiting Times Improvement Plan and realignment of capacity.

As at January 2019, there were a total of 5,608 patients waiting > 6 weeks for one of the key diagnostic tests and investigations. This was in excess of the trajectory of 2,818. Mr Best described the plans in place to improve performance in this area including additional endoscopy capacity at GJNH; additional Saturday sessions at Stobhill and Gartnavel; and continued use of Medinet to support endoscopy sessions at QEUH.

Discussion took place about delayed discharge, specifically in relation to patients out with the Board area and it was suggested that there could be a return to invoicing procedures to other Board areas. Mr White noted that this had been used before however there was an informal agreement in place with other Board areas that this practice would not be undertaken on the proviso that there were improvements in performance. Mr White could revisit this, however it was suggested that this may be a decision for the Finance & Planning Committee, and Ms Vanhegan agreed to consider the most appropriate governance process for agreement.

Ms Vanhegan

Compliance with Stage 2 Complaints continued to be a challenge, due to increased sickness absence within the Complaints team. Dr McGuire assured the Committee that extensive work was underway to improve performance.

Mrs MacPherson noted that the sickness absence rate in January had increased from the December position. A root and branch review of guidance and policy was underway. Following questions from Committee members regarding how sickness absence rates could be addressed, Mrs MacPherson noted that extensive support had been provided to managers and suggested that further work was needed in relation to reduction of stress. The Scottish Government expect a further reduction in sickness absence by 0.5% by 2020, and Mrs Grant suggested that focus groups with staff would be useful in identifying what is important to staff.

NOTED

22. FINANCIAL MONITORING REPORT – MONTH 10

The Committee considered the paper 'Financial Monitoring Report' [Paper No. 19/12] presented by the Director of Finance, Mr Mark White. The paper sets out the Acute Division's financial position to month 10 of financial year 2018/19 and covered the period up to 31st January 2019. At the end of month 10, the Board reported an over spend of [REDACTED]. The Acute Division reported an over spend of [REDACTED] at the end of month 10. [REDACTED] of this was related to unachieved savings; [REDACTED] related to pay; [REDACTED] related to non-pay; and an income under recovery of [REDACTED]. Mr White described achievements made within the medical and nursing pay position, which were both in balance for the third consecutive month. Mr White also noted achievements in relation to the Financial Improvement Programme and of the [REDACTED] Acute Division target, a total of [REDACTED] had been phased in to date. This shows an achievement of [REDACTED] at month 10, equating to an FYE of [REDACTED]. Focus continued to progress current schemes and identify new opportunities.

Mr Finnie thanked Mr White for the update and invited questions from Committee members.

In response to questions from Committee members in relation to variance in performance between North and South sectors, Mr White noted a number of challenges and agreed that consideration would be given to the disparities.

Mr White

Committee members sought assurances in relation to the approach taken to consider the whole system and whether there was additional pressure on staff due to greater financial control. Mr Best assured the Committee that patient safety remained absolutely paramount and staffing levels maintained to appropriate levels. An absence rate of 22% is used to calculate staffing levels required in all wards which covers all types of leave as well as sickness absence.

Committee members were encouraged by the paper and suggested that it would be helpful to hear more information on the Financial Improvement Programme, CRES and efficiency savings at a Seminar Meeting. Mr White agreed to provide this at a future session.

Mr White

NOTED

23. WAITING TIMES IMPROVEMENT PLAN

The Committee considered the paper 'Waiting Times Improvement Plan' [Paper No. 19/13] presented by the Director of Finance, Mr Mark White. The update provided an overview of progress against the Scottish Governments Waiting Times Improvement Plan, published in October 2018. The Committee were asked to note the key elements of the plan, funding bids, trajectories and progress made by NHSGGC.

Mr Finnie thanked Mr White for the update and invited comments and questions from Committee members.

In response to questions from Committee members in relation to generating

additional capacity, Mr Best assured members that there were a number of ongoing projects being designed to consider areas such as Advanced Nurse Practitioners and Nurse Led Clinics.

In response to questions from Committee members in relation to increased use of the Golden Jubilee National Hospital, Mr Neil advised that the portfolio would be increased to target specific areas, increasing use from approximately [REDACTED] to [REDACTED].

NOTED

24. CORPORATE RISK REGISTER

The Committee considered the paper 'Extract from the Corporate Risk Register' [Paper No. 19/14] presented by the Director of Finance, Mr Mark White.

The Committee reviewed the risks noted within the register and were content to note these.

NOTED

25. COWLAIRS DECONTAMINATION UNIT

The Committee considered the paper 'Cowlairs Decontamination Unit Update' [Paper No. 19/16] presented by the Director of Estates and Facilities, Mr Tom Steele. The paper provided an update on the position regarding the loss of European Certification at the Cowlairs Decontamination Unit between 12th November and 26th November 2018. Phase 1 of the investigation which involved a root cause analysis has been completed. A number of areas were highlighted including improved governance and reporting mechanisms, and the escalation process. An external peer review has also been undertaken, along with significant retraining for staff. Preparation was underway to carry out a critical incident review and plans were in place to undertake resilience planning with national agencies. A further unannounced inspection was carried out and initial feedback was positive, with only 1 minor recommendation. A further visit would take place in June.

Mr Finnie thanked Mr Steele for the update and invited comments and questions from Committee members.

In response to questions from Committee members regarding the cause of the issue and how the situation arose, Mrs Grant assured Committee members of the intention to formally report this to the Board in due course, however noted that as the investigation process may invoke HR policies, further information was not available at this time. The Committee had previously discussed this and were content to receive interim progress reports from Mr Steele until such times as the full report could be presented to the Board.

NOTED

26. PATIENT EXPERIENCE REPORT – SUMMARY QUARTER 3

The Committee considered the paper 'Patient Experience Report – Summary for Acute Services Committee Quarter 3' [Paper No. 19/17] presented by the Director of Nursing, Dr Margaret McGuire.

Dr McGuire noted that performance had deteriorated in relation Stage 2 complaint responses, however the Complaints Team remain focused on improving this. Complaint themes have remained consistent, and Dr McGuire noted that there had been a slight increase in those related to attitude and behaviour of staff. Work was underway to address this as a priority. Dr McGuire also highlighted the positive feedback received via the increased use of patient feedback mechanisms, and in particular, recent positive feedback from a patient at QEUH.

Mr Finnie thanked Dr McGuire for the update. The Committee were content to note the report.

NOTED

27. MINUTES FOR NOTING

a) ACUTE STRATEGIC MANAGEMENT GROUP: MINUTE OF THE MEETING HELD ON 20TH DECEMBER 2018

The Committee considered the minute of the Acute Strategic Management Group Meeting of 20th December 2018.

NOTED

b) ACUTE STRATEGIC MANAGEMENT GROUP: MINUTE OF THE MEETING HELD ON 31ST JANUARY 2019

The Committee considered the minute of the Acute Strategic Management Group Meeting of 31st January 2019.

NOTED

28. DATE OF NEXT MEETING

9.30am on Tuesday 21st May 2019, in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

ASC(M)19/03
Minutes: 29 - 41

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Acute Services Committee held at 10.00am on Tuesday, 21st May 2019 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 (in the Chair)

Mrs A Thompson
Cllr J Clocherty
Ms M Kerr
Ms A Khan

Ms S Brimelow OBE
Ms AM Monaghan
Mrs D McErlean

OTHER BOARD MEMBERS IN ATTENDANCE

Ms J Grant
Mr M White

Dr M McGuire

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

Mr J Best	..	Chief Operating Officer, Acute Services
Ms Sarah Leslie	..	Depute Director of Human Resources & Organisational Development
Mr T Steele	..	Director of Estates and Facilities
Ms S Bustillo	..	Interim Director of Communications
Ms E Vanhegan	..	Head of Corporate Governance and Administration
Mrs G Mathew	..	Secretariat Manager (Minutes)

29. APOLOGIES, WELCOME AND PRELIMINARIES

Apologies were intimated on behalf of Mr Iain Ritchie, Mr Simon Carr, Mr John Brown, and Mrs Anne MacPherson. Ms Sarah Leslie was in attendance on behalf of Mrs MacPherson.

NOTED

DECLARATIONS OF INTEREST

There were no declarations of interest.

NOTED

30. MINUTES OF PREVIOUS MEETING

The Minutes of the Acute Services Committee meeting held on 19th March 2019 were approved as a complete and accurate record, subject to the following amendments:

Mrs Audrey Thompson had given apologies for the meeting.

APPROVED

31. MATTERS ARISING

a) Rolling Action List

Members considered the rolling action list [Paper No. 19/18] and agreed to close the items recommended for closure.

In addition, Mr Finnie, Chair, provided an update in relation to Item 21 – Integrated Performance Reporting – and noted that a meeting had taken place to consider restructuring of the performance report. Sample templates were reviewed and Mr Best agreed to populate the preferred template with this month's performance data for circulation to the Committee for views. Mr Finnie was clear that any changes to the performance reporting template would need to ensure that they did not result in additional administrative burden.

**Chief Operating
Officer**

Mr Steele, Director of Estates and Facilities, provided an update on progress of the review of the temporary closure of Cowlares Decontamination Unit. The review was making good progress and Mr Steele was confident that this would be concluded by July 2019. A Critical Incident Review had been completed and some significant learning points identified. Once this work had been concluded, a full report would be presented to the Committee in due course.

**Director of
Estates and
Facilities**

Mr White advised that the Annual Operational Plan for 2019/20 had been submitted to the Scottish Government on 30th April 2019. Discussions with Scottish Government colleagues were ongoing to ascertain further information in respect of funding to allow agreement of trajectories. Mr White will provide a further update to Finance and Planning Committee in June 2019.

**Director of
Finance**

NOTED

32. URGENT UPDATES

Ms Bustillo, Interim Director of Communications, referred to a recent briefing note circulated to Board members in relation to an expected media report following the publication of the Health Improvement Scotland report following the inspection of QEUH and RHC.

NOTED

33. REVIEW OF TERMS OF REFERENCE

The Committee considered the paper 'Acute Services Committee - Review of Terms of Reference' [Paper No. 19/19] presented by the

Head of Corporate Governance and Administration, Ms Elaine Vanhegan. The Committee was asked to review its remit to ensure this remained fit for purpose, as part of the annual review process.

Ms Vanhegan explained that the broader review being carried out in respect of the Blueprint for Good Governance, focused mainly on the mandatory Committees of the Board. Ms Vanhegan was keen to ensure that cross linkages were made along with greater clarity on the responsibilities and definitions, and a reduction in duplication.

The Committee felt that further clarity was required regarding the responsibilities of this Committee and those of the Clinical and Care Governance Committee. Ms Vanhegan assured Committee members that both Committees were being considered in the context of the overall position.

The Committee were content to delegate authority to Ms Vanhegan to continue with review and amendment of the remit, and noted that the final remit would be presented to the Board in due course.

Head of
Corporate
Governance and
Administration

Ms Vanhegan would circulate the amended remit within one week for further comment from Committee members. The final remit would then be presented to Board in due course.

NOTED

34. ACUTE SERVICES INTEGRATED PERFORMANCE REPORT

The Committee considered the paper 'Acute Services Integrated Performance Report' [Paper No. 19/20] presented by the Director of Finance, Mr Mark White.

Mr White noted the areas of improvement including the financial performance; key diagnostic testing; 31 day cancer target, stroke care bundle and alcohol brief interventions (ABI).

There was however, deterioration in performance in some areas such as sickness absence rates; number of bed days occupied; and the 12 week treatment time guarantee. These remained the key areas of focus, along with the 62 day cancer waiting time.

Mr Best went on to describe the current levels of demand and highlighted the 4% year on year growth in attendance at Emergency Departments and an increase in attendance at Assessment Units. Work continued in partnership with HSCP colleagues to manage demand and delayed discharge continued to be a key focus. A joint approach was crucial to ensure improvement in performance and a range of activities were underway to engage with patients, clinicians, staff and members of the public, to generate innovative ideas of how to redesign service provision.

Director of
Public Health

Mr Finnie noted, in respect of the work to identify causes of the increase in demand, that Dr de Caestecker would present a further update paper on this to the Committee in July.

Mr Best also highlighted discussions with Scottish Government colleagues in respect of the Waiting Times Improvement Plan and access funding.

Although the 31 day cancer target was being achieved, further work was required to improve the 62 day cancer target. However, progress was being made in this area and Mr Best noted a number of actions being taken to address this including the appointment of a Cancer Waiting Times Manager; the re-establishment of frequent meetings to discuss breaches; appointment of a Consultant Radiographer, a locum Surgeon and a Mammographer; a revised cancer performance management process; and additional colonoscopy capacity created.

Mr Best was pleased to advise the Committee that new outpatient appointment target had been exceeded, and commended teams and staff for their efforts to achieve this. Mr Alan Hunter, Director of Access continued to meet with Sector Leads and Teams to identify the longest waiting patients and implement actions to address this. All Directors meet on a monthly basis to review the position and identify further actions. The Business Intelligence Team had also completed a task to extract data for approximately 50 specialties and work would commence to analyse this and identify any gaps.

In respect of the treatment time guarantee, Mr Best noted that performance remained challenging in this area. The temporary closure of Cowlairs Decontamination Unit had had an impact on this. However, Mr Best assured the Committee that activities to address performance were underway including negotiation with Golden Jubilee National Hospital regarding additional capacity; discussions with Scottish Government colleagues; implementation of the Waiting Times Improvement Plan; and the Access Collaborative. Other actions undertaken included the use of an independent sector organisation to carry out weekend scopes; the recruitment of a Locum; and training of Band 8a Nurse Endoscopists.

In respect of diagnostic imaging, Mr Best highlighted a continual rise in the number of referrals. This contributed to challenges in maintaining reporting timescales. Mr Arwel Williams, Director of Diagnostics, was working on plans to bring the reporting timescales for diagnostic imaging to an acceptable level.

Mr Finnie thanked Mr Best for the update and invited questions from Committee members.

In response to questions from Committee members in relation to the scopes issues and increased demand, Mr Best assured the Committee that a number of areas of work were being progressed to address the

number of unnecessary referrals including work with primary care colleagues. Discussions were also ongoing in relation to 5 year surveillance scopes, as set out in the UK national guidelines. Mr Best also acknowledged an increase in referrals due to uptake of QFIT bowel screening.

Following questions from Committee members in respect further information about the Access Collaborative, Mr Best explained that this was a national piece of work being undertaken collaboratively with a number of groups such as the Access Team at Scottish Government; members of the public; patient groups; clinicians; and representatives from Royal colleges. The work had begun by looking at a number of specialties to consider the current service; processes and procedures undertaken; and how this could be redesigned to meet the challenge of the 30 month plan to meet the 12 week treatment time guarantee, whilst maintaining the outpatient position. Ms Grant further noted the scale of the challenge and that it was crucial that base efficiency; traditional additionality and redesign were considered as part of this.

Delayed Discharges

Dr McGuire provided an overview of performance for March 2019, which showed marginal improvement in performance of delayed discharge. The reduction in occupied bed days was below the monthly reduction target and continued to be a challenge for both Acute Division and the HSCPs. Glasgow City HSCP delayed discharges had increased significantly in the period and challenges remained with North and South Lanarkshire Board areas. A number of activities were being undertaken to address performance including development of pathways of care, Anticipatory Care Planning, and primary care and HSCP based initiatives to address this. The work of both the Access Collaborative and the Moving Forward Together Programme were fundamental to ensuring improvements were made.

In response to questions from Committee members in relation to analysis of the data and any emerging patterns, Dr McGuire highlighted that prevention of delirium was a key area. Work was ongoing with care homes and carers to address this issue. Dr McGuire further noted the complex nature of this, given the diversity of the challenges across individual HSCPs. Dr McGuire was confident that increased partnership working would have a positive effect on this.

Following questions from Committee members in respect of the consistent performance in Inverclyde HSCP and shared learning of models of best practice, Dr McGuire assured Committee Members that Chief Officers had been collaborating to consider different models and share learning, however it was acknowledged that all of the HSCPs had unique challenges, and were at different stages of development.

Absence Management

Ms Sarah Leslie, Deputy Director of Human Resources and Organisational Development, gave an overview of the sickness absence

rates to March 2019, which was reported as 5.71%. This was an improvement on the previous months figure of 6.21%, but remained higher than the national target rate of 4%. The challenge remained to reduce sickness absence to 0.5% and sustain this. Following the pilot conducted under the Financial Improvement Plan, an evaluation was concluded in April 2019. The pilot involved working with services to reduce sickness absence, coaching of managers, utilisation of support services to assist staff to remain at work. Ms Leslie noted that national work continued to support the implementation of the 0.5% target rate and the broader culture framework.

In response to questions from Committee members in respect of the issues which may affect sickness absence such as stress and high volume of work, Mrs McErlean explained that there were various work streams being taken forward to address a number of contributing factors such as increase in workload, increasingly complex work, and the demographics of the workforce, in a more innovative way.

Following questions from Committee members in relation to the review of the absence support team and the outcomes of the Auditors report, Ms Leslie explained that the report provided helpful and illustrative information in terms of alignment of the support team to services, teams and management.

KSF/TURAS

The TURAS performance demonstrated that gradual progress had been achieved and work continued with Acute Directors to implement change. The Executive Team were clear that this was an important task to ensure staff were valued and supported.

Stroke Care Bundle

Mr Best noted an achievement of 73%, which was below the target rate of 80%. Although there had been steady progress reported, there remained variable performance across hospitals and sectors. Mr Best highlighted the addition of the target of 90% of patients scanned within 12 hours. All sites, with the exception of Glasgow Royal Infirmary (GRI) were achieving the target. A new scanner had recently been installed at GRI and Mr Best was confident that this would improve performance. He noted that the swallow test target remained the most challenging area, and again, variances across hospital sites and sectors were noted. The Stroke Bundle Lead, Ms Marie Farrell, Director of Clyde Sector, continued to develop strategies and steady progress was acknowledged.

In response to questions from Committee members in relation to the difficulties in achieving target in this area, Mr Best and Ms Grant assured the Committee that this was being focused on as a priority, however it remained a challenge for all NHS Boards in Scotland.

MRSA/MSSA

Dr McGuire provided an overview of MRSA/MSSA performance and noted that Dr Armstrong, Medical Director, had presented this to the Board Meeting in April. Dr McGuire noted a small increase and particular focus on PVC lines had been undertaken to address this. A new monitoring system for patient lines had been introduced in the form of a new patient record. All staff were aware of the importance of checking PVC sites regularly and removing as soon as is appropriate.

Questions were raised in relation to the variable performance in this area, the repeated discussion about this issue and the efficacy of procedures adopted. Dr McGuire clarified that the procedure remained the same, however the monitoring process had been changed. Dr McGuire was clear that consistent reinforcement was crucial to ensuring that all staff were aware of the importance of this. Fluctuations in performance may arise due to the turn-over of staff.

In summary, the Committee were content to note the Integrated Performance Report and Mr Finnie thanked all those who provided updates.

NOTED

35. FINANCIAL MONITORING REPORT – MONTH 12

The Committee considered the paper 'Financial Monitoring Report Month 12' [Paper No. 19/21] presented by the Director of Finance, Mr Mark White.

Mr White noted that as of 31st March 2019, the Board reported an operating surplus of [REDACTED]. This was in comparison to the initial overspend predicted. Mr White noted that [REDACTED] of non-recurring funding had been factored in to support the overall position. He also noted that the Financial Improvement Programme recorded projects totalling [REDACTED] on an FYE and [REDACTED] on a CYE. The key return for this financial year was the ability of the organisation to reduce the underlying deficit by [REDACTED], from [REDACTED] to [REDACTED]. The figures reported in the paper were subject to the final audit process, and the 12 month report to the Finance and Planning Committee in June would reflect this.

Mr White went on to note that the Acute Division reported an over spend of [REDACTED], almost all of which related to unachieved savings. However, Mr White was pleased to note improvements made in relation to senior medical pay spends and nursing pay spends, which had both been in balance for the 5th consecutive month.

The Committee were pleased to note the overall position and the efforts made to control pay spend. However, Committee members expressed concern regarding potential gaps in service which may be contributing to the performance position. Concern was also raised regarding the unachieved savings within Acute, along with the impact on waiting times performance. The Committee were keen to ensure the right balance

between achievement of performance and achievement of financial targets.

Mr White went on to describe in more detail, the performance to achieve financial balance in respect of medical and nursing pay. The junior medical pay spend continued to be a challenge and remained a big area of focus, however a significant decrease from last financial year in relation to medical agency spend was reported. Greater levels of scrutiny and monitoring were implemented to maintain balance of spend and performance. Mr White also noted the reduction in nursing pay, however noted that bank nursing spend has increased slightly, due to the pay increase.

The non-pay position reported a slight over spend however Mr White noted achievements made to reduce the prescribing budget and achieve savings. Mr White commended the team for their efforts to achieve this.

Mr White noted that the drug costs schemes had been the most successful projects undertaken within the Financial Improvement Programme. The main areas of focus of the FIP for 2019/20 would be clinical productivity and clinical processes.

Mr Finnie thanked Mr White for the update and invited questions from Committee members.

In response to questions from Committee members in relation performance variances across sectors, Mr White advised that Mr Hunter, Director of Access, was undertaking work to achieve consistent performance across all sites.

Following questions from Committee members in respect of the Financial Improvement Programme and the longer term sustainability of these, Mr White assured members that most projects identified in 2018/19 would be carried forward to 2019/20. Mr White was confident that the savings achieved were sustainable, as demonstrated by the reduction of the underlying deficit.

There were questions raised by members about sharing of learning from the Financial Improvement Programme. Mr White highlighted that NHSGG&C have shared the methodology used with other Boards and there was replication of projects.

Ms Grant wished to commend all teams involved in the Financial Improvement Programme, and the achievements made to reduce the underlying financial deficit.

In summary, the Committee were content to note the financial position for 2018/19.

NOTED

36. CORPORATE RISK REGISTER EXTRACT

The Committee considered the paper 'Extract from Corporate Risk Register [Paper No. 19/22] presented by the Director of Finance, Mr Mark White.

Mr White noted no significant changes to the register in month, and assured the Committee that the scores were maintained. Mr White provided an overview of the risks, and highlighted that Dr de Caestecker, Director of Public Health, and the Public Health Team continued to address the civil contingencies risk. He also noted that Mr Steele, Director of Estates and Facilities, continued to progress the survey of the estate and estimated that this would be completed by end of summer 2019.

Mr Finnie thanked Mr White for the update and invited questions from Committee members.

In response to questions from Committee members in respect of timescales for completion of the actions described within the risk register, Mr White noted that timescales for completion would become clearer following the meeting with Scottish Government colleagues and assured members that timescales would be set in the next few weeks.

Following discussion regarding the safe staffing legislation, the Committee were assured that this risk was included within the remit of the Staff Governance Committee. However, it was further noted that a discussion was required to gain a shared understanding of the risks which are shared across Committees. For example, the implementation of the safe staffing legislation would be a shared risk across Staff Governance Committee and the Clinical and Care Governance Committee. Dr McGuire assured Committee members that once further guidance was available, this would be circulated to the relevant Committees.

Director of
Nursing

In summary, the Committee were content to note the extract of the Corporate Risk Register.

NOTED**37. INTERNAL REVIEW QEUH/RHC – CAPACITY AND FLOW UPDATE**

The Committee considered the paper 'Internal Review of QEUH/RHC – Update on Capacity and Flow [Paper No. 19/23] presented by Chief Operating Officer, Mr Jonathan Best. The paper provided an update on progress of the assessment of capacity and flow within QEUH work stream, following the establishment of the Programme Board to co-ordinate the review of the QEUH, as agreed at the February 2019 Board meeting.

Mr Best advised the Committee of the appointment of an external specialist contractor and the commencement of an audit of capacity and flow. Work was underway to review the whole of the ground floor at QUEH, to assess how the space was being utilised, along with an assessment of the data of admissions and capacity.

Mr Finnie thanked Mr Best for the update and invited questions from Committee members.

In response to questions from members in relation to the original assumptions made when the building was under construction and the flexibility of the model to accommodate potential changes in respect of the Moving Forward Together programme, Ms Grant assured the Committee that this would be taken into account, along with ensuring maximisation of efficiencies.

Following questions from Committee members in respect of the timescales for completion of this work, Ms Grant assured Committee members that she would shortly meet with the team to discuss these, and expected that an update on the position would be available in July.

In response to questions from members in relation to the work of the external contractor and the timescales of completion, Mr Best advised that given the time of year, agreement has been reached with the Caldicott Guardian in relation to the audit and the organisation has been given authority to do using retrospective data.

In summary, the Committee were content to note the report and were assured by the wide range of support obtained from both internal and external parties.

NOTED

38. PATIENT EXPERIENCE REPORT – SUMMARY REPORT QUARTER 4

The Committee considered the paper 'Patient Experience Report – Quarter 4 1st January to 31st March 2019' [Paper No. 19/24] presented by the Director of Nursing, Dr Margaret McGuire.

Dr McGuire highlighted that work continued with the Patient Experience Team and the Complaints Team to further develop the report. Further work was also required to include primary care and HSCP information.

Performance had improved, with the most common complaints being in relation to attitude and behaviour of staff, and Dr McGuire assured the Committee that work continued in a number of areas to improve this. A number of activities were being progressed to promote the use of the Patient Care Opinion; the use of patient questionnaires; and universal feedback. Dr McGuire was also progressing work with the e-Health Team to develop an app to complete universal feedback online.

Dr McGuire also noted work with the Scottish Public Services Ombudsman (SPSO) in relation to SPSO outcomes. Ms Vanhegan, Head of Corporate Governance and Administration, and Ms Jennifer Haynes, Corporate Services Manager, recently attended a meeting with representatives from the SPSO and an Advisor has been identified to work with the Complaints Team to improve performance in this area.

Mr Finnie thanked Dr McGuire for the update and the Committee were content to note the report.

NOTED

39. MINUTES FOR NOTING

a) ACUTE STRATEGIC MANAGEMENT GROUP: MINUTE OF THE MEETING HELD ON 28TH FEBRUARY 2019

The Committee considered the minute of the Acute Strategic Management Group Meeting of 28th February 2019.

NOTED

b) ACUTE STRATEGIC MANAGEMENT GROUP: MINUTE OF THE MEETING HELD ON 28TH MARCH 2019

The Committee considered the minute of the Acute Strategic Management Group Meeting of 28th March 2019.

NOTED

40. AOCB

Mr White advised the Committee of Mr Colin Neil's recent appointment as Director of Finance at Golden Jubilee National Hospital. The Committee wished to note congratulations and thanks to Mr Neil for his support and commitment to the organisation and the Committee.

41. DATE OF NEXT MEETING

9.30am on Tuesday 16th July 2019, in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

ASC(M)19/04
Minutes: 42 - 55

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Acute Services Committee held at
10.00am on Tuesday, 16th July 2019 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 (in the Chair)

Mrs A Thompson	Ms S Brimelow OBE
Mr I Ritchie	Ms AM Monaghan
Ms M Kerr	Mrs D McErlean
Ms A Khan	Mr S Carr

OTHER BOARD MEMBERS IN ATTENDANCE

Mr J Brown CBE	Mrs J Grant
Dr J Armstrong	Dr M McGuire
Mr M White	

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

Mr J Best	..	Chief Operating Officer, Acute Services
Mrs A MacPherson	..	Director of Human Resources & Organisational Development
Mr T Steele	..	Director of Estates and Facilities
Ms S Bustillo	..	Interim Director of Communications
Ms J Carrigan	..	Interim Assistant Director of Finance, Acute Services
Mr G Forrester	..	Deputy Head of Corporate Governance and Administration
Mrs L Russell	..	Secretariat Officer (Minutes)

42.	APOLOGIES, WELCOME AND PRELIMINARIES		
	Apologies were intimated on behalf of Cllr J Clocherty.		
	<u>NOTED</u>		
	DECLARATIONS OF INTEREST		
	There were no declarations of interest.		
	<u>NOTED</u>		
43.	MINUTES OF PREVIOUS MEETING		
	The Minutes of the Acute Services Committee meeting held on 21 st May 2019 were approved as a complete and accurate record.		

	<u>APPROVED</u>		
44.	MATTERS ARISING		
	a) <u>Rolling Action List</u>		
	Members considered the rolling action list [Paper No. 19/25] and agreed to close the items recommended for closure. <u>NOTED</u>		
45.	URGENT UPDATES		
	Ms Grant, Chief Executive, informed members that the conclusion of the IVR Clyde unannounced safety inspection is expected today. Dr McGuire informed members that the Equality and Human Rights Commission (EHRC) have launched a legal challenge in respect of AWI patients accommodated in the Quayside and Darnley Care Homes. A number of meetings had taken place with key colleagues and with representatives of EHRC, for the purpose of identifying additional actions that could be taken to support patients accommodated within these units. Dr McGuire advised the committee that consideration was being given to how to make most appropriate provision for these patients, noting that changes to current arrangements could have a significant impact on bed capacity and patient care. The Board will continue to work to manage this matter, with oversight being through the Clinical and Care Governance Committee. <u>NOTED</u>		
46.	<u>ACUTE SERVICES INTEGRATED PERFORMANCE REPORT</u>		
	The Committee considered the paper 'Acute Services Integrated Performance Report' [Paper No. 19/26] presented by the Director of Finance, Mr Mark White. The Committee noted the revised report format to ensure a stronger focus on defining trajectories and providing a balanced message by reporting targets met as well as unachieved targets. Mr White noted that performance was within the proposed trajectory for new outpatients waiting, scopes and TTG. He highlighted the targets that have been achieved as at the end of May 2019. Further improvements were required to reduce the number of DNA's (Did Not Attend)		

	<p>The Chief Operating Officer, Acute Services, Mr Jonathan Best, went on to describe the ongoing issues to meet the national waiting time standard. Performance remains challenging in this area. He reported that work was taking place with the Scottish Access Team. Mr Best went on to describe actions that were being carried out, which included in sourcing activity for Neurology which was currently at the tender review stage. The Committee noted that vacancies for consultants in Neurology was a UK wide issue. The Committee recognised that there were a number of factors contributing to this, for example the potential tax and pension implications for working additional hours. Weekly performance calls with all Acute Directors continued to take place every Monday. Directors continued to meet on a monthly basis to monitor the position.</p> <p>Mr Best reported that in order to meet the criteria for orthopaedic spinal patients, some activity was outsourced, and that 25 procedures were carried out per month.</p> <p>The Committee discussed the impact of consultant shortages was having on the Treatment Time Guarantee. In response to a question regarding how the impact was being addressed, Mr Best informed members that a number of options for consultant roles have been taken forward. The possibility of recruiting 1 year or 2 year locum posts has been discussed. Five Nurse Endoscopists have been trained as well as nurse injectors employed in order to free up time for consultants.</p> <p>Mr Best informed members that work was underway to improve the Treatment Time Guarantee (TTG). The report highlighted that by June 2019, no more than 8,500 patients will be waiting over 12 weeks for an inpatient/day case procedure. Monthly performance review meetings with Directors and General Managers across Acute continue to take place, along with the appointment of locums to support additional activity.</p> <p>Mr Best provided an update to members on performance in respect of the Stroke Care Bundle. A Standard Operating Procedure has been developed and implemented in May 2019 for the water swallow screen test. The Committee noted that there has been a gradual improvement.</p> <p>Performance for Emergency Department (ED) 4 hour waiting time remained below the 95% target. Mr Best reported that work was taking place with Health and Social Care Partnerships to gain a better understanding of the causes of increased demand. Allied Health Professionals (Physiotherapists) have been introduced to ED's at the Queen Elizabeth University Hospital (QEUH) and Glasgow Royal Infirmary (GRI) to ensure patients will be directed to the appropriate specialists, avoid unnecessary delays and reduce the length of stay in EDs. In April 2019, new Demand and Capacity Flow Managers were introduced to provide additional leadership in the hospital flow hubs. Three managers have been appointed to each site.</p>	
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	<p>Mr Best reported that the May 2019 position for the number of ED presentations and Assessment Unit attendances was significantly above the monthly planned position. The Committee noted the number of improvement actions being taken forward. In response to a question on the effectiveness of the 'Know Who To Turn To' campaign, Dr McGuire reported that there was no data available yet as this work had just recently commenced. . Work will continue to take place with HSCP's and GP's to promote the campaign.</p> <p>The Committee noted that the target for delayed discharges and bed days occupied by delayed patients was no more than 56,661 bed days occupied by delayed patients across NHSGGC by March 2020. For May 2019, the total number of beds days occupied by delayed patients was 4,790. This was higher than the monthly target of 4,722. Dr McGuire reported that work was taking place locally to reduce the number. To date, 3 HSCP's (East Dunbartonshire, Inverclyde and East Renfrewshire) have achieved the planned position. The remaining 3 HSCP's have clear actions in place to address performance. The Chief Executive reported that discussions have taken place with Scottish Government colleagues regarding target setting.</p> <p>The Medical Director, Dr Jennifer Armstrong, reported that work will take place to look at the Staphylococcus aureus bacteraemia (SAB) infection rate. Dr Armstrong reported that NHSGGC will benchmark infection rates with other Board areas in Scotland. The Committee noted that the approved peripheral venous cannula (PVC) care plan was being rolled out across NHSGGC. The plan focuses on the removal of the device as soon as possible. It also promotes the switch from IV to oral administration of medication. Dr Armstrong also noted that there was an increased presence of pharmacists in wards.</p> <p>Mr White provided an update on the percentage of stage 2 complaints responded to within 20 working days. During April – June 2019, 68% of Acute stage 2 complaints were responded to within 20 working days. Mr White reported that there has been a month on month improvement in performance, with the June 2019 monthly position currently at 77%. The function of the complaints team has been redesigned and enhanced which was having a positive impact on performance.</p> <p>The Committee noted the figures for the new outpatient DNAs. As at May 2019, 8.9% of all new outpatient appointments booked did not attend. The roll out of the Patient Focussed Booking process has helped to address this. The process includes phoning patients and sending texts to remind patients about their appointment. The cost of missing an appointment was also marked on appointment letters. The performance shows that there has been a reduction in the number of missed appointments compared to last year, however the Committee noted that further work was required to bring this in line with other Health Boards. This was being addressed as part of the Financial Improvement Programme work streams.</p>	
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	<p>Mrs MacPherson provided an update on Acute Sickness Absence. As of May 2019, the Acute sickness absence was 5.7%. This comprised of 3.4% long term and 2.3% short term. Overall, the performance has shown a month on month improvement since January 2019. The Committee noted that significant work was underway in the South Sector in particular. The Scottish average was reported as 5.4%. A number of actions have been taken forward to improve performance, including; self help on HR Connect, additional training for managers, addressing long term sickness and changes to the method of calculating absence.</p> <p>In response to a question from the Chairman in relation to calculating the average working days lost through sickness, Mrs MacPherson agreed to explore this and provide further details.</p> <p>Mrs MacPherson provided an update on KSF/PDP reviews recorded on TURAS. Overall performance has continued to improve. PDP compliance will be monitored as part of the Acute Performance Review Groups. The TURAS administration reporting function was scheduled for completion at the end of July 2019. The next development will be automated emails from the system. In the interim, personal emails are sent to those that have an email address registered on the TURAS system and have out of date reviews or reviews due in June and July 2019. This will continue until the dashboards for managers and reviewers have been implemented in Autumn 2019.</p> <p>In summary, the Committee was content to note the Integrated Performance Report. Mr Finnie thanked all those who provided updates.</p> <p><u>NOTED</u></p>		Mrs MacPherson
47.	FINANCIAL MONITORING REPORT – MONTH 2		
	<p>The Committee considered the paper 'Financial Monitoring Report Month 12' [Paper No. 19/27] presented by the Director of Finance, Mr Mark White. The report covers the month 2 revenue position, the financial position, including position and progress of the Financial Improvement Programme (FIP) and an overview of the capital position.</p> <p>Mr White noted that as of 31st May 2019, the Board was reporting expenditure levels [REDACTED] over budget. The Board has factored in [REDACTED] of non-recurring funding to support the overall financial position. He also noted that the FIP tracker recorded projects totalling circa [REDACTED] on a FYE and [REDACTED] on a CYE. In the assessment of the financial plan for 2019/20, it was estimated that there was a potential deficit of [REDACTED] at 31st March 2020. Mr White highlighted the work that continued in order to minimise the forecast deficit.</p> <p>Mr White went on to note that the Acute Division reported an overspend of [REDACTED]. Of this deficit, [REDACTED] was related to unachieved savings,</p>		

	<p>██████ was related to pay and ██████ was associated with non-pay. He reported that the main pressures in pay were associated with medical ██████ and nursing ██████ salaries. Mr White reported that medical and nursing pay budgets were a key focus for cost containment initiatives and the overspend in these areas has reduced throughout the last 10 months.</p> <p>The Senior medical position reported a YTD (year to date) overspend of ██████. Junior medical pay remained a challenge, with the YTD position for Acute across all Junior Doctors showing an overspend of ██████.</p> <p>Mr White provided an update on nursing pay spends. He highlighted that bank nursing expenditure has increased by ██████, however ██████ of this expenditure that was attributable to the in-year pay award/superannuation increase. As such, the expenditure was at a lower level than last year in real terms.</p> <p>Members discussed the use of locum and agencies. The progress the South Sector has made in reducing these costs were noted. The Committee was assured that vacancies were being filled, which has helped to eliminate premium rate costs. Over 400 newly qualified nursing staff will take up post in September/October. Overall, the Committee were assured that vacancies were being monitored and that there was no impact to patient care.</p> <p>Mr White provided an update on non-pay and prescribing costs. He noted that there were some concerns regarding potential spend on ultra orphan drugs. This issue will remain under close review.</p> <p>The report provided an update on the Financial Improvement Programme (FIP).</p> <p>Mr White provided an update on the 2019/20 capital position. The current forecast core capital resources available to the Board for investment in 2019/20 amount to just over ██████. Mr White went on to highlight the major areas of planned spend.</p> <p>In summary, the Committee noted all three elements of the report and was content to note the financial position for 2019/20.</p> <p><u>NOTED</u></p>		
48.	ANNUAL INTERNAL AUDIT PLAN AND CORPORATE RISK REGISTER		
	<p>The Committee noted the paper 'Extract from Corporate Risk Register' [Paper No. 19/28] for information.</p> <p><u>NOTED</u></p>		

49.	INTERNAL AUDIT REPORTS – WAITING TIMES AND CAPACITY PLANNING		
	<p>The Committee considered the paper ‘Internal Audit Reports – Waiting Times and Capacity Planning’ [Paper No. 19/29] presented by Chief Operating Officer, Acute Services, Mr Jonathan Best.</p> <p>The paper provided an update on the outcome of the audits, and offered assurance to the Committee that the agreed actions were being carried out.</p> <p>The Committee noted that a revised version of the NHSGGC Access Policy has been drafted as the previous version had expired. The Scottish Government has advised however that the policy document should not be updated in preparation for a move towards harmonisation of policies across NHS Scotland.</p> <p>The Chief Executive took assurance from the audit reports that waiting times reporting is accurate.</p> <p>The Committee was content to note the report.</p> <p><u>NOTED</u></p>		
50.	INTERNAL REVIEW QEUH/RHC – DEMAND AND CAPACITY UPDATE		
	<p>The Committee considered the paper ‘Internal Review of QEUH/RHC – Demand and Capacity Update’ [Paper No. 19/30] presented by Chief Operating Officer, Acute Services, Mr Jonathan Best.</p> <p>The paper provided an update on progress of the capacity and demand work stream of the internal QEUH review, as agreed at the February 2019 Board meeting.</p> <p>Mr Best reported that the North of England Commissioning Support Team (NECS) have now visited the QEUH campus and met with a number of key stakeholders to discuss the demand and capacity model. Following agreement of the data required to conduct the review, the Business Intelligence Team in NECS have analysed the data. This offered an early indication of potential modelling capabilities. Mr Best reported that so far early insights were impressive. A report will be submitted to members at the next meeting in September, following completion of the work.</p> <p>Mr Finnie thanked Mr Best for the update and invited questions from Committee members.</p> <p>The Committee noted that work was ongoing with the Planning Team and the Acute Services Division to create a matrix. Work will also take</p>		

	<p>place with the Director of Estates and Facilities to discuss the high impact of estates. The Committee noted that this was a major piece of work, the outcome of which may result in the need for some challenging decisions. A paper will be presented to the Finance Planning and Performance Committee in October.</p> <p>In summary, the Committee was content to note the report and was assured by the wide range of support obtained from both internal and external parties.</p> <p><u>NOTED</u></p>		Mr Best
51.	COWLAIRS DECONTAMINATION UNIT REVIEW UPDATE		
	<p>The Committee considered the paper 'ISO Certificate Suspension Cowlairs Central Decontamination Unit' [Paper No. 19/31] presented by the Director of Estates and Facilities, Mr Tom Steele</p> <p>The report provided members with an update following the investigation into the events at Cowlairs Central Decontamination Unit, following suspension of the ISO Certificate in November 2018.</p> <p>A preliminary cause analysis investigation was concluded in March 2019 involving key members of the Senior Management Team, with further investigation in accordance with the Board Disciplinary Policy.</p> <p>Members noted the key findings of the investigations in the report. Mr Steele reported that staff were being supported through the process. A new Head of Decontamination has been appointed which has provided stability to the team.</p> <p>Mr Steele informed members that a robust improvement plan has been developed. The Committee noted the recommendations included in the report that will be taken forward as part of the improvement plan.</p> <p>The report detailed lessons learned following the review.</p> <p>Key recommendations to improving performance focussed on the following areas:</p> <ul style="list-style-type: none"> - Building design - Capacity/Contingency - Tracking system - Training <p>Mr Steele reported that at time of renewal of the lease on the building, consideration would be given to risks from the surrounding environment that may adversely affect the building structure/fabric.</p>		

	<p>Planning for the future included ensuring involvement in development of National Contingency Plans and ensuring procurement of a tracking system compatible with requirements across NHSGGC.</p> <p>The Committee was assured that appropriate systems had been put in place. In relation to a question as to whether issues like this should be reflected in the Corporate Risk Register, Mr Steele informed members that the risks were held at a Directorate level. The Committee agreed that Mr Steele would take this to the Audit and Risk Committee.</p> <p>The Committee noted that Mr Steele and Head of Board Administration and Corporate Governance, Ms Elaine Vanhegan, were working together to review governance processes.</p> <p>Mr Finnie thanked Mr Steele for the update and the Committee was content to note the report.</p> <p><u>NOTED</u></p>	Mr Steele
52.	INCREASED DEMAND IN ACUTE SERVICES	
	<p>A presentation was delivered by Director of Public Health, Dr Linda de Caestecker, on the agreed work requested at the January Committee in relation to increased demand in Acute Services.</p> <p>An in-depth analysis of emergency attendances has been carried out. Dr de Caestecker reported that nationally, there had been a reduction in out of hours attendances, however the reduction was more prominent in NHSGGC.</p> <p>Dr de Caestecker highlighted that attendance at ED and Minor Injuries Units (MIU) greatly increased for children and the elderly. Attendance was also significantly more likely for those living in the most deprived quintiles. More qualitative research was required to understand how patients could be encouraged to utilise the most appropriate services.</p> <p>Dr de Caestecker reported that a small number of patients make frequent attendances at EDs and MIUs, and noted that these patients are a vulnerable group. A more detailed survey of these patients was underway in both Inverclyde and West Dunbartonshire HSCPs. Initiatives have been put in place and further work is required to evaluate their effectiveness and to understand the variations between areas. There are also wide variations by GP practice that require further analysis</p> <p>In response to a question regarding whether an increase in presentations to OOHs and MIU's had been noted when GP OOH clinics have been unavailable, Dr de Caestecker reported that significant impact on attendances had not been observed, however Mr Best</p>	

	<p>reported that a change in pattern was noted in relation to an increase in presentations to ED at QEUH between 4pm -11pm.</p> <p>Following discussion, the Committee agreed that further work was required in order to fully understand the impact. Members noted that clinical pathways for minor head injuries and chest pain were required and this will be taken forward by the Unscheduled Care Group.</p> <p>A report will be prepared for the next meeting to provide assurance to the Committee.</p> <p>Mr Finnie thanked Dr de Caestecker for the update.</p> <p><u>NOTED</u></p>		Dr de Caestecker
53.	MINUTES FOR NOTING		
a)	ACUTE STRATEGIC MANAGEMENT GROUP: MINUTE OF THE MEETING HELD ON 25TH APRIL 2019		
	<p>The Committee considered the minute of the Acute Strategic Management Group Meeting of 25th April 2019.</p> <p><u>NOTED</u></p>		
b)	ACUTE STRATEGIC MANAGEMENT GROUP: MINUTE OF THE MEETING HELD ON 30TH MAY 2019		
	<p>The Committee considered the minute of the Acute Strategic Management Group Meeting of 30th May 2019.</p> <p><u>NOTED</u></p>		
54.	AOCB		
	None.		
55.	DATE OF NEXT MEETING		
	9.30am on Tuesday 17 th September 2019, in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.		

ASC(M) 19/05
Minutes: 56 - 66

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Acute Services Committee
held in the Boardroom, JB Russell House, Gartnavel Royal Hospital,
on Tuesday 17th September 2019**

PRESENT

Mr Simon Carr (in the Chair)

Cllr Jim Clocherty	Cllr Mhairi Hunter
Ms Margaret Kerr	Ms Amina Khan
Dr Margaret McGuire	Ms Anne Marie Monaghan
Mrs Audrey Thompson	Mr Mark White

IN ATTENDANCE

Mr Jonathan Best	..	Chief Operating Officer
Ms Sandra Bustillo	..	Interim Director of Communications
Ms Jacqueline Carrigan	..	Interim Assistant Director of Finance
Mrs Anne MacPherson	..	Director of Human Resources and Organisational Development
Ms Angela O'Neill	..	Deputy Director of Nursing
Ms Louisa Yule	..	Senior Auditor, Audit Scotland
Mrs Geraldine Mathew	..	Secretariat Manager (Minutes)

		ACTION BY
56.	WELCOME AND APOLOGIES	
	<p>Apologies for absence were intimated on behalf of Mr Ross Finnie, Ms Susan Brimelow OBE, Ms Dorothy McErlean, Mr Ian Ritchie, Dr Jennifer Armstrong, Mr Tom Steele, and Mrs Jane Grant.</p> <p>Dr McGuire introduced Ms Angela O'Neill to Committee members. Ms O'Neill had recently taken up post as Deputy Nurse Director.</p> <p><u>NOTED</u></p>	
57.	DECLARATIONS OF INTEREST	
	<p>The Chair invited members to declare any interests in any of the items being discussed. There were no declarations made.</p> <p><u>NOTED</u></p>	

58.	MINUTES OF THE MEETING HELD 16th JULY 2019		
	<p>The Committee considered the minute of the meeting held on Tuesday 16th July 2019 [Paper No. ASC(M)19/04] and were content to approve the minutes as an accurate record.</p> <p>Clarity was sought in relation to page 4, Item 46, second paragraph, specifically the number of bed days occupied by delayed discharge patients. Dr McGuire confirmed that this was the number of bed days target set by the Ministerial Strategic Group. Mr White further clarified that there were two targets reported in respect of delayed discharges, those being the number of bed days occupied by delayed patients, and the number of delayed patients.</p> <p><u>APPROVED</u></p>		
59.	MATTERS ARISING		
a)	ROLLING ACTION LIST		
	<p>The Committee considered the 'Rolling Action List' [Paper No. 19/32] and were content to accept the recommendation that 5 actions were closed.</p> <p>In addition, the following updates were provided on the remaining 2 open actions:</p> <p><u>Item 21 – Integrated Performance Report</u> The Committee agreed to close this action, given that this had been considered and approved by the Finance, Planning and Performance Committee.</p> <p><u>Item 46 – Sickness Absence</u> Mrs Anne MacPherson confirmed that a detailed sickness absence report had been presented to the Staff Governance Committee for assurance, therefore the Committee were content to accept the recommendation to close this item.</p> <p><u>Item 52 – Increased Demand in Acute Services</u> The Committee were content to note that Dr de Caestecker would provide a further update on this at a future meeting.</p> <p>There were no other matters arising noted.</p> <p><u>APPROVED</u></p>	<p>Secretary</p> <p>Secretary</p> <p>Secretary</p>	
60.	URGENT ITEMS OF BUSINESS		
a)	UPDATE ON INTERNAL REVIEW OF QEUH/RHC – DEMAND AND CAPACITY UPDATE		
	<p>Mr Jonathan Best, Chief Operating Officer, provided an overview of progress with the Internal Review of QEUH/RHC – Demand and Capacity Work stream. The Demand and Capacity work stream would form part of the overall Internal Review of QEUH/RHC and would be presented to the Acute Services Committee in due course. Mr Best clarified that the Clinical Outcomes work stream part of the Internal Review would be reported to the Clinical and Care Governance</p>		

	<p>Committee, and the Estates and Facilities Work stream would be reported to the Finance, Planning and Performance Committee.</p> <p>In terms of the Demand and Capacity work stream, Mr Best highlighted that the North East of England Commissioning Team had undertaken work to consider a number of factors in relation to the QEUH/RHC including the Emergency Department model, the Immediate Assessment Unit model and the use of beds. He highlighted that there was emerging evidence in relation to changes over the past two years in respect of the number of presentations to the ED. Given that 71% of patients who had presented to ED were discharged from ED, and 50% of patients who had presented to the AU were discharged after diagnostic tests carried out, focus was required to redirect patients to the most appropriate service. Mr Best highlighted that a meeting with the North East of England Commissioning Team had been arranged to discuss the detail of the findings and alternative models. He confirmed that the final report, analysis, and action plan, would be presented to the Committee at the next meeting in November.</p> <p>Mr Best also provided an update on the current position associated with Wards 2a and 2b of the RHC and Ward 6a of the QEUH. The work underway in Wards 2a and 2b was expected to be completed by April 2020. He further noted that the Incident Management Group (IMT) continued to meet weekly. Mr Best assured Committee members that regular communications with patients and families continued. No new infections had been identified and infection rates remained within the expected levels.</p> <p>Ms Bustillo added that Communications remained a key item discussed at each IMT Meeting. She noted that a closed Facebook page had been created for patients families to address concerns. The Communications Team continued to respond to enquiries from members of the Press and noted that the issues had become topical again, given the recent media attention in relation to the RHC in Edinburgh.</p> <p>Mr Best advised that a single point of contact was being put in place for families, and Dr McGuire highlighted that staff were being supported. Ms Bustillo added that detailed statements were being communicated through the Core Brief to support staff to address enquiries from families.</p> <p>Mrs MacPherson advised Committee members that the Health and Safety Executive were also undertaking a review of systems and processes and had carried out interviews with key staff in July and August; a full report would be presented to the Staff Governance Committee in due course.</p> <p>In response to comments from members in relations to the process of contacting NHS24 and GP response times, Mr Best assured members that work continued to ensure that all parts of the system were working together effectively. Ms Bustillo added that communications and public messaging was a priority area of the MFT programme. Part of this work would ascertain the reasons why patients present to ED and identify ways to ensure patients attend the most appropriate service for their needs.</p> <p>Mr Carr thanked Mr Best, Dr McGuire, Mrs MacPherson and Ms Bustillo for the update.</p> <p><u>NOTED</u></p>	<p>Mr Best</p>

61.	ACUTE INTEGRATED PERFORMANCE REPORT	
	<p>The Committee considered the paper 'Acute Integrated Performance Report' [Paper No. 19/33] presented by the Chief Operating Officer, Mr Jonathan Best.</p> <p>Mr Best noted amendments to the format of the report which included the suite of Acute related Local Delivery Plan (LDP) standards, Ministerial Steering Group (MSG) measures, alongside National Key Performance Indicators, HR and Governance related metrics.</p> <p>Mr Best provided an overview of Acute performance and noted that during April to July 2019 a total of 355,106 new and return outpatients were seen; there was 63,041 elective and non-elective admissions recorded alongside 56,949 day cases and 24,804 Treatment Time Guarantee (TTG) patients were seen. He highlighted improvements to Laboratory and Radiology/Imaging results for Acute based services, following the migration of paper delivery of results to electronic delivery on 2nd September.</p> <p>Mr Best noted congratulations to Ms Jennifer Rodgers, Chief Nurse for Women and Children's Services, who recently picked up a prestigious Scottish Women of the Year Award for Services to Medicine in recognition of her outstanding work in paediatric medicine.</p> <p>In addition, Glasgow Royal Infirmary (GRI) was recognised as a world-leading healthcare facility named by Newsweek earlier in the year as one of the top 100 hospitals in the world.</p> <p>The Orthopaedic Team at the Royal Alexandra Hospital (RAH) recently won the 'Golden Hip' award for the third time since the award was launched in 2016.</p> <p>Mr Best highlighted page 4 and 5 of the report which detailed performance at a glance. He described the success achieved in respect of the Waiting Times Improvement Plan and assured the Committee that efforts continued to improve sustainability in this area.</p> <p>Mr Best paused for questions and comments.</p> <p>Committee members were pleased to note the improvements made to the overall format of the report. Questions were raised in respect of the colour coding of sickness absence performance, which did not appear consistent with other measures in the report. Mr White agreed to look into this.</p> <p>Mr Best went on to describe performance of new outpatients waiting >12 weeks for a new outpatient appointment. He noted that as at July 2019, there was 23,285 new outpatients waiting >12 weeks for a new outpatient appointment. Whilst current performance was above the trajectory of 21,000 new outpatients waiting >12 weeks for September 2019, he noted that the number of patients waiting >12 weeks was 10% less than the same month of the previous year. Mr Best noted challenges in respect of recruitment of consultant Neurology posts, however one vacant post had been filled recently. In-sourcing activity had also been implemented for Neurology, along with outsourcing activity for Orthopaedic Spinal cases. There were also challenges in relation to recruitment of three consultant vacancies in Ear, Nose and Throat (ENT). In-sourcing arrangements with Medinet continued in respect of both ENT and Ophthalmology. In addition, Access Collaboratives had been established for Gastroenterology, Trauma and</p>	<p>Mr White</p>

<p>Orthopaedics, and would review patient pathways across primary and secondary care. Outsourcing was also in place for Orthopaedic Spinal treatment with Ross Hall, with the Golden Jubilee National Hospital (GJNH) treating the longest waiting patients for hip and knee surgery.</p> <p>Mr Best highlighted that access to key diagnostic tests performance was now being reported separately for scopes and imaging. He noted performance against the target of no more than 1,200 patients waiting >6 weeks to access a scope test and described a number of actions to improve performance including the recruitment of five Nurse Endoscopist posts, and continued support of a Locum Endoscopist to support additional activity. Mr Best advised that additional Saturday sessions at Stobhill, Gartnavel Hospital and across the Clyde Sector continued. The independent sector re-tender had been concluded and a change in provider was implemented on 17th August. A review and revalidation of surveillance scope waiting lists was underway across GGC, in line with recently revised national guidance to ensure demand remained appropriate.</p> <p>Mr Best described performance against the target of no patient waiting more than 6 weeks to access an imaging test. He noted the actions underway to improve performance including tendering for additional private sector capacity from September 2019 and the recruitment of three Radiology Consultant posts.</p> <p>In respect of performance against the Treatment Time Guarantee, Mr Best noted that as at July 2019, a total of 9,059 eligible TTG patients were waiting >12 weeks for an inpatient/day case procedure. This was above the 2019/20 AOP trajectory of no more than 7,500 patients waiting >12 weeks. He described a range of measures being taken to improve performance including additional waiting list sessions; in-sourcing activity through Medinet for adult Ophthalmology and Paediatric ENT, Ophthalmology and Paediatric Surgery; outsourcing activity for Orthopaedics (General and Spinal); and appointment of locums to support additional surgery e.g. Anaesthetics and additional capacity secured through GJNH. Mr Best confirmed that funding to support additional initiatives of [REDACTED] had been received from Scottish Government, which was [REDACTED] more than the 2018/19 allocation.</p> <p>Mr Best paused for comments and questions.</p> <p>Committee members welcomed the addition of the comparison figures with other Health Boards, however highlighted that these were not arranged in the same way in each section of the report.</p> <p>The Committee also highlighted a marked difference in the figures reported in June and those reported in July, and asked if there was a specific reason for this. Mr Best assured Committee members that this was due to the holiday period, and was confident that there was no other underlying issue.</p> <p>In response to questions from Committee members in respect of the trajectory for the referral to treatment target, Mr Best confirmed that the trajectory aimed to address the longest waiting patients in the first instance.</p> <p>Questions were raised in respect of the tendering process to identify an external provider, given the small market. Mr White explained that the process remained the same as with all tendering in respect of negotiation and criteria of quality. Due to an increase in the number of consultants opting to work on a freelance</p>	
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<p>basis, Mr White was confident that there would be a significant number of companies submitting bids.</p> <p>In response to questions regarding when the actions being taken in relation to paediatric ENT; gastroenterology, neurology, were likely to yield results, Mr Best advised that as part of the collaborative work being undertaken, a number of groups had been established to consider specific pathways. This work was in the process of being concluded, and Mr Best advised that this would be reported to the Committee once complete. Mr Best also noted that there was a detailed plan in place to return to a 6 week position. Once this had been achieved, consideration of the capacity required to meet demand would be clear. Mr Best confirmed that some areas were close to achieving this position.</p> <p>Mr Best continued with the report, and highlighted the position in respect of the Stroke Care Bundle. Overall compliance with the Stroke Care Bundle was 72% as at July 2019. This was below the target of 80%. Three of the four elements of the bundle exceeded target, with the swallow screen remaining below target. He noted that a Swallow Screen Standard Operating Policy had been produced and shared with senior nurses in Emergency Departments (ED), Receiving and Stroke Units. Education and training sessions for nursing staff within these departments at Inverclyde Royal Hospital (IRH) and Royal Alexandra Hospital (RAH) sites had been arranged.</p> <p>In respect of the A&E 4 hour wait target, Mr Best advised that as at July 2019, 88.4% of patients presenting to A&E were either admitted, discharged or transferred for treatment >4 hours. Performance had shown an improvement on the previous month position, however remained below the target of 95%. He noted a number of improvement actions currently in place including collaboration with the North East Commissioning Support Team to develop a demand and capacity model to support future decision making about service configuration and process change. In addition, outputs from the Winter Planning workshop have been produced and operational leads will be assigned to deliver improvements across these areas in advance of winter.</p> <p>Mr Best noted performance in respect of the target for number of A&E Attendances. He confirmed that attendances across the 6 HSCPs was 62% above the year to date (YTD) planned position as set and agreed by each of the 6 HSCPs. He described a number of actions being taken to address this, including a review of frequent ED attendees and work with the Communications Team to promote the 'Know Who to Turn To' campaign to raise awareness of alternatives to A&E. Clinical Directors had also undertaken a number of site visits to Emergency Departments (ED) during May 2019 and work will progress to promote alternatives to ED with a focus initially on Minor Injuries. In addition, HSCPs continued to develop local processes using the Frailty Assessment Tool to ensure improved awareness and management of frail people in a community and homely setting. Mr Best also noted the second phase of the 'Red Bag' rollout across care homes in NHSGGC, had concluded with positive feedback from staff, care homes, patients and relatives.</p> <p>Mr Best paused for comments and questions.</p> <p>In response to questions from members in relation to the 'Take 5' programme at Glasgow Royal Infirmary (GRI), Mr Best noted that this project was bespoke to the GRI. He highlighted that improvements in performance were being maintained. Each ED site was undertaking a different approach to ascertain</p>	<p>Mr Best</p>
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<p>which models were most effective. The effective models would then be rolled out across all ED sites.</p> <p>Committee members were pleased to note the good examples of positive changes being made and asked what the next step changes were to achieve a much bigger shift in demand of ED, and when the organisation would know if the models used were effective. Mr Best clarified that there were a number of key issues which required consideration, those being, the physical space available to the organisation and fluctuations in demand; whole system impact and effects; and staffing rotas to manage changes in flow.</p> <p>In response to questions from Committee members in relation to HSCP targets, Mr Best advised that there remained different challenges in different HSCP areas; however work continued to consider all of the challenges on a system wide basis.</p> <p>There was discussion about inappropriate use of Emergency Departments and GP Out of Hours services. Mr Best described work underway to implement the Redirection Policy; to increase awareness amongst members of the public to access the most appropriate service for their needs; and to promote the use of NHS24.</p> <p>Dr McGuire provided an update on performance of delayed discharge. She noted that improvements were required to improve the position. She described a number of areas of work being progressed to address this including work within communities to prevent admissions; work with the eHealth Team to maximise the use of available technology; and implementation of Anticipatory Care Planning to prevent hospital admissions.</p> <p>Dr McGuire paused for questions.</p> <p>In response to questions from members in relation to the availability and effectiveness of home care. It was noted that regular reports were available which provided information on the specific nature of delays, however these were confidential. Dr McGuire did note however that the summary report recently presented to the Board which detailed Acute and Mental Health delays, provided additional information on the causes of delays.</p> <p>Dr McGuire went on to provide an update on the position in relation to Staphylococcus aureus bacteraemias (SABs) performance. As at July 2019, the total number of SAB infections was 46, which comprised of 38 healthcare associated cases and 8 community associated cases. This was more than the aim to have no more than 25 SAB infections, reported each month. A number of actions were underway to address this, including implementation of the approved PVC Care Plan; and the evaluation of sample PVC packs.</p> <p>Mr Best provided an update on performance of Stage 2 Complaints responded to within 20 working days. During the period April – June 2019, 68% of Acute Stage 2 complaints were responded to within 20 working days. However, there had been significant month on month improvement in performance during the past few months and the June 2019 monthly position was 77%.</p> <p>Mr Best described performance of the Cancer 62 Day target, and noted that as at July 2019, 77.1% of patients referred urgently with a suspicion of cancer began treatment within 62 days of receipt of referral. Actions were being taken</p>	
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	<p>to improve performance including redirection of patients from South Sector to North and Clyde Sectors for breast; additional Nurse Endoscopist recruitment for colorectal; and a review of colorectal cancer pathways.</p> <p>Mr Best paused for questions.</p> <p>In response to questions from Committee members in relation to the impact of bowel screening, Mr Best advised that there had been a greater number of referrals, due to the sensitivity of the test. He also noted an increase in referrals following recent campaigns. However, Mr Best noted that despite the significant increase in referral rates, the number of cancers detected had remained the same.</p> <p>Mr Best noted performance in respect of Smoking Cessation, Alcohol Brief Interventions, and Did Not Attend (DNA) rates. He added that the addition of Patient Focused Booking had proved beneficial in reducing the number of DNA's.</p> <p>Mrs MacPherson provided an overview of performance in relation to sickness absence. She noted that July rates were similar to absence rates from the previous year. She described further analysis which was being done to consider a number of areas such as seasonal impact; and the effects of stress. Mrs MacPherson referred to a report recently presented to the Audit and Risk Committee and highlighted areas being addressed to promote a healthier workplace.</p> <p>In response to questions from members in relation to progress of peer immunisation for flu, Mrs MacPherson advised that the Public Health Team have undertaken a significant amount of work to promote peer vaccination. She advised that stocks of vaccination had been ordered and promotion of peer immunisation through local teams continued. The programme will be launched in October.</p> <p>Questions were raised in relation to national statistics for sickness absence. Mrs MacPherson clarified that this data was available for internal use only due to sensitivity, however she assured Committee members that senior colleagues review this data to establish NHSGGC position on a national basis.</p> <p>In terms of the Better Workplace priority, Mrs MacPherson noted that additional metrics had been added to the report to provide a greater understanding of the position, those being, iMatter; statutory and mandatory training compliance; and Turas.</p> <p>In response to questions from members in relation to the better workplace performance measures; specifically those reported for the South Sector, Mrs MacPherson advised that a member of the HR Team had been allocated to the South Sector to work with the team to address this. She also advised of the recent appointment of the Head of Organisational Development. She assured members that this remained an area of focus for management teams.</p> <p>Mr Carr thanked Directors for the update, and the Committee were content to note the report.</p> <p><u>NOTED</u></p>	

62.	EXTRACT FROM CORPORATE RISK REGISTER		
	<p>The Committee considered the paper 'Extract from Corporate Risk Register' [Paper No. 19/35] presented by the Chief Operating Officer, Mr Jonathan Best.</p> <p>The Chair was pleased to note the addition of target dates within the Corporate Risk Register.</p> <p>The Committee were content to note the report.</p> <p><u>NOTED</u></p>		
63.	FINANCIAL MONITORING REPORT		
	<p>The Committee considered the paper 'Financial Monitoring Report' [Paper No. 19/34] presented by the Director of Finance, Mr Mark White.</p> <p>As at July 2019, the Board reported expenditure levels [REDACTED] over budget. The Financial Improvement Plan Tracker recorded projects totalling [REDACTED] on a FYE and [REDACTED] on a CYE. Mr White noted that following analysis of the month 4 results, the forecast potential gap predicted was [REDACTED] at 31st March 2020. Mr White confirmed that [REDACTED] of non-recurring funding had been factored in to support the financial position. He noted that HSCPs reported an under spend of [REDACTED].</p> <p>Mr White noted performance of medical salaries across the Directorate, which reported an over spend of [REDACTED] at month 4. This compared to [REDACTED] over spend in month 4 of the previous year, and Mr White noted that there was improvement this month based on last year's trend. Mr White also noted improvements made in respect of nursing salaries, which reported an over spend of [REDACTED] at month 4. He described a number of actions being undertaken to improve performance in these areas including monthly meetings with senior colleagues. He also noted the recruitment of approximately 400 student nurses in October which would help to improve the position.</p> <p>Mr White highlighted the challenges associated with non-pay spend, which reported an over spend of [REDACTED] at month 4. There were emerging pressures noted in relation to prescribing costs and additional costs for fast moving stock items to support Brexit readiness.</p> <p>The reduction of the funding associated with the outcomes framework continued to be a financial pressure. In addition, contingency arrangements for the uplift and disposal of clinical waste, was expected to result in a cost pressure of between [REDACTED] and [REDACTED], which was significantly more than the original estimate of [REDACTED]. Mr White also noted a current over spend in respect of property maintenance of [REDACTED] at month 4 and advised the Committee that this was being discussed with the Director of Estates and Facilities to identify ways to address this.</p> <p>The disposal of the former Stoneyetts Hospital site continued to prove challenging, due to a number of uncertainties in respect of planning.</p>		

	<p>Mr White added that discussions were underway with colleagues from Scottish Government Access Team in respect of Access funding, which remained a cost pressure.</p> <p>In response to questions from members in relation to the reported over spend of █████ in Acute Services, detailed on page 5 of the report, Mr White clarified that this was a cumulative figure comprising of unachieved savings; over spends in property maintenance, and the additional costs associated with the uplift and disposal of clinical waste.</p> <p>Questions were raised in respect of the junior medical position and the excess costs of filling gaps. It was confirmed that these gaps were filled however the organisation does not receive funding for these gaps from NHS Education Scotland (NES). Mrs MacPherson advised that West of Scotland Boards had written to both NES and the Scottish Government in relation to this issue.</p> <p>In response to questions raised regarding the costs of increased attendance to ED departments, Mr White confirmed that there had been additionality for winter months put in place, however due to increasing demand on ED, the additionality has remained in place.</p> <p>Questions were raised in relation to the number of emerging issues, if and when the organisation would consider the possibility of utilising the new arrangements to break even over 3 years. Mr White acknowledged the increasing challenges, however assured the Committee that every effort was being made to improve the position before the winter period, to avoid the need to utilise the new arrangements available. Ms Carrigan added that focus continued on transformational change opportunities through the Moving Forward Together programme.</p> <p>In response to questions from members in relation to the decant of the Yorkhill site, Mr White noted that plans were in place for non-clinical teams, however the challenge remained the decant of clinical teams. He emphasised that it would be important to consider the wider implications of any clinical team moves to other sites, in the context of the wider organisation.</p> <p>Mr White advised that the capital report did not convey any significant changes and remained within a positive position.</p> <p>Mr Carr thanked Mr White for the update. The Committee were content to note the report.</p> <p><u>NOTED</u></p>	
64.	ACUTE PATIENT EXPERIENCE REPORT	
	<p>The Committee considered the paper 'Acute Patient Experience Report' [Paper No. 19/36] presented by the Nurse Director, Dr Margaret McGuire.</p> <p>Dr McGuire highlighted the revised format of the report and noted thanks to Mrs Jennifer Haynes, Board Complaints Manager, and Ms Angela Carlin, Associate Chief Nurse, for their efforts to improve the format and content of the report. She described a number of ways in which feedback was obtained including complaints, SPSO information and patient experience information. She was</p>	

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	<p>pleased to note improvements made to the quality of complaint responses. She noted that actions were underway to improve performance in relation to Care Opinion feedback and Dr McGuire advised that training was being developed for staff, to promote the use of the facility with patients.</p> <p>Mr Carr thanked Dr McGuire for the update and invited comments and questions from members.</p> <p>In response to questions from members in relation to the number of complaints not upheld, Dr McGuire provided further clarity on the figures reported. She noted that frequently, complaints were upheld however no recommendations were made as these had already been addressed. She further noted that work was ongoing with the SPSO to improve performance in this respect. Mr Best added that complaint responses now ask for feedback on how the complaint has been handled.</p> <p>Questions were raised in relation to delayed discharges and if there was data on the number of complaints received in respect of this. Dr McGuire advised that this data could be obtained, however she highlighted that the majority of issues in respect of delayed discharges were in relation to family matters.</p> <p>The Committee noted that this was a positive report. Members suggested that an Executive Summary be included in the report to detail the major themes.</p> <p><u>NOTED</u></p>	
65.	ACUTE STRATEGIC MANAGEMENT GROUP	
a)	MINUTE OF MEETING HELD 27TH JUNE 2019	
	<p>The Committee considered the minute of the Acute Strategic Management Group Meeting of 27th June 2019 [Paper No. SMG(M)19/07] and were content to note this.</p>	
66.	CLOSING REMARKS AND KEY MESSAGES TO THE BOARD	
	<p>Mr Carr summarised the key messages to the Board.</p> <ol style="list-style-type: none"> 1. The Committee received an update on Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC), and the actions underway to address previously identified issues in respect of Wards 2a and 2b of RHC and Ward 6a of QEUH. 2. The Committee noted an update on progress of the Internal Review of QEUH/RHC – Demand and Capacity Work stream and would expect the final report and action plan to be presented to the next Committee meeting in November. The Committee were pleased to note the major work streams of the North East of England Commissioning Team and the whole systems approach taken. 3. The Committee received the Finance Monitoring Report to Month 4, and noted expenditure levels [REDACTED] over budget at Month 4. The Committee 	

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	<p>were informed of a predicted financial gap of [REDACTED] at 31st March 2020 and noted the emerging financial pressures in year.</p> <p>4. The Committee received the revised Patient Experience Report and noted the actions being undertaken to further improve performance. The Committee suggested the addition of an Executive Summary section to the report.</p>		
67.	DATE OF NEXT MEETING		
	Tuesday 19 th November 2019, 09:30am, Boardroom, JB Russell House		

ASC(M) 19/06
Minutes: 67 - 80

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Acute Services Committee
held in the Boardroom, JB Russell House, Gartnavel Royal Hospital,
on Tuesday 19th November 2019**

PRESENT

Mr Ross Finnie (in the Chair)

Prof John Brown CBE	Mrs Jane Grant
Mr Simon Carr	Ms Susan Brimelow OBE
Cllr Jim Clocherty	Cllr Mhairi Hunter
Ms Margaret Kerr	Ms Amina Khan
Mr Mark White	Ms Anne Marie Monaghan
Ms Dorothy McErlean	

IN ATTENDANCE

Mr Jonathan Best	..	Chief Operating Officer
Ms Sandra Bustillo	..	Interim Director of Communications
Ms Jacqueline Carrigan	..	Interim Assistant Director of Finance
Mr Graeme Forrester		Deputy Head of Corporate Governance and Administration
Mr Tom Steele		Director of Estates and Facilities
Ms Sarah Leslie	..	Deputy Director of Human Resources and Organisational Development
Dr Scott Davidson	..	Deputy Medical Director, Acute
Ms Liz McConnachie	..	Senior Audit Manager, Audit Scotland
Mrs Louise Russell	..	Secretariat Officer (Minutes)

		ACTION BY
67.	WELCOME AND APOLOGIES	
	Apologies for absence were intimated on behalf of Mr Ian Ritchie, Dr Jennifer Armstrong, Dr Margaret McGuire, Mrs Audrey Thompson and Mr William Edwards.	
	NOTED	
68.	DECLARATIONS OF INTEREST	
	The Chair invited members to declare any interests in any of the items being discussed.	
	Mr Simon Carr declared that in his role with Scottish Federation of Housing Associations (SFHA), he was involved in preparation of a national report in relation to housing and delayed discharge.	

	<u>NOTED</u>		
69.	MINUTES OF THE MEETING HELD 17th SEPTEMBER 2019		
	<p>The Committee considered the minute of the meeting held on Tuesday 17th September 2019 [Paper No. ASC(M)19/05] and were content to approve the minutes as an accurate record pending the following addition:</p> <p>A specific urology performance report would be submitted to a future meeting. The minute will be updated to reflect this.</p> <p><u>APPROVED</u></p>	Mr Best	
70.	MATTERS ARISING		
a)	ROLLING ACTION LIST		
	<p>The Committee considered the 'Rolling Action List' [Paper No. 19/37] and were content to accept the recommendation that 3 actions were closed and 2 actions remained ongoing.</p> <p>There were no other matters arising noted.</p> <p><u>APPROVED</u></p>		
71.	URGENT ITEMS OF BUSINESS		
	<p>The Chief Executive, Mrs Jane Grant, provided a verbal update on issues raised in relation to infection prevention, management and control at the Queen Elizabeth University Hospital and the Royal Hospital for Children.</p> <p>Mrs Grant reported that there has been significant media attention. She went on to provide background information on two cases in particular that have appeared in the media. Mrs Grant assured the Committee that infection control protocol was followed in these cases and assured the Committee that any complaints or allegations raised have been fully reported and investigated.</p> <p>It has been recognised that communication with families could be improved. The Board continued to take steps to do so and continued to answer questions from families openly and truthfully. Mrs Grant informed the Committee that a number of meetings have taken place with families. The Board were also working with Professor Craig White to develop better ways of engaging with families. Mrs Grant reported that a meeting was held with the Cabinet Secretary. Seventy one questions were raised, and these have been answered. Mrs Grant reported that following feedback from patients some improvements have been put in place immediately, for example a playroom and a tea room for staff.</p> <p>Mrs Grant informed the Committee that the restriction on Ward 6a receiving new patients has been removed. Health Protection Scotland were in agreement of reopening the Ward to new admissions, however the Board awaited final sign off from the Scottish Government.</p>		

	<p>The Committee noted that HAI inspectors arrived at the Queen Elizabeth University Hospital today and will remain there until Friday 22nd November 2019.</p> <p>The Committee were assured that a robust whistleblowing process was in place and staff could raise concerns which would be dealt with in full confidence. The Committee noted that it remained challenging to deal with issues on occasions when the whistleblowing process was not followed.</p> <p>Mrs Grant assured the Committee that communication with families and staff would continue to take place and any lessons to be learned would be taken on board. NHSGGC were committed to making any necessary improvements. The impact of media attention on staff, both professionally and personally, was noted. Staff continued to be supported and Mrs Grant and Dr Davidson were carrying out regular visits.</p> <p>Mrs Grant thanked the Executive Team and members of staff for their support during this distressing and difficult time.</p> <p>Mr Finnie summarised the key messages from the update:-</p> <ol style="list-style-type: none"> 1. A detailed update report would be submitted to the Clinical and Care Governance Committee. 2. The Acute Services Committee were assured that patients were receiving the appropriate level of care. 3. Staff would be supported with both internal and external pressures. 4. The Senior Management Team would continue to address any additional pressures as they emerge. <p><u>NOTED</u></p>	
72.	ACUTE INTEGRATED PERFORMANCE REPORT	
	<p>The Committee considered the paper 'Acute Integrated Performance Report' [Paper No. 19/38] presented by the Chief Operating Officer, Mr Jonathan Best.</p> <p>Mr Best provided an overview of Acute performance and noted that during April to September 2019, a total of 538,330 new and return patients were seen; there was 93,304 elective and non-elective admissions recorded alongside 85,617 day cases and 37,798 Treatment Time Guarantee (TTG) patients seen.</p> <p>Mr Best went on to describe performance of new outpatients waiting >12 weeks for a new outpatient appointment. He noted that as at September 2019, a total of 23,336 available new outpatients were waiting >12 weeks for a new outpatient appointment. Whilst current performance was marginally above (2%) the trajectory of 22,900 new outpatients waiting >12 weeks for September 2019, he noted that the number of patients waiting >12 weeks was 16% less than the same month the previous year. Mr Best highlighted that Gastroenterology and Trauma and Orthopaedic Access Collaboratives' have been established to review patient pathways across primary and secondary care. He also highlighted that vacant outpatient clinic slots were being reviewed daily in order to maximise available outpatient capacity.</p> <p>Mr Best highlighted that as at September 2019, a total of 791 patients were waiting >6 weeks to access a scope test. This was well within the projected</p>	

<p>position of 1,200 for September 2019. It was predicted that this number would reduce to 600 by the end of December 2019. Mr Best reported that recruitment of 5 Band 8A Nurse Endoscopists was unsuccessful, however it was planned that the resource for this would now be utilised for six training grade Endoscopists. Locum Endoscopists continued to support additional activity across Sectors. Mr Best reported that following recent UK & Scottish guidance, there was strong evidence to support the cessation of repeat scopes. Surveillance of the scope list would be carried out and patients would be contacted to inform them that no further repeat tests were required.</p> <p>Mr Best described performance against the target of no patient waiting more than 6 weeks to access an imaging test. Mr Best reported that tendering for additional reporting has concluded. A mobile screening van has been set up to help improve waiting times.</p> <p>In respect of performance against the TTG, Mr Best noted that as at September 2019, a total of 9,447 eligible TTG patients were waiting >12 weeks for an inpatient/day case procedure. Whilst current performance was marginally above the revised 2019-20 Annual Operational Plan trajectory of no more than 9,100 patients waiting >12 weeks for September 2019, the rate of growth in numbers waiting has begun to slow down. Mr Best went on to describe a range of measures being taken to improve performance, including; patients being admitted in order of clinical priority and then date, outsourcing activity for Orthopaedics (general and spinal) and appointment of locums to support additional surgery and capacity secured through Golden Jubilee National Hospital for 2019/20.</p> <p>Mr Best reported that as at September 2019, overall compliance with the stroke care bundle was 73%. This was below the target of 80%. Two of the four elements of the Stroke Care Bundle exceeded the target. The remaining two elements below target were 84% of patients had the swallow screen test <4 hours following admission (an improvement on the 81% reported at the last meeting) and 87% of patients admitted to a stroke unit on day of admission/day following presentation. Mr Best reported that good progress was being made with scanning and admissions.</p> <p>In respect of the A&E 4 hour wait target, Mr Best reported that as at September 2019, 86.9% of patients presented at A&E were either admitted, discharged or transferred for treatment <4 hours. Mr Best noted that the number of patients presenting at A&E remained challenging.</p> <p>Mr Best provided an update on delayed discharges and bed days occupied by delayed patients. Mr Best reported that discussion was ongoing to improve the discharge process.</p> <p>M Best described performance of the Cancer 62 day target and noted that as at September 2019, 79.8% of patients referred urgently with a suspicion of cancer began treatment within 62 days of receipt of referral. Mr Best noted difficulty in recruiting for specialist areas.</p> <p>Mr Best reported that as at September 2019, 8.3% of all new outpatients appointments booked did not attend. Current performance represents an improvement on the previous month's position (9.3%), the lowest reported during this financial year and remains within the target of 11.4%. Mr Best noted that the performance highlighted that the direction of travel remained positive. The</p>	
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	<p>reduction in the number of DNA's were due to the continued roll out of the Patient Focussed Booking process, which included phoning patients and sending text messages to remind patients about their appointment.</p> <p>The Deputy Director of Human Resources and Organisational Development, Ms Sarah Leslie provided an overview of performance in relation to sickness absence. There was a focus on long term absence with active review of all cases exceeding three months to ensure that there was an immediate and long term plan to assist staff in returning to work with relevant adjustments and support. Ms Leslie noted that stress and anxiety related sickness was the main cause of long term absence. Areas were being addressed to promote a healthier workplace for staff, for example mindfulness and staff engagement services. Training on long term condition management and cancer was currently underway across Acute Services and to wider Board staff during October 2019. The Committee noted their concern in relation to the sickness absence rate.</p> <p>Ms Leslie noted that overall, there was an average iMatter response rate of 58% across Acute Services. Three of the six directorates across Acute exceeded the 60% response rate and a further two demonstrated an improvement when compared with the previous years' position. The action planning progress to date showed an improvement in four areas. Regional services and North Sector were showing improved engagement in this part of the iMatter process. Work continued to encourage managers and staff to engage with iMatter.</p> <p>Ms Leslie reported that as at 30 September 2019, 49.7% of KSF/PDP reviews had been recorded on TURAS Appraisal across Acute Services. This falls short of the expected position.</p> <p>Ms Leslie reported that statutory and mandatory training continued to show a month on month improvement. Ms Leslie highlighted that Fire Safety training compliance was currently at 80.1%. She noted that significant work was still required in order to improve compliance.</p> <p>Active promotion of the flu vaccination continued to take place. Ms Leslie reported that as at October 2019, 28.3% of staff within acute had received the flu vaccination. The Committee noted their concern at the low percentage of staff being vaccinated. The Committee agreed that the Executive Team need to give more thought as to how uptake of the vaccination could be improved.</p> <p>The Committee agreed it would be helpful for the next report to include how practice has been improved by the better workplace performance measures that have been put in place.</p> <p>The Committee noted that a piece of work was being carried out to review the GP Out of Hours service. Mr Best noted challenges with filling shifts. A piece of work was being carried out to develop a pathway for the Vale of Leven GP OOH service to improve the system.</p> <p>Mr Finnie thanked Mr Best and Ms Leslie for the updates, and the Committee were content to note the report.</p> <p><u>NOTED</u></p>	
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73.	FINANCIAL MONITORING REPORT	
	<p>The Committee considered the paper 'Financial Monitoring Report' [Paper No. 19/39] presented by the Director of Finance, Mr Mark White.</p> <p>As at 30 September 2019, the Board reported expenditure levels █████ over budget. The Financial Improvement Plan Tracker recorded projects totalling █████ on a FYE and █████ on a CYE. Mr White noted that the potential gap predicted was █████ as at 31 March 2020.</p> <p>Mr White confirmed that █████ of non-recurring funding has been factored in to support the financial position. A number of unforeseen cost pressures have emerged in-year. As such, the forecast potential gap had increased to █████. Mr White noted a number of areas where the Board continues to work in order to minimise the forecast deficit. This includes focussing on delivering existing schemes and reduce the risk rating and increase the potential yield.</p> <p>The report included analysis of the key pressure areas. Mr White noted that the main pressures in pay were associated with medical █████ and nursing █████ salaries due to the inherent cost of providing certain services, service demands (particularly A&E attendances) and the requirement to cover sickness/absence and vacancy via bank and agency spend. Mr White noted improvement in both medical and nursing overspend on the previous financial year.</p> <p>Mr White highlighted the challenges associated with non-pay pressures, increasing from the 2018/19 position which was a significant decrease on previous years. Mr White noted emerging pressures in relation to prescribing costs and maintenance contracts ending. These would continue to be monitored.</p> <p>Mr White noted performance of medical salaries across the Directorate, which reported an over spend of █████ at month 6. This compared to █████ over spend in month 6 of the previous year, and Mr White noted that there was improvement this month based on last year's trend. Mr White reported that the Senior Medical position reported a YTD underspend of █████ however Clyde and Women and Children's Sectors were over spent in Senior Medical on a YTD basis. Mr White reported that Junior Medical reported a YTD overspend in North, Clyde, Regional and Women and Children's Sectors.</p> <p>Mr White noted that the organisation was experiencing a range of financial pressures in-year which were impacting on the current deficit position and the forecast year end deficit. This included Outcomes Framework, Clinical Waste, Medical Pay Award, Property Maintenance, Access Funding and Cystic Fibrosis drugs.</p> <p>Mr White reported the Financial Improvement Programme (FIP) continued into 2019/20.</p> <p>The report provided an update on the Capital Plan. Mr White reported that major areas of planned spend included the programme of ward refurbishments, investment in e-Health priorities and provision of █████ for the Boards Hub Schemes. The plan currently included █████ of unallocated capital.</p> <p>Mr Finnie thanked Mr White for the update and invited comments and questions from members.</p>	

	<p>In response to a question regarding plans to prepare for a gap at the end of the year, Mr White informed the Committee that discussions were in early stages with Scottish Government colleagues. It was predicted that the figure would reduce however this was dependant on winter performance. Further discussions would be held at the Finance and Planning Committee.</p> <p>The Committee agreed it would be helpful to understand the impact sickness absence has on the Board financially. Mr White agreed to carry out this piece of work however noted that it may be challenging as absence doesn't always equate to a cost. Mr White agreed to present a paper to a future meeting.</p> <p>A presentation on finance within the Estates and Facilities Directorate was delivered by the Director of Facilities and Estates, Mr Tom Steele.</p> <p>Mr Steele reported a current over spend of [REDACTED] within Estates and Facilities. He went on to provide an update on property maintenance costs. Mr Steele reported that a piece of work was being carried out to create a resource plan in order to improve the maintenance planning system.</p> <p>Following comments in relation to the cost of running the estate, Mr Steele assured members that work being taken forward to develop a Resource Plan would improve the maintenance planning system and address running costs.</p> <p>Mr Finnie thanked Mr Steele for the presentation and update.</p> <p><u>NOTED</u></p>	
74.	EXTRACT FROM CORPORATE RISK REGISTER	
	<p>The Committee considered the paper 'Extract from Corporate Risk Register' [Paper No. 19/40] presented by the Chief Operating Officer, Mr Jonathan Best.</p> <p>The Committee were content to note the report.</p> <p><u>NOTED</u></p>	
75.	QEUH DEMAND AND CAPACITY REVIEW	
	<p>The Committee considered the paper 'NHSGGC QEUH Demand and Capacity' [Paper No. 19/41] presented by the Chief Operating Officer, Mr Jonathan Best.</p> <p>Mr Best provided an overview on the progress to date on the Demand and Capacity Review of the QEUH and informed the Committee on the current work plan developed with the support of the North East Commissioning Support Team (NECS).</p> <p>The report provided a chronology from 2002 to 2015 and an overview of the service change strategy and associated timelines.</p> <p>The Committee noted that a large number of patients continued to present at the front door. Mr Best reported that there was a focus on promoting alternative options and redirecting patients to the most appropriate service. The Moving</p>	

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	<p>Forward Together (MFT) programme would help to gain a better understanding as to why patients present to Emergency Departments (ED), and would help to promote self-management. Mr Best reported that the introduction of two triage rooms would help reduce the waiting time at the front door considerably. Dr Davidson reported that work was ongoing with the MFT programme to look at providing support in the community. He noted that a piece of work was ongoing in relation to anticipatory care planning for patients for end of life care.</p> <p>The Interim Director of Communications, Ms Sandra Bustillo, noted that national communications work was ongoing to prepare for winter. A campaign would be created which would focus on promoting alternatives to ED, for example the use of the Minor Injuries Unit.</p> <p>In response to a question raised regarding the profile of patients attending ED, Mrs Grant reported that a detailed piece of work was being carried out to look at patient profiles, in particular, for those patients who had attended but were subsequently not admitted. Further detail would be shared with members in due course.</p> <p>The Committee noted an update would be provided to the Board in February on short term plans for Gartnavel General Hospital in relation to winter planning, orthopaedic additional work and surgical capacity.</p> <p>The Chair noted that the level of detail within the reports was helpful to put into context the movement that has taken place. The Committee noted the NECS Demand and Capacity Model final report and recommendations. The report highlighted a number of recommendations to steer NHSGG&C in preparation for winter 2019/20 and planning future system sustainability. In response to a question on whether the Board has signed up to an implementation plan, Mr Best highlighted the timescales on the last two pages of the NECS report. He noted that work has started to break down the recommendations in order to drive forward implementation.</p> <p>Mr Best reported that plans were underway to establish a regional Major Trauma Centre. It has been proposed that the Major Trauma Centre (MTC) would be sited at the QEUH and would provide care for around 450-550 critically and severely injured patients per annum.</p> <p>The Committee noted plans for Ward 6a to return to QEUH in Spring 2020.</p> <p>The Finance, Planning and Performance Committee would discuss reduction in demand and balance of care in detail over the coming months.</p> <p>In summary, the Committee noted that the current level of demand on the QEUH was significantly higher than was originally planned. Despite this, the hospital has performed at or above the peer average efficiencies that were proposed in the full business case. Staff and teams were commended for their efforts.</p> <p>The Committee requested an assurance report to be submitted to a future meeting to update on the progress.</p> <p><u>NOTED</u></p>	<p>Mr Best</p>

76.	PATHWAYS COLLABORATIVE WORK UPDATE		
	<p>The Committee considered the paper 'Pathways – NHSGGC Access Collaborative Briefing' [Paper No. 19/42] presented by the Chief Operating Officer, Mr Jonathan Best.</p> <p>Mr Best provided an overview of the NHS GG&C Access Collaboratives' for Gastroenterology and Orthopaedics. The purpose of the review was to ensure Gastroenterology and Trauma and Orthopaedics services work to the same clinical pathway in all locations to ensure equity of patient access and care.</p> <p>A series of three workshops facilitated by Digital Health Institute (DHI) identified short and medium term actions, which were agreed by stakeholders involved as priority areas to focus on during 2019/20. The Committee noted the identified actions from the workshops included in the report.</p> <p>An application was submitted to the Scottish Government "Bringing it Together" for funding to support the acceleration of the implementation plans. Mr Best reported that the second application was successful. This would be one year of non-recurring funding.</p> <p>The Committee noted that this was an ongoing process. An update report would be submitted at a future meeting.</p> <p><u>NOTED</u></p>	Mr Best	
77.	LANGLANDS UNIT UPDATE		
	<p>The Committee considered the paper 'QEUH – Langlands Building/Provision of Domestic Services' [Paper No. 19/43] presented by the Director of Estates and Facilities, Mr Tom Steele.</p> <p>The report provided an update concerning the provision of Domestic Services, within QEUH Langlands Building and offered assurance that continuous service review remained in place between the QEUH Facilities Management and contract provider for Domestic Services.</p> <p>Mr Steele noted that Domestic Services cleanliness standards within Langlands building required improvement as quality assurance audits from August 2019 resulted in partial compliance with the NHS Scotland National Cleanliness Services Specification Quality Framework. Mr Steele noted that the Langlands building was a PFI arrangement. Mr Steele reported that a change in contractual responsibilities resulted in Serco taking over the operational delivery of Domestic Services from Carillion. The SPV was Imagile.</p> <p>Mr Steele reported that as at October 2019, cleanliness audits remained partially compliant with the NCSS quality framework. It was recognised however that there has been an improvement in cleanliness standards from August 2019. He noted that following formal dialogue between NHSGGC, Serco and Imagile, a number of support measures have been implemented. This included the separation of cleaning tasks between Domestic Services and ward based staff being reviewed and communicated to ensure that there was no</p>		

	<p>misunderstanding of cleaning responsibilities. NHSGGC were providing support to Serco and were in the process of providing awareness training to Serco domestic staff and supervisors to improve their knowledge of the NCSS Quality Framework and Quality Monitoring. NHSGGC had received advice and guidance from Health Facilities Scotland, PFI Liaison Manager, together with advice from the Central Legal Office.</p> <p>The Committee were assured by the report and noted that internal and external quality assurance audits were taking place.</p> <p>The Committee were content to note the report. A further update would be provided at the next meeting.</p> <p><u>NOTED</u></p>	Mr Steele
78.	ACUTE STRATEGIC MANAGEMENT GROUP	
a)	MINUTE OF MEETING HELD 29TH AUGUST 2019	
	<p>The Committee considered the minute of the Acute Strategic Management Group Meeting of 29th August 2019 [Paper No. SMG(M)19/08] and were content to note this.</p> <p><u>NOTED</u></p>	
b)	MINUTE OF MEETING HELD 26TH SEPTEMBER 2019	
	<p>The Committee considered the minute of the Acute Strategic Management Group Meeting of 26th September 2019 [Paper No. SMG(M)19/09] and were content to note this.</p> <p><u>NOTED</u></p>	
79.	CLOSING REMARKS AND KEY MESSAGES TO THE BOARD	
	<p>Mr Finnie summarised the key messages to the Board.</p> <ol style="list-style-type: none"> 1. The Committee were assured by the update provided by the Chief Executive on the issues raised in relation to infection prevention, management and control at the Queen Elizabeth University Hospital and the Royal Hospital for Children. 2. The Committee noted receipt of the reports on the Demand and Capacity Review element of the Internal Review of QEUH and RHC and development at a strategic level. 3. The Committee reviewed the Integrated Performance Report in depth, and were assured by the actions being taken to address performance. 4. The Committee reviewed the Financial Monitoring Report and were assured by the actions described. <p><u>NOTED</u></p>	

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80.	DATE OF NEXT MEETING		
	Tuesday 21 st January 2020, 09:30am, Boardroom, JB Russell House		

ASC(M) 20/01
Minutes: 01 - 16

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Acute Services Committee
held in the Boardroom, JB Russell House, Gartnavel Royal Hospital,
on Tuesday 21st January 2020**

PRESENT

Mr Ross Finnie (in the Chair)

Mrs Jane Grant	Dr Jennifer Armstrong
Ms Susan Brimelow OBE	Mr Ian Ritchie
Cllr Jim Clocherty	Mrs Audrey Thompson
Ms Margaret Kerr	Ms Amina Khan
Mr Mark White	Ms Anne Marie Monaghan
Ms Dorothy McErlean	

IN ATTENDANCE

Mr Jonathan Best	..	Chief Operating Officer
Ms Sandra Bustillo	..	Interim Director of Communications
Ms Jacqueline Carrigan	..	Interim Assistant Director of Finance
Mr Tom Steele		Director of Estates and Facilities
Mrs Anne MacPherson	..	Director of Human Resources and Organisational Development
Dr Scott Davidson	..	Deputy Medical Director, Acute
Ms E Vanhegan		Head of Corporate Governance and Administration
Ms T Dungan		Programme Manager Digital Health/Board Administration
Ms Susanne Millar	..	Chief Officer, Glasgow City HSCP
Mrs Louise Russell	..	Secretariat Officer (Minutes)

		ACTION BY
01.	WELCOME AND APOLOGIES	
	Apologies for absence were intimated on behalf of Mr Simon Carr and Cllr Mhairi Hunter.	
	<u>NOTED</u>	
02.	DECLARATIONS OF INTEREST	
	The Chair invited members to declare any interests in any of the items being discussed.	
	No declarations of interest were made.	
	<u>NOTED</u>	

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03.	MINUTES OF THE MEETING HELD 19th NOVEMBER 2019		
	<p>The Committee considered the minute of the meeting held on Tuesday 19th November 2019 [Paper No. ASC(M)19/06] and were content to approve the minutes as an accurate record pending the following minor amendment:</p> <p>Item 67 – Welcome and Apologies – Cllr Mhairi Hunter to be removed from the list of apologies, as Cllr Hunter was in attendance at the meeting.</p> <p>The minute will be updated to reflect this change.</p> <p><u>APPROVED</u></p>		
04.	MATTERS ARISING		
a)	ROLLING ACTION LIST		
	<p>The Committee considered the 'Rolling Action List' [Paper No. 20/01] and were content to accept the recommendation that 4 actions were closed.</p> <p>In addition, it was agreed that the action related to Delayed Discharge Performance in Acute Hospital System, could now be closed, as this was included on the agenda. The action related to Increased Demand in Acute Services would remain ongoing.</p> <p>There were no other matters arising noted.</p> <p><u>APPROVED</u></p>		
05.	URGENT ITEMS OF BUSINESS		
	<p>The Chief Executive, Mrs Jane Grant, provided a verbal update on the progress into the issues raised in relation to infection prevention and management control at the Queen Elizabeth University Hospital and the Royal Hospital for Children following escalation to stage 4 of the NHS Scotland Performance Framework.</p> <p>An Oversight Board has been established, chaired by Professor Fiona McQueen, Chief Nursing Officer, Scottish Government. The Terms of Reference for the Oversight Board have been finalised and shared with NHS Board members. Three subgroups of the Oversight Board have been established; Communications and Engagement Subgroup, chaired by Prof Craig White, Infection Prevention and Control Subgroup, chaired by Ms Diane Murray and a Technical Subgroup chaired by Mr Alan Morrison. The Terms of Reference for the subgroups will be circulated to members once finalised.</p> <p>Professor Marion Bain has been appointed as Director of Infection Prevention and Control. Professor Bain commenced post on Monday 6th January 2020.</p> <p>In response to a question in relation to the format of the responses to media questions, Mrs Grant informed members that NHS Greater Glasgow and Clyde has adopted the format set out by the Scottish Government. Ms Bustillo, Interim Director of Communications, informed members that discussions were ongoing with the Scottish Government colleagues regarding the process and responsiveness to enquiries.</p>		

	<p>Mrs Grant reported that a significant amount of work was being carried out to manage requests sent to the Project Management Office.</p> <p>Mrs Grant thanked the Executive Team and members of staff for their support during this challenging time.</p> <p>Mr Finnie thanked Mrs Grant for the update.</p> <p><u>NOTED</u></p>	
06.	REVIEW OF TERMS OF REFERENCE	
	<p>The Committee considered the paper 'Review of Terms of Reference' (Paper 20/02) presented by the Head of Corporate Governance and Administration, Ms Elaine Vanhegan. The Committee were asked to review its remit as part of the Annual Review of Governance.</p> <p>Ms Vanhegan reported that the Terms of Reference were revised as part of the wider governance review to ensure they remain fit for purpose and robust for the year ahead. The Committee noted that no significant changes have been made to the Terms of Reference following the review last year.</p> <p>The Committee were content to accept the minor amendments made to the Terms of Reference, to better describe the process for the appointment of members of the Committee and to reflect the introduction of Chair's Reports to the Board.</p> <p>In response to a question regarding timescales for national Terms of Reference as part of the implementation of NHS Scotland's 'A Blueprint for Good Governance', Ms Vanhegan reported that the work of the NHS Corporate Governance Steering Group continued, and so far, the Group had approved for national use, consistent standing orders, and induction and member appraisal processes. This work will, in due course, lead to the introduction of nationally consistent Terms of Reference for all mandatory committee's and these would be presented to the relevant committee's for adoption, once finalised.</p> <p><u>APPROVED</u></p>	
07.	ACUTE SERVICES INTEGRATED PERFORMANCE REPORT	
	<p>The Committee considered the paper 'Acute Services Integrated Performance Report' [Paper No. 20/03] presented by the Chief Operating Officer, Mr Jonathan Best. The report provided the Committee with a balanced overview of performance in the context of the key themes outlined in the 2019-20 corporate objectives.</p> <p>Mr Best noted that the report now included GP Out of Hours service closures, following the recommendation of the last Acute Services Committee.</p>	

<p>Mr Best provided an overview of Acute performance and noted that during April to November 2019, a total of 234,945 new and 494,394 return patients were seen; there was 29,604 elective and 95,489 non-elective admissions recorded, alongside 115,714 day cases and 51,970 Treatment Time Guarantee (TTG) patients seen.</p> <p>The Interim Director of Communications, Ms Sandra Bustillo, provided an update on the Minor Injuries Unit (MIU) campaign which launched on 12th December 2019. The campaign aimed to promote the range of minor injuries that could be treated at MIU's. Real time data has been used to highlight the benefits to patients including faster treatment times compared with A&E Departments. The campaign was using a number of methods to reach patients, including; posters, online and radio campaigns. Ms Bustillo reported that the campaign appeared to be having a positive impact. The Committee were content to note that progress on the campaign would be monitored.</p> <p>Mr Best highlighted page 6 of the report which provided an update on the 18 weeks Referral to Treatment (RTT) target. Mr Best reported that the focus continued to be targeting patients with the highest clinical priority and reduction of the number of patients with the longest waiting times. In response to a question on whether there was an estimate of when performance would be back in balance, Mr Best agreed to obtain further information for the next meeting.</p> <p>Mr Best went on to describe performance of new outpatients waiting >12 weeks for a new outpatient appointment. He noted that as at November 2019, a total of 22,325 available new outpatients were waiting >12 weeks for a new outpatient appointment. Whilst current performance was marginally above (2%) the trajectory of 21,868 new outpatients waiting >12 weeks for November 2019, he noted that the number of patients waiting >12 weeks was 16% less than the same month the previous year. As at November 2019, 71.5% of available new outpatients on the waiting list were waiting <12 weeks for a new outpatient appointment, a further improvement on the previously reported position. The Committee noted that a new model of pain management has been implemented. There was a commitment to achieve a trajectory of 19,800 outpatients waiting >12 weeks by 31 March 2020. Monthly and fortnightly performance review meetings with Directors and General Managers continued to take place across all Sectors/Directorates.</p> <p>As at November 2019, a total of 609 patients were waiting >6 weeks to access a scope test. It was predicted that this number would reduce to 600 by the end of December 2019. Significant progress has been made with the positive monthly reduction trend in the number of patients waiting >6 weeks to access a scope continuing in November 2019. The Committee noted that performance remained on track for the second consecutive month and was expected to remain this way. Mr Best reported that bowel screening demand remained high however waiting times have improved across all Acute Sectors. Negotiations were taking place with the Golden Jubilee National Hospital (GJNH) regarding capacity for next year. Mr Best reported that training has commenced for 6 nurse endoscopists. Discussions were ongoing with the Golden Jubilee National Hospital in relation to establishment of a training academy for nurse endoscopists. Mr Best reported that a review and re-validation of surveillance waiting lists was underway to ensure surveillance remained in line with the revised national clinical guidance.</p>	
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<p>As at November 2019, a total of 3,320 patients were waiting >6 weeks for an imaging test. Current performance was above the standard of no patient waiting >6 weeks to access key diagnostic tests however, the rate of growth has slowed down. Mr Best reported that work was underway with three new outsourcing companies in order to organise the IT infrastructure and information governance procedures to allow remote reporting and reduce backlog. Two companies began reporting in November 2019, with the third scheduled to go online in February 2020. Local management information indicated that the imaging backlog has significantly reduced as a result. Nationally, the Scottish Radiology Transformation Programme was developing a business case that included implementation of Clinical Decision Software in Scotland to further support demand management. Funding of the development was agreed by the NHS Board Chief Executive's Group in November 2019, and will be rolled out during 2020.</p> <p>In respect of performance against Treatment Time Guarantee (TTG), Mr Best noted that as at November 2019, a total of 9,291 eligible TTG patients (available and unavailable patients) were waiting >12 weeks for inpatient/day case procedures. Whilst current performance was above the trajectory of no more than 8,230 patients waiting >12 weeks for November 2019, the number of patients waiting >12 weeks continued to reduce, albeit marginally, for the third consecutive month reducing from 9,447 in September 2019 to 9,291 in November 2019. Mr Best described a number of measures taken to improve performance, including; use of in-sourcing clinicians through Medinet and Synaptik to provide support for Ophthalmology and Paediatric Surgery and validation of inpatient/daycase waiting lists by secretarial staff, with ongoing reviews every twelve weeks.</p> <p>Mr Best paused for questions and comments.</p> <p>The Committee commended the team on the Minor Injuries Unit (MIU) campaign however members sought assurance that the campaign would reduce Emergency Department attendances. Ms Bustillo reported that the design of the Minor Injuries Unit campaign was based on international evidence. The Committee recognised that culture change was a major factor in redirecting patients from A&E to the MIU. Further work would take place to continue promotion of the MIU service. In response to a question on whether there would be a campaign to promote pharmacy services as an alternative, Ms Bustillo reported that the next phase was to devise a significant campaign to promote pharmacy services. The Committee noted that the results of a pharmacy redirection pilot carried out in Inverclyde highlighted that referrals to pharmacy significantly increased and patients were treated quicker and closer to home. Ms Audrey Thompson, Lead Pharmacist, Prescribing Services, agreed to clarify whether a minimum standard of consultation space in pharmacies was being considered.</p> <p>In response to a question in relation to retention of the nurse endoscopists once trained, Mr Best reported that NHS GGC would invest in staff by offering further development and training packages. Mr Best informed members that discussions were also ongoing in relation to offering weekend overtime.</p> <p>In response to a question in relation to religious and cultural paediatric circumcision being carried out, the Committee noted that discussions remain ongoing. Currently 450 patients were on the waiting list. The target was to reach 0 by the end of March 2020. NHSGGC were working alongside NHS Lanarkshire</p>	
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<p>in order to reach the target. The Committee noted that detailed discussions have taken place in relation to providing this service in the community. The Committee agreed that it was imperative that patient safety was considered if this service were to be provided in the community.</p> <p>Mr Best reported that as at November 2019, overall compliance with the stroke care bundle was 65%. This was below the target of 80%. Two of the four elements of the stroke care bundle exceeded target. The remaining two elements below target were: 87% of patients admitted to a stroke unit on day of admission/day following presentation, marginally below the 90% target, and 85% of patients had swallow screen <4 hours following admission against a target of 100%.</p> <p>In respect of the A&E 4 hour wait target, Mr Best reported that as at November 2019, 81.8% of patients presenting at A&E were either admitted, discharged or transferred for treatment <4 hours. Mr Best noted that the number of patients presenting at A&E remained challenging. The Committee noted that Consultant Connect (CC) has been expanded and rolled out across the three main Emergency Department (ED) sites.</p> <p>As at November 2019, a total of 192 patients were delayed across Acute Services resulting in a total of 5,152 acute bed days occupied by delayed patients. Of these totals, there were 144 delayed patients affected and 3,956 bed days lost were from across each of the six HSCP's.</p> <p>The Medical Director, Dr Jennifer Armstrong, highlighted page 17 of the report which provided an update on Staphylococcus Aureus Bacteraemia (SABs) and Clostridioides Difficile Infections (CDIs) infection rates. The Committee noted that work was ongoing to actively implement guidance to switch from administering intravenous antibiotics to oral antibiotics. The Infection Prevention and Control Team was carrying out a piece of work monitor the impact of this.</p> <p>Mr Best described performance of the Cancer 62 day target and noted that as at November 2019, 80.1% of patients referred urgently with suspicion of cancer began treatment within 62 days of receipt of referral. Mr Best highlighted that the first outpatient appointment for suspicion of breast cancer continued to be a pressure in the South Sector. Patients were being redirected to Clyde Sector; a locum breast surgeon has been appointed 2 days per week; and other options to secure additional capacity continue to be explored. Significant progress was being made, with a backlog of patients waiting for a colonoscopy, following positive bowel screening result, now cleared. Recruitment of 5 Nurse Endoscopist posts was unsuccessful and alternative options were being reviewed. Mr Best noted that the prostate cancer pathway was a key challenge affecting overall urological cancer performance. An NHSGGC standard operating procedure has been developed in line with nationally agreed principles.</p> <p>As at November 2019, 9.1% of (3,061) of all new outpatient appointments booked (33,789) did not attend. Mr Best reported that the current performance remained within the target of 11.3%.</p> <p>Mr Best reported that during November 2019, a total of 94 closures were reported across the GP Out of Hours Service. This represented an increase on the same month the previous year. Mr Best reported that closure of sites remained challenging. The Committee noted that the number of GP's interested</p>	
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<p>in working in the Out of Hours service was declining for a number of reasons. A Chief Officer has been seconded to the GP Out of Hours Service to provide senior leadership capacity. Work would be carried out to look at stabilising the service and delivering a more sustainable GP Out of Hours service. GP Workforce recruitment and the recruitment of Advanced Nurse Practitioners would be carried out to ensure a full complement of staff to support the service. Mr Best agreed to include a breakdown of closures by area in the next report.</p> <p>The Director of Human Resources and Organisational Development, Mrs Anne MacPherson, provided an overview of performance relating to attendance management. As at November 2019, sickness absence across Acute Services was 6.3%, comprising of 3.3% long term absence and 3.0% short term absence. The focus on long term absence has achieved improvements. There would now be a focus on short term absence to understand the reasons for the increase in absence. Mrs MacPherson reported that the 'Once for Scotland' programme of work was ongoing, with significant training taking place and a new absence policy being developed.</p> <p>Mrs MacPherson reported that a deep dive analysis was required to review staff mental health and wellbeing concerns to ensure reporting remained robust and that staff were fully supported. Further updates would be reported to the Staff Governance Committee.</p> <p>Mrs MacPherson reported that overall, there was an average iMatter response rate of 58% across Acute Services. As at November 2019, compliance with each of the nine elements of the statutory and mandatory training across Acute Services continued to show a month on month improvement. Work continued with Training Grade Doctors to ensure they have access to LearnPro. Individual emails highlighting current compliance would continue to be sent to relevant staff. Mrs MacPherson reported that manager emails were also in place to provide an overview of team compliance in order to help direct action and support.</p> <p>As at November 2019, 48.5% of KSF/PDP Reviews have been recorded on TURAS Appraisal across Acute Services. Overall performance demonstrated an ongoing improvement since December 2018, however the current position falls short of the 80% target. Mrs MacPherson reported that discussions would take place with Mr Best to consider ways to improve performance in this area.</p> <p>The Committee noted concern at the levels of sick absence. Mrs MacPherson reported that work was being carried out as part of the Staff Health Strategy to understand the reasons for staff absence. The Committee noted that issues were reported to the Staff Governance Committee.</p> <p>The Committee discussed the target set for statutory and mandatory training. The report highlighted that two of the nine elements were achieving 90% or more in terms of compliance. Further work would be carried out to improve performance and achieve a balance.</p> <p>Mr Finnie thanked Mr Best, Ms Bustillo, Dr Armstrong and Mrs MacPherson for the updates, and the Committee were content to note the report.</p> <p><u>NOTED</u></p>	
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08.	FINANCIAL MONITORING REPORT	
	<p>The Committee considered the paper 'Financial Monitoring Report' [Paper No. 20/04] presented by the Director of Finance, Mr Mark White.</p> <p>As at 30 November 2019, the Board reported expenditure levels [REDACTED] over budget. The Financial Improvement Programme (FIP) Tracker recorded projects totalling [REDACTED] on a FYE and [REDACTED] on a CYE. Mr White explained that the Month 5 Financial Monitoring Report presented to the Board at the meeting on 22nd October 2019, had projected a financial deficit as at 31st March 2020 of [REDACTED]. Following extensive work by the Finance Team, including a line by line assessment of all assumptions, budgets and savings opportunities, the projected financial deficit had been revised, and was now estimated at [REDACTED] as at 31st March 2020.</p> <p>Mr White confirmed that [REDACTED] of non-recurring funding has been factored in to support the overall financial position.</p> <p>The report included analysis of the key pressure areas. The main overspends were in relation to equipment maintenance repair and service contracts of [REDACTED], an overspend in prescribing of [REDACTED], surgical sundries of [REDACTED], CSSD and Diagnostics [REDACTED], and hotel services overspend of [REDACTED]. Mr White reported that further work needs to be carried out to bring this area back in control. Mr White noted that the main pressures in pay were associated with medical [REDACTED] and nursing [REDACTED] salaries due to the inherent cost of providing certain services, service demands (particularly A&E attendances) and the requirement to cover sickness/absence and vacancies via bank and agency spend. Mr White noted improvement in both medical and nursing overspend on the previous financial year.</p> <p>Mr White highlighted the challenges associated with non-pay pressures, increasing from the 2018/19 position which was a significant decrease on previous years.</p> <p>Mr White reported that medical salaries across the Directorate, which reported an over spend of [REDACTED] at Month 8. This compared to [REDACTED] over spend in Month 8 of the previous year. Mr White reported that the Senior Medical position reported a YTD underspend of [REDACTED] which represented an improvement of [REDACTED] in-month. Clyde and Women and Children's sectors were the main areas of pressure in respect of senior medical spend. Mr White reported that the junior medical position reported a YTD overspend of [REDACTED], which represented a deterioration against the Month 8 2018/19 position.</p> <p>Mr White informed the Committee that the organisation was experiencing a range of financial pressures in-year which were impacting on the current deficit position and the forecast year end deficit. This included Outcomes Framework, Clinical Waste, Medical Pay Award, Property Maintenance, Access Funding and Cystic Fibrosis drugs.</p> <p>Mr White reported the Financial Improvement Programme (FIP) continued into 2019/20. The Programme Board continued to meet on a weekly basis. The overall financial challenge for 2019/20 has been estimated as [REDACTED] and sectors and Directorates were developing plans to achieve this target.</p>	

	<p>The report provided an update on the Capital Plan. Mr White reported that the programme was progressing as predicted. The report highlighted major areas of planned spend. This included; ward refurbishments at Glasgow Royal Infirmary (GRI), provision for ventilation upgrade and associated works at QEUH campus, replacement of medical equipment, investment in e-Health priorities, provision of [REDACTED] for the Board's hub schemes and local minor works projects. The plan currently included [REDACTED] of unallocated capital.</p> <p>Mr Finnie thanked Mr White for the update and invited comments and questions from members.</p> <p>In response to a question regarding the expected year end position, Mr White reported that winter performance would play a factor in the year end position. Discussions continue to take place with Scottish Government colleagues to explore ways to address this and further discussions would be held at the Finance, Planning and Performance Committee to prepare for the year end.</p> <p>Mr Finnie thanked Mr White for the update. The Committee noted the Month 8 financial position and the projected financial deficit as at 31st March 2020, of [REDACTED].</p> <p><u>NOTED</u></p>	
09.	EXTRACT FROM CORPORATE RISK REGISTER	
	<p>The Committee considered the paper 'Extract from Corporate Risk Register' [Paper No. 20/05] presented by the Chief Operating Officer, Mr Jonathan Best.</p> <p>The Committee discussed risks in relation to the recent issues and concerns relating to the QEUH and RHC and it was agreed that this risk would be remitted to the Risk Management Steering Group, for inclusion within the Corporate Risk Register. In addition, the risk would be cross referenced with the Infection Control Risk, which was included within the remit of the Clinical and Care Governance Committee.</p> <p>The Committee were content to note the report and were satisfied that the risks and controls recorded were appropriate and the further actions were sufficient to mitigate the risks described.</p> <p><u>NOTED</u></p>	Mr Best
10.	DELAYED DISCHARGE IN ACUTE HOSPITAL SYSTEM	
	<p>The Committee considered the paper 'Delayed Discharges in GG&C' [Paper No. 20/06] presented by the Interim Chief Officer, Glasgow City HSCP, Ms Susanne Millar.</p> <p>The paper provided an update on all delayed discharges, and the actions underway to improve performance and outcomes for patients.</p> <p>The report highlighted that performance on delayed discharges has declined over the past 12 months, particularly delays in the Acute hospital sector. The Committee noted that this mirrored a national trend across Scotland.</p>	

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	<p>Ms Millar highlighted that there has been an increase in emergency admissions. This has caused significant pressure during periods of high demand.</p> <p>Performance reporting on Acute hospital delays focussed on three distinct patient groups those being; patients over 65, patients aged 18-64 and Adults with Incapacity (AWI). The Committee noted that patients over the age of 75 represented the highest volume patient group with increasing frailty and multi-morbidities. Ms Millar reported that the number of patients defined as AWI under the Adults with Incapacity (Scotland) Act has increased in recent months. Of the three patient groups, AWI delays place the greatest strain on the health and social care system.</p> <p>Ms Millar reported that each Health and Social Care Partnership (HSCP), working closely with the Acute Services Division, has a number of actions in order to improve outcomes for patients and current performance. Progress was reported to Integrated Joint Boards (IJB's). The report highlighted the key actions being taken in each HSCP.</p> <p>Dr McGuire provided an update on the legal challenge made by the Equalities and Human Rights Commission (EHRC) in regards to accommodating adults with incapacity at the Quayside and Darnley Care Homes. Meetings have taken place with the Scottish Government and Mental Health Welfare Commission. Dr McGuire informed members that a procedural hearing was due to take place on 22 January 2020 and a court date set for the following week. Dr McGuire informed members that NHS Greater Glasgow and Clyde has agreed to cease all admissions until further notice. Each of the current patients would be reviewed on a case by case basis to ensure legal orders were in place. Dr McGuire reported that two patients have been identified for interim guardianship test cases.</p> <p>Mr Finnie thanked Ms Millar and Dr McGuire for the update and invited comments and questions from members.</p> <p>Following a question in relation to a review of intermediate care beds, Ms Millar noted that following the outcome of the review and audit, improvements have been made. Ms Millar agreed to share the results of the Internal Audit that was carried out.</p> <p>The Committee were content to note the report which detailed performance in respect of all delayed discharges in NHSGGC, and were assured by the actions being taken by both HSCPs and the Acute Services Division, that positive integrated working was in place to improve performance and outcomes for patients.</p> <p>The Chair thanked Ms Millar and Dr McGuire for the update.</p> <p><u>NOTED</u></p>	

11.	NHSGGC – UROLOGICAL CANCER PERFORMANCE SUMMARY JANUARY 2020	
	<p>The Committee considered the paper ‘NHSGGC Urological Cancer Performance Summary January 2020’ [Paper No. 20/07] presented by the Chief Operating Officer, Mr Jonathan Best.</p> <p>The report provided a detailed update on performance against the 31 day target and the 62 day target for urological cancer. The report highlighted that performance against the 31 day target for urological cancer has improved over recent months, with over 95% of patients commencing treatment within 30 days in October and November 2019. Performance against the 62 day target for urological cancers was below trajectory. Mr Best highlighted that the majority of breaches were related to patients with prostate cancer. As a result, prostate cancer patients were being assessed and prioritised for treatment based on clinical risk factors and burden of disease.</p> <p>Mr Best went on to report that performance was affected by consultant vacancies across the sectors. The Committee noted that there were 5 vacancies across NHS GGC (25% of establishment). In addition, sickness absence across all sectors had contributed to the challenges. Mr Best assured members that there was a focus on recruitment and supporting trainees.</p> <p>Mr Best reported that key challenges in the prostate pathway have occurred due to vacancies and recent nursing staff changes. A pan NHSGGC meeting was held on 7th October 2019 to review the prostate cancer pathway, and actions were agreed to streamline the pathway.</p> <p>The Committee noted the report and were assured by the range of improvement actions underway to address performance.</p> <p><u>NOTED</u></p>	
12.	LANGLANDS UNIT UPDATE	
	<p>The Committee considered the paper ‘Position Paper – Langlands Building QEUH/Provision of Domestic Services’ [Paper No. 20/08] presented by the Director of Estates and Facilities, Mr Tom Steele.</p> <p>The report provided an update concerning the provision of Domestic Services, within the QEUH Langlands Building and offered assurance that continuous service review remained in place between the QEUH Facilities Management and contract provider for Domestic Services, within the QEUH Langlands Building.</p> <p>The report highlighted that cleanliness compliance audits undertaken throughout November and December 2019 demonstrated satisfactory performance results. Mr Steele reported that this was an improved position.</p> <p>Mr Steele reported that a review of the Contract Specification Schedule 21 Service Level Agreement continued. This formed part of a wider remediation process between NHSGGC and Imagile.</p>	

	<p>Mr Steele reported that NHSGGC were receiving advice and guidance from Health Facilities Scotland, PFI Liaison Manager, together with direction from Central Legal Office, in respect of this.</p> <p>The report highlighted a number of NHSGGC support measures that have been successfully implemented. This included; supporting Serco domestic management and supervisors with training, separating and communicating cleaning tasks between domestic services and ward based staff, investment in replacement of ward equipment and providing access to Serco to the Facilities Management Tool.</p> <p>Mr Steele informed the Committee that the next steps were to conclude the remediation process between NHSGGC and Imagile to ensure the current cleanliness standards were being consistently met. He reported that cleanliness audit arrangements would be undertaken with increased frequency to ensure cleanliness standards within Langlands building continue to improve and comply with the NCSS Quality Framework.</p> <p>The Chair thanked Mr Steele for the report. The Committee were assured by the report that continuous service review remained in place between QEUH Facilities Management and the contract provider for Domestic Services within the QEUH Langlands Building.</p> <p><u>NOTED</u></p>	
13.	QUARTER 2 PATIENT EXPERIENCE REPORT	
	<p>The Committee considered the paper 'Acute Patient Experience Report Quarter 2 (1 July 2019 to 30 September 2019) [Paper No. 20/09] presented by the Nurse Director, Dr Margaret McGuire.</p> <p>The report highlighted a number of ways in which feedback was obtained including complaints, Scottish Public Services Ombudsman (SPSO) information and patient experience information.</p> <p>Dr McGuire reported that through the Care Opinion website and Patient Feedback through the NHSGGC website, 379 people provided feedback on their experience via the two online methods during the period of 1 July 2019 to 30 September 2019. Dr McGuire reported that 68% of the feedback reported during this period was positive. The report highlighted the positive progress that has been made, however it was recognised that further work was required.</p> <p>The Committee noted that the new format of the report was helpful. It was suggested that more emphasis on lessons learned would be beneficial.</p> <p>Mr Finnie invited comments and questions from members.</p> <p>Following a question in relation to potential to link with complaints with Consultant and Doctor's appraisals, Mrs MacPherson agreed to explore this.</p> <p>The Chair thanked Dr McGuire for the update. The Committee were assured by the actions undertaken to improve patient care.</p> <p><u>NOTED</u></p>	Mrs MacPherson

14.	ACUTE STRATEGIC MANAGEMENT GROUP		
a)	MINUTE OF MEETING HELD 31ST OCTOBER 2019		
	<p>The Committee considered the minute of the Acute Strategic Management Group Meeting of 31st October 2019 [Paper No. SMG(M)19/10] and were content to note this.</p> <p><u>NOTED</u></p>		
b)	MINUTE OF MEETING HELD 28th NOVEMBER 2019		
	<p>The Committee considered the minute of the Acute Strategic Management Group Meeting of 28th November 2019 [Paper No. SMG(M)19/11] and were content to note this.</p> <p><u>NOTED</u></p>		
15.	CLOSING REMARKS AND KEY MESSAGES TO THE BOARD		
	<p>Mr Finnie summarised the key messages to the Board.</p> <p>1. Queen Elizabeth University Hospital and Royal Hospital for Children Update</p> <p>The Committee was assured by the update provided by the Chief Executive on the progress into the issues raised in relation to infection prevention, management and control at the Queen Elizabeth University Hospital and the Royal Hospital for Children following escalation to stage 4 of the NHS Scotland Performance Framework.</p> <p>2. Acute Services Committee – Review of Terms of Reference</p> <p>The Committee received a report by the Head of Corporate Governance and Administration, Ms Elaine Vanhegan, which asked the Committee to review its remit as part of the annual review process. The Committee was content to accept the minor amendments proposed to the Terms of Reference.</p> <p>3. Acute Integrated Performance Report</p> <p>The Committee received the report, and sought detailed assurances from: (i) Mr Jonathan Best, on a number of key areas including Treatment Time Guarantee (TTG); performance of new outpatients waiting no longer than 12 weeks for a new outpatient appointment; access to diagnostics tests; Accident and Emergency (A&E) 4 hour target; and cancer 62 day target; (ii). Dr Jennifer Armstrong on <i>Staphylococcus aureus</i> Bacteraemia (SABs) and <i>Clostridioides difficile</i> (CDIs) infection rates; and (iii). Mrs Anne MacPherson, Director of Human Resources and Organisational Development, on key measures in relation to sickness absence; iMatter, statutory and mandatory training; and Turas Appraisal.</p>		

	<p>4. Financial Monitoring Report</p> <p>The Committee noted, the Month 8 Financial Monitoring Report as at 30th November 2019, presented by Mr Mark White, Director of Finance. The Board was reporting expenditure levels of [REDACTED] over budget. Mr White explained that the Month 5 Financial Monitoring Report presented to the Board at the meeting on 22nd October 2019, had projected a financial deficit as at 31st March 2020 of [REDACTED]. Following extensive work by the Finance Team, including a line by line assessment of all assumptions, budgets and savings opportunities, the projected financial deficit as at 31st March 2020, detailed within the Month 8 Financial Monitoring Report, was now estimated at [REDACTED].</p> <p>5. Corporate Risk Register</p> <p>A new risk has been added in relation to the recent issues and concerns expressed relating to the Queen Elizabeth University Hospital and Royal Hospital for Children. The Committee requested that this be cross referenced with the infection control risk within the Clinical and Care Governance risk register.</p> <p>6. Delayed Discharges in NHSGG&C</p> <p>The Committee noted the paper presented by the Interim Chief Officer, Glasgow City HSCP, Ms Susanne Millar. The Committee noted the current performance in respect of all delayed discharges in NHSGG&C, and the actions being taken by HSCPs and the Acute Services Division to improve performance and outcomes for patients. The Committee noted the number of patients defined as Adults with Incapacity (AWI) under the Act have been increasing in recent months. The pressure this placed on the health and social care system due to the delays was recognised. The paper highlighted the complexities in managing delays. The Committee was assured that the HSCP's and the Acute Services Division have a number of actions in place to improve outcomes for patients and performance. In addition, Dr Margaret McGuire provided a brief update on the legal challenge made by the Equalities and Human Rights Commission (EHRC). The Committee noted that a number of meetings have taken place and further updates will be provided in due course.</p> <p><u>NOTED</u></p>	
16.	DATE OF NEXT MEETING	
	Tuesday 24 th March 2020, 09:30am, Boardroom, JB Russell House	

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**Meeting of the Acute Services Committee on
Tuesday 22nd September 2020 at 09:30am
via Microsoft Teams**

AGENDA

1.	Welcome and Apologies		
2.	Declarations(s) of Interest(s)		
3.	Minutes of Previous Meeting 21st July 2020	Approval	ASC(M) 20/02
4.	Matters Arising a) Rolling Action List	Discussion	Paper 20/17
5.	Urgent Items of Business	Discussion	Verbal
6.	Acute COVID-19 Update Verbal update by the Chief Executive and Chief Operating Officer	Verbal	Verbal
PERFORMANCE OVERVIEW			
7.	a) Acute Services Integrated Performance Report Paper presented by Chief Operating Officer	For Noting	Paper 20/18
	b) Cancer Recovery Presentation by General Manager, Oncology	Discussion	Verbal
8.	Financial Monitoring Report Paper presented by the Director of Finance	For Noting	Paper 20/19
9.	Extract from Corporate Risk Register Paper presented by the Director of Finance	For Noting	Paper 20/20
CLINICAL SERVICES OVERVIEW			
10.	Patient Experience Report Quarter 3, Quarter 4 & Quarter 1 Paper presented by the Nurse Director	For Noting	Paper 20/21

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ITEMS FOR NOTING			
11.	Acute Strategic Management Group		
	a) Minute of Meeting held 27th February 2020 b) Minute of Meeting held 25th June 2020	For Noting	
12.	Closing Remarks and Key Messages for the Board		
	Chair		
13.	Date and Time of Next Scheduled Meeting Tuesday 17 th November 2020, 09:30am via Microsoft Teams.		

OFFICIAL SENSITIVE



**Meeting of the Acute Services Committee on
Tuesday 17th November 2020 at 09:30am
via Microsoft Teams**

AGENDA

1.	Welcome and Apologies		
2.	Declarations(s) of Interest(s)		
3.	Minutes of Previous Meeting 22nd September 2020	Approval	ASC(M) 20/03
4.	Matters Arising a) Rolling Action List	Discussion	Paper 20/22
5.	Urgent Items of Business	Discussion	Verbal
6.	Acute COVID-19 Update Update by the Chief Operating Officer	Discussion	Presentation
PERFORMANCE OVERVIEW			
7.	a) Acute Services Integrated Performance Report Paper presented by Chief Operating Officer	For Noting	Paper 20/23
	b) Presentation – Trauma Centre Update Presentation by Medical Director, Dr Jennifer Armstrong	Discussion	Presentation
8.	Extract from Corporate Risk Register Paper presented by the Director of Finance	For Noting	Paper 20/24
ITEMS FOR NOTING			
9.	Acute Strategic Management Group		
	a) Minute of Meeting held 23rd July 2020 b) Minute of Meeting held 27th August 2020	For Noting For Noting	SMG(M)20/04 SMG(M)20/05

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10.	Closing Remarks and Key Messages for the Board Chair		
11.	Date and Time of Next Scheduled Meeting 19 th January 2021, 09:30am via Microsoft Teams.		

ASC(M) 21/01
Minutes: 01 – 12

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Acute Services Committee held via MS Teams on Tuesday 18th May 2021

PRESENT

Mr Ian Ritchie (in the Chair)

Mrs Jane Grant	Ms Margaret Kerr
Prof John Brown CBE	Mr Mark White
Mr Simon Carr	Mrs Audrey Thompson
Cllr Jim Clocherty	Dr Margaret McGuire
Ms Paula Speirs	Mr Tom Steele

IN ATTENDANCE

Mr Jonathan Best	..	Chief Operating Officer
Ms Sandra Bustillo	..	Director of Communications
Ms Jacqueline Carrigan		Assistant Director of Finance Acute/Access
Ms Nareen Owens	..	Head of People and Change - Development and Support
Dr Scott Davidson	..	Deputy Medical Director (Acute)
Ms Lisa Duthie	..	Senior Audit Manager, Audit Scotland
Mr William Edwards	..	Director of eHealth
Ms Susan McFadyen	..	General Manager (in attendance for item 7b only)
Ms Elaine Vanhegan	..	Head of Corporate Governance
Mrs Louise Russell	..	Secretariat Officer (Minutes)
Mrs Amy White	..	Observer

		ACTION BY
01.	WELCOME AND APOLOGIES	
	<p>The Chair welcomed those present to the meeting and welcomed Mrs Amy White who was in attendance to observe proceedings.</p> <p>Board member apologies for absence were intimated on behalf of Ms Susan Brimelow OBE.</p> <p>Other apologies were intimated on behalf of Mrs Anne MacPherson.</p> <p><u>NOTED</u></p>	

02.	DECLARATIONS OF INTEREST		
	<p>The Chair invited members to declare any interests in any of the items being discussed.</p> <p>No declarations of interest were made.</p> <p><u>NOTED</u></p>		

03.	MINUTES OF THE MEETING HELD 17 NOVEMBER 2020		
	<p>The Committee considered the minute of the meeting held on Tuesday 17th November [Paper No. ASC(M)20/04] and were content to approve the minute as an accurate record.</p> <p><u>APPROVED</u></p>		
04.	MATTERS ARISING		
a)	ROLLING ACTION LIST		
	<p>The Committee considered the 'Rolling Action List' [Paper No. 21/01] and were content to accept the recommendation that 1 action was closed.</p> <p>There were no other matters arising noted.</p> <p><u>APPROVED</u></p>		
05.	URGENT ITEMS OF BUSINESS		
	<p>The Chair invited members to raise any urgent items of business. There were no items raised.</p> <p><u>NOTED</u></p>		
06.	ACUTE COVID-19 UPDATE		
	<p>The Chief Operating Officer, Mr Jonathan Best, provided an update on the current position in respect of the NHSGGC response to manage COVID-19 in Acute Services, and provided assurance to members of the actions being taken in response to the pandemic.</p> <p>Mr Best reported that there had been a slight increase in the number of COVID patients within Acute Services. He reported that patient numbers</p>		

	<p>remained low in the Intensive Care Unit, with 1 patient diagnosed as positive within the last 28 days and 3 patients in total being treated. He reported that up to 33 inpatients had tested positive within the last 28 days, this was an increase from 20 patients. Mr Best reported that the position would continue to be closely monitored.</p> <p>Mr Best reported that a strong focus on remobilisation continued.</p> <p>Mr Best provided an update on ward closures. He reported that 2 wards had been closed at the Royal Infirmary due to COVID infections. Mr Best assured the Committee that monitoring would continue to take place through the Infection Control Management Team in order to manage the situation.</p> <p>The Committee noted that red and green pathways continued. Mr Best reported that the pathways in Surgery, High Dependency Unit and Intensive Care Unit were green. He reported that SATA pathways remained in operation and the Emergency Department front door continued to link with the Community Assessment Centres (CACs). Mr Best reported that deployment of point of care testing, managed through the laboratories, continued to assist with improving patient placement.</p> <p>Mr Best provided an update on staffing. Following updates to Scottish Government guidance, some members of staff previously shielding returned to work at the end of April 2021. Mr Best informed the Committee that individual risk assessments had been carried out. He reported that 350-380 members of staff remained shielding for various reasons, including pregnancy and long term COVID symptoms.</p> <p>Mr Best reported that pre-testing of patients 72 hours prior to a procedure was well embedded. Staff testing kits continued to be distributed and staff were encouraged to use the kits.</p> <p>The Committee noted that a strong focus remained on the COVID Vaccination Programme and the second vaccine.</p> <p>Mr Ritchie thanked Mr Best for the update and invited questions from the Committee.</p> <p>In response to a question regarding the current position in Glasgow City in relation to COVID levels rising and whether there was a shift in the approach to vaccinations, the Committee noted that dialogue with the Scottish Government was ongoing. Discussions continued to take place regarding bringing forward the second dose of the vaccination in those particular postcodes and bringing forward the vaccination for the younger age group. The Committee noted that this would be dependent on vaccination supply. In response to a question regarding vaccination supply and whether this would be redistributed from other areas or sourced additionally, the Committee noted that NSS would be responsible for supplies.</p>	
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	<p>In response to a question regarding whether vaccinations were resulting in reduction of the number of people being admitted and whether patients were less likely to be admitted to the Intensive Care Unit, the Committee noted that the low levels were positive, however there were cohorts of the population where the uptake of the vaccination was lower. The Committee noted that this was being monitored. Research had been carried out to review where patients had been admitted from and checked against the database to see if the patient had been vaccinated.</p> <p>The Committee were content to note the update and, although slightly anxious, were optimistic that the vaccination process had been effective. There was some concern noted regarding the areas that had not been fully vaccinated.</p> <p>The Committee were content to note the update and were assured by the information provided of the actions taken by NHSGGC in respect of the response to COVID-19.</p> <p><u>NOTED</u></p>	
07	ACUTE SERVICES INTEGRATED PERFORMANCE	
a.	REPORT	
	<p>The Committee considered the paper 'Acute Services Integrated Performance Report' [Paper No. 21/02] presented by the Chief Operating Officer, Mr Jonathan Best and the Director of Finance, Mr Mark White. The report provided the Committee with a balanced overview of the current performance position across Acute Services in relation to a number of high level key performance indicators during these unprecedented times.</p> <p>The Director of Finance, Mr Mark White, informed the Committee that the report provided an overview of performance in relation to the metrics outlined in Phase 2 Remobilisation Plan (RMP2). An update on the Phase 3 Remobilisation Plan (RMP3) would be provided in due course.</p> <p>The report provided an overall summary of performance. The report highlighted that NHSGGC were performing well in relation to remobilisation and elective programme targets were being achieved. The Committee noted that that the mix of activity was challenging. Mr White reported that unscheduled care numbers were starting to increase, which was highlighted in red on the table provided in the paper. Mr White reported however that overall NHSGCC were in a good position and were slightly ahead of where the Board expected to be.</p> <p>In response to a question regarding the plan for Scottish Government to move from TTG to clinical prioritisation and whether NHSGGC were close to being input driven rather than outcome drive, the Committee noted that new administration was being formed by the Scottish Government which would focus on a blended approach. The Committee</p>	

<p>noted that work was taking place with the clinical teams and weekly meetings were ongoing with the Scottish Government Access Team. The Committee noted that national guidance would be released in due course.</p> <p>In response to a question regarding trajectories and being able to look forward towards the next quarter, the Committee noted the Board were confident that they could meet the scheduled care RMP2 targets. The Board recognised that the unscheduled care targets would be challenging, however were confident that the RMP3 targets overall were achievable.</p> <p>In response to a question on the increased burden of the work that was required and whether NHSGGC were facing greater challenges, the Committee noted that this was difficult to monitor. The Committee noted that although hospitals were not back to pre-pandemic attendance, there had been a spike in attendance. The Flow Navigation Hub and better use of the Minor Injuries Unit would assist in alleviating this pressure. The Committee noted the Flow Navigation Hub was a useful tool to assist with the new ways of working and engaging with services. In response to a question on whether this was reducing the number of people in the system, the Committee noted that some reductions were evident.</p> <p>The Committee noted that discussions were being held with the Scottish Government regarding a national campaign for the Flow Navigation Hubs for all Boards and NHS24. The Committee noted a soft launch was carried out in NHSGGC, however the flow hub was still very early into its journey. The Committee noted that an article was included in the Glasgow Times outlining the service. The Committee noted the next phase would look at developing pathways for other services including ophthalmology, optometry and sexual health. The Committee noted that a national formal launch was required and discussions regarding this were taking place.</p> <p>In response to a question relating to RMP3 targets and whether the targets were low, Mr White reported that RMP2 targets were drafted early summer 2020, therefore the numbers fixed at that time were realistic with the information available. The RMP3 targets were revised in the autumn. The Committee noted the targets were 60% of previous elective and 80% of outpatient activity. The Committee noted that these were challenging targets and the Scottish Government had signed off the targets as challenging but realistic.</p> <p>In response to a question in relation to AWI pressure on the system and the impact on the patient, the Committee noted that work had taken place with the Scottish Government to look at planning some improvement activity in order to reach some long term benefits. The Committee noted that discussions were also taking place in partnerships.</p>	
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<p>In response to a question relating to the 7 day working and implementation capacity included in the report and whether including operational items, for example purchasing of mobile units, was appropriate to include, the Committee noted that the report would no longer be in this format. The Committee would however continue to see detail by exception for a few months. The Committee recognised that the current situation was fluid and acknowledged that staff wellbeing was priority and staff required time off for annual leave in order to recover. The Committee agreed that this was an essential part of the activity.</p> <p>The Committee noted that balancing the elective programme with the need to prioritise p1 and p2 patients would be challenging.</p> <p>In response to a question in relation to scope and imaging waiting lists and whether there had been issues or delays with the mobile unit for scopes and the ultra sound hub for imaging, Mr Best informed members that a national working group had been established for endoscopy and scopes. A Tactical Group were looking at the mobile unit which was currently out to tender using a national framework. Results from the tender process were expected in the next few weeks. The Committee noted that locums and additionality were being used to try to balance with remobilisation. The Committee noted that estates and facilities were looking at the new standards for endoscopy to ensure these were met. This included ventilation.</p> <p>The Committee noted that NHSGGC were making positive progress within imaging, currently achieving MRI and CT within 6 weeks. The Committee noted that work was taking place with Primary Care colleagues through the Interface Group to look at clinical prioritisation for GP referrals for routine ultrasounds.</p> <p>A question was raised regarding the redesign of urgent care and how effective the new pathway was in relation to A&E numbers. It was also raised that accessing GP appointments could be challenging at times. The Committee were keen to know how this was being evaluated to understand the impact. In response to the questions, the Board acknowledged that unscheduled care was challenging. The Board continued to work closely with Primary Care colleagues. Collaborative work was taking place with Primary Care colleagues to look at a whole system approach. It was recognised that additional work was required to look at the public perception that a “hands on” approach was always required. The Committee noted that feedback by patients on virtual appointments had been very positive. The Committee recognised the pressure that GP colleagues faced due to high demand. The challenge of social distancing and hygiene reduced the amount of patients that could be seen safely. The Committee noted that similar discussions had taken place at the Inverclyde IJB yesterday and the pressure on Primary Care colleagues was noted. The Director of Communications, Ms Sandra Bustillo, informed committee members that an evaluation of the</p>	
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	<p>flow navigation hub and unscheduled care was planned. The results of that evaluation would be submitted to the Committee in due course.</p> <p>The Committee were content to note the update and acknowledged the complex and fluid situation in respect of COVID-19. The Committee recognised that not all information was available to make a realistic assessment, however the Committee were assured that a lot of activity and actions were being taken forward to ensure the health of the population at this difficult time.</p> <p><u>NOTED</u></p>	
07 b.	PRESENTATION - OUTPATIENT REDESIGN VIRTUAL PATIENT MANAGEMENT	
	<p>Dr Scott Davidson, Deputy Medical Director (Acute), provided a presentation on Virtual Patient Management and the Active Clinical Referral Triage (ACRT).</p> <p>Dr Davidson reported that an Oversight Group was established in June 2020 to maximise the use of Virtual Patient Management (VPM) through remote and virtual technologies and drive the implementation of Active Clinical Referral Triage (ACRT). A multidisciplinary group with eHealth, Health Records, Management, Clinical and Planning representation set out the Board's expectations around service level adoption, provide support and monitor progress of implementation. The Committee noted that Service Improvement Managers had been appointed for Clyde, North & South Sectors, working with the Clinical Service Managers, senior Clinical Staff and service support staff to: support key areas/sub-specialties for focus and establish cross Sector agreement, and standardisation of vetting practice and pathways across GG&C.</p> <p>Dr Davidson reported that more than 60% of referrals were now vetted through ACRT. The Committee noted that ACRT was widely accepted by clinical teams as the model for management of new referrals into secondary care to ensure patients were triaged to the optimal, evidence based, locally agreed pathway. Dr Davidson highlighted that work was underway with e-health colleagues to update the Trakcare interface to more accurately capture the ACRT options at the point of triage.</p> <p>Dr Davidson highlighted the GGC Board ARCT progress from January 2020 to December 2020. This highlighted a gradual improvement with an overall increase of 25%. The next graph highlighted a rapid increase towards 100% from January 2021 to April 2021. Dr Davidson highlighted there was an overall increase of 60%.</p> <p>Dr Davidson provided an update on Virtual Patient Management (VPM). The Board trajectory was minimum 40%. Dr Davidson highlighted the current position which was 30% of appointments being carried out</p>	

<p>remotely. This was increase from 5% in March 2020, which highlighted that the use of remote consultations had become routine within NHSGGC. The Committee noted that telephone was the most widely used method. Dr Davidson reported that Near Me consultations would be promoted and supported by a significant investment programme of equipment across GG&C. Dedicated training would be available for clinical staff on the use of the Near Me system. Dr Davidson updated on Trakcare system developments and face to face consultations.</p> <p>Mr Ritchie thanked Dr Davidson for the presentation and invited questions from the Committee.</p> <p>In response to a question on the Moving Forward Together work and whether there was any reluctance to engage with virtual technology, Dr Davidson reported that people were initially anxious, however were becoming more confident. Dr Davidson reported that the team were considering champions to promote the system. In response to a question on what barriers there were, Dr Davidson reported that telephone was preferred method over video conference as patients were slightly more anxious to use the video platform.</p> <p>In response to a question on whether incentives would be used, Dr Davidson reported that there was no financial incentive. Encouraging use would come from word of mouth and patient experience. Dr Davidson highlighted that, in his opinion, the use of video to assess patients was transformational. This allowed clinicians to visually meet with the patient, which could help with patient assessments. Ms Susan McFadyen, General Manager, also highlighted that direct clinic outcome and optimising time was a benefit. It also assisted with continuity and ensured that all staff were working the same way. The Committee noted that huge progress had been made in setting up clinics. Blended clinics were developed which helped to optimise the clinician's time and the flexible approach had made a difference. The Committee recognised that digital scaling up was a benefit, however also recognised the challenges with this. In response to a question on the challenges, which included clinician push back, sustainability, English not being the patient's first language and access to equipment, the Committee noted that early reviews indicated that patient feedback had been positive. The Committee noted that a significant piece of work was carried out last year to evaluate patient experience using video and telephone communications. The feedback received was positive. Patients were provided with a self-questionnaire at the end of each consultation which they had the choice to participate in. The Committee noted that there was high levels of patient satisfaction. The Committee noted that further work would be carried to gather feedback from patients, particularly regarding accessibility. The Committee noted that virtual appointments help balance accessibility issues for patients, for example it removed transport issues to sites. Families could also be dialled in to virtual consultations.</p>	
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	<p>In response to a question regarding technical investment and whether the resources were available to support change, the committee noted that NHSGGC had made significant investment in technology and additional kit. Investment had been made in additional laptops and cameras. Pre COVID 33,000 pieces of equipment was available, this had now increased to 40,000. GP practices were enabled with kit and the feedback received was that this was gratefully received. The Committee noted that progress was still being made. The desktop refresh programme was moving forward and had been include in future capital plans.</p> <p>In response to a question on how NHSGGC compare to the rest of the UK and the world, the committee noted that local benchmarking takes place.</p> <p>In response to a question on how NHSGGC were approaching implementation of policy, the Committee noted that this was high on the Acute Services Division agenda. A balanced approach was required with space and time to increase use.</p> <p>The Committee were content to note the presentation and were assured by the progress being made.</p> <p><u>NOTED</u></p>	
08.	FINANCIAL MONITORING REPORT	
	<p>The Committee considered the paper 'Financial Monitoring Report' [Paper No. 21/03] presented by the Assistant Director of Finance Acute/Access, Ms Jacqueline Carrigan.</p> <p>The Committee noted that, as at the 31st March 2021, the Board's financial ledger reported a financial position of [REDACTED] under budget. This was as a result of the receipt of the full COVID-19 funding from Scottish Government plus the impact of additional funding allocations.</p> <p>The report provided analysis of the financial position as at 31st March 2021. This highlighted that Acute area reported an expenditure underspend of [REDACTED], with partnerships and corporate departments at a break even position.</p> <p>The Committee noted the overall, Pays were [REDACTED] underspent and Non Pay was [REDACTED] overspent. The FIP position reported a break even position due to the non-recurring support received from Scottish Government related to COVID-19.</p> <p>The report included the Sector and Directorate year-end outturns, Medical Salaries and a non-pay costs summary. The report also included the financial performance for partnerships and showed their position.</p>	

Financial Improvement Programme 2020/21

The Committee noted the Financial Improvement Programme continued throughout 2020/21. The overall financial challenge for 2020/21 was [REDACTED], which was fully achieved in year. This achievement was in part due to non-recurring support from Scottish Government and underspends arising from reduced elective activity being released against FIP. As at 31st March 2021, savings of [REDACTED] had been achieved on a full year effect basis with a current year effect of [REDACTED].

The Committee noted the overall financial challenge for 2021/22 had been estimated as [REDACTED]. The approach to the FIP programme followed a similar approach adopted last year. The FIP Delivery Board continued to meet on a weekly basis.

Ms Carrigan provided an update on the capital position for 2021/22. The level of core capital resources made available to the Board for investment in 2020/21 amounted to [REDACTED]. This figure comprised gross capital allocations received from SGHSCD of [REDACTED], together with [REDACTED] income from in-year Capital Receipts generated through property disposals, and an amount of revenue funded capital expenditure, which amounted to [REDACTED].

Mr Ritchie thanked Ms Carrigan for the update and invited questions from the Committee.

In response to a question on when the end of year position for partnerships would be available, the Committee noted that this would be submitted to the Financial Planning and Performance Committee on 15th June 2021.

In response to a question on the junior medical costs being a key priority for 2021/22 and what work would take place, the Committee noted that this would be reviewed in detail to gain insight and support rotas. The Committee noted that analytical work had been carried out which was a good baseline. The Committee noted that rota compliance was being reviewed. There were 4 at the moment that were non-compliant. The Committee noted that work was being carried out, led by Kenny Tracey and Lindsay Donaldson regarding natural breaks and the timetabling of breaks to ensure staff wellbeing. The Committee noted an update paper would be submitted to the Staff Governance Committee to provide assurance. The Committee noted that a Junior Doctors Monitoring Group had been established and conversations had already taken place. The Committee also noted that a letter had been sent to Junior Doctors, with support from the BMA and LMC, regarding rota compliance and breaks. A summary could be provided to the Staff Governance Committee for assurance.

In response to a question in relation to the Financial Improvement Programme (FIP) and the [REDACTED] savings that had been achieved on a

	<p>full year effect basis with a current year effect of [REDACTED], the Committee noted the remainder was non-recurring support from in the system. In response to a question in relation to the spread of savings and variance in some areas, the Committee noted the Director of FIP would be invited to the Financial Planning & Performance Committee</p> <p>The Committee noted that equipment costs and repair maintenance costs varied year on year. There had been an increase in costs this year, however the Committee noted that controls were well embedded.</p> <p>The Committee were content to note the update.</p> <p><u>NOTED</u></p>		
09.	EXTRACT FROM CORPORATE RISK REGISTER		
	<p>The Chief Operating Officer, Mr Jonathan Best, provided a verbal update on the Corporate Risk Register. The Committee noted that the Corporate Risk Register was undergoing review as part of the review of active governance.</p> <p>The Committee noted a proposal for updating the Corporate Risk Register and closing of historic risks would be submitted to the next meeting.</p> <p><u>NOTED</u></p>		
10.	ACUTE STRATEGIC MANAGEMENT GROUP		
a)	MINUTE OF MEETING HELD 24 SEPTEMBER 2020		
	<p>The Committee considered the minute of the Acute Strategic Management Group Meeting of 24th September 2020 and were content to note this.</p> <p><u>NOTED</u></p>		
b)	MINUTE OF MEETING HELD 26th NOVEMBER 2020		
	<p>The Committee considered the minute of the Acute Strategic Management Group Meeting of 26th November 2020 and were content to note this.</p> <p><u>NOTED</u></p>		

11.	CLOSING REMARKS AND KEY MESSAGES TO THE BOARD		
	Mr Ritchie summarised the key messages to the Board.		
	<p>1. Acute COVID-19 Update</p> <p>The Committee noted the overview provided in respect of the current position and ongoing response to COVID-19. The Committee noted concern regarding the slight rise in COVID related cases, however were assured that Acute Services were managing the situation effectively. The team would continue to look for the improvements to be maintained.</p> <p>2. Performance Update</p> <p>The Committee noted the current position in respect of Performance and the impact of COVID-19. The Committee widely discussed the Integrated Performance Report and recognised the remobilisation plans varied from the set included in the appendix, which was the target set pre COVID.</p> <p>3. Outpatient Redesign Virtual Patient Management</p> <p>The Committee received a presentation by the Deputy Medical Director (Acute) which described progress in respect of the Virtual Patient Management & Active Clinical Referral Triage (ACRT). The Committee were assured by the information provided and the transformational elements continuing through the onset of COVID-19.</p> <p>4. Financial Monitoring Report</p> <p>The Committee noted the Month 12 Financial Monitoring Report and the benefits accrued in respect of finance available to manage the crisis.</p> <p><u>NOTED</u></p>		
12.	DATE OF NEXT MEETING		
	Tuesday 20 th July 2021, 09:30am, MS Teams		

ASC (M) 21/02
Minutes: 13 – 26

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Acute Services Committee held on Tuesday 20 July 2021 at 10.00 am via Microsoft Teams

PRESENT

Mr Ian Ritchie (in the Chair)

Mrs Jane Grant	Dr Paul Ryan
Ms Susan Brimelow OBE	Ms Paula Speirs (until 11am)
Prof John Brown CBE	Mr Mark White
Mr Simon Carr	Dr Margaret McGuire
Cllr Jim Clocherty	

IN ATTENDANCE

Mr Jonathan Best	..	Chief Operating Officer
Ms Sandra Bustillo	..	Director of Communications
Ms Jacqueline Carrigan	..	Assistant Director of Finance Acute/Access
Dr Scott Davidson	..	Deputy Medical Director (Acute)
Mrs Jennifer Haynes		Corporate Services Manager - Governance
Dr Paul Jenkins		Consultant Orthopaedic Surgeon (for item 7b only)
Mrs Anne MacPherson		Director of Human Resources & Organisational Development
Ms Liz McConachie		Audit Scotland
Ms Susan McFadyen	..	Director of Access (for item 7b only)
Mrs Louise Russell		Secretariat Officer (Minutes)

		ACTION BY
13. WELCOME AND APOLOGIES		
<p>The Chair welcomed those present to the meeting.</p> <p>Apologies were intimated on behalf of Professor Linda de Caestecker, Mr William Edwards and Mr Tom Steele.</p> <p>The Chair advised members that there had been some recent changes to the membership. The Chair welcomed new Board member, Dr Paul Ryan, to the Committee. The Chair extended thanks to Mrs Margaret</p>		

		ACTION BY
	Kerr and Mrs Audrey Thompson for their thoughtful contributions and valued input during their time on the Committee. <u>NOTED</u>	
14.	DECLARATIONS OF INTEREST	
	The Chair invited members to declare any interests in any of the items being discussed. No declarations of interest were made. <u>NOTED</u>	
15.	MINUTES OF THE MEETING HELD 18 MAY 2021	
	The Committee considered the minute of the meeting held on Tuesday 18 th May [Paper No. ASC(M)21/01] and were content to approve the minute as an accurate record pending the following amendments; <u>Acute Services Integrated Performance Report</u> Page 5, second last paragraph; the second sentence to be amended to: The RMP3 targets were <i>revised</i> in the autumn. <u>Presentation – Outpatient Redesign Virtual Patient Management</u> Paragraph 7, first sentence to be amended to; In response to a question on the Moving Forward Together work and whether there was any reluctance <i>to engage with virtual technology</i> , Dr Davidson reported that people were initially anxious, however were becoming more confident. <u>APPROVED</u>	
16.	MATTERS ARISING	
	There were no matters arising noted. <u>NOTED</u>	
17.	URGENT ITEMS OF BUSINESS	
	The Chair invited members to raise any urgent items of business. There were no items raised. <u>NOTED</u>	

		ACTION BY
18.	ACUTE COVID-19 UPDATE	
	<p>The Chief Operating Officer, Mr Jonathan Best, provided an update on the current position in respect of the NHSGGC response to manage COVID-19 in Acute Services, and provided assurance to members of the actions being taken in response to COVID-19.</p> <p>Mr Best reported that there had been a slight increase in the number of COVID patients within Acute Services since the last update. He reported that the number of in-patients today was 127, which was a decrease from 141 in-patients the previous day. He reported that 9 patients had tested positive within the last 14 days which was mainly community acquired. The Committee noted that there was currently 10 patients in Intensive Care Units across GGC. Mr Best reported that no wards had been closed. Mr Best highlighted that although a slight upturn in numbers was noted, there had been a reduction in community acquired infection.</p> <p>Mr Best informed the Committee that point of care (POC) testing at the Hospital front door continued to make good progress and continued to assist with improving patient placement. Mr Best reported that SATAs remained open and in operation at the front door. The Committee noted that Community Assessment Centres (CACs) continued to work well.</p> <p>Mr Best reported that work continued on maintaining the elective programme based on pre assessment testing at 72 hours prior to surgery.</p> <p>Mr Best informed the Committee that promotion of the vaccination continued to take place, particularly with the younger cohort of patients.</p> <p>The Committee noted that staffing levels remained challenging for various reasons including staff isolating, long COVID symptoms and annual leave. Mr Best noted that although continued pressure remained, the team continued to manage the situation.</p> <p>Mr Ritchie thanked Mr Best for the update and invited questions from members.</p> <p>In response to a question on whether there had been a change in demographic of patients in ICU, Dr Scott Davidson, Deputy Medical Director (Acute) reported that work continued to take place to monitor the demographic. He reported that the patient group was younger, however the length of stay was shorter due to treatment developments. Dr Davidson reported that work would take place in due course to review the vaccination profile in detail.</p>	

		ACTION BY
	<p>In response to a question on the type of testing used at the front door, Mr Best reported that PCR testing was the method used. The Committee noted that the kit was supplied by the Scottish Government.</p> <p>The Committee acknowledged the commitment of staff and the vast amount of work that had been carried out.</p> <p>The Committee were assured by the update provided and were assured that the programme was being maintained.</p> <p><u>NOTED</u></p>	
19.	ACUTE SERVICES INTEGRATED PERFORMANCE REPORT	
	<p>The Committee considered the paper 'Acute Services Integrated Performance Report' [Paper No. 21/05] presented by the Chief Operating Officer, Mr Jonathan Best and the Director of Finance, Mr Mark White. The report provided the Committee with a balanced overview of the current performance position across Acute Services in relation to a number of high level key performance indicators outlined in the Remobilisation Plan 3, covering 1st April 2021 to 30th June 2021. Mr White highlighted that the format and structure of the report had been revised to reflect the key priorities and the suite of measures outlined in the RMP3.</p> <p>The report highlighted the current performance status. The table highlighted that the performance status for 6 of the RMP3 measures were green and the remaining 2 RMP3 measures were red.</p> <p>Mr Best reported that the priority areas to focus on were Cancer and Urgent Referrals. He noted that remobilisation of outpatients was challenging due to social distancing requirements. Further national guidance was awaited. Mr Best reported that TTG numbers were gradually reducing.</p> <p>Mr Best reported the key focus areas were 62 day cancer, urology and endoscopy. He reported that discussions were being held with the Scottish Government regarding funding additionality and bringing in a mobile Endoscopy unit. The Committee noted that work continued to take place to mobilise as quickly as possible.</p> <p>Mr Best reported that A&E continued to see increased numbers. It was anticipated that numbers were returning to pre COVID however progress was being made overall.</p> <p>Mr Ritchie thanked Mr Best for the update and invited questions from members.</p>	

		ACTION BY
<p>In response to a question relating to the two red on the dashboard and whether the trajectory for the remainder of the year was original or updated, the Committee noted that the Board were working on the RMP3 trajectory.</p> <p>The Committee noted that Delayed Discharges was a fairly complex situation, however it was anticipated that numbers would decrease in the next 6 months.</p> <p>Mr Best reported that performance continued to remain positive in relation to urgent cancer referrals. He reported that referrals had increased to over 1000 per week. The management of cancer patients continued to remain a clinical priority.</p> <p>In response to a question regarding including integrated care in this report, the Committee noted that discussions regarding this had taken place and it was agreed that this would sit with Finance Planning and Performance and the IJB's. The Committee agreed it would be helpful to understand any underlying issues. The Committee noted that a presentation was due to be provided by Mr Jonathan Best and Ms Susanne Millar at the August Finance Planning and Performance Committee meeting in order to provide assurance to members. The Committee noted that the Glasgow IJB had scheduled a session in September 2021 which would focus on adults with incapacity. The Committee noted that further consideration would be given on how assurance was provided.</p> <p>In response to a question in relation to imaging figures and the waiting lists increasing, Mr Best reported that following decommissioning of the CT Pod at Louisa Jordan, this was in the process of being relocated to the Queen Elizabeth University Hospital. He also reported that capital funding had been received to replace two MRI machines.</p> <p>In response to a question regarding additional capacity and the use of proleptic appointments, Mr Best clarified that if a member of staff was retiring for example, a replacement would be appointed early to ensure there was not a reduction in capacity.</p> <p>In response to a question regarding urgent care performance, the Committee were assured that a detailed piece of analysis had been carried out. Following this piece of work, an action plan was in the process of being developed and further specific work would be carried out, including a bed base review. The Committee noted that a further update would be provided at the next meeting.</p> <p>The Committee discussed unscheduled care attendance at A&E. The Committee noted that work continued to take place to communicate with the public, including radio adverts and a soft launch of the flow navigation hub. The Committee noted that signposting continued to take</p>		Mr Best

		ACTION BY
	place at the front door. The Committee acknowledged that changing public perception would take time, however the committee were assured that the progress being made via the flow navigation hub was positive, with 32-37% of calls being closed off. The Committee noted that a subgroup had completed a data exercise and reviewed data from 2019. The Committee noted that a detailed 11 week analysis would be carried out to look at pre COVID attendance how it compared to present. The Committee noted that an update on key drivers and emerging findings would be provided at the next meeting.	
	The Committee noted the update provided	
	<u>NOTED</u>	
20.	STRATEGIC APPROACH TO RECOVERY OF ELECTIVE PROGRAMME - ORTHOPAEDICS	
	Dr Paul Jenkins, Consultant Orthopaedic Surgeon, provided a presentation on the Strategic Approach to Recovery of Elective Programme – Orthopaedics.	
	Dr Jenkins provided an overview on the impact of COVID-19.	
	The presentation provided an update on the following areas;	
	<ul style="list-style-type: none"> • NHS GGC in the National context • Outpatient Key Metrics • Outpatient innovation • Current Outpatient position • Outpatient Recovery • Inpatient/Daycases Key Metrics • Introduction of Intermediate Surgery at ACH sites • Current Inpatient Position • Orthopaedic Recovery 	
	Mr Ritchie thanked Dr Jenkins for the presentation and congratulated Dr Jenkins and his colleagues for the valuable work that had been carried out. Mr Ritchie invited questions from members.	
	In response to a question regarding workload capacity and trainees, Dr Jenkins noted that there were challenges to recruit in certain areas of orthopaedics, however teams had been combined which helped to resolve any issues.	
	In response to a question regarding differentiating between patients with chronic pain, Dr Jenkins reported that a prioritisation tool with 4 categories had been used. Administration staff maintained the waiting list and carried	

		ACTION BY
	<p>out 3 month calls to patients, therefore if patient's pain had increased then they could be escalated on the list.</p> <p>The secretary agreed to circulate a copy of the presentation to members following the meeting.</p> <p><u>NOTED</u></p>	Secretary
21.	FINANCIAL MONITORING REPORT – MONTH 2	
	<p>The Committee considered the paper 'Financial Monitoring Report' [Paper No. 21/06] presented by the Assistant Director of Finance Acute/Access, Ms Jacqueline Carrigan.</p> <p>The Committee noted the Acute Division was reporting an expenditure overspend of [REDACTED] at Month 2. The FIP position reported an underachievement of [REDACTED].</p> <p>The report highlighted Sector and Directorate positions together with the 2020/21 outturn for comparison purposes. The report highlighted that Nursing was 213 over as at end May 21. The Committee noted that regional was experiencing pressures in the Forensic Mental Health wards due to the complexity of patients.</p> <p><u>The Financial Improvement Programme (FIP) –2021/22</u></p> <p>The Committee noted the 2021/22 Financial Improvement Programme (FIP) had allocated the Acute Division a target of [REDACTED] split across all the Sectors and Directorates.</p> <p>Ms Carrigan reported that to date there were 51 schemes that had been ratified and a further 81 schemes in the pipeline due to be worked into viable project plans and delivered.</p> <p>Mr Ritchie thanked Ms Carrigan for the update and invited questions from the Committee.</p> <p>In response to a question regarding the 100% target and whether this was achievable, the Committee noted that the aim was to reach 40% by August. There was [REDACTED] of schemes to move to delivery. The Committee noted that a stepped approach would be taken.</p> <p>The Committee discussed the financial pressure of delayed discharges and delegated budgets for IJB's and Acute Services. The Committee acknowledged the significant cost pressure and recognised this was a challenging area. The Committee noted that different routes had been explored in order to recover costs from IJB's outwith the Board area however further consideration would be given to this. Following detailed discussion, the Committee agreed that the remit would be given to the Finance Planning and Performance Committee to discuss further.</p>	

		ACTION BY
	<p>The Committee noted the update provided.</p> <p><u>NOTED</u></p>	
22.	REVIEW OF COMMITTEE TERMS OF REFERENCE	
	<p>The Committee considered the paper 'Review of Committee Terms of Reference' [Paper No. 21/07] presented by the Corporate Services Manager – Governance, Mrs Jennifer Haynes.</p> <p>The Committee was asked to review its remit as part of the annual review process to ensure the remit remained fit for purpose providing assurance for onward approval at the Board.</p> <p>The Committee were asked to reconsider the following section: Section 3.3 Voting; should a vote need to be taken, only the Non-Executive members of the Committee shall be allowed to vote, either by show of hands, or a ballot. This ensured there was a standardised approach as the Non-Executive Members on the Board were in a position to vote. Mrs Haynes agreed to discuss this further with the Head of Board Administration and Corporate Governance, Ms Elaine Vanhegan.</p> <p>The Committee also discussed the financial planning and management of Acute Services. The Committee acknowledged that this was an opportunity to review for overlaps and avoid duplication.</p> <p>The Committee noted that final approval would take place at the next Board meeting, therefore Mrs Haynes and Ms Vanhegan would take comments back for review.</p> <p><u>NOTED</u></p>	Mrs Haynes
23.	CORPORATE RISK REGISTER	
	<p>The Committee considered the paper 'Corporate Risk Register Extract' [Paper No. 21/08] presented by the Director of Finance, Mr Mark White.</p> <p>The Audit and Risk Committee (ARC) commissioned a review of the Corporate Risk Register (CRR) to be carried out by professional advisers Azets. The Committee noted that Azets have overseen the revision and updating of the CRR. The full revised and updated CRR was approved by the ARC on 22 June 2021, and was also discussed by the Corporate Management Team. The next step involved each relevant standing Committee approving the current open risks and the removed or down-graded risks.</p> <p>The Committee were asked to note and approve the revised and updated Corporate Risk Register, the process for removed and down-graded risks and the next steps in the overall improvement process.</p>	

		ACTION BY
	<p>In respect of risks that related to the Acute Services Committee, 3 risks were closed and 1 was downgraded to the operational risk register, therefore 2 risks remained open.</p> <p>The Committee agreed it would be helpful to discuss the two open risks over the next 2 meetings to allow for fuller discussion and deal with the risks more effectively and gain assurance.</p> <p><u>APPROVED</u></p>	All
24.	ANNUAL CYCLE OF BUSINESS	
	<p>The Committee considered the paper 'Annual Cycle of Business' [Paper No. 21/09].</p> <p>The Committee discussed what the most appropriate forum for the Patient Experience Reports to be submitted to in order to avoid duplication. The Committee agreed reports would be submitted to the Clinical and Care Governance Committee with reports by exception to the Acute Services Committee.</p> <p><u>AGREED/NOTED</u></p>	
25.	CLOSING REMARKS AND KEY MESSAGES FOR THE BOARD	
	<p>Mr Ritchie summarised the key messages to the Board.</p> <p>1. Acute COVID-19 Update</p> <p>The Committee noted the increase in COVID-19 infections but also that they were less of a burden than in previous waves for the Acute Sector, principally due to the younger age of patients involved. Fewer numbers in ICU were noted.</p> <p>2. Acute COVID-19 Update</p> <p>The Committee noted that the elective programme had continued despite the upturn in covid-19 cases.</p> <p>3. Performance Update</p> <p>The Committee noted that work continued to deliver care according to the parameters of RMP3. Also note that RMP4 was being discussed and will be in place later in the year.</p>	

			ACTION BY
	<p>4. Strategic Approach to Recovery of Elective Programme – Orthopaedics</p> <p>Considerable assurance obtained from a presentation about the work of orthopaedic surgeons across all sectors of GG&C designed to recover from the backlog of work following the COVID pandemic.</p> <p><u>NOTED</u></p>		
26.	DATE OF NEXT MEETING		
	<p>Tuesday 21 September 2021, 9.30am via MS Teams</p> <p><u>NOTED</u></p>		

OFFICIAL SENSITIVE



**Meeting of the Acute Services Committee on
Tuesday 21 September 2021 at 09.30am via Microsoft Teams**

AGENDA

1.	Welcome and Apologies		
2.	Declarations(s) of Interest(s)		
3.	Minutes of Previous Meeting: 20 July 2021	Approval	ASC(M) 21/02
4.	Matters Arising a) Rolling Action List	Approval	Paper No 21/09 To Follow
5.	Urgent Items of Business	Awareness	Verbal
6.	Acute COVID-19 Update Update by the Chief Operating Officer	Awareness	Verbal
PERFORMANCE OVERVIEW			
7.	a) Acute Services Integrated Performance Report Paper presented by Chief Operating Officer and Director of Finance	Assurance	Paper No 21/10
	b) Presentation: Robotics Presentation by the Chief of Medicine, South Sector	Awareness	Presentation
8.	Financial Monitoring Report Paper presented by the Director of Finance	Awareness	Paper No 21/11
9.	Corporate Risk Register – Relevant Extract Paper presented by the Director of Finance	Assurance	Paper No 21/12

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ITEMS FOR ASSURANCE			
10.	Annual Cycle of Business Chair	Assurance	Paper No 21/13
11.	Closing Remarks and Key Messages for the Board Chair	Assurance	Verbal
DATE OF NEXT MEETING			
12.	Date and Time of Next Scheduled Meeting 16 November 2021, 09:30am via Microsoft Teams.		

ASC (M) 21/04
Minutes: 39 – 52

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Acute Services Committee Held on Tuesday 16 November 2021 at 9.30 am via Microsoft Teams

PRESENT

Mr Ian Ritchie (in the Chair)

Professor John Brown CBE	Ms Susan Brimelow OBE
Mrs Jane Grant	Dr Paul Ryan
Mr Simon Carr	Dr Margaret McGuire
Ms Paula Speirs	Mr Mark White

IN ATTENDANCE

Mr Jonathan Best	..	Chief Operating Officer
Ms Sandra Bustillo	..	Director of Communications and Public Engagement
Ms Jacqueline Carrigan	..	Assistant Director of Finance Acute/Access
Dr Scott Davidson	..	Deputy Medical Director, Acute
Ms Gillian Duncan	..	Secretariat (Minute)
Mrs Jennifer Haynes		Corporate Services Manager - Governance
Ms Liz Maconachie	..	Audit Scotland
Processor Colin J Mackay	..	Chief of Medicine, North Sector (for item 7c)
Mrs Anne MacPherson	..	Director of Human Resources & Organisational Development
Ms Susan McFadyen	..	Director of Access (for item 7c)
Mrs Angela O'Neill	..	Deputy Director of Nursing, Acute
Ms Fiona McEwan	..	Assistant Director of Finance – Financial Planning and Performance

			ACTION BY
39.	WELCOME AND APOLOGIES		
	Mr Ritchie welcomed those present to the meeting.		

			ACTION BY
	<p>Before moving on to the formal items of business, Mr Ritchie addressed the Committee and asked them to note the successes of the last 18 months which include managing the pandemic, the vaccination programme, providing support to care homes and the considerable preparations for COP26. In addition, the substantial legal claims and information flows required for several enquiries, particularly the ongoing Public Inquiry have imposed additional burdens on the Executive team.</p> <p>Mr Ritchie also asked the Committee to acknowledge the challenges that acute services are facing, including the number of unscheduled care attendances at ED and the number of inpatient admissions while maintaining services and managing increasing waiting lists and sustained demand alongside the continuing challenges of COVID-19 and the onset of winter.</p> <p>Mr Ritchie reminded Committee members that the focus of the Acute Services Committee should be to recognise the day-to-day challenges facing the Executive Team and all NHSGGC staff while looking for assurance that services are being delivered appropriately and with patience and understanding at the forefront of the care provided. He said it is important to support the staff and Executive Team, particularly in thinking ahead to the challenges that will come once the winter is over and COVID-19 becomes endemic. Mr Ritchie also thanked the Executive Team for starting the process of improving the data that Committee members can use to get that assurance.</p> <p>Apologies were intimated on behalf of Councillor Jim Clocherty and Professor Linda de Caestecker.</p>		
40.	DECLARATIONS(S) OF INTEREST(S)		
	<p>Mr Ritchie invited members to declare any interests in any of the items being discussed.</p> <p>No declarations of interest were made.</p> <p><u>NOTED</u></p>		

			ACTION BY
41.	MINUTES OF PREVIOUS MEETING: 21 SEPTEMBER 2021		
	<p>The Committee considered the minute of the meeting held on Tuesday 21 September 2021 [Paper No. ASC (M) 21/03] and were content to approve the minute as an accurate record.</p> <p><u>APPROVED</u></p>		
42.	MATTERS ARISING		
a)	Rolling Action List		
	<p>The Committee considered the Rolling Action List [Paper No. 21/14].</p> <ul style="list-style-type: none"> - Minute 33a – Dr Davidson was providing a presentation on patient flows at today's meeting. - Minute 35 – the Corporate Risk Register had been amended following discussion at the previous meeting. - Minute No 36 - Mr Ritchie proposed that the Annual Cycle of Business should be discussed at the agenda setting meetings and not be added to the agendas for the Committee in future. <p>There was discussion on the role of the Acute Services Committee as the three corporate objectives on the Annual Cycle of Business were led by the Finance, Planning and Performance Committee and the Clinical and Care Governance Committee. Mr Ritchie explained that the Acute Services Committee has a responsibility and requirement to consider these items for assurance purposes and to provide feedback to the lead Committee who had responsibility for that action.</p> <p>Mrs Grant added that the detail of performance information was in the process of being refined as part of the Active Governance work and this would be available from April 2022 following review by all governance Committees.</p> <p>The Committee were content to approve the closure of the three items on the Rolling Action List.</p> <p><u>APPROVED</u></p>		

			ACTION BY
43.	URGENT ITEMS OF BUSINESS		
	No items raised.		
	<u>NOTED</u>		
44.	ACUTE COVID-19 UPDATE		
	<p>Mr Jonathan Best, Chief Operating Officer, provided an update on the current position in respect of the NHSGGC response to managing COVID-19 in Acute Services, and provided assurance to members of the actions being taken in response to COVID-19.</p> <p>Mr Best advised that there was currently a total of 698 COVID-19 positive inpatients across all Acute sites, 200 of whom had tested positive in the last 28 days. He advised that there was a total of 15 patients in ICU, 7 of whom had tested positive in the last 28 days. Mr Best advised that the figures were reviewed daily at meetings with the local teams.</p> <p>Mr Best reported that there were currently six wards closed, five due to COVID-19 and one due to norovirus. He advised that these were monitored daily with Infection Control colleagues.</p> <p>Mr Best advised that there had been a slight increase in walk-ins to the Emergency Departments (EDs) but said that good work on Unscheduled Care was ongoing with the Scottish Ambulance Service and NHS24.</p> <p>Mr Best said that the key message was to promote the uptake of COVID-19 booster and flu vaccinations.</p> <p>Mr Best reported that good systems had been put in place to manage COP26 and as a result the impact on Acute services had been minimal with very few recorded inpatients or outpatients</p> <p>In response to a query regarding visiting, Ms O'Neill advised that while most sites had returned to person centred care visiting arrangements this had been restricted in four areas due to Infection Control concerns around COVID-19. She acknowledged that this was disappointing for patients and their families but assured the Committee that this was necessary because of the potential risks. The position is reviewed every three weeks.</p> <p>The Committee were content to note the update.</p>		

			ACTION BY
	<u>NOTED</u>		
45.	PERFORMANCE		
	a) Acute Integrated Performance Report		
	<p>Mr Mark White, Director of Finance, presented the Acute Services Integrated Performance Report [Paper 21/15] that provided a summary of performance against the Key Performance Indicators (KPIs) outlined in Remobilisation Plan 4 (RMP4).</p> <p>Mr White advised that RMP4 had still to be formally ratified and would be considered by the NHS Board meeting in December. There are 14 key performance indicators and performance against these was summarised in the report. The Report is an evolving document and he would appreciate feedback on the content and targets.</p> <p>Mr Ritchie said that he was grateful for the work that had been undertaken to improve the presentation of data and asked Committee members if they had any comments.</p> <p>In response to a query about including further analysis of the issues and the challenges in resolving these, Mr White would add further narrative on the risks and issues facing each area.</p> <p>In response to a query about how the trajectories were set, Mr White explained that some were Scottish Government national targets, some took cognisance of COVID-19 and current pressures and were set in conjunction with the Scottish Government.</p> <p>Mrs Grant said that all reports were being reviewed and signed off by each Committee Chair and the lead Non Executive. Professor Brown added that building an Assurance Framework was part of the Active Governance programme. Once this had been reviewed by all Standing Committee Chairs, any overlaps would be removed and a package would come to the Board for approval.</p> <p>The Committee were content to note the report and welcomed the new format.</p> <p><u>NOTED</u></p>		Mr White

			ACTION BY
	b) Presentation: Unscheduled Care Patient Flows		
	<p>Dr Scott Davidson, Deputy Medical Director Acute, presented on unscheduled care patient flows and the work to achieve the aim of right care at the right place at the right time.</p> <p>Mr Ritchie thanked Dr Davidson for the presentation which provided assurance on unscheduled care patient flows and said that this was a good example of reviewing the information available and using this to identify challenges and solutions.</p> <p>In response to a query about communication, Dr Davidson said that it was important to change the perception that patients are unable to access primary care and there needed to be a consistent message that GPs were open and virtual consultations were a good thing.</p> <p>Dr Davidson said that the population usage of Acute services was high and redirection was essential but this would take time and require fundamental culture change. Mrs Grant said this was a whole system issue and all parties, including the Scottish Government, NHS24 and GPs, needed to ensure the message was clear both locally and nationally.</p> <p>Dr Davidson acknowledged that attendance numbers at the Flow Navigation Centre (FNC) were not as high as had been hoped but this relied on external input to refer patients in. He advised that the next step would be to look at how to performance manage the capacity of the FNC as he would be keen to improve this quickly.</p> <p>Dr Davidson confirmed that there are action plans for each pathway with target dates for implementation. These are reported through the Unscheduled Care Group and the Strategic Executive Group. He highlighted the importance of performance managing the pathways and being assured that they were making a difference.</p> <p>In response to a query about encouraging members of the public to contact NHS24 or GPs in the first instance rather than attending hospital, Dr Davidson said that the message had to be that this was the right thing to do and that would require local communication, national communication and redirection.</p> <p>Professor Brown asked about the availability of performance data from external sources as it was important to understand how other</p>		

			ACTION BY
	<p>parts of the system, for example, NHS24 and GPs, contributed to attendances. Mrs Grant and said that understanding performance metrics across the whole pathway was raised during the regular Unscheduled Care discussions with the Scottish Government.</p> <p>Ms Bustillo said that her team worked closely with the Scottish Government, NHS24 and others to ensure communications were consistent in approach. She said there were three main strands to this work:</p> <ul style="list-style-type: none"> - A national campaign was being led by the Scottish Government reinforcing the direction message. - Work with the Acting Director of Primary Care and the Deputy Medical Director for Primary Care to reinforce the message that GPs were open for business. - Developing supportive messaging on redirection to alternative care <p>The Committee were assured by the update provided and agreed that they would receive a further update in 12 months' time on how the work was progressing and what demonstrable changes had been made.</p> <p>Mr Ritchie thanked Dr Davidson for the update.</p> <p>NOTED</p>		Dr Davidson
	c) Presentation: Endoscopy		
	<p>Professor Colin J Mackay, Chief of Medicine, North Sector and Ms Susan McFadyen, Director of Access provided a short presentation on endoscopy services across NHSGGC. This provided an overview of services, the waiting time position and the actions underway on future capacity.</p> <p>Mr Richie thanked Mr Mackay and Ms McFadyen for the presentation which he felt had provided an enhanced understanding of the challenges the service was facing.</p> <p>In response to a query about expanding the new ways of working, Mr Mackay said there were a number of challenges in scaling up, much of which was around administrative processes, for example, integration with electronic patient records, the ordering system for different tests, but there was a considerable amount of work underway to resolve these issues. There are also staffing</p>		

			ACTION BY
	<p>challenges but work was underway to increase the workforce accordingly by ensuring more staff were trained and recruited. Mr Best said that the three new modalities that were being introduced (Colon Capsule Endoscopy (CCE), Cytosponge and Transnasal Endoscopy) were being nationally driven but further work was required on how to scale these up.</p> <p>In response to a query about the current waiting list, Mr Best assured the Committee that there was regular communication with patients and the list was reviewed daily to ensure clinical prioritisation. Mr Mackay agreed that there was concern around waiting times but said it was important to be able to prioritise patients appropriately and have the necessary clinical and biochemical information to do so. He said that they are considering whether some patients could be managed in a different way which would lead to the development of a more sustainable model for the future.</p> <p>Mr Ritchie thanked Mr Mackay and Ms McFadyen for their assurance on the work to improve patient care and help further understanding the challenges. It was agreed that a further update would be provided to the Committee in 12 months.</p> <p><u>NOTED</u></p>		Mr Mackay/ Ms McFadyen
46.	FINANCIAL MONITORING REPORT		
	<p>Ms Jacqueline Carrigan, Assistant Director of Finance Acute, presented the Financial Monitoring Report for month 6 to the end of September 2021 [Paper 21/16] which set out the Acute revenue position and progress with the Financial Improvement Programme (FIP).</p> <p>Ms Carrigan advised that the overspend at the end of month 6 was [REDACTED], [REDACTED] of which was unachieved savings. She reported that pay was [REDACTED] underspent and non-pay [REDACTED] overspent. In relation to pay, Ms Carrigan clarified that although some specific areas, for example, medical salaries, were overspent this was offset by other areas leading to an overall underspend.</p> <p>Ms Carrigan advised that direct COVID-19 costs were being fully funded by the Scottish Government and a decision was awaited on whether unachieved savings due to COVID-19 would be funded.</p>		

			ACTION BY
	<p>In response to a query about the Financial Improvement Programme and the current climate, Mr White said that it was important to meet the targets but understood the need to get the balance right given other pressures in the system.</p> <p>Ms Carrigan advised that the COP26 business case had been approved by the UK Government and all costs would be fully funded.</p> <p>In response to a query about nurse recruitment, Ms O'Neil said the newly qualified nurse recruitment programme had been very successful, however, there had been some attrition so there were still some vacancies in the system but this was in line with the experience in other Boards. Ms O'Neil added that most of these nurses had started in September and this would reflected in the budget for the next period.</p> <p>In response to a query about the cost of out of area forensic mental health beds, Mr Best said that these were specialist treatment packages for individuals who had been assessed as requiring a step down in their care and funding these ensured that individuals could be moved to appropriate medium secure care and this would maintain the flow through the different levels of care. Work was ongoing to look at whether the expansion of low secure facilities would help with this issue.</p> <p>Mr Ritchie thanked Ms Carrigan for the update and said this had provided assurance on the current position. He noted that the more detailed version of the report goes to the Finance, Planning and Performance Committee and Mr White would be happy to share the full report with any Member who would find this helpful.</p> <p>The Committee were content to note the update.</p> <p><u>NOTED</u></p>		
47.	ACUTE PATIENT EXPERIENCE REPORT		
	<p>Dr Margaret McGuire, Nurse Director, presented the Acute Patient Experience Report [Paper 21/17] which provided an overview of feedback and complaints mechanisms, and the resultant performance, actions and improvements for Quarter 2. She introduced Ms Angela O'Neil, Deputy Director of Nursing Acute.</p> <p>Ms O'Neil provided a brief overview of the assessment around patient experience for Quarter 2 and how the team were taking forward the</p>		

			ACTION BY
	<p>learning and improvement from feedback received, Care Opinion responses, complaints and SPSO outcomes.</p> <p>73% of the feedback received across Acute Services, Primary Care and Mental Health was wholly or partially positive. Those instances rated moderately critical or strongly/severely critical were automatically alerted to Ms O'Neill, the Deputy Medical Director Acute and the Chief Operating Officer. The average response times were within target.</p> <p>Nine SPSO decisions were received, four were upheld fully, three upheld partially and two not upheld. SPSO have a robust tracking process in place allowing cases to be tracked at each stage and this was a regular part of 1-2-1s with Chief Nurses and Chiefs of Medicine.</p> <p>Ms O'Neil hoped the report provided assurance on the work undertaken to respond to complaints within target and take episodes of feedback in whatever format and to share the learning from these.</p> <p>Mr Ritchie thanked Ms O'Neil for the update and was happy to see that less than 1% of contacts resulted in a complaint. He noted that the top ten themes remained largely unchanged and asked if work had been undertaken to identify whether there were any particular problem areas. Ms O'Neil stated that work with individual clinicians formed part of the regular patient feedback process and there was no evidence to suggest that there were any specific areas of concern. Dr Armstrong provided assurance that complaints and feedback formed part of a clinician's PDP, yearly appraisal and 5 year revalidation.</p> <p>The Committee asked for comparative information to identify changes over time and against other Board areas. Dr McGuire agreed to work with Ms O'Neil and Ms Catriona Kent, Corporate Services Manager Complaints, to look at how comparisons could be included in future reports.</p> <p>Professor Brown agreed that it would be helpful to include comparisons and benchmarking to provide assurance on NHSGGC's position nationally, however, he was conscious that this should not duplicate the discussion at other Committees and it would be good to reflect on this and agree the approach as a Board when the Assurance Information package was produced.</p> <p>Mr Ritchie agreed that this was a moving process that was developing in line with the Active Governances programme.</p>		

			ACTION BY
	<p>Mr Ritchie thanks Dr McGuire and Ms O'Neil for the update and summarised by saying that the Committee recognised the good work being done in this area. He emphasised that only 1% of contacts resulted in a complaint, which was a small number but was important for learning and improvement. The Committee agreed that there would be benefit in including benchmarking against other organisations and trends over time.</p> <p><u>NOTED</u></p>		
48.	EXTRACT FROM CORPORATE RISK REGISTER		
	<p>Mr White presented the Extract from the Corporate Risk Register for the Acute Services Committee [Paper 21/18] and asked the Committee to confirm that they were content that the risks were clearly described and that the risk scores were appropriate.</p> <p>Mr White summarised the changes that had been made following discussion at the September meeting of the Committee, including splitting the first risk into scheduled and unscheduled care and rescored this based on the current position. Mr Ritchie invited comments from the Committee.</p> <p>Professor Brown thought that the score for the second risk in relation to waiting times should be higher given the scale of the challenge and while noting that a narrative on impact had been added he asked if a cause could also added as had been discussed previously. Professor Brown said the wording in risk three should be amended to reflect that the reputational impact was in relation to the organisation not the Board. He also asked if the corporate objective/operational priority could be included in full in the document rather than just the number for ease of reference. Mr White agreed that some further work was required across all Corporate Risk Registers and would pick up these points as part of that, ensuring that this was in line with what had originally been agreed by the Audit and Risk Committee.</p> <p>In response to a query, Mrs Grant clarified that the third risk in relation to the Oversight Board and Case note Review was on the Finance, Planning and Performance Committee Annual Cycle of Business as the lead Committee for that work. However, Mrs Grant confirmed that all actions had been completed except for a few modest actions or those that were for the Scottish Government.</p>		Mr White

			ACTION BY
	<p>In response to a query about funding, Mr White advised that there had been a number of budget announcements made by the UK Government and advice on the Scottish Government consequentials and the budget statement were awaited. Mr White said that there were also a number of clinical priorities and activity targets so this was not all about waiting times.</p> <p>Professor Brown said that the Acute Services Committee was a necessary part of the governance system but it was important that the discussion was distinct from the other Committees who had a focus on finance, performance and clinical governance. Mr Ritchie agreed that this was an important Committee which was complementary to the Finance, Planning and Performance and Clinical and Care Governance Committees. He said it was important to ensure that the agenda was relevant to this Committee and if there was duplication in items then the focus of the papers and discussion needed to be appropriate to this Committee.</p> <p><u>NOTED</u></p>		
49.	ANNUAL CYCLE OF BUSINESS		
	<p>Mr Ritchie asked members to consider the Annual Cycle of Business [Paper 21/19]</p> <p>It was agreed that in future this would be reviewed by at the agenda setting meeting and would not be a routine agenda item for the Committee. Mr Ritchie asked Committee members to advise the Chair, Vice Chair or Executive leads of any items that it was proposed should be included in the cycle and this would be discussed at the agenda setting meeting.</p> <p><u>NOTED</u></p>		Secretariat
50.	CLOSING REMARKS AND KEY MESSAGES FOR THE BOARD		
	<p>Mr Ritchie asked members to raise any other competent business. There was no other business noted.</p> <p>The key messages for the Board were: In closing, Mr Ritchie said the two presentations had been very helpful and had provided assurance to the Committee. The key messages for</p>		

			ACTION BY
	<p>the Board would be produced from the minute for the December Board meeting.</p> <p>Mr Ritchie thanked members for attending and closed the meeting.</p> <p><u>NOTED</u></p>		
51.	SCHEDULE OF MEETINGS 2022/23		
	<p>Mr Ritchie asked the Committee to note the schedule of meetings for financial year 2022/23</p> <p>The Committee were content to note this.</p> <p><u>NOTED</u></p>		
52.	DATE AND TIME OF NEXT SCHEDULED MEETING		
	The next meeting would take place on Tuesday 18 January 2022 at 9.30 am via Microsoft Teams.		

OFFICIAL SENSITIVE



**Meeting of the Acute Services Committee on
Tuesday 18th January 2022 at 9.30am via Microsoft Teams**

AGENDA

1.	Welcome and Apologies		
2.	Declarations(s) of Interest(s)		
3.	Minutes of Previous Meeting: 16 November 2021	Approval	ASC(M) 21/04
4.	Matters Arising		
	a) Rolling Action List	Approval	Paper No 22/01
5.	Urgent Items of Business	Awareness	Verbal
6.	Acute COVID-19 Update Update by the Chief Operating Officer	Awareness	Verbal
PERFORMANCE OVERVIEW			
7.	Performance		
	a) Acute Services Integrated Performance Report Paper presented by Chief Operating Officer and Director of Finance	Assurance	Paper No 22/02 To Follow
8.	Financial Monitoring Report Paper presented by the Director of Finance	Awareness	Paper No 22/03
ITEMS FOR ASSURANCE			
9.	Extract from Corporate Risk Register Paper presented by the Director of Finance	Approval	Paper No 22/04

OFFICIAL SENSITIVE

10.	Closing Remarks and Key Messages for the Board	Assurance	Verbal
	Chair		
DATE OF NEXT MEETING			
11.	Date and Time of Next Scheduled Meeting		
	Tuesday 22 March 2022 at 9:30am via Microsoft Teams.		

ASC (M) 22/02
Minutes: 12 – 23

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Acute Services Committee Held on Tuesday 22 March 2022 at 9.30 am via Microsoft Teams

PRESENT

Mr Ian Ritchie (in the Chair)

Ms Jane Grant	Dr Lesley Rousselet
Ms Susan Brimelow OBE	Dr Paul Ryan
Professor John Brown CBE	Mr Simon Carr
Cllr Jim Clocherty	

IN ATTENDANCE

Ms Sandra Bustillo	..	Director of Communications and Public Engagement
Ms Jacqueline Carrigan	..	Assistant Director of Finance Acute/Access
Dr Scott Davidson	..	Deputy Medical Director, Acute
Ms Lisa Duthie	..	Audit Scotland
Mr William Edwards	..	Chief Operating Officer
Ms Liz Maconachie	..	Audit Scotland
Mrs Anne MacPherson	..	Director of Human Resources & Organisational Development
Mrs Angela O'Neill	..	Interim Board Nurse Director
Ms Elaine Vanhegan	..	Director of Corporate Services and Governance
Mrs Geraldine Mathew	..	Secretariat Manager
Mrs Louise Russell	..	Secretariat Officer (Minutes)

			ACTION BY
12.	WELCOME AND APOLOGIES		
	Mr Ritchie welcomed those present to the meeting.		
	Apologies were intimated on behalf of Mr Mark White and Dr Emilia Crighton.		
	<u>NOTED</u>		

			ACTION BY
13.	DECLARATIONS(S) OF INTEREST(S)		
	<p>Mr Ritchie invited members to declare any interests in any of the items being discussed.</p> <p>No declarations of interest were made.</p> <p><u>NOTED</u></p>		
14.	MINUTES OF PREVIOUS MEETING: 18 JANUARY 2022		
	<p>The Committee considered the minute of the meeting held on Tuesday 18 January 2022 [Paper No. ASC (M) 22/01] and were content to approve the minute pending the following minor amendments;</p> <p>Page 7, Item 10 - Closing Remarks And Key Messages For The Board: second bullet point to state that declining infection rates were in relation to COVID-19.</p> <p>Page 5, Item 08 – Financial Monitoring Report: paragraph 4 to note that the Vanguard mobile endoscopy unit would run for 5 days and not 6 as currently stated.</p> <p>The Committee noted that the Vanguard unit was not yet in operation. The Committee were assured that discussions were ongoing with Glasgow City Council to establish the unit as soon as possible. A number of tests were in the process of being carried out prior to the unit being established on site. An update on the unit was expected by the end of the week.</p> <p><u>APPROVED</u></p>		
15.	MATTERS ARISING		
a)	Rolling Action List		
	<p>The Committee considered the Rolling Action List [Paper No. 22/05].</p> <p>The Committee were content to approve the closure of the two items on the Rolling Action List.</p> <p><u>APPROVED</u></p>		

			ACTION BY
16.	URGENT ITEMS OF BUSINESS		
	<p>Mr William Edwards, Chief Operating Officer, informed the Committee that an unannounced Health Improvement Scotland (HIS) inspection visit commenced today at QEUH. The Committee noted that a new approach had been adopted by HIS to review safety, quality and care. Mrs Angela O'Neill, Interim Board Nurse Director, reported that the team were aware of the change and awareness had been raised with staff prior to the visit. Mrs O'Neill assured the Committee that peer reviews were carried out regularly to ensure that staff were delivering a high standard of care.</p> <p>In response to a question in relation to the availability of feedback from the inspection and when it would be available, the Committee noted that informal feedback was expected at the end of each day. A draft report would be available 1 month after the inspection to allow time to review the report for factual accuracy. It was anticipated that the final report would be published in May/June 2022. The Committee agreed that it was appropriate that HIS continued to be assured on quality of care during the pandemic, however agreed that this had to be proportionate. The Committee noted concern of the timing of the inspection given the current pressures that COVID-19 and staff absence had created. It was hoped that HIS would recognise these unique set of circumstances and recognise the current pressures on staff due during the inspection.</p> <p>In response to a question in relation to the selection method for the location and timing of inspections, the Committee noted that this was at the discretion of HIS. The challenge of the inspection was recognised by the Board, however the Committee were assured that staff had worked hard to maintain a reasonable position despite the current pressures due to COVID-19 and staff absence. The Committee were assured that members of staff were aware that these visits were unannounced and practice development staff had reinforced that message.</p> <p>In response to a question in relation to the Fatal Accident Inquiry (FAI) at the Royal Alexandra Hospital (RAH) and the timescale for the Glasgow City Health and Social Care Partnership(HSCP) FAI, the Committee noted that the FAI in relation to the RAH had commenced. An action plan was drawn up at the time of the incident and had been progressed. The Committee noted that there had been minimal media coverage on the FAI to date. The Committee were assured that the Communications Department were working with colleagues in</p>		

			ACTION BY
	<p>preparation of the outcome. The Committee noted that the Glasgow City HSCP FAI was due to commence in July 2022.</p> <p><u>NOTED</u></p>		
17.	ACUTE COVID-19 UPDATE		
	<p>Mr William Edwards, Chief Operating Officer, provided an update on the current position in respect of the NHSGGC response to managing COVID-19 in Acute Services, and provided assurance to members of the actions being taken in response to COVID-19.</p> <p>Mr Edwards informed the Committee that challenges had increased due to COVID-19 pressures. As at 22 March 2022, there was a total of 671 COVID-19 positive in-patients in the last 28 days. There was a total of 8 patients in ICU, 6 of whom had tested positive in the last 28 days.</p> <p>Mr Edwards noted that the occupancy rate was currently 95%. He reported that Delayed Discharges continued to increase the pressure on occupancy rates. Mr Edwards reported that 298 beds were occupied as a result of patients delayed in their discharge. As at 22 March 2022, 24 Acute wards were closed due to COVID-19 and it was noted that this was clearly adding to the pressure. In response to a question regarding what hospitals were predominately affected, Mr Edwards confirmed that the ward closures were mainly at the Royal Alexandra Hospital (RAH) and Glasgow Royal Infirmary (GRI). Mr Edwards reported that the decision had been taken to pause all elective surgery, other than cancer surgery, and this had assisted with freeing capacity. He reported that significant effort continued to ensure that the endoscopy service was maintained.</p> <p>Mr Edwards highlighted the COVID-19 modelling data and noted that, in line with the data, it was expected that infection numbers would plateau within the coming weeks.</p> <p>In response to a question regarding the number of care homes currently closed to admissions, the Committee noted that as at 21 March 2022, there were 54 care homes across Greater Glasgow and Clyde that were closed to admissions. In response to a question in relation to the reason and the length of time the care homes stay closed to admissions, the reasons were described as varied, The Committee noted that some care homes could either completely close, close a wing or admit less patients per week. It was also highlighted</p>		

			ACTION BY
	that discharges had been delayed from 50 patients from other Health Boards, further illustrating the scale of the challenge in relation to delayed discharges. The Committee noted that meetings were ongoing with external agencies to discuss the current infection control guidance in order to try to influence change, given that the strain of the virus had changed over time. The Committee recognised the challenges that NHSGGC faced were multifactorial, with the demand profile and staffing issues particular key issues. The Committee acknowledged that staff were continuing to work hard during this challenging time. The Committee were content to note the update. <u>NOTED</u>		
18.	PERFORMANCE		
	a) Acute Integrated Performance Report		
	Ms Jacqueline Carrigan, Assistant Director of Finance Acute/Access, presented the Acute Services Integrated Performance Report [Paper 22/06] that provided a summary of performance against the Key Performance Indicators (KPIs) outlined in Remobilisation Plan 4 (RMP4). The report included the 15 key performance indicators. The current performance against the indicators and the projected performance as at 31 st March 2022 was summarised in the report. The report included data for each of the metrics and the actions taken to address each one, particularly those that were red status. The Committee acknowledged the reasons why the performance in some areas was low, however noted that a piece of work to look at how issues could be resolved over the longer term was required. In response to a question in relation to the percentage of cancer patients commencing first treatment within 62 days of receipt of referral and why the indication trajectory was stable or increasing when the performance compared to the rest of Scotland was reducing, the Committee noted that the data for the January position was in the process of being reviewed. A number of plans in relation to 5 of the cancer types were being developed and a 62 day cancer recovery plan		

			ACTION BY
	<p>would be put into place. The Committee agreed it would be helpful to receive a presentation at a future meeting highlighting the performance for particular cancer types, for example breast and colorectal cancer. Mr Edwards noted that future reports would include improvement actions against each cancer type.</p> <p>In response to a question in relation to the Emergency Department waiting time standard performance, and what impact the flow issue would have on this, the Committee noted that the position was multifactorial. The pressures included demand, capacity and staff absence. The Committee noted that the average length of stay for COVID-19 patients had decreased from earlier waves of the pandemic, however, the primary issue in terms of ED performance was harder to measure as the issues were more complex. The Committee noted that the number of out-patients had increased which was considered positive. The Committee noted that a significant amount of Paxlovid, Tranexamic Acid (TXA) and Remdesivir was being supplied to patients, and that these drugs were being delivered through flow navigation hubs and pharmacists which was working well.</p> <p>In terms of elective care, Mr Edwards described the work that was being carried out to consider the longer term impact and how NHSGGC could reduce the waiting lists. Mr Edwards and his team were initially focussing on P2, urgent patients and long waiting patients. Work would also commence to revise capacity plans and a more detailed plan for orthopaedics would be developed. The Committee were assured that plans were being considered and detailed discussions were being held to deal with the longer term issues. The Committee agreed that a future report detailing the high level approach and expected outcomes would be helpful.</p> <p>The Committee noted that work was ongoing with the Scottish Government to review the impact of COVID in its entirety, including the impact of long COVID.</p> <p>The Committee noted that pause had been placed on day surgery at Victoria and Stobhill Hospitals in order to mobilise staff. Mr Edwards assured the Committee that this was reviewed on a daily basis, taking into consideration the COVID-19 infection rates and staff absence.</p> <p>The extraordinary challenges in relation to recruitment and staff absence rates was acknowledged by the Committee and it was noted that other Boards within Scotland were experiencing similar challenges. The Human Resources department had led a recruitment campaign to increase the number of Healthcare Support Workers. The Committee</p>	<p>Mr Edwards</p> <p>Mr Edwards</p>	

			ACTION BY
	<p>noted that a number of posts had been advertised and additional Band 2 & 3 posts had been recruited for ward areas. The Committee also noted that 41 registered members of staff had been recruited through a NHSGGC recruitment campaign and were due to commence in post within the coming weeks. The Committee noted that members of staff due to retire had been given the option to 'retire and return' in order to assist with short term challenges.</p> <p>It was highlighted that last week, 1500 members of staff throughout the workforce were absent from work. The Committee were assured that work was being carried out to try and alleviate staffing issues. A wellbeing initiative remained in place to provide mental health and wellbeing support to staff.</p> <p>Mr Ritchie thanked Ms Carrigan, Mr Edwards and Mrs McPherson for the update provided and invited questions from members.</p> <p>In response to a question on whether the staffing issues were isolated to Acute Services or across the whole service, it was confirmed that the absence issues were experienced across the whole service. The Committee noted that bank staff availability had also been affected, therefore filling gaps had become challenging. The Committee were assured on hearing that each site reported back on a daily basis, therefore the situation was being closely monitored and any perceived risks mitigated.</p> <p>The Committee recognised the immense pressures currently on the system in relation to the COVID-19 infection rates, the number of wards that were closed, the pressure due to short term staff absence and the impact of staff absence due to long COVID issues. The Committee recognised the impact that these multifactorial issues had on the service on a daily basis and the added pressure this had on the patient waiting lists. Members noted that discussions were ongoing with the Scottish Government on how this could be managed at a national level. The Committee gained assurance that work would be ongoing to look at the long term issues ahead.</p> <p><u>NOTED</u></p>		
19.	FINANCIAL MONITORING REPORT		
	Ms Jacqueline Carrigan, Assistant Director of Finance Acute, presented the Financial Monitoring Report for month 10 to the end of 31 January 2022 [Paper 22/07] which set out the Acute revenue		

			ACTION BY
	<p>position and progress with the Financial Improvement Programme (FIP).</p> <p>Ms Carrigan advised that the overspend at the end of month 10 was [REDACTED]. The Committee noted that there was unachieved savings of [REDACTED].</p> <p>The Committee noted that overall, Pay was [REDACTED] under budget with a positive movement in the month, across a range of pay headings. Non pay was [REDACTED] over budget, with improvements in the month seen in other therapeutics, surgical sundries and drugs.</p> <p>The Committee noted that the unachieved savings for the full year were forecast at [REDACTED]. The unachieved savings were expected to be fully funded from allocations received from the Scottish Government.</p> <p>The Committee noted that Acute COVID-19 costs incurred for the period April 2021– January 2022 were [REDACTED], which had been funded from allocations received from Scottish Government. The allocations did not include any funding for unachieved savings as a result of COVID-19, although the Scottish Government had confirmed that non-recurring support for unachieved savings would be made available in the next allocation letter. The Committee noted the projected balance to 31st March 2022 was [REDACTED], however this was indicative and could change through monthly review. The Committee noted that COVID-19 funding received from the Scottish Government was only applied to the 2021/22 target. The Committee noted concern that the funding would come to an end at some point, however members were assured that discussions were ongoing with the Scottish Government regarding future funding, particularly as the COVID-19 Vaccination Programme continued to be rolled out. The Committee were also assured that work was underway to plan for 2022/23 financial year.</p> <p>Mr Ritchie thanked Ms Carrigan for the update and invited questions from members.</p> <p>In response to a question in relation to carrying over a [REDACTED] gap from this year into the next financial year and how much was not being realised due to COVID-19 pressures, the Committee were assured that the financial work on this had commenced. A number of schemes that were unable to be delivered would carry over into the next financial year. The Committee were assured that the issues for the future had been recognised.</p>		

			ACTION BY
	<p>The Committee were content to note the Acute revenue position at month 10 and the Acute position with the Financial Improvement Programme (FIP) at month 10.</p> <p><u>NOTED</u></p>		
20.	ACUTE PATIENT EXPERIENCE REPORT Q3		
	<p>Mrs Angela O'Neill, Interim Board Nurse Director, presented the Acute Patient Experience Report Q3 [Paper 22/08] which provided an overview of feedback and complaints mechanisms, and the resultant performance and actions and improvements based on these. The paper also included comparison against other NHS boards.</p> <p>Mrs O'Neill highlighted that the percentage of positive feedback received had remained stable at 74% (73% in quarter 2). The mechanisms to receive feedback included Care Opinion, via the website and by learning from complaints.</p> <p>Mrs O'Neill reported that the nature and themes of the feedback and complaints received had not changed. A consistent theme remained waiting times for appointments. The Committee noted that there had been an overall reduction in the number of Ombudsman cases. Mrs O'Neill highlighted that we have adopted a process of seeking 'heads of complaint' from complainants, which has seen our response time reduce. There had also been earlier resolutions due to direct telephone calls taking place which had been positively received.</p> <p>Mrs O'Neill assured the Committee that the feedback received was reviewed regularly to consider any changes that could be made to improve practice.</p> <p>Mrs O'Neill reported that the feedback provided was built into local action plans. Mrs O'Neill agreed to consider how this could be demonstrated through future reports.</p> <p>The Committee noted the content of the report and recognised that performance improvement needs to be realistic and achievable.</p> <p>Ms Sandra Bustillo, Director of Communications and Public Engagement, highlighted that NHSGGC were performing well with Care Opinion and were one of the top performing Boards within the UK. Whilst Care Opinion and the web feedback system offered important indicators of patient opinion about our services, there were other ways to assess sentiment towards the organisation. Independent</p>		Mrs O'Neill

			ACTION BY
	research has now been commissioned to measure public opinion of NHSGGC and our services and this will be repeated at regular intervals to monitor changes in attitude.		
	Mr Ritchie thanked Ms O'Neill and Ms Bustillo for the updates provided.		
	The Committee were content to note the Patient Experience Report Q3.		
	<u>NOTED</u>		
21.	EXTRACT FROM CORPORATE RISK REGISTER		
	<p>Ms Carrigan presented the Extract from the Corporate Risk Register for the Acute Services Committee [Paper 22/09] for the Committee to consider and confirm that they were content that the risks were clearly described and that the risk scores were appropriate.</p> <p>Ms Carrigan highlighted the new format of the report. A new report template for Corporate Risk Register reviews had been included as part of the report. The paper now included description, impact, cause and trends. The risks were reviewed by the Risk Management Steering Group and the Audit and Risk Committee.</p> <p>Mr Edwards informed members that the plans to repatriate ward 6A to ward 2A/B went well with minimal snagging issues. He reported that 11 patients were transferred on Wednesday 9th March 2022. He noted that the upgraded ward was well received by patients and the feedback received had been positive. The Committee recognised the immense amount of work that had gone into the ward reopening.</p> <p>The Committee discussed the current scores and were of the opinion that the scores should be reviewed, in particular for the risk in relation to the reputational risks around facilities, environmental issues and capacity flow. The Committee were aware of the actions from the Oversight Board report and were aware of one action still to be taken in relation to the appointment of an Infection Control Director. The Committee noted that the post was advertised and had proceeded to the selection process. It was highlighted that that all the recommendations from external reports were complete and these had gone through the Action and Assurance Review Group (AARG) process. The Committee noted that a robust process to audit the implementation of recommendations was underway.</p>		

			ACTION BY
	<p>Ms Carrigan agreed to submit the comments on the Corporate Risk Register to the Risk Management Group for consideration.</p> <p><u>NOTED</u></p>		Ms Carrigan
22.	CLOSING REMARKS AND KEY MESSAGES FOR THE BOARD		
	<p>Mr Ritchie asked members to raise any other competent business.</p> <p>There was no other business noted.</p> <p>The key messages for the Board were:</p> <ul style="list-style-type: none"> • The Acute Services Committee recognised the challenges that the organisation was facing due to COVID-19 and staffing pressures and the impact this was having across the whole system • The Committee received the Acute Services Performance Report and discussed the longer term pressures that the organisation was facing. The Committee were assured that the executive team, along with the Scottish Government, were holding detailed discussions on how to manage the situation. An update report would be submitted to a future meeting of the Acute Services Committee. • The Committee received the Month 10 Finance Report. The challenges for the 2022/23 financial year were noted as it was recognised that funding from the Scottish Government was uncertain. The Committee were assured, however, that discussions were underway to plan for 2022/23. • The Committee received the Q3 Patient Experience Report which provided comparative data to benchmark NHSGGC performance against other NHS Boards. The Committee were reassured by the data provided. Further work would be considered to look at demonstrating how feedback was implemented to improve performance. 		

			ACTION BY
	<ul style="list-style-type: none"> The Committee discussed changes to the Corporate Risk Register scoring. This would be submitted to the Risk Management Steering Group for consideration. <p>Mr Ritchie thanked members for attending and closed the meeting.</p> <p><u>NOTED</u></p>		
23.	DATE AND TIME OF NEXT SCHEDULED MEETING		
	The next meeting would take place on Tuesday 17 May 2022 at 9.30 am via Microsoft Teams.		

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NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Acute Services Committee Held on Tuesday 17 May 2022 at 9.30 am via Microsoft Teams

PRESENT

Mr Ian Ritchie (in the Chair)

Ms Susan Brimelow	Dr Lesley Rousselet
Professor John Brown CBE	Dr Paul Ryan
Mr Simon Carr	Prof Angela Wallace
Ms Jane Grant	

IN ATTENDANCE

Ms Sandra Bustillo	..	Director of Communications and Public Engagement
Ms Jacqueline Carrigan	..	Assistant Director of Finance Acute/Access
Dr Scott Davidson	..	Deputy Medical Director, Acute
Mr William Edwards	..	Chief Operating Officer
Mrs Angela O'Neill	..	Interim Board Nurse Director
Ms Nareen Owens	..	Deputy Director of Human Resources
Prof Tom Steele	..	Director of Estates and Facilities
Ms Kim Donald	..	Corporate Services Manager – Governance/Board Secretary
Mrs Louise Russell	..	Secretariat Officer (Minutes)

			ACTION BY
24.	WELCOME AND APOLOGIES		
	Mr Ritchie welcomed those present to the meeting and welcomed Ms Kim Donald, Corporate Services Manager – Governance/Board Secretary, to her first meeting.		
	Apologies were noted on behalf of Mrs Anne MacPherson.		
	<u>NOTED</u>		

			ACTION BY
25.	DECLARATIONS(S) OF INTEREST(S)		
	<p>Mr Ritchie invited members to declare any interests in any of the items being discussed.</p> <p>No declarations of interest were made.</p> <p><u>NOTED</u></p>		
26.	MINUTES OF PREVIOUS MEETING: 22 MARCH 2022		
	<p>The Committee considered the minute of the meeting held on Tuesday 22 March 2022 [Paper No. ASC (M) 22/02] and were content to approve the minute.</p> <p><u>APPROVED</u></p>		
27.	MATTERS ARISING		
a)	Rolling Action List		
	<p>The Committee considered the Rolling Action List [Paper No. 22/10].</p> <p>The Committee were content to approve the recommended closure of three items on the Rolling Action List.</p> <p>The following updates were provided;</p> <p>Minute 18a - Performance Acute Integrated Performance Report</p> <p>The Committee noted that the trajectory and outcomes were in the process of being agreed. These would be incorporated into local process when they had been agreed. A meeting had been scheduled with the Chief Executive and Mr John Burns, Chief Operating Officer for NHS Scotland, to discuss the overall position.</p> <p>Minute 20 - Acute Patients Experience Report Q3</p> <p>The Committee were assured that comparison across all Boards, including trends and the improvements that had been made, would be included in future reports.</p> <p>In response to a question regarding the status of the Vanguard Unit, the Committee were assured that significant work had been carried out with the Estates Department, and Glasgow City Council, to establish</p>		

			ACTION BY
	<p>the Unit. The Committee noted that, following a final visit from Glasgow City Council yesterday, the final building control warrant had been approved. The Committee noted that plans were progressing for the unit to be operational next week.</p> <p>In response to the impact of long COVID, the impact on mental health in areas of deprivation, and what work had been undertaken, the Committee were reassured that a programme of work had been established. The Committee noted that this work was in the early stages and the main strands included Population Health, Mental Health and the impact on the Health Service. The Committee were content to note a further update on this work in relation to Acute Services later in the year.</p> <p>The Committee noted that, following the recent Healthcare Improvement Scotland (HIS) visit carried out at the Queen Elizabeth University Hospital, final comments and updates were being made to the draft report for submission. The final report would be published on Thursday 19th May 2022 at 10am. A tribute was paid to the team for the work involved during challenging times. The Committee were assured that the report was largely positive with leadership and staff response to Infection Control being commended by HIS.</p> <p>In response to a question in relation to Day Surgery at Stobhill Hospital and Victoria Hospital, the Committee noted that the aim was to resume services as soon as possible.</p> <p><u>APPROVED</u></p>		
28.	URGENT ITEMS OF BUSINESS		
	<p>The Committee noted that a Fatal Accident Inquiry (FAI) was underway for a case in 2015. The initial opening was last week and it was expected to continue throughout June. An action plan had been implemented at the time and the Board continued to provide support. An update would be provided to the next Clinical and Care Governance Committee.</p> <p>Professor Tom Steele, Director of Facilities and Estates, provided an update on work that was being carried out at the Queen Elizabeth University Hospital. Mr Steele reported that work had commenced in the Atrium in order to inspect the underside of the lift shafts. The Committee noted that the inspection could potentially inform further design work. Professor Steele he explained that the scaffolding would be visible in the Atrium for the next 2 weeks and would take up a small area of the cafe. Professor Steele reported that GRAHAM, a leading</p>		

			ACTION BY
	<p>player in construction throughout the UK, had been commissioned to review the exterior of the building.</p> <p>Professor Steele assured the Committee that previous risk assessments had supported the presence of the thermal insulation and that public safety continued to remain a priority. The Committee noted that third party fire engineers had also been commissioned to carry out an assessment. It was expected that all work being carried out would take 12 months to conclude. Professor Steele reported that NHSGGC had the option to serve another Court Summons against Multiplex until 14th June 2022. The Committee noted that this information would be available in the public domain. In response to a question regarding funding, it was confirmed that the Scottish Government had provided cover which was capped at [REDACTED]. The potential summons against Multiplex would be considered to recoup losses.</p> <p>In response to a question regarding communication with staff and managing media interest, Ms Sandra Bustillo, Director of Communications and Public Engagement, informed the Committee that a Core Brief had been issued to staff detailing the work that would be carried out. The Committee noted that clear signage at the Queen Elizabeth University Hospital had been put in place for members of the public. The Committee recognised that the work being carried out at the Queen Elizabeth University Hospital was an ongoing issue, therefore, the media would continue to be updated and responded to as the situation developed. The Committee were assured that all communication with patients, visitors and staff would be clear. The Committee recognised the vast amount that would be carried out, therefore Ms Bustillo agreed to reflect on the detail that was included in the communications.</p> <p>The Committee noted the update provided.</p> <p><u>NOTED</u></p>		
29.	ACUTE COVID-19 UPDATE		
	<p>Mr William Edwards, Chief Operating Officer, provided an update on the current position in respect of the NHSGGC response to managing COVID-19 in Acute Services, and provided assurance to members of the actions being taken in response to COVID-19.</p> <p>Mr Edwards informed the Committee that challenges had increased due to COVID-19 pressures. As at May 2022, there was a total of 671 COVID-19 positive in-patients in the last 28 days. There was also a total of 3 patients in ICU who had tested positive in the last 28 days.</p>		

			ACTION BY
	<p>Mr Edwards highlighted that the Board wide occupancy rate was 94.7%. The Committee noted that this was having an impact on the front door, Delayed Discharges and Emergency Department performance. Mr Edwards reported that this performance was in line with other Boards in Scotland.</p> <p>Mr Edwards reported that Delayed Discharges continued to increase the pressure on occupancy rates. A total of 296 beds were currently occupied as a result of patients delayed in their discharge. The Committee noted that Hospitals throughout Scotland were experiencing the same challenges. The Committee were assured that the Chief Officers continued to meet on a weekly basis to review and discuss the situation. The Committee noted that the ACH had reduced sessions and continued to run at 60% of the previous activity with the Victoria Hospital being used for Care of the Elderly beds.</p> <p>The Committee noted that 478 members of staff were absent from work due to a COVID related illness, which was a reduction on previous figures reported. The Committee noted that this had resulted in improved ward cover and less red wards, however, there was ongoing pressure on the system. In response to a question regarding whether the changes in the COVID isolation rules had positively impacted on staff absence, the Committee noted that the largest proportion of COVID related staff absence was in relation to long COVID symptoms. Ms Nareen Owens, Deputy Director of Human Resources, informed the Committee that an update report on COVID absence was recently provide to the Area Partnership Forum. The report provided assurance that staff continued to be supported. A detailed support package was in place for staff which included face to face meetings and peer review. The Committee noted that, in line with current Government guidance, staff absence in relation to COVID related illness was managed separately from the usual staff absence process, however, these guidelines were under review.</p> <p>The Committee recognised the ongoing challenges, in particular with occupancy rates, which matched the same challenges throughout Scotland, and Delayed Discharges. The Committee noted that, although a relatively modest number of wards were closed, there was still a significant challenge ahead to increase work flow. It was recognised that the flow through the Emergency Department was challenging and elective work continued to be reduced due to the current pressures. The Committee recognised the work that had been carried out to date and commended the staff within the health service for the hard work that had been carried out during these challenging times.</p>		

			ACTION BY
	<p>The Committee were content to note the update provided.</p> <p><u>NOTED</u></p>		
30.	PERFORMANCE		
	a) Acute Integrated Performance Report		
	<p>Mr William Edwards and Ms Jacqueline Carrigan, Assistant Director of Finance Acute/Access, presented the Acute Services Integrated Performance Report [Paper 22/11] that provided a summary of performance against the Key Performance Indicators (KPIs) outlined in Remobilisation Plan 4 (RMP4).</p> <p>The report included the 14 key performance indicators. The current performance against the indicators, and the projected performance as at 31st March 2022, was summarised in the report. The Committee noted that there were 8 indicators reporting green, 2 reporting amber and 4 reporting red. The report included data for each of the metrics and the actions taken to address each metric, particularly those that had a red status. The Committee noted an improvement in performance against the last period reported.</p> <p>In response to a question regarding the Cancer 62 day target and the reason why some of the cancer types were less than what was achieved in the forecast, the Committee noted that there was a number of actions ongoing in relation to cancer performance. The Committee were assured that the team would refocus on the current cancer performance and the actions in place. The Committee noted that scope activity remained the primary performance issue and an action plan was in place, including the use of the Vanguard Unit with regards to scope activity. The Committee noted that discussions were ongoing with the Scottish Government regarding the baseline. It was hoped that this would be agreed before the next Committee meeting.</p> <p>In response to a question in relation to the average length of stay and how this had impacted on Delayed Discharges, the Committee noted that there were various factors, including Delayed Discharges, COVID patients and other comorbidities would add to the mean length of stay. A piece of work would be considered to work through any mitigating factors.</p>		

			ACTION BY
	<p>In response to a question regarding RMP5, the Committee noted that there was ongoing dialogue with the Scottish Government regarding this matter.</p> <p>The Committee were content to note the update.</p> <p><u>NOTED</u></p>		
31.	FINANCIAL MONITORING REPORT		
	<p>Ms Jacqueline Carrigan, Assistant Director of Finance Acute, presented the Financial Monitoring Report for month 12. [Paper 22/12] which set out the Acute revenue position and the position with the Financial Improvement Programme (FIP).</p> <p>Ms Carrigan advised that the Acute Division reported a breakeven position, as at Month 12, 31 March 2022.</p> <p>The Committee noted that overall Pay was [REDACTED] under budget with a positive movement in the month, across a range of pay headings. Non pay was [REDACTED] over budget, with improvements in the month seen in Other Therapeutics, Surgical Sundries and Drugs.</p> <p>The FIP position reported an achievement of the target in year with the support of Scottish Government non-recurring funding. Acute Corporate reported an overspend of [REDACTED] following year-end adjustments.</p> <p>The Acute Covid-19 costs incurred for the period April 2021– March 2022 were [REDACTED], which had been funded from allocations received from Scottish Government.</p> <p>In response to a question regarding the Lighthouse Laboratory continuing to be used for Covid-19 testing, the Committee noted that discussions with Glasgow University and the Scottish Government regarding retaining a small area for testing were ongoing.</p> <p>In response to a question regarding additional cost for forensics, the Committee were assured that this was a recurrent issue that continued to be monitored. The Committee noted that Covid-19 had impacted and contributed to a delay in the process.</p> <p>In response to a request to include a reconciliation table or statement to show movement, Ms Carrigan agreed to incorporate that in future reports.</p>		

			ACTION BY
	<p>The Committee were content to note the report.</p> <p><u>NOTED</u></p>		Ms Carrigan
32.	JUNIOR DOCTOR WORKFORCE GROUP UPDATE		
	<p>Dr Scott Davidson, Deputy Medical Director, Acute, presented the report “Junior Doctor Workforce Group Update” [Paper 22/13] which provided a progress update on work associated with Dentists and Doctors in Training (DDiT), with a focus on junior doctors across the Acute Sector.</p> <p>Dr Davidson informed the Committee that a Junior Doctors Workforce Group had been established to ensure internal governance oversight and consistency in relation to junior doctor governance, including escalation and oversight of ongoing monitoring and compliance of rotas, financial governance in relation to rota compliance, financial governance and oversight of medical agency spend and review of junior doctor provision and placement across NHS Greater Glasgow and Clyde (NHSGGC). The group meet on a monthly basis and was chaired by the Deputy Medical Director - Acute.</p> <p>The Committee noted the three main work streams were Junior Doctor Rotas, enhance control environment and future proofing Junior Doctor requirements.</p> <p>Dr Davidson reported that a risk matrix had been established for all Junior Doctor rotas. The Escalation Register had also been extended to incorporate outputs from Deanery visits that identify early warnings of issues affecting rotas. An Escalation Register was considered at each meeting, to allow for consideration of those areas prioritised as high priority risk. Dr Davidson reported that there were significant issues in relation to natural breaks. The report highlighted that there were ongoing discussions through the Wellbeing Group to consider wider wellbeing support to improve rota compliance, and ensure junior doctors are supported to take appropriate rest and breaks. The matter had also been raised as a national discussion, as well as with the local BMA representatives.</p> <p>Dr Davidson reported that work had commenced which was being led by the Depute Finance Director and would focus on current regional contract, opportunities, risks and next steps. The work would also include a review of governance arrangements in relation to Clinical Fellow posts.</p>		

			ACTION BY
	<p>A piece of work was underway to consider future proofing baseline establishment for NHSGGC in relation to junior doctors in advance of August 2022 rotation and in response to governance and resourcing issues raised.</p> <p>Dr Davidson highlighted that, although the Junior Doctor Workforce Group was in its infancy, the work that had been carried out had progressed well over the last few months. The work would remain ongoing to ensure that less rotas were at risk.</p> <p>The Committee discussed the Clinical Fellows posts and noted that these posts had some additional non-clinical time.</p> <p>In response to a question regarding who sets the number of people in training, the Committee noted that the trainees were set by the training programme directly.</p> <p>In response to a question in relation to junior doctors supporting rotas to allow the organisation to not rely on agencies, the Committee noted that this would be the next step.</p> <p>The Committee suggested adding this item to the annual plan, however, consideration would need to be given as to how this links with the Staff Governance Committee. It was suggested that the Chair of the Workforce Group had a conversation with the Staff Governance Committee Chair to ensure there was flow of information and no duplication. The Committee agreed that the main focus for Acute Services Committee was to consider any financial aspects.</p> <p>In response to a question regarding chief residents, Dr Davidson reported that the chief residents would be involved. The Committee noted that engagement had taken place with the BMA.</p> <p>The Committee were assured that the Civility Saves Lives Programme was being taken into account. There is ongoing encouragement for breaks to be taken to ensure patient and staff safety and care. There was an ongoing focus to address the rotas to ensure they were compliant. The Committee noted that rotas had been developed to ensure that there was sufficient overlap of time to allow for handovers during shifts.</p> <p>The Committee were content to note the update.</p> <p>NOTED</p>		

			ACTION BY
33.	REVIEW TERMS OF REFERENCE		
	<p>The Committee considered the paper 'Review of Committee Terms of Reference' [Paper No. 22/14] presented by the Director of Corporate Governance and Administration, Mrs Elaine Vanhegan.</p> <p>The Committee were asked to review its remit as part of the annual review process to ensure the remit remained fit for purpose, and approve the minor amendments proposed. The current Terms of Reference were approved by the Committee, and subsequently by the NHS Board at its meeting on 21st September 2021 as part of the Governance Framework Review.</p> <p>The Committee noted that the current Non Executive membership of the Committee had reduced from 8 to 6, as highlighted to the NHS Board through updates presented on the Active Governance Programme, under other Board business.</p> <p>The Committee were content to approve the updated Terms of Reference.</p> <p><u>APPROVED</u></p>		
34.	EXTRACT FROM CORPORATE RISK REGISTER		
	<p>Ms Carrigan presented the Extract from the Corporate Risk Register for the Acute Services Committee [Paper 22/15] for the Committee to consider and confirm that they were content that the risks were clearly described and that the risk scores were appropriate.</p> <p>Ms Carrigan reported that following the last meeting, the risk scores were reviewed by the Acute Services SMG in April 2022. The Committee noted that the residual risk score in relation to the Unscheduled Care Waiting Time Targets had reduced to 16 which had been based on additional actions. The Committee noted that the current risk score remained unchanged, which reflected the impact of the most recent COVID surge. The expectation was that the current risk score would reduce in line with the residual score as the COVID impact eased and there were improvements in staffing and occupancy rates across sites.</p>		

			ACTION BY
	<p>The Committee noted that the risk score in relation to Reputational Risks Around Facilities and Environmental Issues and Capacity Flow was reduced to 9 due to the actions outlined in the AARG Action Plan.</p> <p>In response to a question in relation to the timescales and how the risk scores could reduce when they were 'static', Ms Carrigan reported that a reduction was predicted in the first quarter. Ms Carrigan agreed to review the use of the word 'static'.</p> <p>The Committee recognised that reducing risk scores in relation to reputational risks was challenging. Following discussion, the Committee agreed that environmental risks and capacity and flow were two separate risks. Ms Carrigan agreed to discuss this further with the Chief Risk Officer.</p> <p><u>NOTED</u></p>		<p>Ms Carrigan</p> <p>Ms Carrigan</p>
35.	CLOSING REMARKS AND KEY MESSAGES FOR THE BOARD		
	<p>Mr Ritchie asked members to raise any other competent business.</p> <p>There was no other business noted.</p> <p>The key messages for the Board were:</p> <ul style="list-style-type: none">• The Acute Services Committee recognised the challenges that the organisation was facing due to COVID-19 and staffing pressures and the impact this was having across the whole system• The Committee received the Acute Services Performance Report and noted an improvement in performance against the last period reported. The Committee noted an update on the Cancer 62 day target. The Committee noted that the final building control warrant for the Vanguard Unit had been approved, therefore the unit would soon be operational and would assist with scope activity.• The Committee received the Month 12 Finance Report which set out the Acute revenue position and the position with the Financial Improvement Programme (FIP). The Committee noted that the Acute Division reported a breakeven position as at Month 12, 31 March 2022.		

			ACTION BY
	<ul style="list-style-type: none"> • The Committee received an update on the Junior Doctor Workforce Group. The report provided an update on the progress on work associated with Dentists and Doctors in Training (DDiT), with a focus on Junior Doctors across the Acute Sector. • The Committee received an update from the Director of Facilities and Estates on the planned work in the atrium Queen Elizabeth University Hospital and a review of part of the exterior. • The Committee discussed changes to the Corporate Risk Register scoring. The risks in relation to environmental risks and capacity flow would be discussed with the Chief Risk Officer. <p>Mr Ritchie thanked members for attending and closed the meeting.</p> <p><u>NOTED</u></p>		
36.	DATE AND TIME OF NEXT SCHEDULED MEETING		
	The next meeting would take place on Tuesday 19 July 2022 at 9.30 am via Microsoft Teams.		

ASC (M) 22/04
 Minutes: 37 – 50

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Acute Services Committee Held on Tuesday 19 July 2022 at 9.30 am via Microsoft Teams

PRESENT

Mr Ian Ritchie (in the Chair)

Professor John Brown CBE	Dr Lesley Rousselet
Mr Simon Carr	Dr Paul Ryan
Councillor Colette McDiarmid	Professor Angela Wallace

IN ATTENDANCE

Ms Sandra Bustillo	..	Director of Communications and Public Engagement
Ms Jacqueline Carrigan	..	Assistant Director of Finance Acute/Access
Dr Scott Davidson	..	Deputy Medical Director, Acute
Mr William Edwards	..	Chief Operating Officer
Ms Morag Gardner	..	Chief Nurse, South Sector
Mrs Anne MacPherson	..	Director of Human Resources and Organisational Development
Ms Fiona McEwan	..	Interim Director of Finance
Ms Susan McFadyen	..	Director of Access
Ms Elaine Vanhegan	..	Director of Corporate Services and Governance
Mr Arwel Williams	..	Director of Diagnostics and Regional Services
Ms Kim Donald	..	Corporate Services Manager – Governance/Board Secretary
Mrs Louise Russell	..	Interim Secretariat Manager (Minutes)

			ACTION BY
37.	WELCOME AND APOLOGIES		
	Mr Ritchie welcomed those present to the meeting and welcomed new members, Councillor Colette McDiarmid and Councillor Chris Cunningham, to the Committee.		
	Apologies were noted on behalf of Ms Susan Brimelow, Ms Denise Brown and Professor Tom Steele.		
	NOTED		

			ACTION BY
38.	DECLARATIONS(S) OF INTEREST(S)		
	Mr Ritchie invited members to declare any interests in any of the items being discussed. No declarations of interest were made. <u>NOTED</u>		
39.	MINUTES OF PREVIOUS MEETING: 17 MAY 2022		
	The Committee considered the minute of the meeting held on Tuesday 17 May 2022 [Paper No. ASC (M) 22/03] and were content to approve the minute pending the following amendments; <ul style="list-style-type: none"> • Page 3, second paragraph: The minute should accurately reflect that this was in relation to the specific impact on Acute Services. • Page 6, Core Morbidities to be amended to Comorbidities. • Page 9, second last paragraph: The Union to be removed and replaced with BMA. <u>APPROVED</u>		Secretary
40.	MATTERS ARISING		
a)	Rolling Action List		
	The Committee considered the Rolling Action List [Paper No. 22/16]. The Committee were content to approve the recommended closure of four items on the Rolling Action List. The Committee noted the following updates; Minute 28, Urgent Items of Business Ms Bustillo highlighted that the planned work in the atrium at the Queen Elizabeth University Hospital would not proceed until written confirmation had been received that the Scottish Government would underwrite the costs. Ms Bustillo also highlighted that the original plan for internal scaffolding was no longer feasible due to the intensive nature of the work required. The Committee were assured that amended plan for work should commence early August 2022.		

			ACTION BY
	Minute 30 – Performance Acute Integrated Performance Report The Committee agreed that an update should be presented to the September 2022 ASC on the impact that Delayed Discharges had on the average length of stay. <u>APPROVED</u>		Mr Edwards
41.	URGENT ITEMS OF BUSINESS		
	The Committee noted that a letter had been received from the Scottish Government on 6 th July 2022 detailing the elective targets going forward. As this impacted on the work of the Committee, consideration would be given to what prioritisation was required. The Committee noted the update provided. <u>NOTED</u>		
42.	ACUTE COVID-19 UPDATE		
	Mr William Edwards, Chief Operating Officer, provided an update on the current position in respect of the pressure of Covid-19 within the Acute Services. Mr Edwards informed the Committee that there was currently a total of 662 Covid-19 positive inpatients in the last 28 days. As at 18 th July 2022, 66 beds were unavailable due to ward closures or Infection Prevention Control measures which was causing increased pressure across the system. The Committee noted that staffing challenges remained ongoing, with unplanned absence remaining a particular challenge. On 15 th July 2022 there were 915 staff absences; 490 of which related to Acute Services. The Committee noted that Delayed Discharges continued to increase the pressure on occupancy rates. At the time of the meeting there were 318 Delayed Discharges in NHSGGC. The impact Delayed Discharges had on outward flow was adding to the challenge of moving to full recovery. The Committee noted that the occupancy rate was currently over 95%. The Front Door performance to adhere to the 4 hour target was 67.8%, however, it was recognised that the Scottish position was 66.8%,		

			ACTION BY
	<p>In response to a question on whether the Delayed Discharge performance would improve if Adults with Incapacity (AWI) and admissions to Care Homes were removed from the statistics, the Committee received assurance that there would be a continued focus on Delayed Discharges and significant work carried out to address each section of the pathway. The Committee noted that actions being taken forward included; writing out to other Boards who were non GG&C HSCPs, re-patriating patients to their own Board area, ongoing partnership work and reviewing urgent and emergency care. The Committee received assurance that the focus remained in place and every partnership was optimising the processes.</p> <p>In response to a question regarding the biggest challenge in relation to Care Home admissions, the Committee noted that various factors had an impact. A number of Care Homes were private providers, therefore, could control the admission of residents. The Committee noted that 2 audits in relation to Delayed Discharges and time of day discharge had been carried out. The results from the Delayed Discharge audit highlighted that robust processes were in place. The time of day discharge was more challenging due to staffing pressures.</p> <p>The Committee discussed the current Covid-19 Infection Prevention and Control measures and whether they remained fit for purpose. The Committee noted that the Government guidance continued to be followed, including continuing to test for Covid-19. The Committee were assured that regular feedback was being provided to the Scottish Government.</p> <p>In response to a question regarding planned staff absence, in particular encouraging annual leave over the summer period, the Committee noted that this was the current policy to ensure staff had appropriate time off for their wellbeing. The Committee agreed it would be helpful to understand the overall staff absence rate to receive assurance on staffing levels. This information was reported through the Staff Governance Committee, however, information regarding the overall absence figures and the impact on Acute Services could be included at future meetings under the Acute update.</p> <p>The Committee were content to note the update provided.</p> <p><u>NOTED</u></p>		Ms MacPherson

			ACTION BY
43.	PERFORMANCE		
	a) Acute Integrated Performance Report		
	<p>Mr William Edwards and Ms Jacqueline Carrigan, Assistant Director of Finance Acute/Access, presented the Acute Services Integrated Performance Report [Paper 22/17] that provided a summary of performance against the Key Performance Indicators (KPIs) outlined in the Performance Assurance Framework.</p> <p>The report included the 14 key performance indicators. The Committee were assured of the work that was taking place to look at the current position of Access to Cancer Services within 62 Days of Receipt of Referral with a Suspicion of Cancer. The Committee noted that the recovery actions were in line the trajectory.</p> <p>The Committee recognised that the 18 week referral to treatment performance status remained a key challenge. The Committee discussed robotic surgery and the benefits of this resource. The Committee were pleased to note that a Robotics presentation would be added to the agenda at a future meeting. In response to a question regarding the Urology Locum post and whether a permanent position had been considered, the Committee noted that the operator in robotic surgery post was an additional post to support recovery.</p> <p>In response to a question in relation to the Upper GI waiting list and the expectation on when this could be cleared, the Committee were assured that P1 patients could be accommodated within 19 days and P2 patients would be accommodated within 48 days. The Committee noted that Upper GI were specialist procedures carried out by 4 Consultants two times per week. The Committee were assured that ongoing work was helping to reduce the waiting time.</p> <p>The Accident and Emergency 4 hour Waiting Time Standard remained a challenge Scotland wide. Mr Edwards highlighted that NHSGGC were above or in line with the Scottish position based on published national data.</p> <p>Mr Arwel Williams, Director of Diagnostics and Regional Services, provided an update on the amended referral route for CT scanning from GP Practices. The Committee noted that rollout in the North sector was now complete and rollout continued in the South sector. The Committee were advised that an end date for full rollout would be dependent on GP uptake. The Committee were assured that work</p>		Secretary

			ACTION BY
	<p>remained ongoing in partnership with the HSCP's to encourage GP Practices to take part.</p> <p>In response to a question regarding GP's adopting the new pathways, the Committee noted that rollout in the North East sector was complete. The Committee noted that work was ongoing to support GP colleagues and improve confidence in this new way of working.</p> <p>The Committee were advised that each Board was asked by the National Urgent and Unscheduled Care Collaborative to undertake a self-assessment. The Committee were assured that the mapping exercise work was being carried out. The Committee acknowledged that research into patient behaviours was limited, however, some evidence included patients suggesting an expert had asked them to go or believing their condition warranted attendance. The Committee acknowledged that changing behaviours was challenging. The Committee agreed that re-direction played a key part in improving challenges faced at the front door of A&E Departments. The Committee noted that re-direction was on the annual cycle of business for the Finance, Planning and Performance Committee to be discussed further.</p> <p>The Committee agreed that further discussion regarding operational research as to why patients attend emergency departments was required, therefore, an item would be added to the agenda for a future Acute Services Committee meeting and update will be provided in due course.</p> <p>The Committee were content to note the update provided.</p> <p><u>NOTED</u></p>		Mr Edwards/Dr Davidson
44.	SCOTTISH GOVERNMENT WAITING TIME TARGET		
	<p>Ms Susan McFadyen, Director of Access, attended the meeting to provide a presentation on 'Scottish Government Waiting Time Target'.</p> <p>Prior to the presentation, Mr Edwards updated the Committee on the announcement of targets received in a letter from Mr John Burns, Chief Operating Officer of NHS Scotland, dated 6 July 2022. The Committee noted the key principle areas of challenge, recognising that capacity would remain a key challenge in some specialties in achieving the targets.</p> <p>Ms McFadyen informed the Committee that previous national deliberation on the maximum wait time of 2 years indicated that this</p>		

			ACTION BY
	<p>would likely be achieved by the end of March 2023 for Out Patients and Inpatients/Day Cases. However, the position had changed and a letter had been received advising of Cabinet Secretary announcement on targets. The Committee noted the targets which were;</p> <ul style="list-style-type: none"> • 2 year wait for Outpatients in most specialties by end of Aug 22; • 18 month wait for Outpatients in most specialties by end of Dec 22; • 1 year wait for Outpatients in most specialties by end of March 23; • 2 year waits for Inpatients/Day Cases in majority of specialties by Sept 22; • 18 month for Inpatients/Day Cases in majority of specialties by Sept 23; • 1 year wait for Inpatients/Day Cases in majority of specialties by Sept 24. <p>It was noted that the areas of challenge included Orthopaedics, Adult and Paediatric ENT, Neurosurgery and Surgical Paediatrics and that, in general, patients are requiring an Inpatient stay and are not the majority not able to be managed as a Day Case, for example Adult Tonsillectomy cases.</p> <p>Ms McFadyen highlighted that there was a continued need to balance clinically urgent patient demand with a reduction in the long waiting patient position, noting Paediatrics were seeing increased numbers of priority 2 patients. Ms McFadyen reported that consideration of Religious Circumcisions backlog had been highlighted to the Scottish Government as clinicians have expressed a view around the clinical relevance. The Committee agreed that the September 2022 target would be challenging but sought further updates as the forecasting became clearer.</p> <p>The Committee noted the information provided in the presentation and agreed that the capacity and trajectories were realistic, however, acknowledged the staffing , bed capacity due to current Covid numbers and financial challenges that would likely impact on the targets.</p> <p>In response to a question in relation to what impact the new targets would have on the six priorities that had been set by the Board, the Committee were assured that the Executive Team would do a cross check on Board priorities and ensure consistency.</p> <p>In response to a question in relation to digital innovation, for example Apps, the Committee were assured that digital work was ongoing. The Committee noted that the Citizens Access Board were driving an</p>		Ms Vanhegan

			ACTION BY
	<p>innovation programme, which included COPD patients registering symptom scores and remote monitoring of Heart failure patients. The Committee noted that clinicians were fully engaged with innovation and a number of programmes were clinically led. The Committee were advised that digital intervention pre-operative management work was also being considered. The Committee were assured by the information provided.</p> <p>The Committee thanked Ms McFadyen for the update and were assured by the information provided.</p> <p>NOTED</p>		
45.	FINANCIAL MONITORING REPORT		
	<p>Ms Jacqueline Carrigan, Assistant Director of Finance Acute, presented the Financial Monitoring Report for Month 2 [Paper 22/18] which set out the Acute revenue position and the position with the Financial Improvement Programme (FIP).</p> <p>Ms Carrigan advised as at the 31st May 2022 the Acute Division reported an overspend of [REDACTED]. This was broken down to direct expenditure relating to delivery of services relating to Covid-19 of [REDACTED], which remained unfunded at this stage, unachieved savings of [REDACTED] and Scottish Government allocations under review and awaiting confirmation of [REDACTED].</p> <p>The Committee noted that discussions regarding the IJB holding reserve were ongoing. It was highlighted that there would be a gap in funding, however, the total spend would be reviewed. The Committee were advised that funding would cover flu and Covid-19 vaccinations and that Covid-19 exit planning work was ongoing. The Committee discussed Covid-19 funding from the Scottish Government. The Committee noted that the Q1 spend to date would be funded, however, at present, no further funding was available; however, the Scottish Government was reviewing all allocations to Boards.</p> <p>In response to a question in relation to the variance in spending between the sectors, the Committee were informed that each sector was structured differently and issues varied in each sector. The Committee noted that a Pan NHSGGC Working Model was in place for newly qualified consultants to assist with staffing issues across GG&C. The Committee were assured that significant steps had been made to address the issues pertaining to locum use in certain sectors.</p>		

			ACTION BY
	<p>The Committee discussed medical contracts, and the negotiations of job plans regarding locations of work. The Committee noted that the BMA were involved in conversations, and that contracts highlight that the clinicians are employees of the Health Board, as opposed to a specific hospital. The Committee also raised variation across sectors re junior doctor spending and were assured that the disparity in spending across the sectors was being reviewed and addressed.</p> <p>The Committee were content to note the report and were assured by the information provided.</p> <p><u>NOTED</u></p>		
46.	CANCER WAITING TIMES		
	<p>Mr Arwel Williams, Director of Diagnostics and Regional Services, attended the meeting to provide a presentation on 'Cancer Waiting Times' Performance.</p> <p>Mr Williams informed the Committee that referrals continued to exceed pre-pandemic levels with approximately 1200 referrals per week compared to 1000 pre-pandemic.</p> <p>The Committee noted that the national percentage for 62 Day Performance was 71.1% and NHSGGC were at 75.8% from May 2022. The Committee noted performance challenges, which included theatre and bed capacity impacting cancer pathways.</p> <p>Mr Williams highlighted issues in Urology regarding access to P3/4 Robotic Assisted Laparoscopic Prostatectomy (RALP) which remained a key challenge, however, confirmed that robotic surgery was exempt from the standards. Additional weekend sessions were in place where possible, however, a backlog of cases requiring treatment would continue to impact performance in the coming months.</p> <p>He also reported that Upper GI performance was under pressure due to complex diagnostic pathway (scope, CT, PETCT, EUS, laparoscopy) issues impacting the early part of patient journey. He reported that screening/scope capacity was the primary performance issue,</p> <p>In response to a question on the position against national figures, the Committee noted that as NHSGGC had the robotic surgery and deal with other specific tumour groups which may have had an impact against the national statistics.</p>		

			ACTION BY
	<p>In response to a question regarding resources, the Committee noted that staffing remained a key challenge. The Committee were assured that improvement plans were in place.</p> <p>In response to a question regarding the impact on screening programmes, the committee noted that the provision for Bowel Screening was being rebalanced and was being re-categorised as P2.</p> <p>The Committee were content to note the update.</p> <p><u>NOTED</u></p>		
47.	SAFE TO START UPDATE		
	<p>Ms Morag Gardner, Chief Nurse, attended the meeting to provide a presentation on 'Safe to Start Update'. The presentation provided an update on the processes to align nursing resources to wards in order to manage and mitigate risk.</p> <p>Ms Gardner reported that Hospital Huddles formed part of daily Hospital management which assisted with improving patient safety, flow and communication.</p> <p>The Committee noted that a RAG system was in place and that this scoring system determined by the Senior Charge Nurse in order to view the safety of the wards. This approach was utilised to minimise the use of supplementary staffing across acute in-patient services. The Committee noted that 3 levels of RAG status were used; Green (first line defence), Amber (second line defence) and Red (third line defence).</p> <p>Ms Gardner informed the Committee that as at 19 July 2022, the RAG status for staffing was 37 Green status, 109 Amber status and 60 Red status.</p> <p>Ms Gardner provided an update on staffing issues noting that there was currently 702 Band 5 vacancies across Acute sites. The Committee noted that 542 newly qualified Nurses and Midwives would be joining the organisation in the Autumn which was 54% of what as required. Ms Gardner reported that events had been carried out to attract candidates noted that 50 International Nurses had been recruited and were going through the on boarding process.</p> <p>Ms Gardner informed the Committee that, despite staffing challenges, the feedback received from a recent unannounced Healthcare</p>		

			ACTION BY
	<p>Improvement Scotland (HIS) Inspection at the QEUH was positive. It was highlighted in particular that the management and transparent recording of staffing issues was excellent.</p> <p>The Committee noted that the challenges with nurse staff figures was mirrored across Scotland. The Committee were assured that a Task Force Group had been set up to look at International recruitment and increasing the skills of the current workforce. Work was also taking place to attract staff to come back on the register.</p> <p>The Committee recognised the ongoing challenges in relation to staffing and retaining the current workforce. The Committee were assured that a good system was in place and recognised that longer term work to address the issue was required.</p> <p>In response to a question regarding the Safer Staffing Legislation, the Committee noted that 'Safe to Start' sits well with the legislation.</p> <p>The Committee were content to note the update provided.</p> <p><u>NOTED</u></p>		
48.	EXTRACT FROM CORPORATE RISK REGISTER		
	<p>Ms Carrigan presented the Extract from the Corporate Risk Register for the Acute Services Committee [Paper 22/19] for the Committee to consider and confirm that they were content that the risks were clearly described and that the risk scores were appropriate.</p> <p>The Committee noted that the Corporate Risk Register had been modified and the title of the first risk had been updated to reflect the current position and nature of the outstanding risk. The Committee were assured that the risk would remain on the main Corporate Risk Register, however would no longer be submitted to the Acute Services Committee.</p> <p>It was suggested that the second risk in relation to Scheduled Care Waiting Time Targets was split into Outpatients and Inpatients as they were 2 separate targets that required different mitigation.</p> <p>It was suggested that the third risk in relation to Unscheduled Care Waiting Time Targets was reviewed and the mitigating actions considered.</p> <p><u>NOTED</u></p>		Ms Carrigan/ Mr Gibson

			ACTION BY
49.	CLOSING REMARKS AND KEY MESSAGES FOR THE BOARD		
	<p>Mr Ritchie asked members to raise any other competent business.</p> <p>There was no other business noted.</p> <p>The key messages for the Board were:</p> <ul style="list-style-type: none"> • The Acute Services Committee recognised the challenges that the organisation was facing due to Covid-19 and ongoing staffing pressures. • The Committee received the Acute Services Performance Report and noted the performance against the 14 key performance indicators. • The Committee received the Month 2 Finance Report which set out the Acute revenue position and the position with the Financial Improvement Programme (FIP). The Committee noted the Acute Division reported an overspend of 19.6m as at 31st May 2022. • The Committee received presentations on the 'Scottish Government Waiting Time Target', 'Cancer Waiting Times' and 'Safe to Start'. <p>Mr Ritchie thanked members for attending and closed the meeting.</p> <p><u>NOTED</u></p>		
50.	DATE AND TIME OF NEXT SCHEDULED MEETING		
	The next meeting would take place on Tuesday 20 September 2022 at 9.30 am via Microsoft Teams.		

ASC (M) 22/05
Minutes: 51 – 66

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Acute Services Committee Held on Tuesday 20 September 2022 at 9.30 am via Microsoft Teams

PRESENT

Mr Ian Ritchie (in the Chair)

Ms Susan Brimelow	Ms Jane Grant
Professor John Brown CBE	Dr Lesley Rousselet
Mr Simon Carr	Dr Paul Ryan
Councillor Colette McDiarmid	

IN ATTENDANCE – TO BE UPDATED

Ms Sandra Bustillo	..	Director of Communications and Public Engagement
Ms Jacqueline Carrigan	..	Assistant Director of Finance Acute/Access
Dr Scott Davidson	..	Deputy Medical Director, Acute
Mr William Edwards	..	Chief Operating Officer
Ms Morag Gardner	..	Deputy Nurse Director, Acute Division
Mr Andrew Gibson	..	Chief Risk Officer
Mrs Anne MacPherson	..	Director of Human Resources and Organisational Development
Ms Susan McFadyen	..	Director of Access
Mr Colin Neil	..	Director of Finance
Ms Elaine Vanhegan	..	Director of Corporate Services and Governance
Ms Kim Donald	..	Corporate Services Manager – Governance/Board Secretary
Mrs Louise Russell	..	Interim Secretariat Manager (Minutes)

			ACTION BY
51.	WELCOME AND APOLOGIES		
	Mr Ritchie welcomed those present to the meeting and welcomed Ms Morag Gardner, Deputy Nurse Director, to her first meeting of the Committee. Apologies were noted on behalf of Professor Angela Wallace.		

			ACTION BY
	<u>NOTED</u>		
52.	DECLARATIONS(S) OF INTEREST(S)		
	Mr Ritchie invited members to declare any interests in any of the items being discussed. No declarations of interest were made. <u>NOTED</u>		
53.	MINUTES OF PREVIOUS MEETING: 19 JULY 2022		
	The Committee considered the minute of the meeting held on Tuesday 19 July 2022 [Paper No.ASC(M)22/04] and were content to approve the minute. The Committee noted the following comments; <ul style="list-style-type: none"> • Page 6, Item 43, Acute Integrated Performance Report – the Committee received assurance that the operational research scoping work had commenced and the findings would be presented at a future meeting. • Page 22, Item 48, Extract from the Corporate Risk Register – the Committee suggested at the last meeting that the risk in relation to Scheduled Care Waiting Time Targets was split into Outpatients and Inpatients. Mr Andrew Gibson, Chief Risk Officer, agreed to progress this with the Chief Operating Officer. <u>APPROVED</u>		Mr Gibson
54.	MATTERS ARISING		
a)	Rolling Action List		
	The Committee considered the Rolling Action List [Paper No.22/20]. The Committee were content to approve the recommended closure of ten items on the Rolling Action List. <u>APPROVED</u>		

			ACTION BY
55.	URGENT ITEMS OF BUSINESS		
	<p>Mr William Edwards, Chief Operating Officer, informed the Committee that as at 20th September 2022, there was a total of 196 Covid-19 positive inpatients in the last 28 days. There were 2 patients in ICU who had tested positive in the last 28 days.</p> <p>Mr Edwards informed the Committee that DL32 Covid-19 guidance had been issued by the Scottish Government. The Guidance recommended that routine asymptomatic testing for Health Care workers and pre-elective surgery admissions would cease by the end of September. The Committee noted that a recommendation would be made to SEG to stop routine testing in NHS GGC in line with the guidance. Mr Edwards reported that the existing Specialist Assessment and Treatment Area (SATA) pathways would also be reviewed in context of the new guidance</p> <p>Mr Edwards informed the Committee that a number of senior vacancies across Acute services had been successfully filled. Ms Morag Gardner had been appointed as Deputy Nurse Director and had commenced in post. Ms Ann Smith had been appointed as Director of Diagnostics and Ms Susan Groom had been appointed as Director of Regional Services; start dates were in the process of being confirmed.</p> <p>In response to a question in relation to discharge lounges, the Committee noted that the Queen Elizabeth University Hospital (QEUE) discharge lounge had been relocated to Langlands during pandemic. The Committee were advised that discussions were ongoing in relation to closure of the SATA pathway and the potential return of the lounge back to the QEUE ground floor.</p> <p>The Committee noted the update provided.</p> <p><u>NOTED</u></p>		
56a	ACUTE UPDATE		
	<p>Mr William Edwards had no further information to add to his update during the previous item.</p> <p><u>NOTED</u></p>		
57b	STAFFING POSITION		

			ACTION BY
	<p>Ms Anne MacPherson, Director of Human Resources and Organisational Development, attended the meeting to provide a presentation on the current staffing position.</p> <p>Ms MacPherson provided figures in relation to sickness and Covid-19 absence. The Committee noted that July and August were particularly challenging months, with some variation noted across the sectors.</p> <p>Mrs MacPherson highlighted that a number of staff remained absent due to long term illness and this included staff shielding due to underlying health conditions.</p> <p>. The Committee were assured that significant work remained ongoing to support staff, which included particular focus areas and interventions. Detailed case reviews through the Occupational Health Pathway were carried out with staff who were absent due to long terms sickness and supports available included Cognitive Behaviour Therapy (CBT), workshops and psychological services support. A specific piece of person centred work was being carried out in relation to supporting staff.</p> <p>The Committee noted that Covid-19 absence had reduced. Mrs MacPherson informed the Committee that the rules regarding Covid-19 absence had changed and as at 1st September 2022, absence would be registered as a sickness absence.</p> <p>Mrs MacPherson informed the Committee that there was a focus on recruitment. The Committee noted that 576 candidates for posts in Acute Services had been recruited and the majority were due to commence in post on 3rd October 2022. The Committee noted that a vacancy gap remained to be filled by business as usual recruitment was 260 WTE. The Committee were assured that recruitment campaigns had been successful, for example through the RCN event in London.</p> <p>Mrs MacPherson informed the Committee that 39 former Scottish Ambulance Service staff had been appointed in Regional Services and Clyde in Band 2 posts. There had been 46 candidates appointed in Band 2 posts through the 'Pre-employment Programme' and since June 2022, 34 HealthCare Support Workers (Bands 2-4) had been recruited.</p> <p>Mrs MacPherson provided an update on Bank Staffing numbers and highlighted the aim to reduce agency use. The Committee noted that international recruitment had been successful and a campaign for a second cohort of registered nurses had been approved.</p>		

			ACTION BY
	<p>In response to a question regarding what work could be carried out regarding negative media activity, the Committee were assured that work remained ongoing to highlight the successes in NHSGGC to demonstrate that NHSGGC was a good place to work. There were positive messages sent to staff via the Chief Executive updates and Core Briefs. The Committee noted that discussions were active with the Royal College of Nursing (RCN) to discuss specific issues.</p> <p>The Committee were content to note the update provided and acknowledged the work that had been carried out.</p> <p><u>NOTED</u></p>		
58.	PERFORMANCE		
	a) Acute Integrated Performance Report		
	<p>Mr William Edwards and Mr Colin Neil, Director of Finance, presented the Acute Services Integrated Performance Report [Paper 22/21] that provided a summary of performance against the Key Performance Indicators (KPIs) outlined in the Performance Assurance Framework.</p> <p>The report included the 18 key performance indicators. The Committee noted significant progress against a number of KPI's.</p> <p>The Committee acknowledged an increase in the number of urgent suspicion of Cancer referrals received in comparison to the previous year, and received assurance that the 31 day pathway was being maintained and remained stable. The Committee were advised that key actions were being carried out to address the current position of Access to Cancer Services within 62 days of receipt of referral with a suspicion of Cancer, particularly in the tumour types facing ongoing challenges.</p> <p>The Committee noted that the target submitted to the Scottish Government for the number of outpatients waiting over 2 years for a new outpatient appointment was met at the end of August 2022. An additional target by Scottish Government outlines that no patient should wait more than 18 months for outpatients in most specialties by the end of September 2022.</p> <p>In response to a question regarding day surgery, and the work taking place to reduce attendance at the Victoria Hospital, the Committee</p>		

			ACTION BY
	<p>noted that maximising day cases was part of the remobilisation plan. Work was ongoing to clear the outpatient lists by using patient focussed booking to maximise slots and help reduce the overall Did Not Attend (DNA) numbers.</p> <p>In response to a question regarding whether the Cancer Management Group had been established, the Committee noted that the group had refocussed and were carrying out a number of deep dives and breach analysis alongside creating improvements.</p> <p>In response to a question regarding Netcall, and the progress that had been made in relation to discharge protocols, the Committee noted that the Netcol platform allowed different methods of communication with patients, for example using text messages for appointments and questionnaires.</p> <p>The Committee highlighted the need for a focussed piece of work regarding discharge protocols and ensuring time of day discharge was a focus to support unscheduled care flow.</p> <p>The Committee were content to note the report and were assured by the information provided and the actions being taken forward.</p> <p><u>NOTED</u></p>		
59.	FINANCIAL MONITORING REPORT		
	<p>Mr Colin Neil, Director of Finance, presented the Financial Monitoring Report for Month 4 [Paper 22/22] which set out the Acute revenue position and the position with the Financial Improvement Programme (FIP).</p> <p>Mr Neil advised as at the 31 July 2022 the Acute Division reported an overspend of [REDACTED]. This was broken down to direct expenditure relating to delivery of services relating to Covid-19 of [REDACTED], Test and Protect of [REDACTED] and [REDACTED] of other expenditure where funding allocations were under review and unachieved savings of [REDACTED].</p> <p>The Committee noted that the overall board Covid-19 costs were over [REDACTED]. A significant amount of work had been carried out to mitigate and reduce cost and this led to a reduction of [REDACTED]. It was hoped that the changes in relation to asymptomatic testing and SATA Pathways would result in a further reduction.</p>		

			ACTION BY
	<p>The Committee acknowledged the position in relation to Medical Salaries. As at Month 4 the total overspend was [REDACTED], however, after taking into account funding allocations, the overspend would be [REDACTED]. This included Senior Medical and Junior Medical salaries.</p> <p>The Committee were advised that, following funding allocations and taking account of Covid-19 expenditure, Nursing salaries would be [REDACTED] under budget. It was expected that Month 5 would report slightly under budget or a breakeven position.</p> <p>The Non-Pay lines were reporting an overspend of [REDACTED]. This included spend related to drugs of [REDACTED]. The Committee were assured that this was an area that was being reviewed.</p> <p>The Committee received an update on the Financial Improvement Programme (FIP) for 2022/23. The year to date target of [REDACTED] had received delivery of [REDACTED], which left an underachievement of [REDACTED]. The Committee were assured that schemes to the value of [REDACTED] had been identified and work continued to identify further opportunities.</p> <p>The Committee noted that of the overall [REDACTED] target within Acute, a recurring achievement of [REDACTED] was reported at Month 4. This represented 13.4% of the target. The Committee were assured that this remained a key area of focus for the Board.</p> <p>In response to a question regarding the FIP and the anticipated [REDACTED] identified schemes, the Committee were assured that work was ongoing and that the schemes would be deliverable by the end of financial year. The Committee noted that working groups with cross sector representation had been established to look across the sites.</p> <p>The Committee noted that an area of activity was looking at Non Payees level of activity and variation across sectors. A national benchmarking tool would be used to explore the data further and match the cost per activity. A further update on the progress would be provided at a future meeting.</p> <p>The Committee discussed Acute Services expenditure and how that could be costed, for example A&E, GP OOH and Delayed Discharges. The Committee were assured that Nursing services carried out regular deep dives. This provided an opportunity to focus on areas, for example areas with high bank agency spend, and put supports in place.</p> <p>The Committee were content to note the update provided.</p>		Mr Neil

			ACTION BY
	<u>NOTED</u>		
60.	SCOTTISH GOVERNMENT WAITING TIME TARGET - PROGRESS		
	<p>Ms Susan McFadyen, Director of Access, attended the meeting to provide a presentation on 'Scottish Government Waiting Time Target - Progress'.</p> <p>Ms McFadyen provided an update on the progress made against the targets announced by the Scottish Government in July 2022. The Committee noted that no additional funding had been confirmed to support with meeting the new targets, however, the funding position was expected to be clarified soon.</p> <p>Ms McFadyen highlighted the following update in relation to the targets;</p> <ul style="list-style-type: none"> • 2 year wait for Outpatients in most specialties by end of Aug 22 had been met; • A significant reduction was expected in the 18 month wait for Outpatients in most specialties by end of Dec 22; • Further work was being carried out with Gynaecology due to the current demands; <p>The Committee were assured that work would continue to build on the momentum of reductions in the long waiting patients, there would be a continued focus on treatment of urgent and long waiting patients and digital solutions would be optimised to aid efficiency.</p> <p>In response to a question regarding clinical prioritisation, the Committee noted that ongoing monitoring ensured that clinicians had an overall view.</p> <p>In response to a question regarding meeting the target for the 2 year wait for inpatients, the Committee noted that this was a challenge faced by all Boards in Scotland.</p> <p>The Committee thanked Ms McFadyen for the update and were assured by the information provided.</p> <p><u>NOTED</u></p>		

			ACTION BY
61.	LENGTH OF STAY – IMPACT OF COVID AND DELAYED DISCHARGE		
	<p>Mr William Edwards, provided a presentation on ‘Length of Stay – Impact of Covid-19 and Delayed Discharge’.</p> <p>Mr Edwards informed the Committee that a review was carried out to look beyond the high level mean length of stay data. Mr Edwards provided a site by site analysis of data for the emergency average length of stay. The impact of the pandemic was evident in the data for 2020/21. Mr Edwards noted that the Queen Elizabeth University Hospital and the Royal Alexandra Hospital were back in line with pre pandemic length of stay. The Glasgow Royal Infirmary, the Vale of Leven and Glasgow Victoria Infirmary had been impacted due to ward closures and delayed discharges.</p> <p>The analysis looked at the number of days lost. The Committee noted that during 2021/22, 99,902 bed days were lost due to delayed discharges. The Committee noted that improvement actions included a review of high volume & high bed utilisation procedures and clinical pathway redesign.</p> <p>The Committee were advised that Covid-19 was the main diagnosis for bed days used. Pneumonia was the next highest in bed days used and COPD and Heart Failure continued to be next highest.</p> <p>In response to a question regarding the length of stay admission rate and whether there was any noticeable difference, the Committee noted that there was variance in admission rates across the sites and work was taking place to look at monitoring this. A piece of work was being undertaken at the moment to look at bed days used by diagnosis.</p> <p>Mr Edwards agreed to bring back a progress report to a future meeting and the annual cycle of business would be updated to reflect this.</p> <p>The Committee were content to note the update provided.</p> <p><u>NOTED</u></p>		Mr Edwards/ Secretary
62.	UPDATE ON GP DIRECT TO CT SCAN NORTH EAST PILOT		

			ACTION BY
	<p>Ms Susan McFadyen and Mr William Edwards, presented the paper 'Update on Rollout of Direct Access CT Chest Requesting by GP's' [Paper 22/23].</p> <p>The Committee noted that the roll out in Glasgow City and the North East region had gone well and implementation of the final phase had been accelerated.</p> <p>The Committee noted that feedback from GP's had been positive.</p> <p>The Committee were content to note the update provided.</p> <p><u>NOTED</u></p>		
63.	EXTRACT FROM CORPORATE RISK REGISTER		
	<p>Mr Andrew Gibson, Chief Risk Officer, presented the Extract from the Corporate Risk Register for the Acute Services Committee [Paper 22/24] for the Committee to consider and confirm that they were content that the risks were clearly described and that the risk scores were appropriate.</p> <p>Mr Gibson reported that since the last meeting, the following amendments had been made;</p> <ul style="list-style-type: none"> • Target date for actions reviewed for all risks • Controls and mitigating actions reviewed throughout • The risk scores were reviewed and remained static for this reporting period. <p>Mr Gibson agreed to work with the Chief Operating Officer to refine and split the scheduled care risk as discussion earlier in the meeting.</p> <p>The Committee noted that the Corporate Risk Register</p> <p><u>NOTED</u></p>		
64.	ANNUAL CYCLE OF BUSINESS		
	<p>Ms Elaine Vanhegan, Director of Corporate Services and Governance, presented the Annual Cycle of Business [Paper 22/25] for consideration.</p>		

			ACTION BY
	<p>The Committee were advised that an amendment would be made to the A&E attendance item scheduled for November 2022. The item would be named A&E Attendance Research.</p> <p>The Committee agreed that the Committee Terms of Reference would be submitted to the January 2023 meeting.</p> <p>The Committee were assured that the 2023/24 committee meeting dates were in the process of being approved and would be submitted to the Board in due course.</p> <p>The Committee were content to approve the Annual Cycle of Business and were content that the topics were within the appropriate timetable.</p> <p><u>APPROVE</u></p>		<p>Secretary</p> <p>Secretary</p>
65.	CLOSING REMARKS AND KEY MESSAGES FOR THE BOARD		
	<p>Mr Ritchie asked members to raise any other competent business. There was no other business noted.</p> <p>The key messages for the Board were:</p> <ul style="list-style-type: none"> • The Acute Services Committee recognised the ongoing pressures in relation to staffing and delayed discharges. • The Committee received the Acute Services Performance Report and noted the performance against the 18 key performance indicators. • The Committee received the Month 4 Finance Report which set out the Acute revenue position and the position with the Financial Improvement Programme (FIP). The Committee noted the Acute Division reported an overspend of [REDACTED] as at 31st July 2022. • The Committee received a presentation providing an update on the progress made on the 'Scottish Government Waiting Time Target' and a presentation on the 'Length of Stay – Impact of Covid-19 and Delayed Discharge'. 		

			ACTION BY
	<ul style="list-style-type: none"> The Committee received an update on the Rollout of Direct Access CT Chest Requesting by GP's and noted the positive progress that had been made. <p>Mr Ritchie thanked members for attending and closed the meeting.</p> <p><u>NOTED</u></p>		
66.	DATE AND TIME OF NEXT SCHEDULED MEETING		
	The next meeting would take place on Tuesday 15 November 2022 at 9.30 am via Microsoft Teams.		

ASC (M) 22/06
Minutes: 67 – 80

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Acute Services Committee Held on Tuesday 15 November 2022 at 9.30 am via Microsoft Teams

PRESENT

Dr Paul Ryan (in the Chair)

Dr Jennifer Armstrong	Ms Jane Grant
Professor John Brown CBE	Mr Colin Neil
Councillor Chris Cunningham	Dr Lesley Rousselet
Mr Simon Carr	Professor Angela Wallace
Councillor Colette McDiarmid	

IN ATTENDANCE

Ms Sandra Bustillo	..	Director of Communications and Public Engagement
Ms Jacqueline Carrigan	..	Assistant Director of Finance Acute/Access
Dr Scott Davidson	..	Deputy Medical Director, Acute
Mr William Edwards	..	Chief Operating Officer
Ms Morag Gardner	..	Deputy Nurse Director, Acute Division
Mr Andrew Gibson	..	Chief Risk Officer
Mrs Anne MacPherson	..	Director of Human Resources and Organisational Development
Ms Susan McFadyen	..	Director of Access
Ms Elaine Vanhegan	..	Director of Corporate Services and Governance
Ms Kim Donald	..	Corporate Services Manager – Governance/Board Secretary
Mrs Louise Russell	..	Interim Secretariat Manager (Minutes)

			ACTION BY
67.	WELCOME AND APOLOGIES		
	Dr Ryan welcomed those present to the meeting.		
	Apologies were noted on behalf of Mr Ian Ritchie and Ms Susan Brimelow.		
	NOTED		

			ACTION BY
68.	DECLARATIONS(S) OF INTEREST(S)		
	Dr Ryan invited members to declare any interests in any of the items being discussed. No declarations of interest were made. <u>NOTED</u>		
69.	MINUTES OF PREVIOUS MEETING: 20 SEPTEMBER 2022		
	The Committee considered the minute of the meeting held on Tuesday 20 September 2022 [Paper No.ASC(M)22/05] and were content to approve the minute. In response to a question regarding the focussed piece of work on discharge protocols, the Committee noted that this was an ongoing programme of work regarding unscheduled care and were assured that this piece of work would form part of the overall winter plan. <u>APPROVED</u>		
70.	MATTERS ARISING		
a)	Rolling Action List		
	The Committee considered the Rolling Action List [Paper No.22/26]. The Committee were content to approve the recommended closure of 5 items on the Rolling Action List. <u>APPROVED</u>		
71.	URGENT ITEMS OF BUSINESS		
	Mr William Edwards, Chief Operating Officer, informed the Committee that following the Healthcare Improvement Scotland (HIS) Inspection at the Queen Elizabeth University Hospital, a draft report had been received for review and a response would be submitted by the deadline on 30 th November 2022. Mr Edwards reported that overall the report was positive.		

			ACTION BY
	<p>The Committee noted that the Inverclyde Royal Hospital inspection report had not been received yet and would be brought to the Committee when available.</p> <p>In response to a question regarding potential industrial action, the Committee noted that the 8 trade unions in GG&C had balloted and a formal response was awaited. The Committee received assurance that business continuity plans were being prepared and there was ongoing dialogue with the Scottish Government. The Committee noted that the Scottish Ambulance Service (SAS) intimated industrial action on 28th November 2022 and were assured that work was ongoing out to assess and minimise the impact.</p> <p>The Committee noted the update provided.</p> <p><u>NOTED</u></p>		
72.	ACUTE UPDATE		
	<p>Mr Edwards provided an update on the current position in respect of COVID-19 and the current pressure within Acute Services.</p> <p>The Committee noted that the unscheduled and planned care positions remained challenging with unscheduled care performance for September sitting at 72%. However, the Committee were assured that the position was monitored on a weekly basis and recognised that challenges remained ongoing with regards to occupancy rates.</p> <p>There were a total of 276 COVID-19 positive inpatients that had tested positive in the last 28 days and 1 patient in ICU. The Committee noted that 7 wards were closed and that elective activity was being maintained at 1220 cases per week.</p> <p>The Committee noted the update provided.</p> <p><u>NOTED</u></p>		
73.	PERFORMANCE		
	a) Acute Integrated Performance Report		
	Mr William Edwards and Mr Colin Neil, Director of Finance, presented the Acute Services Integrated Performance Report [Paper 22/27] that		

			ACTION BY
	<p>provided a summary of performance against the Key Performance Indicators (KPIs) outlined in the Performance Assurance Framework.</p> <p>The report highlighted that a significant number of the performance indicators were delivering against the target. The Committee noted significant progress against a number of KPI's with the revised TTG target for the end of September being met, as was the target set for the end of August in relation to no new outpatients waiting more than 2 years. The Committee received assurance that an action plan had been put in place to address performance, which was outlined in the report. The Committee recognised that a significant increase in performance would not take place until the backlog had been cleared.</p> <p>The Committee acknowledged the A&E waiting times pressures and noted that work continued to take place with the IJBs and local authorities regarding the challenges with delayed discharges. The Committee received assurance that Professor Angela Wallace, Executive Nurse Director, was leading on a piece of work in relation to Delayed Discharges and continued to work closely with the Chief Officers. The plan to reduced Delayed Discharges by 25% by the end of December was underway. The Committee were assured that work was being carried out in relation to time of day discharge, use of the discharge lounge and working in conjunction with care home staff. A piece of work was also being carried out to increase the number of Healthcare Support Workers. Use of the flow navigation centre continued to be maximised and work was ongoing with the Scottish Ambulance Service (SAS).</p> <p>In response to a question regarding the impact on delayed discharges with Adults with Incapacity (AWI), and whether a change in emergency legislation was expected, the Committee noted that a meeting had been held with the Mental Health Commission. The Committee noted that any agreed changes would take time to be implemented. The Committee noted that work in relation to the performance management process was ongoing. Staffing challenges were contributing to the significant increase in AWI figures in partnerships. Ms Jennifer Rodgers, Deputy Nurse Director, was carrying out a piece of work to deploy Nurse and HSCW Bank staff to provide support. In response to a question regarding whether the Care Commissioning Plan was still in operation, the Committee noted that the plan overlapped with the Unscheduled Care Plan.</p> <p>In response to a question regarding NHS24 performance, the Committee noted that regular discussions were held with NHS24 and</p>		

			ACTION BY
	<p>the Scottish Ambulance Service regarding flow. The Committee noted that discussion was underway with NHS24 regarding data collection. With regards to the performance level of Primary Care and the impact on Acute Services, the Committee noted that the IJB's continued to work with Primary Care. Some progress regarding data had been made and work remained in progress.</p> <p>The Committee were advised that the data pulled from the workstreams above were being reviewed by FP&P. The Committee were content to note the report and were assured by the information provided and the actions being taken forward.</p> <p>NOTED</p>		
74.	FINANCIAL MONITORING REPORT		
	<p>Mr Neil presented the Financial Monitoring Report for Month 6 [Paper 22/28] which set out the Acute revenue position and the position with the Financial Improvement Programme (FIP).</p> <p>Mr Neil advised as at the 30th September 2022, the Acute Division reported a deficit of [REDACTED]. The annual forecast for Acute Covid-19 spend had been reviewed and reduced to [REDACTED] from the previous forecast of [REDACTED], with budget allocated for agreed spend to date. The unachieved savings for month 6 amounted to [REDACTED]. Mr Neil reported that Pays were [REDACTED] over budget, with Medical Pays being the main driver at [REDACTED]. The Committee noted that agency and locums were a key element of expenditure.</p> <p>The Committee were advised that Nursing salaries reported a breakeven position for Month 6.</p> <p>The Non-Pay lines were reporting an overspend of [REDACTED]. This included spend related to drugs of [REDACTED] which had been impacted due to short supply and price increases. The Committee were assured that this expenditure was being reviewed.</p> <p>The Committee received an update on the Financial Improvement Programme (FIP) for 2022/23. The year to date target of [REDACTED] had received delivery of [REDACTED] at month 6 and a forecast that this would rise to [REDACTED] by year end. The Committee were assured that further pipeline schemes were in place to take this value to [REDACTED], and work continued to identify further opportunities.</p>		

			ACTION BY
	<p>The Committee noted the information provided in regards to the Financial Improvement Programme and sought assurance that the schemes identified would come to fruition. The Committee received assurance that ongoing progress had been made.</p> <p>In response to a question regarding medical salaries overspend and whether steps had been taken to address this area in the longer term, the Committee noted that several pieces of work were underway in regards to reducing this spend across the senior and junior medical lines. With regards to nursing it was noted that there was an ongoing recruitment programme in place and it was expected that the newly qualified nurses that commenced in post in October would have a positive impact on the position.</p> <p>The Committee were content to note the update provided.</p> <p><u>NOTED</u></p>		
75.	PLANNED CARE UPDATE		
	<p>Ms Susan McFadyen, Director of Access, attended the meeting to provide a presentation on 'Planned Care Update'.</p> <p>Ms McFadyen provided an update on the progress made against the targets;</p> <p><u>Adult Outpatient Specialties: December 2022 Target</u></p> <ul style="list-style-type: none"> As at 1st October 2022, there had been significant reduction in the numbers of patients over 78 weeks. <p><u>Paediatric Outpatient Specialties</u></p> <ul style="list-style-type: none"> There were no Paediatric specialties with patients waiting more than 78 weeks, and the position was predicted to continue to the end of December 2022. All Paediatric specialties were predicting to have no patients waiting over 52 weeks by the end of March 2023. <p><u>Inpatients/Daycases</u></p> <ul style="list-style-type: none"> At the end of September 22 GG&C reported 1,769 patients waiting more than 104 weeks. This was a reduction to the previous prediction of 1,899 patients. <p><u>Progress since Sept 22</u></p> <ul style="list-style-type: none"> On target to achieve 80% of appropriate services using Patient Focussed Booking by the end of 2022. 		

			ACTION BY
	<ul style="list-style-type: none"> • Innovative work by Health Records to develop robust Trakcare processes for Patient Initiated Follow Up. Testing due to begin in November/December 2022. • Continued use of Waiting List Initiatives; insourcing agreed for Gynaecology which was at the tender evaluation stage. • Levels of 100+ elective TTG admissions/week were being maintained. • Surgical Hubs at GGH, IRH and SACH supported increased Orthopaedic activity. • Cross Sector lists for longest waiting patients commenced in October 22 in General Surgery. • Potential for Forth Valley National Treatment Centre allocation to begin to become available before April 2023. <p>The Committee received assurance that there would be a continued focus on clinical prioritisation, maximising capacity and making use of external capacity.</p> <p>Ms McFadyen provided an update on the delivery risks for Winter 2022. This included;</p> <ul style="list-style-type: none"> • Holding the current elective position would be challenging. • There was an expectation that elective activity at main inpatient sites would be reduced for an extended period to support the unscheduled care demand. Wherever possible elective activity would be streamed to the non-receiving sites. • Staffing support for unscheduled care would be required. <p>The next steps included;</p> <ul style="list-style-type: none"> • Maintain current capacity for outpatients throughout the winter period. • Plan for reductions in elective inpatient activity over the peak winter period and maximise use of non-receiving sites for day case/short stay surgery. • Focused clinical and managerial review to balance requirements. • Plan for potential NTC capacity in early 2023. <p>In response to a question regarding whether there was risk involved in contacting patients, the Committee received assurance that there was a validation route and contact with patient would depend on the condition. For example, DNA patients with a Cancer profile would trigger information back to the GP. The Committee noted that the process was being refined further.</p>		

			ACTION BY
	<p>The Committee were content to note the update and were assured by the information provided.</p> <p><u>NOTED</u></p>		
76.	A&E ATTENDANCE RESEARCH		
	<p>Ms Sandra Bustillo, Director of Communications and Public Engagement provided a presentation on 'A&E Attendance Research'.</p> <p>An Evaluation of the Emergency Department usage in Greater Glasgow and Clyde was carried out by capturing users views by text messaging people who recently visited an Emergency Department. There were 1125 responses to the survey.</p> <p>Ms Bustillo highlighted the main reasons for patients attending the Emergency Department included injury (45%), illness (11%), long term health condition (8%), had a recent fall (16%), asked by A&E at an earlier visit and for other reasons (35%).</p> <p>The survey also highlighted variation in attendance reasons across areas of deprivation, sex and age.</p> <p>The Committee noted the next steps which included identifying targeted areas of action to improve patient experience and awareness of A&E alternatives. A previous survey was carried out in 2019 and the results of this would be compared against the 2022 survey. This would be brought back to a future ASC.</p> <p>In response to a question regarding whether any of the trends in the survey had not been seen before, the Committee noted that a large proportion of the trends were expected, however, not accessing GP's prior to attending A&E was unexpected.</p> <p>In regards to the SIMD being broadly similar, the Committee noted that age was a factor, however, further work would take place to establish what area patients came from and different methods of engagement would be considered further.</p> <p>A detailed piece of work was being taken forward with the Inequalities and Human Rights Team to ensure that responses to future surveys were representative of the total population.</p> <p>The Committee were content to note the update and noted the valuable information from the survey.</p>		Ms Bustillo

			ACTION BY
	<u>NOTED</u>		
77.	PATIENT EXPERIENCE REPORT		
	<p>Professor Angela Wallace, Executive Nurse Director, presented the paper ‘Patient Experience Report’ [Paper 22/29] for Quarter 2: 1st July 2022 to 30th September 2022.</p> <p>The paper provided an overview of feedback and complaints mechanisms, the resultant performance and the actions and improvements based on these.</p> <p>Prof Wallace reported that 90% of all Stage 1 complaints received a response within 5 working days and 63% of Stage 2 complaints received a response within 20 working days. The Committee noted that clinical treatment, attitude and behaviour/communication and waiting times were all common themes. The Committee received assurance that future iterations of the report would focus on improvement actions, include comparative data from previous years and benchmarking across Health Boards within Acute Services in relation to these themes.</p> <p>The Committee were assured that discussions were taking place to ensure that reporting was appropriate and duplication across the Standing Committees would be avoided.</p> <p>The Committee were content to note the update provided.</p> <u>NOTED</u>	<p>Prof Wallace</p> <p>Ms Vanhegan</p>	
78.	EXTRACT FROM CORPORATE RISK REGISTER		
	<p>Mr Andrew Gibson, Chief Risk Officer, presented the Extract from the Corporate Risk Register [Paper 22/30] for the Committee to consider and confirm that they were content that the risks were clearly described and that the risk scores were appropriate.</p> <p>The Committee noted that following discussion at the last meeting, the risk scores had been reviewed and the existing Scheduled Care waiting times risk was separated into two distinct risks. The Risk scores had been reviewed and remained static for this reporting period.</p> <p>The Committee were content to approve the Corporate Risk Register</p> APPROVED		

			ACTION BY
79.	CLOSING REMARKS AND KEY MESSAGES FOR THE BOARD		
	<p>Dr Ryan asked members to raise any other competent business. There was no other business noted.</p> <p>The key messages for the Board were:</p> <ul style="list-style-type: none"> • The Acute Services Committee recognised the ongoing pressures in relation to staffing and delayed discharges. • The Committee received the Acute Services Performance Report and noted the performance against the 17 key performance indicators. • The Committee received the Month 6 Finance Report which set out the Acute revenue position and the position with the Financial Improvement Programme (FIP). The Committee noted the Acute Division reported an overspend of [REDACTED] as at 30th September 2022. • The Committee received presentations providing an update on the Planned Care Update and noted the challenges ahead. • The Committee received a presentation on A&E Attendance Research and noted the valuable information provided. • The Committee received the Quarter 2 Patient Experience Report and noted that the format of the report was under review. • The Committee were content to approve the Corporate Risk Register for Acute Services. <p>Mr Ryan thanked members for attending and closed the meeting.</p> <p><u>NOTED</u></p>		
80.	DATE AND TIME OF NEXT SCHEDULED MEETING		
	The next meeting would take place on Tuesday 17 January 2023 at 9.30 am via Microsoft Teams.		

ASC (M) 23/01
 Minutes: 01 – 15

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
 Acute Services Committee
 Held on Tuesday 17 January 2023 at 9.30 am
 via Microsoft Teams**

PRESENT

Mr Ian Ritchie (in the Chair)

Professor John Brown CBE	Mr Colin Neil
Ms Susan Brimelow.	Dr Lesley Rousselet
Councillor Chris Cunningham	Dr Paul Ryan
Ms Jane Grant	Professor Angela Wallace
Councillor Colette McDiarmid	

IN ATTENDANCE

Ms Sandra Bustillo	..	Director of Communications and Public Engagement
Ms Jacqueline Carrigan	..	Assistant Director of Finance Acute/Access
Dr Scott Davidson	..	Deputy Medical Director, Acute
Mr William Edwards	..	Chief Operating Officer
Ms Morag Gardner	..	Deputy Nurse Director, Acute Division
Mr Andrew Gibson	..	Chief Risk Officer
Ms Susan Groom	..	Director of Regional Services
Ms Susan McFadyen	..	Director of Access
Ms Kim Donald	..	Corporate Services Manager – Governance/Board Secretary
Ms Pamela Metcalfe	..	Secretariat Officer (Observer)
Mrs Louise Russell	..	Interim Secretariat Manager (Minutes)

			ACTION BY
01.	WELCOME AND APOLOGIES		
	Mr Ritchie welcomed those present to the meeting.		
	Apologies were noted on behalf of Mr Simon Carr, Mrs Anne MacPherson and Mr Tom Steele.		
	<u>NOTED</u>		

			ACTION BY
02.	DECLARATIONS(S) OF INTEREST(S)		
	Mr Ritchie invited members to declare any interests in any of the items being discussed. No declarations of interest were made. <u>NOTED</u>		
03.	MINUTES OF PREVIOUS MEETING: 15 NOVEMBER 2022		
	The Committee considered the minute of the meeting held on Tuesday 15 November 2022 [Paper No. ASC(M)22/06] and were content to approve the minute. The Committee noted the following points; <ul style="list-style-type: none"> • Page 4: The Committee received assurance that plans were in place for additional winter capacity and there was active recruitment in nursing services. • Page 4: Dialogue with the Scottish Government continued in relation to AWI patients. • Inverclyde Healthcare Improvement Scotland (HIS) report was due to be published at the end of January 2023. <u>APPROVED</u>		
04.	MATTERS ARISING		
a)	Rolling Action List		
	The Committee considered the Rolling Action List [Paper No.23/01]. The Committee were content to approve the recommended closure of 3 items on the Rolling Action List. <u>APPROVED</u>		
05.	URGENT ITEMS OF BUSINESS		
	There were no urgent items of business to discuss. <u>NOTED</u>		

			ACTION BY
06.	ACUTE UPDATE		
	<p>Mr William Edwards, Chief Operating Officer, provided an update on the current position in respect of COVID-19 and the current pressure within Acute Services. Mr Edwards reported that significant pressures across the system were ongoing and occupancy rates remained high.</p> <p>As at 16th January 2023, there were a total of 338 COVID-19 positive inpatients. The Committee received assurance that the number of COVID-19 positive inpatients and Influenza inpatients were reducing.</p> <p>The Committee noted that a number of actions from the Winter Plan had been implemented, including reduction in elective activity and an increase from 5 day to 7 day wards. A continuous flow model had been introduced and would continue to be rolled out at the Royal Alexandra Hospital (RAH) and Glasgow Royal Infirmary (GRI). The Committee noted that day surgery at all sites continued to be carried out and monitored.</p> <p>In response to a question regarding opening of additional beds, the Committee noted that additional capacity had been created at Ward 5C at Gartnavel General Hospital and the Brownlee Centre. The Committee noted that staffing remained challenging, however, plans were in place to utilise staff skill mix across the Board. The Committee receive assurance that monitoring remained in place and staff wellbeing checks remained ongoing.</p> <p>Prof Wallace highlighted that staffing remained a challenge, however, they had recently recruited 53 HCSW and have a target of recruiting 167 international nurses.</p> <p>The Committee discussed Home for Lunch and noted that an area of focus was the collection of data in relation to patient transport, which was monitored on a weekly basis. The Committee received assurance that any risk was safely shared across the organisation and regular meetings with staff take place to share data.</p> <p>The Committee noted the update and were assured by the information provided.</p> <p><u>NOTED</u></p>		
07.	PERFORMANCE		
	a) Acute Integrated Performance Report		

			ACTION BY
	Mr Colin Neil, Director of Finance, presented the Acute Services Integrated Performance Report [Paper 23/02] which provided a summary of performance against the Key Performance Indicators (KPIs) outlined in the Performance Assurance Framework.		
	<p>The Committee noted the following;</p> <ul style="list-style-type: none"> • As at November 2022, there continued to be no new outpatients waiting over 104 weeks for an appointment. The number of new Outpatients waiting over 18 months was within the planned position for December 2022. • Performance in relation to Treatment Time Guarantees (TTG's) and Scopes were positive. • Performance in relation to the A&E 4 hour target remained a significant challenge. • Performance in relation to the Cancer 62 day waiting time standard remained challenging. <p>The Committee noted the update provided.</p> <p>NOTED</p>		
09.	PROGRESS ON PLANNED CARE UPDATE		
	<p>Ms Susan McFadyen, Director of Access, attended the meeting to provide a presentation on 'Progress on Planned Care Update'.</p> <p>Ms McFadyen provided an update on the progress made against the targets and the next steps, which included;</p> <ul style="list-style-type: none"> • Maintain current capacity for outpatients throughout the winter period. • Plan for reductions in elective inpatient activity over the peak winter period. • Plan for potential National Treatment Centre (NTC) capacity in early 2023. <p>The Committee acknowledged the challenges in maintaining current capacity and noted that there was a focus on streamlining activity. The Committee also noted that weekly meetings were held around planned care funding and capacity which included additional capacity at the Golden Jubilee. Ms McFadyen highlighted that this was being co-ordinated by the Scottish Government as the additional capacity at the GJNH incorporated all Health Boards.</p>		

			ACTION BY
	<p>It was recognised that Gynaecology had the biggest growth in waiting list numbers since the pandemic and this was largely due to the requirement for a physical examination prior to diagnosis/treatment. The Committee noted that in-sourcing had been arranged for Endoscopy and that this was working well in bringing down the waiting list.</p> <p>In response to a question regarding management of appointment attendance, the Committee noted that use of the patient focus booking system which assisted with the validation of the waiting lists. Ms McFadyen also highlighted that patient packs were being issued to patients waiting on an appointment which offered more information.</p> <p>The Committee discussed the challenges in relation to Urology. It was noted that performance was a challenge nationally. The Committee were assured that the Robotics action plan would assist to reduce the current backlog and a group had been set up to consider the Diagnostics Pathway further in order to create capacity.</p> <p>The Committee were content to note the update and were assured by the information provided.</p> <p><u>NOTED</u></p>		
10.	CANCER PERFORMANCE UPDATE		
	<p>Ms Susan Groom, Director of Regional Services provided a presentation on 'Cancer Performance Update'.</p> <p>Ms Groom provided an overview of the current position in relation to cancer performance for Quarter 2 including the position in relation to the 31 day target and the 62 day target. The Committee noted that achieving the 62 day target remained challenging. The Committee received assurance on the improvement actions being taken against the challenging cancer types.</p> <p>The Committee noted that Urology seemed to be a challenging area. Ms Groom advised that they had appointed a Locum Consultant Urologist for 12 months and this will have a positive impact on the 31 day target.</p> <p>Ms Groom noted that there had been a notable increase in Urgent Suspicion of Cancer (USOC) referrals since the pandemic, however, there had not been a corresponding increase in the number of cancers diagnosed. Ms Groom noted that to mitigate the increase there is work ongoing to introduce referral templates through the GP lead and CfSD.</p>		

			ACTION BY
	<p>Ms Groom highlighted that the team continue to focus on the long waiters meaning it will take time for the performance to increase as it is based on patients treated in the month.</p> <p>In response to a query regarding NHSGGC resource being used within NHS Tayside, Ms Groom confirmed that the role was an Oncology post and that this would not have an impact on the current diagnostic waiting lists.</p> <p>The next steps included;</p> <ul style="list-style-type: none">Continued focus on the reduction in long waiting patients.Revise demand and capacity modelling, with key focus on Urology.Ensure cancer slippage funding continued to be targeted towards areas of improved performance. <p>The Committee noted the update provided.</p> <p><u>NOTED</u></p>		
11.	FINANCIAL MONITORING REPORT		
	<p>Mr Neil presented the Financial Monitoring Report for Month 8 [Paper 23/03] which set out the Acute revenue position and the position with the Financial Improvement Programme (FIP).</p> <p>As at the 30th November 2022, the Acute Division reported a deficit of [REDACTED]. Funding of [REDACTED] had been allocated against the Acute COVID-19 expenditure, which would be funded in full. The unachieved savings for month 8 amounted to [REDACTED]. Mr Neil reported that Pays were [REDACTED] over budget, with Medical Pays being the main driver at [REDACTED]. This included Senior Medical lines at [REDACTED] spend and Junior medical spend at [REDACTED]. The Committee noted that agency and locums continued to be a key element of expenditure. Nursing salaries reported a breakeven position for Month 8.</p> <p>The Non-Pay lines were reporting an overspend of [REDACTED]. This included spend related to drugs due to short supply.</p> <p>The Committee noted that the [REDACTED] savings had been achieved against the Year to Date Target of [REDACTED]. The Committee received assurance that further schemes had been identified.</p>		

			ACTION BY
	<p>The Committee noted that planning for 2023/24 would be completed at the end of the month.</p> <p>The Committee noted the following;</p> <ul style="list-style-type: none"> • A review of Clinical Fellows would be carried out. • Discussion was ongoing with SG regarding new medicines funds. • Non recurring funding had been identified for additional beds and was included in the financial position. • Calculations in regards to the pay settlement were being carried out and final figures would be submitted to the Scottish Government. • There would be an increased focus on Bank and Agency staff, including Junior Medical staff in order to improve process in this area of spend. • A forecast of the overall position at year end would be encapsulated in future reports. <p>The Committee were content to note the update provided.</p> <p><u>NOTED</u></p>		Mr Neil
12.	EXTRACT FROM CORPORATE RISK REGISTER		
	<p>Mr Andrew Gibson, Chief Risk Officer, presented the Extract from the Corporate Risk Register [Paper 23/04] for the Committee to consider and confirm that they were content that the risks were clearly described and that the risk scores were appropriate.</p> <p>The Committee noted that no changes to the risk scores were proposed. Mr Gibson highlighted that the Corporate Risk Register had been updated to reflect the risk management process outlined in the new Risk Management Strategy approved by the Board.</p> <p>The Committee were content to approve the Corporate Risk Register</p> <p><u>APPROVED</u></p>		
13.	ANNUAL CYCLE OF BUSINESS		
	<p>The Committee noted the Annual Cycle of Business [Paper 23/05] provided for assurance and information regarding future topics of discussion.</p>		

			ACTION BY
	<p>The Committee considered the Annual Cycle of Business and agreed that Theatre Efficiency would be a future topic of discussion.</p> <p>Ms Donald highlighted that all Standing Committees were reviewing their ACOB in advance of the Governance Evaluation scheduled to take place in June 2023. Ms Donald assured members that the document was dynamic and would reflect the priorities and any urgent items that come up through the year.</p> <p>The Committee were asked to submit future topics to the Chair or Ms Donald for consideration.</p> <p>The Committee were content to approve the current Annual Cycle of Business.</p> <p><u>APPROVED</u></p>		<p>Secretariat</p> <p>All</p>
14.	CLOSING REMARKS AND KEY MESSAGES FOR THE BOARD		
	<p>Mr Ritchie asked members to raise any other competent business. There was no other business noted.</p> <p>The key messages for the Board were:</p> <ul style="list-style-type: none"> • The Acute Services Committee recognised the ongoing pressures in relation to staffing and delayed discharges and the immense work being carried out. • The Committee received the Acute Services Performance Report and noted the performance against the Key Performance Indicators (KPI's). • The Committee received the Month 8 Finance Report which set out the Acute revenue position and the position with the Financial Improvement Programme (FIP). The Committee noted the Acute Division reported an overspend of [REDACTED] as at 30th November 2022. • The Committee received presentations providing an update on the Progress on Planned Care and a Cancer Performance Update and noted the next steps being taken. • The Committee noted the Annual Cycle of Business. 		

			ACTION BY
	<ul style="list-style-type: none"> The Committee were content to approve the Corporate Risk Register for Acute Services. <p>Mr Ritchie thanked members for attending and closed the meeting.</p> <p><u>NOTED</u></p>		
15.	DATE AND TIME OF NEXT SCHEDULED MEETING		
	The next meeting would take place on Tuesday 21 March 2023 at 9.30 am via Microsoft Teams.		

ASC (M) 23/02
Minutes: 15-27

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Acute Services Committee Held on Tuesday 21 March 2023 at 9.30 am via Microsoft Teams

PRESENT

Mr Ian Ritchie (in the Chair)

Mr Simon Carr	Councillor Chris Cunningham
Mrs Jane Grant	Mr Colin Neil
Dr Lesley Rousselet	Dr Paul Ryan

IN ATTENDANCE

Ms Lesley Aird	..	Assistant Director of Finance
Ms Sandra Bustillo	..	Director of Communications and Public Engagement
Ms Jacqueline Carrigan	..	Assistant Director of Finance Acute/Access
Mr Daniel Connelly	..	Deputy Director of Public Engagement
Ms Emilia Crighton	..	Deputy Director of Public Health Health Services
Dr Scott Davidson	..	Deputy Medical Director, Acute
Mr William Edwards	..	Chief Operating Officer
Ms Morag Gardner	..	Deputy Nurse Director, Acute Division
Mr Andrew Gibson	..	Chief Risk Officer
Ms Susan Groom	..	Director of Regional Services
Ms Sara Khalil	..	Secretariat (Minutes)
Ms Anne MacPherson	..	Director of Human Resources and Organisational Development
Prof Tom Steele	..	Director of Estates and Facilities
Ms Elaine Vanhegan	..	Director of Corporate Services and Governance

			ACTION BY
15.	WELCOME AND APOLOGIES		
	Mr Ritchie welcomed those present to the Acute Services Committee meeting and noted Ms Susan Groom's first meeting as a new member of the Committee.		

			ACTION BY
	Apologies were noted on behalf of Prof Angela Wallace, Ms Susan McFadyen, Ms Nareen Owens, Cllr Colette McDiarmid, and Dr Jennifer Armstrong. <u>NOTED</u>		
16.	DECLARATIONS(S) OF INTEREST(S)		
	Mr Ritchie invited members to declare any interests. No declarations of interest were made. <u>NOTED</u>		
17.	MINUTES OF PREVIOUS MEETING: 17 January 2023		
	The Committee considered the minute of the meeting held on Tuesday, 17 January 2023 [Paper No. ASC(M)23/01] and approved these as an accurate record. <u>APPROVED</u>		
18.	MATTERS ARISING		
a)	Rolling Action List		
	The Committee considered the Rolling Action List [Paper No.23/06] and were content to approve. <u>APPROVED</u>		
19.	URGENT ITEMS OF BUSINESS		
	There were no urgent items of business to discuss. <u>NOTED</u>		
20.	ACUTE UPDATE		
	Mr William Edwards, Chief Operating Officer, provided an update on Acute services.		

			ACTION BY
	<p>Mr Edwards stated that since the last meeting on 17 January 2023, the focus had been on maximising outpatient and inpatient day case capacity. It was noted from April to January 2023, the numbers were above trajectory and it was hoped that this would exceed further.</p> <p>Performance continued to exceed each of the Acute remobilisation activity targets in relation to New Outpatients, Treatment Time Guarantees (TTGs) and Scopes.</p> <p>Mr Edwards noted since 20 March 2023, there was a total of 436 COVID-19 positive inpatients. This resulted in 13 Ward closures predominantly in the North Sector. Mr Edwards reported significant pressures across the sites and occupancy rates remained high.. Mr Edwards noted additional beds had been opened to support patient flow, but challenges existed with high occupancy rates.</p> <p>Mr Edwards noted the Continuous Flow Model continued to be rolled out across the QEUH, GRI and RAH and more recently the Inverclyde Royal Hospital. It was noted that the model was designed to reduce potential risks to patients which could arise from excessive lengths of stay in Emergency Departments (EDs) and Assessment Units. The model supported teams across Acute services to deliver safe and effective patient flow within hospital sites, alleviating pressures faced by the EDs which allowed the focus to be on moving patients through the appropriate treatment pathways as swiftly and as safely as possible.</p> <p>In response to the question of why there was a higher prevalence of ward closures in GRI. Mr Edwards confirmed that it was indeed due to the Nightingale Wards' setup, and noted that shared rooms were more predisposed to the spread of infection.</p> <p>The Committee noted the update and were assured by the information provided.</p> <p><u>NOTED</u></p>		
21.	PERFORMANCE		
	a) Acute Services Integrated Performance Report		
	Mr Colin Neil, Director of Finance, presented the Acute Services Integrated Performance Report [Paper 23/07] which provided a		

			ACTION BY
	<p>summary of performance against the Key Performance Indicators (KPIs) outlined in the Performance Assurance Framework.</p> <p>Mr Neil advised there continued to be no new outpatients waiting >104 weeks for a new outpatient appointment as of January 2023. Performance in relation to the number of new outpatients waiting >78 weeks and the number of TTGs patients waiting >104 weeks and >78 weeks remained on track to deliver against the revised reduced trajectories for March 2023.</p> <p>Mr Neil reported Accident & Emergency (A&E) 4-hour waits had improved significantly compared to the previous month. However, performance remained a challenge during January 2023 due to the pressures of winter. Performance in relation to the Cancer 62-Day Waiting Times continued to remain a challenge. Performance concerning the Cancer 31-Day Waiting Times had moved from Amber to Red within the reporting period. However, the trajectory was forecast to revert to Amber by March 2023.</p> <p>Mr Neil noted whilst there was an improvement in the overall sickness absence levels across all Sectors/Directorates within Acute services when compared to the previous month, performance remained above the local target.</p> <p>Mr Edwards noted a total of 56,093 Urgent with a suspicion of cancer patient referrals were received during the period April - January 2023, 14% higher than the 49,215 referrals reported in the same period the previous year. Overall pre-pandemic, there had been a 47% increase in referrals and there was work ongoing to cope with the demand.</p> <p>Mr Edwards mentioned that the latest provisional position for cancer treatment 31-day performance was 89.5% for January 2023, below the local target by 5.5%. A Mobile Endoscopy Unit continued to provide additional capacity on NHSGGC sites, with up to 1,000 scopes in each quarter.</p> <p>In response to the question raised on what was the actuality behind the improvement of patient flow, and if this would continue. Mr Edwards replied that the additional beds helped support the flow but the funding usually ended at the end of March for Winter beds and this would pose a threat. In addition, the Continuous Flow Model had helped since going live at all sites.</p> <p>Dr Davidson noted the Flow Navigation Centre (FNC) was continuing to develop and agreed that is it a multifactorial effort to maintain this</p>		

			ACTION BY
	improvement, and noted the initiatives were in place not just for the winter period and this would help long-term improvements. Dr Davidson mentioned that the FNC currently undertook 80-90% video consultations which resulted in 40-43% of cases being closed. Four hundred patients had been seen virtually.		
	In response to the question on the Locum Consultant in Urology leaving in April 2023 and how quickly this gap would be filled. Ms Groom clarified a substantive post would be occupied, as the interviews were taking place in March 2023, and a Locum Consultant was being recruited to fill the gap between the locum leaving and the new start.		
	In response to the question raised on the mean Length of Stay, in particular, the Day of Care (DOC) Audit's learnings achieved and outcomes. Ms Gardner responded that the process already existed through the Scottish Government under Unscheduled Care. Hospitals had routinely participated in DOC Audits routinely for the last 10-15 years, the difference now noted was an approach with an Acute team and a Community team supporting the Audit, meaning it was dual-reviewed. Ms Gardner noted that the e-Health team digitalised all the data and this provided ease for the audit. The data reviewed bed occupancy and supported teams to drive patient discharges. This audit, which was in line with the request from the Scottish Government to reduce delayed discharge patients, resulted in an increased number of discharges from Acute services across the non-delayed patient community and a reduction in patient length of stay.		
	Mrs Grant assured the committee this audit was essential and highlighted that the systems were in place were working efficiently.		
	The Committee noted the update provided.		
	<u>NOTED</u>		
22.	IRH UNANNOUNCED HIS INSPECTION UPDATE		
	Ms Gardner, Deputy Nurse Director, provided an update on the IRH Unannounced Healthcare Improvement Scotland (HIS) Inspection Update.		
	Ms Gardner reported that an unannounced Acute hospital 'safe delivery of care inspection' at Inverclyde Royal Hospital had been carried out by HIS on the 17, 18 and 24 October 2022.		

			ACTION BY
	<p>Ms Gardner noted the following key points; Areas of Good Practice were identified and requirements taken forward, the Improvement Action Plan was sent to HIS on 13 January and documents were published on the HIS website and the ongoing and remaining actions were being progressed through the Improvement Action Plan.</p> <p>Ms Gardner updated members that the focus remained to complete all outstanding actions on target. Externally, there would be an eight-week follow-up from HIS on the status of the improvement plan and actions. Internally, the Clyde Sector Management Team had ensured outstanding actions were being progressed against timelines agreed, and Ms Gardner would provide an update to appropriate governance committees at Board level.</p> <p>In response to the question on why some wards were locked, and if these were psychiatric wards. Ms Garner replied that the locked wards were for older people and locked largely due to habit the three wards locks were removed as it was not clinically indicated.</p> <p>Ms Bustillo advised HIS had asked for public involvement with the Public Action Plan and that the PEPI team would help develop this.</p> <p>The Committee were content to note the update</p> <p>NOTED</p>		
23.	A&E Attendance Research		
	<p>Ms Sandra Bustillo, Director of Communications and Public Engagement provided a presentation on ‘A&E Attendance Research’.</p> <p>The presentation provided an overview of the findings from the NHSGGC ED evaluation project undertaken by the Patient Experience Public Involvement Team to better understand patient awareness of care pathways used by patients to access A&E services across NHSGGC. The report was based on the 1,112 responses received by NHSGGC via both text message and email survey.</p> <p>Ms Bustillo highlighted the main reasons for patients attending the ED included Injury (33.6%) and Illness (31.2%) being the most common reasons for attending, with Cardiovascular concerns and bleeding being the most common ‘other’ (15.9%) reasons shared. The survey also highlighted variations in attendance reasons across areas of deprivation, sex and age.</p>		

			ACTION BY
	<p>The Committee noted the next steps identifying targeted areas of action to improve patient experience and awareness of A&E alternatives.</p> <p>In response to the question of why some age brackets for patients looking online for advice were lower than expected, the committee were advised that several factors contributed to the lower numbers and the matter would be explored further.</p> <p>In response to the question on what the accessibility of digital resources was for those in older age brackets, and to determine why the figures were low if third-party organisations had been contacted. Ms Bustillo noted this was an important sector to work with.</p> <p>The Committee noted the update provided.</p> <p>NOTED</p>		
24.	FINANCIAL MONITORING REPORT		
	<p>Mr Neil presented the 'Financial Monitoring Report' for Month 10 [Paper 23/09] which set out the Acute revenue position and the position with the Financial Improvement Programme (FIP).</p> <p>As of 31 January 2023, the Acute Division reported a deficit of [REDACTED]. Funding of [REDACTED] had been allocated against the Acute COVID-19 expenditure, which would be funded in full. The unachieved savings for Month 10 totalled [REDACTED]. Mr Neil reported that Pays were [REDACTED] over budget, with Medical Pays being the main driver. Non-Pays were [REDACTED] over budget with drugs, surgical sundries, equipment, Interventional Radiology supplies and Interventional Neurology supplies and Out of Area beds being the main drivers.</p> <p>The Committee noted that the year-end forecast was anticipated to be [REDACTED], being pays and non-pays of [REDACTED] and Unachieved Savings of [REDACTED].</p> <p>In response to the review of the Clinical Fellowships that would have been carried out, it was noted that the review was in-depth and would be presented at a future meeting.</p> <p>The Committee were content to note the update.</p> <p>NOTED</p>		

			ACTION BY
25.	EXTRACT FROM THE CORPORATE RISK REGISTER		
	<p>Mr Andrew Gibson, Chief Risk Officer, presented the Extract from the Corporate Risk Register [Paper 23/10].</p> <p>The Committee noted two changes to the risk scores; the In-Patient/Day Case TTG - Scheduled Care Waiting Time Targets had decreased from 20 to 16, and The Outpatients - Scheduled Care Waiting Time Targets had decreased from 20 to 16, reducing overall risk</p> <p>The Committee were content to approve the Register.</p> <p><u>APPROVED</u></p>		
26.	Annual Report of Acute Services Committee 2023		
	<p>Chair, Ian Ritchie, presented an 'Annual Report of Acute Services Committee 2023' which provided an overview of the Committee proceedings during the 2022/23 period. The committee was content to approve the report.</p> <p><u>NOTED</u></p>		
27.	CLOSING REMARKS AND KEY MESSAGES FOR THE BOARD		
	<p>Mr Ritchie asked members to raise any other competent business. There was no other business noted.</p> <p>Mr Ritchie thanked members for attending and closed the meeting.</p> <p><u>NOTED</u></p>		
28.	DATE AND TIME OF NEXT SCHEDULED MEETING		
	The next meeting would take place on Tuesday, 16 May 2023 at 9.30 am via Microsoft Teams.		

ASC (M) 23/03
Minutes: 27 – 40

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Acute Services Committee Held on Tuesday 16 May 2023 at 9.30 am via Microsoft Teams

PRESENT

Mr Ian Ritchie (in the Chair)

Professor John Brown	Mr Simon Carr
Councillor Chris Cunningham	Mrs Jane Grant
Mr Graham Haddock	Councillor Colette McDiarmid
Mr Colin Neil	Dr Lesley Rousselet
Dr Paul Ryan	Professor Angela Wallace

IN ATTENDANCE

Ms Lesley Aird	..	Assistant Director of Finance
Ms Sandra Bustillo	..	Director of Communications and Public Engagement
Ms Jacqueline Carrigan	..	Assistant Director of Finance Acute/Access
Dr Scott Davidson	..	Deputy Medical Director, Acute
Ms Kim Donald	..	Corporate Services Manager, Governance
Ms Gillian Duncan	..	Secretariat (Minutes)
Mr William Edwards	..	Chief Operating Officer
Ms Morag Gardner	..	Deputy Nurse Director, Acute Division
Mr Andrew Gibson	..	Chief Risk Officer
Ms Susan Groom	..	Director of Regional Services
Dr Claire Harrow	..	Chief of Medicine, Clyde Sector (for Item 9)
Ms Anne MacPherson	..	Director of Human Resources and Organisational Development
Ms Melanie McColgan	..	Director, Clyde Sector
Ms Susan McFadyen	..	Director of Access
Mr Arwel Williams	..	Director, South Sector

		ACTION BY
27.	WELCOME AND APOLOGIES	
	<p>The Chair welcomed those attending to the May meeting of the Acute Services Committee.</p> <p>Apologies had been submitted on behalf of Dr Jennifer Armstrong and Professor Tom Steele.</p> <p>The Chair welcomed Mr Graham Haddock as a new member of the Committee. Mr Haddock had joined the NHS Board on 1 May 2023.</p> <p><u>NOTED</u></p>	
28.	DECLARATIONS(S) OF INTEREST(S)	
	<p>The Chair invited members to declare any interests in any of the matters being discussed. Mr Graham Haddock declared that he was Chair of the National Endoscopy Training Programme Board.</p> <p><u>NOTED</u></p>	
29.	MINUTES OF PREVIOUS MEETING: 21 MARCH 2023	
	<p>Members considered the minutes of the Acute Services Committee held on 21 March 2023 [ASC(M)23/02] and were content to approve the minute as a complete and accurate record.</p> <p>In response to a query from the minute, Mr Edwards reported that the winter beds remained open at a similar number to that reported previously due to high occupancy rates. Mr Neil also explained how funding for these beds was recorded.</p> <p><u>APPROVED</u></p>	
30.	MATTERS ARISING	
	<p>a) <u>Rolling Action List</u></p> <p>There were no actions noted on the Rolling Action List.</p>	

		ACTION BY
31.	URGENT ITEMS OF BUSINESS	
	<p>The Chair invited Members to raise any items of business that were not included on the agenda. There were no items of urgent business raised.</p> <p><u>NOTED</u></p>	
32.	ACUTE UPDATE	
	<p>The Chair invited Mr William Edwards, Chief Operating Officer, to provide a brief update on Acute Services.</p> <p>Mr Edwards reported that there were currently 148 COVID-19 positive inpatients and there was currently only one ward closed due to COVID-19. Mr Edwards advised that occupancy across hospitals was high and unscheduled care performance remained challenging. Mr Edwards advised that the actions to support flow, admission and discharge would form part of the presentations at today's meeting.</p> <p>In terms of planned care, Mr Edwards reported that the Board had delivered against the trajectories for the year just ended and active dialogue was underway with Scottish Government colleagues on setting future trajectories.</p> <p>In response to a query about bed occupancy, Mr Edwards advised that this referred to the total number of beds and included those being utilised for winter capacity.</p> <p>Mrs MacPherson, Director of Human Resources and Organisational Development, was asked to provide an update on potential strike action by Junior Doctors. She advised that this was being dealt with nationally but provided assurance that preparatory work was underway should this go ahead.</p> <p>The Committee were content to note the update.</p> <p><u>NOTED</u></p>	
33.	ACUTE SERVICES INTEGRATED PERFORMANCE REPORT	
	<p>The Chair invited Mr Colin Neil, Director of Finance, to present the Integrated Performance Report [Paper 23/12] which summarised performance against the Key Performance Indicators outlined in the Acute Performance Assurance Framework, based on the key</p>	

		ACTION BY
	<p>priorities for Acute Services outlined in the 2022-23 Annual Delivery Plan, the new planned care reduction targets and key national and local targets.</p> <p>Mr Neil reported that performance in relation to the number of new outpatients waiting >78 weeks and the number of TTG patients waiting >104 weeks and >78 weeks had delivered within the agreed trajectories for March 2023. He also reported that the position in respect of 31 day cancer waits was positive at 96.7% and that the performance on new outpatients, TTG and scopes had exceeded the year end remobilisation targets.</p> <p>Mr Neil reported that the A&E 4 hours waiting time target remained challenging and had been just under 70% in March. He said that 62 day cancer also remained challenging but the March position had noted some progression. Sickness absence had also seen an incremental improvement and had been 6.5% at the end of March.</p> <p>Mr Edwards advised that there was a number of actions underway in relation to the 62 day cancer target including additional scope and diagnostic capacity, but reported that the number of referrals per month had significantly increased when compared to previous years.</p> <p>In terms of targets going forward, Mrs Grant advised that the Annual Delivery Plan was due to be submitted to the Scottish Government in June following which the trajectories for this year could then be confirmed. She appreciated that the year had already started but said that this was a complex piece of work and the totality of the package needed to be agreed before the trajectories could be set.</p> <p>In response to a query about mutual aid to other Boards, Ms Groom advised that there were regular meetings between NHS Boards to discuss and review this. In terms of availability of external capacity for NHSGGC patients, there was a small amount of private sector capacity for neurosurgery currently contracted. There was also insourcing for some services and this was aligned with clinical services to ensure patients were being managed as effectively as possible.</p> <p>In response to a query about cancer services, Mr Edwards said that there were a number of action plans in place including increasing diagnostics and additionality. He also advised that external scrutiny had been requested from the cancer lead at the Scottish Government to validate action plans. Ms McFadyen said that theatre capacity had not yet returned to the pre-pandemic base level but there were active plans in place to progress this. There was also a deep dive being undertaken in January 2024 into theatre utilisation and capacity.</p>	

		ACTION BY
	<p>Ms Groom said that in terms of urology and colorectal cancer, colonoscopy availability had been a limiting factor but the recovery plan in place would see improvement soon and additional Radiofrequency Ablation sessions had also been added.</p> <p>Ms McFadyen said that many of the longer waits were in orthopaedics, noting that some patients were not suitable for the additional elective capacity because of comorbidities. Mr Williams noted that more capacity was required for general elective work that needed to be on the QEUH site, for example, supporting trauma.</p> <p>In response to a query about performance metrics related to children's services, Professor Brown advised that this would be taken forward as part of the Assurance Information Framework work that was underway.</p> <p>The Committee asked about the challenges of ensuring robust communication around redirections to manage the front door and noted that, while there were some really good initiatives underway, there were still challenges around delayed discharges. Professor Wallace said that she was working with Chief Officers and colleagues to ensure a systematic performance focus on delayed discharges but she acknowledged that this was not having the required impact and would need to be looked at differently.</p> <p>In response to a query about staffing challenges, Mrs MacPherson said that this was a complex area. She said that there were discussions about developing existing staff and creating different roles that would not require the same academic models making them attractive for people who had not seen university as their preferred route. She also provided assurance that NHSGGC had not lost staff as a result of Brexit and continued to receive applications from non UK nationals. She said that while international campaigns were now more complex these continued to be run and over 200 international nurses had been recruited in addition to the newly qualified nurses. She said that staff turnover was stabilising and retention levels were starting to improve. Recruitment was focusing not just on young people starting their career but also on over 50s and there were significant initiatives being run through staff governance in August.</p> <p>The Chair thanked Members for the discussion and said that the delayed discharge challenges should be escalated to the Finance, Planning and Performance Committee.</p> <p><u>NOTED</u></p>	

		ACTION BY
34.	CONTINUOUS FLOW MODEL UPDATE	
	<p>Mr Arwel Williams, Director, South Sector, presented on the Glasgow Continuous Flow Model (GlasFLOW). Mr Williams described the work that had commenced, the impacts and outcomes. Ms Melanie McColgan, Director, Clyde Sector, then provided an overview of the implementation of the model in Clyde.</p> <p>In response to a query, Mr Williams confirmed that there had been some variation between different wards and the team were reviewing the reasons behind this. Mr Williams also provided reassurance that while the nature of the work had changed this had not added to workload. Dr Davidson added that ultimately this was splitting demand across the day and as this matured there should be visible benefits. Dr Davidson also provided assurance that there had been a significant level of planning and clinical governance across the whole system to ensure patient safety.</p> <p>The Chair thanked the presenters for the helpful and informative presentation and the Committee were content to note the update.</p> <p><u>NOTED</u></p>	
35.	ALTERNATIVES TO EMERGENCY DEPARTMENT ATTENDANCE	
	<p>Dr Scott Davidson, Deputy Medical Director Acute, presented on Alternatives to ED Admission. He said that this had been a whole system approach based around the Redesign of Urgent Care programme and building on the GlasFLOW work which would lead to a better outcomes for both patients and staff in terms of wellbeing and resilience. Dr Davidson then invited Dr Claire Harrow, Chief of Medicine, Clyde Sector, to provide an overview on Outpatient Parenteral Antibiotic Therapy (OPAT).</p> <p>Dr Harrow said that internal communications were critical and there had been discussions around ensuring that everyone who was involved in front door receiving was aware of access to these services. She agreed that to maximise this awareness there should be thought given to creating some bespoke communications for specific staff groups and Ms Bustillo said that she would liaise with Dr Harrow and colleagues on identifying which staff groups might benefit from more bespoke communications and what this should look like. Ms Bustillo added that her team was working closely with Acute and HSCP colleagues to produce a comprehensive internal communications plan. She said that the Core Brief continued to report</p>	

		ACTION BY
	on the monthly Unscheduled Care core project meeting. Ms Bustillo said that she would also pick up the points that had been made in discussion about also having communication on the overall work as well as the individual pieces.	Ms Bustillo/ Dr Harrow
	In response to a query about the impact of NHS24 response levels on patient satisfaction, Ms Bustillo advised that the ED satisfaction rates in the presentation had pre-dated the period where the increase in NHS24 staffing came in and it was therefore not possible to correlate this. She said that the survey was currently being re-run which may show whether the improvement in response times had an effect although she stressed that the priority was satisfaction with NHSGGC services. Dr Davidson said that removing uncertainty for patients was helpful and the GPOOH and FNC offered appointments to patients.	Ms Bustillo
	The Committee thought it would be helpful if there was any data available on NHS24 call handling specific to NHSGGC and Mrs Grant said she would speak to the NHS24 Chief Executive to see what information might be available.	Mrs Grant
	The Chair thanked Dr Davidson and Dr Harrow for their comprehensive review of this work and the engagement activities that were underway.	
	The Committee were content to note the update.	
	NOTED	
36.	FINANCIAL MONITORING REPORT	
	The Chair invited Mr Colin Neil, Director of Finance, to present the Financial Monitoring Report [Paper 23/13] which outlined the month 12 financial position for Acute Services including the Sustainability and Value Programme (SVP).	
	Mr Neil reported that at 31 March 2023, Acute Services had reported a deficit of [REDACTED]. He advised that COVID-19 expenditure had been fully covered. Mr Neil reported that pay spend was over budget by [REDACTED] with medical pays being the main areas of concern and there would be a specific focus on junior medical pay in 2023/24. Mr Neil reported that non-pay was over budget by [REDACTED] with a range of areas contributing to this and there would be a significant focus on mitigating prescribing overspent and work on surgical instruments and review of contracts going forward. Mr Neil said that in terms of the SVP, there had been an overall target in Acute Services of [REDACTED] of which [REDACTED] had been achieved in year which was 64.7% of the overall target. The recurring	

		ACTION BY
	<p>position showed an achievement of [REDACTED] which was 26.9% of target. For 2023/23 the Board had set a savings target for [REDACTED] in Acute Services and all Directors and Sectors had been asked as a minimum to identify 50% of that recurrently by the end of the first quarter.</p> <p>The Chair asked when the work on rota caps in relation to junior medical staffing would start to show a financial impact. Ms Carrigan said that there had been meetings with each Sector and Directorate and the baseline for each Directorate had now been set which would provide the ability to monitor against that baseline with a specific focus on reducing bank and agency staff and she anticipated that a trajectory around this would be available by August. Dr Davidson said that work had been agreed to review the roles of Clinical Fellows. Mr Edwards added that now that rota caps had been agreed then bank and agency usage would be an area of focus with a view to reduce additionality where possible. Mr Neil said that the agency reduction should start to have an impact over the first two quarters of the year with the wider workforce plan including the work around Clinical Fellows taking longer to have an effect.</p> <p>In response to a query about the overspend in surgery, Mr Neil advised that surgical sundries were a high cost area with a number of contracts not having been reviewed over the COVID-19 period and there was now a focus on looking at standardisation and rationalisation of products particularly around the first two quarters of the year.</p> <p>In relation to the underspend on other pays, Mr Neil provided assurance that this had not meant that there had been a missed opportunity to appoint staff given the size of the organisation and turnover rates. He also provided assurance that work was ongoing to fill vacancies.</p> <p>In relation to a query about new medical students, Mrs MacPherson said that there would be detailed conversations with NHS Education for Scotland (NES) around the allocation of students and the budget following which there would be more clarity on the number of FY1s allocated to NHSGGC.</p> <p>In terms of nursing spend, Ms Gardner reported that work had been underway over the last 6 months supporting Senior Charge Nurses on budget and rota management and ensuring operational and professional management were utilising NHSGGC staff resources first. She advised that NHSGGC had responded to the Scottish Government's directive to reduce off framework agency staffing costs by agreeing a 40% reduction by the end of June 2023 rising to 100%</p>	

		ACTION BY
	<p>in October 2023. She said that the amount of requests had reduced and provided reassurance that across Acute Services there had not been any change seen in the metrics on safety and patient and staff experience had also remained static.</p> <p>Ms Gardner also reported that 230 international nurses were due to join NHSGGC and there had been 600 applications received through the through newly qualified nurses programme. In addition, NHSGGC was also continuing to pursue other options to recruit nursing staff, acknowledging that the Band 5 vacancy rate was currently 17% and that this would continue to be the highest focus. She said that Band 4 HCSW Assistant Practitioners were also being introduced and work was underway with three colleges across Glasgow to provide this qualification. Applicants would be appointed to a training post with the expectation that it would take them a year to complete training and receive a recognised qualification that would enable them to practice at higher level. Ms Gardner said that overall there were a number of different and innovative pieces of work underway to create stability in the workforce while ensuring financial efficiency.</p> <p>The Committee were content to note the update.</p> <p><u>NOTED</u></p>	
37.	TERMS OF REFERENCE REVIEW	
	<p>The Chair invited Ms Kim Donald, Corporate Services Manager – Governance, to introduce the Terms of Reference [Paper 23/14].</p> <p>Ms Donald advised that these would form part of the governance pack that would be considered by the NHS Board at its June meeting. Ms Donald reported that all Committee Terms of Reference now included reference to the Assurance Information Framework and this was the only recommendation for change.</p> <p>The Committee were content to approve the Terms of Reference.</p> <p><u>APPROVED</u></p>	
38.	EXTRACT FROM CORPORATE RISK REGISTER	
	<p>The Chair invited Mr Andrew Gibson, Chief Risk Officer, to introduce the Extract from the Corporate Risk Register [Paper 23/15].</p> <p>Mr Gibson reported that the risks had undergone the normal review process by the risk owners and there had been no changes proposed</p>	

			ACTION BY
	<p>to the three risks that were on the Corporate Risk Register for this Committee.</p> <p>The Committee were content to approve the Corporate Risk Register.</p> <p><u>APPROVED</u></p>		
39.	CLOSING REMARKS AND KEY MESSAGES FOR THE BOARD		
	<p>The Chair said it had been an informative meeting and it had been much appreciated that today's presentations had been circulated in advance. There were no further items of business and the Chair thanked Members for attending and closed the meeting.</p> <p><u>NOTED</u></p>		
40.	DATE AND TIME OF NEXT SCHEDULED MEETING		
	The next meeting would be held on Tuesday 18 July 2023 at 9.30 am via Microsoft Teams.		

ASC(M)23/05
 Minutes 54 - 67

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Acute Services Committee held on Tuesday 19 September 2023 at 9.30am via Microsoft Teams

PRESENT

Mr Ian Ritchie (in the Chair)

Mr John Brown	Ms Colette McDiarmid
Mrs Jane Grant	Mr Graham Haddock OBE
Dr Becky Metcalfe	Mr Colin Neil
Dr Paul Ryan	Dr Lesley Rousselet

IN ATTENDANCE

Ms Sandra Bustillo	Director of Communications and Public Engagement
Ms Jacqueline Carrigan	Assistant Director of Finance Acute/Access
Dr Ron Cook	Associate Medical Director, NHS24
Dr Scott Davidson	Deputy Medical Director, Acute
Mrs Maria Doherty	Executive Director for Nursing and Care, NHS24
Ms Kim Donald	Corporate Services Manager, Governance
Mr William Edwards	Chief Operating Officer
Ms Morag Gardner	Deputy Nurse Director, Acute
Ms Susan Groom	Director of Regional Services
Ms Sara Khalil	Secretariat (Minutes)
Mrs Gail MacGregor	Head of Clinical Services, NHS24
Ms Natalie Smith	Depute Director of Human Resources
Ms Elaine Vanhegan	Director of Corporate Services and Governance
Mr Scott Wilson	Senior Business and Delivery Manager to CEO

		ACTION BY
54.	Welcome and Apologies	
	<p>The Chair welcomed those present to the September meeting of the Committee.</p> <p>Apologies were noted on behalf of Cllr Chris Cunningham, Susan McFadyen, Tom Steele, Angela Wallace, and Anne MacPherson</p> <p>NOTED</p>	

		ACTION BY
55.	Introductory Remarks	
	There were no introductory remarks noted by the Chair. <u>NOTED</u>	
56.	Declaration(s) of Interest(s)	
	The Chair invited members to declare any interests in any of the matters being discussed. There were no declarations of interest. <u>NOTED</u>	
57.	Minutes of Previous Meeting	
	The Committee considered the minute of the previous meeting, Tuesday, 18 July 2023 [Paper No. ASC(M)23/04], with one change to page 7, 'end of May position from 50.6M ' to '15.6M' and were content to approve the minute as a complete and accurate record. <u>APPROVED</u>	
58.	Matters Arising	
a)	Rolling Action List	
	The Committee considered the Rolling Action List [Paper No. 23/21]. The Committee were content to accept the recommendation that the two actions were closed. The Committee were content to approve the RAL. <u>APPROVED</u>	
59.	Urgent Items of Business	
	The Chair asked members if there were any urgent items of business. There were no items of urgent business raised. <u>NOTED</u>	
60.	Acute Update	

		ACTION BY
	<p>The Committee considered the presentation on the Acute services provided by Mr William Edwards, Chief Operating Officer.</p> <p>Mr Edwards noted that the primary focus had been on the Planned Care Programme. Additionally, there was a concerted effort to reduce outpatient wait times. Mr Edwards highlighted that the focus extended to unscheduled care, with the main areas of work involving enhancing flow performance, optimizing the flow model, implementing changes, and maximizing the usage of the Minor Injuries Unit.</p> <p>Mr Edwards outlined that high occupancy rates remained a persistent challenge, alongside the increase in the number of COVID-positive cases within the hospital.</p> <p>In response to the question regarding the number of patients with COVID in the wards and its impact on general or critical care wards, Mr Edwards explained that as soon as a patient tests positive, strict infection control measures are implemented to prevent further transmission and that we were not seeing admissions to critical care due to covid.</p> <p>The Committee were content to note the update.</p> <p><u>NOTED</u></p>	
61.	NHS 24 Update	
	<p>The Committee considered the 'NHS 24 Update' presentation presented by Mrs. Maria Docherty, Executive Director for Nursing and Care. Dr Ron Cook, Associate Medical Director and Mrs Gail MacGregor, Head of Clinical Services.</p> <p>The presentation on the Redesign of Urgent Care covered the key points as follows:</p> <ul style="list-style-type: none"> • How It Works • The Impact It Has Made • Key Takeaways • Available Opportunities <p>In response to the question about the patient's pathway, Mrs MacGregor explained that when a patient contacts NHS 24 they are initially screened to rule out immediate urgency requiring ambulance services. Following this, a nurse or clinician makes a decision regarding the appropriate pathway for the patient.</p>	

		ACTION BY
	<p>Regarding call rates and abandoned calls, Mr Cook mentioned that abandoned calls are monitored on a daily basis. The average call wait time is around six minutes. He also noted that approximately 90% of patient referrals are successfully handled during their first call.</p> <p>Mr Cook further explained that abandoned calls can sometimes be challenging to assess accurately because patients can listen to the screening information and decide to seek immediate help, which counts as an abandoned call out with their control.</p> <p>In response to the question whether children referred from NHS 24 had a similar ratio outcome (30/40/30) Mr Cook had shared that approximately 15-20% of patients who presented were children. Mrs Doherty reassured that paediatric care training is provided to the clinicians who handle NHS24 calls.</p> <p>In response to the question about outcomes and the 30% of patients directed to self-care measures, Mr Cook explained that most patients were willing to follow the advice provided over the phone, which often directed them to visit a pharmacy or seek guidance from NHS Inform. Regarding accessibility, he noted that the option for digital and remote consultations benefited patients who could use these platforms.</p> <p>In response to the question about improving performance, particularly achieving the goal of 50% of calls answered before 5 minutes, Mrs MacGregor clarified that some callers listened to the screening information and then pursued alternative options or contacted NHS 24 when trying to reach their GP after hours. There was a shared agreement to delve deeper into strategies for meeting the target of having 50% of calls answered within 5 minutes.</p> <p>The Committee were content to note the update.</p> <p><u>NOTED</u></p>	
62.	Acute Services Integrated Performance Report	
	<p>The Committee considered the Acute Services Integrated Performance Report [Paper 23/22] presented by Mr William Edwards, Chief Operating Officer, and Mr Colin Neil, Director of Finance.</p> <p>Mr Neil noted performance in terms of new outpatients, TTG, and scopes activity has consistently exceeded the planned targets for</p>	

		ACTION BY
	<p>the period spanning April to July 2023. Moreover, the number of TTG patients waiting for more than 78 weeks and 52 weeks remains in line with the planned position for July 2023.</p> <p>Mr Neil noted the number of new outpatients waiting for more than 78 weeks was above the planned position for July 2023. Mr Neil mentioned the overall compliance with the A&E four-hour wait target remained consistent at 73.5%, mirroring previous months' performance.</p> <p>Performance in terms of Cancer 31 Day waiting times experienced a slight decrease, dropping from 93.9% in June 2023 to 93.5% in July 2023. Similarly, performance regarding Cancer 62 Day Waiting Times also saw a decline from 62.0% in June 2023 to 61.2% in July 2023. Mr Edwards explained that certain actions were already in to ensure that outpatient appointments were being delivered within 14 days and that diagnostics were being delivered in a timely fashion. Where dates fell out of those being monitored escalations would be made.</p> <p>Mr Edwards did outline the overall rise in USOC referrals, which was around a 52% increase pre pandemic overall, with some cancer types noticing a 70% increase.</p> <p>Mr Edwards noted after implementing changes to the scheduling system, Radiology is revising its vetting process to fast-track all USOC patients more effectively. This change addressed breaches across multiple pathways.</p> <p>In response to the question regarding the increase in cancer diagnoses, given the 52-70% increase in referrals, and whether this suggests over-referral, Mr Davidson explained that imaging is essential to confirm a cancer diagnosis. While pathway redesign efforts have been made, clinicians may tend to over-refer to avoid the clinical risk of missing something important. Mr Edwards also outlined work underway to support primary care in referrals.</p> <p>The Committee were assured by the update.</p> <p><u>ASSURED</u></p>	
63.	Planned Care Update	
	<p>The Committee considered the Planned Care Update presented by Mr William Edwards, Chief Operating Officer and Mr Scott Davidson, Deputy Medical Director.</p>	

		ACTION BY
	<p>Mr Edwards noted as of August 31, 2023, there was a total of 5,849 outpatients in NHS Scotland waiting for over 78 weeks. Among these, 1,039 patients were waiting for more than 104 weeks, but none of them were from NHS Greater Glasgow and Clyde. Notably, nine Health Boards in Scotland had outpatients waiting for over 104 weeks.</p> <p>Mr Edwards had noted that NHS GGC Annual Delivery Plan (ADP) aimed to have zero outpatients waiting over 78 weeks by Q2 2023/2024. Various measures had been taken to address the situation, including maximizing consultant resources, recruiting locum support, using Optometry support effectively, and implementing waiting list initiatives.</p> <p>In Gynaecology and ENT, insourcing and WLIs helped work towards zero patients waiting >78 weeks. However, OMFS faced challenges due to subspecialisation in a single surgeon service, and solutions were explored for managing this patient cohort.</p> <p>Specialties facing challenges, including Gynaecology, ENT, and Orthopaedics, had been conducting Waiting List Initiative (WLI) clinics to meet their agreed projections for patients waiting over 52 weeks.</p> <p>Reduced delivery of the Orthopaedic Arthroplasty service was expected at the Golden Jubilee National Hospital (GJNH) due to theatre and workforce challenges. Plans were being developed to increase elective Orthopaedic capacity at NHSGGH, with orthopaedic programs at IRH and ambulatory sites were maintained throughout the winter.</p> <p>In response to the question of why religious circumcisions were still being offered by the NHS, despite not being clinically indicated, Mrs Grant advised that this was a directive from the Scottish Government.</p> <p>In response to the question about when the report regarding Transnasal Endoscopy would be brought to the meeting, Mr Davidson replied that it would be presented at the next meeting, as there were still papers in progress.</p> <p>The Committee were content to note the update.</p> <p>NOTED</p>	Mr Davidson
64.	Financial Monitoring Report	

		ACTION BY
	<p>The Committee considered the Financial Monitoring Report [Paper 23/19] presented by Mr Colin Neil, Director of Finance.</p> <p>Mr Neil confirmed the end of July position of [REDACTED] deficit, which included [REDACTED] YTD unachieved savings, [REDACTED] pay position and [REDACTED] non-pay. Mr Neil noted the allocation of [REDACTED] in non-recurring funding to cover 'Winter and Covid' expenses for the four months up to July 2023.</p> <p>Mr Neil noted an overspend in pays, with the main areas being:</p> <ul style="list-style-type: none"> • Medical Salaries exceeding the budget by [REDACTED]. • Nursing pays surpassing the budget by [REDACTED]. • Other pays, including AHPs, Healthcare Sciences, and Admin & Clerical, were under budget by [REDACTED]. <p>Mr Neil reported on the sustainability and value program, stating that the Acute Target was [REDACTED] for the full year. Savings achieved on a recurring basis were [REDACTED] (4.95% of the target). For the current year, they achieved [REDACTED] (6.4% of the target). The year-to-date target was [REDACTED], with an achieved amount of [REDACTED] (8.89% of the target), leaving an unachieved YTD position of [REDACTED].</p> <p>The Committee considered the 'Overview of Medical and Nursing Financial Controls' presented by Mr Scott Davidson, Deputy Medical Director and Morag Gardner, Deputy Nursing Director</p> <p>Mr Davidson outlined that challenges in Medical Salaries resulted in a current Senior Medical pressure of [REDACTED] over budget (1.3% over budget based on a year-to-date budget of [REDACTED]).</p> <p>The impact of these challenges included:</p> <ul style="list-style-type: none"> • The use of high-cost Agency Locums. • Additional EPA's. • Premium Adhoc sessions in Anaesthetics and ED. • Sickness cover. <p>Actions taken to address these challenges included:</p> <ul style="list-style-type: none"> • Ongoing recruitment for hard-to-fill posts. • Ceasing the use of Agency Locums as posts were filled or services were redesigned. • Continual review of Additional EPA's to ensure they were stopped when appropriate. • Ensuring job plans had no more than 12 sessions. • Stopping Adhoc sessions when appropriate after a service review. <p>Ms Gardner highlighted a nursing budget overspend of [REDACTED] in</p>	

		ACTION BY
	<p>July 2023, representing a 1.2% overage based on a [REDACTED] year-to-date budget. Agency staffing accounted for [REDACTED] (3.9%) of the year-to-date spend, and bank staffing amounted to [REDACTED] (10.9%). Efforts to address this challenge included eliminating Premium Rate Agency (PRA) with a 62.9% reduction in usage.</p> <p>Ms Gardner noted Deep Dives were conducted from September 2022 to April 2023, identifying common issues and implementing solutions. Additional measures encompassed roster masterclasses, finance workshops for managers, HR-tailored sessions, and recruitment workshops.</p> <p>Ms Gardner described recruitment initiatives involved hiring Newly Qualified Nurse/Midwife (NQNM) posts, and international nursing recruitment campaigns. Recent modelling suggested that these recruitment efforts, combined with anticipated leavers, would significantly reduce the vacancy gap for Band 5 nursing and midwifery roles in Acute.</p> <p>In response to the question about the [REDACTED] in non-recurring funding to cover 'Winter and Covid' expenses, Mr Neil clarified that this funding was allocated for additional beds built into the forecast and would be on a non-recurring basis.</p> <p>In response to the question about the restriction of EPAs despite the high cost of agency locums, Mr Davidson explained that these positions are difficult to fill, leaving limited scope for EPAs.</p> <p>In response to the question about supporting doctors to ensure they get natural breaks, Mr Davidson reassured that work was being done to reinforce this.</p> <p>In response to the question about the difference in financial performance between the South Sector and other sectors, Mr Neil explained that taking up additional beds accounts for the need for more cover.</p> <p>In response to the question about turnover and the new 36-hour work week, Ms Grant mentioned that working groups are being established to address this issue, and future Risk Registers would provide more insight.</p> <p>The Committee were content to note the update.</p> <p>NOTED</p>	
65.	Overview of Nursing Workforce and Quality	

		ACTION BY
	<p>The Committee considered the 'Overview Nursing Workforce and Quality' presented by Ms Morag Gardner, Deputy Nursing Director.</p> <p>Ms Gardner mentioned key points:</p> <ul style="list-style-type: none"> • An outline of the current Nursing Workforce • Innovation Plans – recruitment and new roles • Winter Planning • Quality Measures • Feedback from the recent unannounced inspection at Gartnavel General Hospital (GGH) <p>Ms Gardner noted established real-time staffing monitoring and data-driven interventions. These included recruitment drives, reducing reliance on off-framework agency staff without significantly affecting metrics, and a strong emphasis on managing Nursing Pays to control costs. Ms Gardner mentioned comprehensive monitoring system tracked quality, staff well-being, and patient experience data from ward to board, showing overall stability.</p> <p>In response to the question about the establishment of Band 7s and Band 8s, Ms Gardner explained that this over establishment is primarily due to the appointment of Advanced Nurse Practitioners in the Emergency Department, among other factors.</p> <p>Ms Gardner highlighted areas of good practice, as well as recommendations and requirements from the recent unannounced inspection at Gartnavel General Hospital, were highlighted.</p> <p>The Committee were content to note the update.</p> <p><u>NOTED</u></p>	
66.	Extract from Corporate Risk Register	
	<p>The Committee considered the Extract from Corporate Risk Register [Paper 23/20] presented by Mr Colin Neil, Director of Finance.</p> <p>Mr Neil advised there were no proposed changes, but updates had been made, which included reviewing the target dates for actions, assessing controls and mitigating actions, and keeping the risk scores static for this reporting period.</p>	

			ACTION BY
	The Committee were content to approve the update. <u>APPROVED</u>		
67.	Closing Remarks and Key Messages for the Board		
	The Chair thanked Members for attending the Acute Services Committee. <u>ASSURED</u>		
68.	Date and Time of Next Scheduled Meeting		
	The next meeting would be held on Tuesday, 21 November 2023 at 9.30am via MS Teams.		

ASC(M)23/06
 Minutes 69 - 84

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Acute Services Committee held on Tuesday 21 November 2023 at 9.30am via Microsoft Teams

PRESENT

Mr Ian Ritchie (in the Chair)

Cllr Chris Cunningham	Ms Colette McDiarmid
Mrs Jane Grant	Mr Graham Haddock OBE
Dr Becky Metcalfe	Mr Colin Neil
Dr Paul Ryan	Dr Lesley Rousselet

IN ATTENDANCE

Ms Sandra Bustillo	Director of Communications and Public Engagement
Ms Jacqueline Carrigan	Assistant Director of Finance Acute/Access
Dr Scott Davidson	Deputy Medical Director, Acute
Ms Kim Donald	Corporate Services Manager, Governance
Ms Morag Gardner	Deputy Nurse Director, Acute
Ms Katrina Heenan	Chief Risk Officer
Ms Sara Khalil	Secretariat (Minutes)
Ms Anne MacPherson	Director of Human Resources and Organisational Development
Ms Susan McFadyen	Director of Access
Ms Natalie Smith	Depute Director of Human Resources
Ms Elaine Vanhegan	Director of Corporate Services and Governance
Ms Angela Wallace	Director of Nursing
Mr Scott Wilson	Senior Business and Delivery Manager to CEO

		ACTION BY
69.	Welcome and Apologies	
	The Chair welcomed those present to the November meeting of the Committee.	
	Apologies were noted on behalf of William Edwards, Jennifer Armstrong and Susan Groom.	
	NOTED	

			ACTION BY
70.	Introductory Remarks		
	There were no introductory remarks noted by the Chair. <u>NOTED</u>		
71.	Declaration(s) of Interest(s)		
	The Chair invited members to declare any interests in any of the matters being discussed. Dr Metcalfe noted a declaration of interest in Junior Doctor Training. <u>NOTED</u>		
72.	Minutes of Previous Meeting		
	The Committee considered the minute of the previous meeting, Tuesday, 19 September 2023 [Paper No. ASC(M)23/05], were content to approve the minute as a complete and accurate record. <u>APPROVED</u>		
73.	Matters Arising		
a)	Rolling Action List		
	The Committee considered the Rolling Action List [Paper No. 23/25]. The Committee were content to accept the recommendation that the two actions were closed. The Committee were content to approve the RAL. <u>APPROVED</u>		
74.	Urgent Items of Business		
	The Chair asked members if there were any urgent items of business. There were no items of urgent business raised. Ms Wallace mentioned the security incident that occurred in July 2023. Ms Wallace noted the issue had been addressed with an		

			ACTION BY
	ongoing investigation. All necessary procedures were followed in handling the situation.		
	NOTED		
75.	Acute Update		
	<p>The Committee considered the presentation on the Acute services provided by Dr Scott Davidson, Deputy Medical Director and Ms Morag Gardner, Deputy Nurse Director [Acute]</p> <p>Dr Davidson highlighted the following key points:</p> <ul style="list-style-type: none"> • Trauma and Orthopaedic TTG (Treatment Time Guarantee) patients continue to face significant pressure, with 1,245 patients waiting over 104 weeks for care by December 2023. Efforts are being made to increase orthopaedic sessions at Gartnavel General Hospital (GGH) by reinstating six sessions weekly for priority waiting patients. • Current performance slightly exceeds the planned position for September 2023. Capacity is focused on urgent, high-priority cases and long-waiting patients. However, elective activity on key inpatient sites remains constrained due to workforce issues, high bed occupancy, and competing priorities for emergency patient activity. Theatre nurse staffing remains a challenge in increasing adult sessions across sectors. • There are 237 COVID inpatients and 7 closed wards. Emphasis remains on Flow performance to increase ED capacity. • Positive progress is noted at the Flow Navigation Centre (FNC), with increased call closures, avoidance of 376 OPAT bed days, and higher percentages of patients discharged within 48 hours and from assessment units without admission, compared to baseline metrics. • A winter 'ABC' campaign has been launched to guide patients to the required services efficiently. A report on its outcomes will be presented at an upcoming meeting. <p>The Committee were content to note the update.</p> <p>NOTED</p>		Ms Bustillo
76.	Acute Services Integrated Performance Report		
	The Committee considered the Acute Services Integrated Performance Report [Paper 23/26] presented Mr Colin Neil, Director of Finance.		

			ACTION BY
	<p>Mr Neil noted key performance highlights:</p> <ul style="list-style-type: none"> • Outpatient, TTG, and scopes activity surpassing targets for April - September 2023. • Patients waiting >78 weeks for NOP and TTG procedures within planned limits for September 2023. • Significant reduction in new outpatients waiting >78 weeks since January 2023, dropping from 737 to 47 patients, with 41 confirmed for appointments. <p>Mr Neil noted areas needing improvement:</p> <ul style="list-style-type: none"> • A&E compliance with four-hour waits slightly dropped to 70.6%. • Cancer 31 Day waiting times saw a slight decrease from 95.3% in August 2023 to 94.1% in September 2023. • Cancer 62 Day Waiting Times, facing increased demand, improved from 63.9% in August 2023 to 65.7% in September 2023. • Sickness absence, though slightly reduced, remains above the local 5% target. <p>In response to the inquiry about the status of the draft guidance to the Scottish Government concerning Urgent Cancer referral criteria and its implementation, Dr Davidson mentioned ongoing work with Primary Care. Efforts are focused on understanding the source of referrals and providing guidance back to the referrer.</p> <p>In response to the question about the number of patients waiting for procedures outside the TTG (Treatment Time Guarantee) and their management, Ms McFadyen mentioned that there were 803 patients. Emphasising the priority on addressing urgent cases first was highlighted to ensure their needs are met promptly.</p> <p>In response to the query about the daily reconciliation of patient cancellation slots being reoffered to others, Ms McFadyen mentioned that efforts are made to fill these slots and inform patients through electronic communication.</p> <p>The Committee were assured by the update.</p> <p><u>ASSURED</u></p>		
77.	Junior Doctor Workforce/ Education Review		
	<p>The Committee considered the 'Junior Doctor Workforce/Educational Review' [Paper 23/27] presented by Dr Colin Perry, Director of Medical Education</p> <p>The paper covered the key points as follows:</p>		

			ACTION BY
	<ul style="list-style-type: none"> • The Directorate of Medical Education (DME) maintains GMC standards and assists struggling units, with some placed under enhanced monitoring after Deanery visits. • Last academic year saw NHSGGC hosting 10 Scotland Deanery visits, four being monitored. QEUH medicine and IRH psychiatry remain monitored, showing improvement despite challenges. • IRH General Internal Medicine and Princess Royal Maternity Obstetrics and Gynaecology were recently removed from monitoring after successful Deanery visits. • A pilot in August 2023 extended FY1s' induction to seven days, beyond the standard five. The DME also launched an enhanced leadership program for selected Chief Residents with a NES Scottish Clinical Leadership Fellow. • The Medical Education team actively supports trainee and overall wellbeing. The Teaching and Learning Centre at QEUH reopened in September 2023 for joint training with the University of Glasgow and NHSGGC. <p>In response to the inquiry about why QEUH was under enhanced monitoring for 7 years, Dr Perry explained that there had been consistent improvement year by year, including a reduction in concerning notifications.</p> <p>In response to the question regarding the learning acquired when sites came off enhanced monitoring, Dr Perry replied that strong leadership was crucial in the process, along with the support of chief residents to facilitate the de-escalation.</p> <p>The Committee were content to note the update.</p> <p>NOTED</p>		
78.	Financial Monitoring Report		
	<p>The Committee considered the Financial Monitoring Report [Paper 23/28] presented by Mr Colin Neil, Director of Finance.</p> <p>Mr Neil confirmed the end of September position of [REDACTED] deficit, which included [REDACTED] YTD unachieved savings, [REDACTED] pay and non-pay position. Mr Neil noted non-recurring funding of [REDACTED] had been allocated to cover costs associated with additional</p>		

		ACTION BY
	<p>service demands including additional beds and pressures with funding identified.</p> <p>Mr Neil noted an overspend in pays, with the main areas being:</p> <ul style="list-style-type: none"> • Medical Salaries exceeding the budget by [REDACTED]. • Nursing pays surpassing the budget by [REDACTED]. • Other pays, including AHPs, Healthcare Sciences, and Admin & Clerical, were under budget by [REDACTED]. <p>Mr Neil highlighted the year-end forecast indicated an overspend of [REDACTED], reflecting a decrease from the current spending levels. This projection was a result of ongoing efforts within sectors and directorates to reduce expenses, especially in Standard Rate Agency and bank expenditures. Additional Newly Qualified Nurses and Midwives (NQNM) and international recruits had a positive impact on this situation. The utilisation of off-framework agency staffing had notably decreased by 97% by month 6 and had reached minimal utilization by the end of October, as planned, with just one shift used during that period.</p> <p>Mr Neil reported on the sustainability and value program, stating that the Acute Target was [REDACTED] for the full year. Savings achieved on a recurring basis were [REDACTED] (16.53% of the target). For the current year, they achieved [REDACTED] and unachieved YTD position of [REDACTED].</p> <p>Mr Neil noted the forecast for 2023/24 anticipates a financial shortfall of around [REDACTED], with pressure totalling [REDACTED] in pay and non-pay areas, coupled with unachieved savings of [REDACTED]. Strategies were underway to trim the projected [REDACTED] deficit, with ongoing efforts to reduce this further. Mitigating pressures and finding extra savings were noted as crucial for the current financial year and for shaping the assumptions for 2024/25.</p> <p>In response to the question about filling the 112 vacancies and addressing Band 3s' rotas, Dr Davidson mentioned ongoing struggles in filling these gaps. Rota changes had been initiated, and efforts to encourage natural breaks were underway with action plans.</p> <p>The Committee were content to note the update.</p> <p><u>NOTED</u></p>	
79.	Transnasal Endoscopy Update	

			ACTION BY
	<p>The Committee considered the Transnasal Endoscopy Update [Paper 23/30] presented by Dr Scott Davidson, Deputy Medical Director.</p> <p>Dr Davidson highlighted the following:</p> <ul style="list-style-type: none"> • The Transnasal Endoscopy (TNE) was initially introduced in NHSGGC back in 2021, with three clinics operational per week, one in each sector. • Patients had positively received TNE as a diagnostic procedure, demonstrating its appropriateness for specific cases. • TNE lists provided the same patient capacity as traditional transoral endoscopy lists. • Efforts were made to transition TNE into outpatient facilities at Stobhill ACH, Victoria ACH, and Inverclyde Royal Hospital, indicating its suitability for community-based delivery. • NHSGGC had established comprehensive staff training plans aimed at increasing the number of trained personnel capable of delivering TNE services. <p>Mr Davidson noted the paper outlined the then-current use of TNE in NHSGGC and the staff training program that supported potential future expansion. The Endoscopy service continued to review opportunities to enhance base capacity in both TNE and traditional transoral Endoscopy.</p> <p>When asked about the cost estimation for community-based delivery and the exploration of implementing Transnasal Endoscopy (TNE) in children, and if there were ongoing discussions to strengthen connections with ENT, Ms McFadyen noted discussions with new trainee nurses to include ENT training in endoscopy. Mr Davidson added that they would delve into the procedure's viability in children and associated costs. Additionally, Mr Davidson highlighted the procedure's good tolerance levels.</p> <p>In response to the inquiry about the nurses' training timeline, Mr. Haddock mentioned it would span 18 months and is conducted in collaboration with Glasgow Caledonian University.</p> <p>The Committee were content to note the update.</p> <p><u>NOTED</u></p>		

			ACTION BY
80.	Organ Donation Update		
	<p>The Committee considered the 'Organ Donation Update' [Paper 23/29] presented by Dr Scott Davidson, Deputy Medical Director.</p> <p>Dr Davidson noted NHSGGC experienced significant improvements in organ donor referral, authorisation, proceeding donor numbers, and transplants over the last fiscal year. These improvements approached pre-pandemic levels of activity.</p> <p>In response to the inquiry about the involvement of the Radiology directorate in organ and tissue donation, Mr Davidson stated that their involvement was focused on implementing CT Angiography. This initiative aimed to support clinical diagnoses related to Death Using Neurological Criteria (DNC) and improve neurological death-testing rates.</p> <p>In response to the query regarding the lower authorisation rate compared to the UK rate and measures for improvement, Mr Ritchie explained that this discrepancy was due to the Deemed Authorisation rate. He emphasised the ongoing efforts towards communication strategies for organ and tissue donation awareness.</p> <p>The Committee were content to note the update.</p> <p><u>NOTED</u></p>		
81.	Extract from Corporate Risk Register		
	<p>The Committee considered the Extract from Corporate Risk Register [Paper 23/31] presented by Ms Katrina Heenan, Chief Risk Officer</p> <p>Ms Heenan reported that no proposed changes were put forward. Nevertheless, updates aligned with the Acute Services Committee's risks had been accomplished:</p> <ul style="list-style-type: none"> • Risk scores had been reviewed and remained static in the reporting period. • An update had been provided concerning the upcoming review scheduled at SMG. <p>The Committee were content to approve the update.</p> <p><u>APPROVED</u></p>		

			ACTION BY
82.	Closing Remarks and Key Messages for the Board		
	The Chair thanked Members for attending the Acute Services Committee. <u>ASSURED</u>		
83.	Date and Time of Next Scheduled Meeting		
	The next meeting would be held on Tuesday, 16 January 2023 at 9.30am via MS Teams.		

ASC(M) 24/01
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NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Acute Services Committee held on Tuesday 16th January 2024 at 9.30am via Microsoft Teams

PRESENT

Mr Ian Ritchie (in the Chair)

Cllr Chris Cunningham	Ms Colette McDiarmid
Ms Jane Grant	Mr Graham Haddock OBE
Dr Becky Metcalfe	Mr Colin Neil
Dr Paul Ryan	Dr Lesley Rousselet
Ms Jennifer Armstrong	Prof Angela Wallace

IN ATTENDANCE

Ms Sandra Bustillo	Director of Communications and Public Engagement
Ms Jacqueline Carrigan	Assistant Director of Finance Acute/Access
Dr Scott Davidson	Deputy Medical Director, Acute
Ms Kim Donald	Corporate Services Manager, Governance
Ms Morag Gardner	Deputy Nurse Director, Acute
Ms Katrina Heenan	Chief Risk Officer
Mr David Ferguson	Secretariat (Minutes)
Ms Anne MacPherson	Director of Human Resources and Organisational Development
Ms Susan McFadyen	Director of Access
Ms Natalie Smith	Depute Director of Human Resources
Ms Elaine Vanhegan	Director of Corporate Services and Governance
Mr Scott Wilson	Senior Business and Delivery Manager to CEO
Mr William Edwards	Chief Operating Officer
Ms Susan Groom	Director of Regional Services
Ms Claire Macdonald	Business Manager
Mr John Crawford	Deputy Chief of Medicine, South
Ms Lesley Thomson	NHSGGC Chair

		ACTION BY
1.	Welcome and Apologies	
	The Chair welcomed those present to the January meeting of the Committee.	

			ACTION BY
	There were no apologies noted. <u>NOTED</u>		
2.	Declaration(s) of Interest(s)		
	The Chair invited members to declare any interests in any of the matters being discussed. No interests were declared. <u>NOTED</u>		
3.	Minutes of Previous Meeting		
	The Committee considered the minute of the previous meeting, Tuesday, 21 November 2023 [Paper No. ASC(M)23/05], and were content to approve the minute as a complete and accurate record. <u>APPROVED</u>		
4.	Matters Arising		
a)	Rolling Action List		
	The Committee considered the Rolling Action List [Paper No. 23/25]. The Committee were content to approve the RAL. <u>APPROVED</u>		
5.	Urgent Items of Business		
	The Chair asked members if there were any urgent items of business. There were no items of urgent business raised. <u>NOTED</u>		
6.	Acute Update		
	The Committee considered the presentation on the Acute Update provided by Mr William Edwards, Chief Operating Officer – Acute. The following was highlighted:		

			ACTION BY
	<ul style="list-style-type: none"> - The present focus is on enacting the winter plan and making sure we can manage the subsequent challenges of winter. - Hospital occupancy remains significantly high at 98.3% across the board. - As was planned, additional winter capacity was opened up on the 3rd of January. The additional beds have helped with the challenges related to Covid, Norovirus and flu. - Due to the high levels of Covid, Norovirus and flu, 19 wards were close across the acute division which has been an additional layer of pressure. - Electives have been maintained via the ring fencing resourcing and surgical wards. <p>The Committee discussed staff shortages and closures due to Norovirus. It was confirmed that staff have been affected but wards closed due to Norovirus were able to reopen much more efficiently.</p> <p>The Committee were content to note the update.</p> <p><u>NOTED</u></p>		
7.	Acute Services Integrated Performance Report		
	<p>The Committee considered the Acute Services Integrated Performance Report [Paper 23/03] presented Mr Colin Neil, Director of Finance. The following was highlighted:</p> <ul style="list-style-type: none"> - Performance was exceeding the planned trajectory in Treatment Time Guarantee (TTG) and other areas. - The number of new outpatients and day patients waiting over 52 weeks was within the planned position. - Performance in relation to the Cancer 31 Day waiting times had improved from the previous month's position increasing from 91.4% in October 2023 to 92.4% in November 2023. - Overall compliance with the A&E four hour waits remained challenging and below the national target. <p>In response to a query regarding the increase in cancer referrals from USOC, Mr Williams confirmed that GP's were being written to across the Board to reinforce the Scottish cancer referral guidelines. With regards to the availability of data across the four different specialties and over the past four or more years; it was noted that pathways have changed significantly in the post-</p>		

			ACTION BY
	<p>pandemic period and the numbers may be harder to directly compare.</p> <p>The Committee discussed the redirection update program, noting that less patients were attending the main sites. The Committee wished to re-emphasise the success that redirection is having even in the face of significant occupancy pressures.</p> <p>The Committee discussed the significant challenges faced across the services, including Ophthalmology and Theatres, and were assured that daily reviews were undertaken by the senior management team to ensure that capacity was released, where available.</p> <p>The Committee were assured by the update.</p> <p><u>ASSURED</u></p>		
8.	Financial Monitoring Report		
	<p>The Committee considered the 'Financial Monitoring Report' [Paper 24/04] presented by Mr Colin Neil, Director of Finance. The following was highlighted:</p> <ul style="list-style-type: none"> - As at the 30th November 2023 Acute Services finance ledger was reporting a deficit of [REDACTED]. - Unachieved savings were [REDACTED] YTD. - Pays were [REDACTED] over budget, with Medical and Nursing pays being the main drivers. - Non Pays were [REDACTED] over budget with drugs, surgical sundries, theatre and radiology supplies and being the key pressures. - The forecast for 2023/24 was based on current run rates adjusted for actions in place giving an overall deficit of [REDACTED], with pay and non-pay by [REDACTED] and unachieved savings forecast to be [REDACTED]. - Through the last quarter the focus was on the review and cap of any discretionary spending. <p>The agency spend has reduced significantly reduced.</p> <p>The Committee discussed the limitations on spending on supplies and sundries. Mr Neil stated that up to [REDACTED] was spent on this in the same period last year meaning this could be a significant saving. Mr Edwards assured that a number of areas were being looked into in great detail to make further savings e.g. reduction in</p>		

			ACTION BY
	spend on nursing agencies and reducing premium rates for medical pays.		
	The Committee were content to note the update.		
	<u>NOTED</u>		
9.	Theatres Update		
	<p>The Committee considered the 'Theatres Update' presentation from Ms Susan McFadyen, Director of Access. The following was highlighted:</p> <ul style="list-style-type: none"> - Total theatre activity has returned to pre-Covid levels, delivering a balance of emergency and elective work to ensure provision for long waiting patients. - New areas of service have been established – Major Trauma, Robotic Surgery. - Funding struggles mean some sites have aging facilities which has a negative impact on patient flow. - Designated Surgical Hubs established at several sites to protect an element of elective activity from the demands of unscheduled care. <p>The Committee considered the impact of the Covid pandemic on theatre colleagues, noting many chose to move on and much of the current staff is newly qualified. The Committee queried why theatres were running at 70% capacity. Ms McFadyen explained that staffing availability is one of the main drivers for this, but efforts were being made to make it more efficient.</p> <p>The Committee were content to note the update.</p> <p><u>NOTED</u></p>		
10.	Winter Update and Comms Campaign		
	<p>The Committee considered the 'Winter Update' presentation from Mr William Edwards, Chief Operating Officer – Acute. The following was highlighted:</p> <ul style="list-style-type: none"> - 146 additional beds were made available last year and were never closed resulting in additional costs. - As of the 3rd of January there was a further 69 beds opened. These will be closed in March. 		

			ACTION BY
	<ul style="list-style-type: none"> - There is a continual focus on delayed discharges. - Winter boarding teams are in place across GRI, QEUH and RAH. Boarding remains high across our sites and numbers rose as anticipated over winter. - The Flow Navigation Centre continues to be key in redirection and has seen an increase of 93 virtual consultations per week. - 45 virtual beds have been made available but the funding is non-recurring. <p>The Committee considered the 'Winter Communications Campaign' presentation from Ms Sandra Bustillo, Director of Communications and Public Engagement. The following was highlighted:</p> <ul style="list-style-type: none"> - From those surveyed, a medical emergency accounted for 35% of the reason people chose to attend A&E in 2023. - Most seek help elsewhere before attending e.g. contacting 111 (39%) or reaching out to their GP (31%). - A disproportionate number of men are going straight to A&E before trying any other avenue – 46% compared to 34% for women. - Campaign objectives were to drive awareness and use of A&E alternatives, to educate specific groups (students and men) on alternative services and to include Redirection Messaging in the materials. - Both the ABC campaign and the adverts targeting men were shown. The adverts are being shown across a large number of different platforms. - Engagement will be evaluated via text survey when the campaign ends in February. <p>The Committee queried when data on the impact will be available. Ms Bustillo advised that the survey data will be ready in a few months but metrics on social media clicks can be sourced immediately. A further update will be available in the summer.</p> <p>The Committee were content to note these updates.</p> <p>NOTED</p>		

Secretariat

			ACTION BY
11.	Extract from Corporate Risk Register		
	<p>The Committee considered the Extract from Corporate Risk Register [Paper 24/05] presented by Ms Katrina Heenan, Chief Risk Officer. The following was highlighted:</p> <ul style="list-style-type: none"> - No proposed changes were put forward for this period - The three risks relating to Acute Services are around scheduled waiting time targets. - Controls and mitigations have been further updated for this risk register. <p>The Committee were content to approve the update.</p> <p><u>APPROVED</u></p>		
12.	Closing Remarks and Key Messages for the Board		
	<p>The Chair thanked Members for attending the Acute Services Committee.</p> <p><u>ASSURED</u></p>		
13.	Date and Time of Next Scheduled Meeting		
	The next meeting would be held on Tuesday, 19 March 2024 at 9.30am via Microsoft Teams.		

ASC(M) 24/02
Minutes 14 - 27

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Acute Services Committee held on Tuesday 19th March 2024 at 9.30am via Microsoft Teams

PRESENT

Dr Paul Ryan (in the Chair)

Cllr Chris Cunningham	Dr Lesley Rousselet
Ms Jane Grant	Mr Colin Neil
Dr Becky Metcalfe	Prof Angela Wallace

IN ATTENDANCE

Ms Sandra Bustillo	Director of Communications and Public Engagement
Ms Jacqueline Carrigan	Assistant Director of Finance Acute/Access
Dr Scott Davidson	Deputy Medical Director, Acute
Ms Kim Donald	Corporate Services Manager, Governance
Ms Katrina Heenan	Chief Risk Officer
Mr David Ferguson	Secretariat (Minutes)
Ms Anne MacPherson	Director of Human Resources and Organisational Development
Ms Susan McFadyen	Director of Access
Ms Natalie Smith	Depute Director of Human Resources
Ms Elaine Vanhegan	Director of Corporate Services and Governance
Mr Scott Wilson	Senior Business and Delivery Manager to CEO
Mr William Edwards	Chief Operating Officer
Ms Susan Groom	Director of Regional Services
Ms Mandy Crawford	Corporate Services Manager - Complaints
Dr Lesley Thomson	NHSGGC Chair

			ACTION BY
14.	Welcome and Apologies		
	The Chair welcomed those present to the March meeting of the Committee. Apologies were noted on behalf of Mr Ian Ritchie and Mr Graham Haddock OBE.		

			ACTION BY
15.	Declaration(s) of Interest(s)		
	<p>The Chair invited members to declare any interests in any of the matters being discussed. No interests were declared.</p> <p><u>NOTED</u></p>		
16.	Minutes of Previous Meeting		
	<p>The Committee considered the minute of the previous meeting, Tuesday, 16 January 2024 [Paper No. ASC(M)23/01], and after making corrections were content to approve the minute as a complete and accurate record.</p> <p><u>APPROVED</u></p>		
17.	Matters Arising		
a)	Rolling Action List		
	<p>The Committee considered the Rolling Action List [Paper No. 24/05].</p> <p>The Committee were content to approve the RAL.</p> <p><u>APPROVED</u></p>		
18.	Urgent Items of Business		
	<p>The Chair asked members if there were any urgent items of business.</p> <p>Professor Angela Wallace raised the study undertaken by Amma Birth Companions, a charity that operates in glasgow and offers birth support and advocacy services to refugee and asylum seeking women. A report is being published on the 20th of March.</p> <p>The review focused on 100 births in GGC in 2021(40 births) and 2022 (60 births). The Glasgow based charity ‘birth outcomes and experiences’ report highlighted inadequate communication, limited choice, lack of interpreter availability which the women and the Amma birthing companions felt that these experiences negatively impacted on the care they received. Professor Wallace shared that a significant amount of work was already underway prior to the</p>		

			ACTION BY
	publication of this report. Over the last 18 months we have undertaken successful outreach to hear from women about their experiences of our services including a text-based survey with 2800 responses. All of the recommendations from the amma report will be addressed and an update report will be presented at clinical and care governance at the earliest opportunity.		Prof Wallace
	The Committee noted this update.		
	<u>NOTED</u>		
19.	Acute / Winter Update		
	<p>The Committee considered the presentation on the Acute / Winter Update provided by Mr William Edwards, Chief Operating Officer – Acute. The following was highlighted:</p> <ul style="list-style-type: none"> - Maintaining flow in our hospitals is our significant priority, with particular attention around the QEUH. Current occupancy rates are over 95% with QEUH sitting at 99.1% occupancy currently - 314 delayed discharges in January 2024. Mr Edwards also outlined the bed days lost due to delayed discharges this year. - Action to be taken in closing around 189 beds that was opened for winter and since covid. This additional capacity is driving the financial position. - 69 beds will be closing on the 8th of April 2024 which is the true annual winter capacity that was opened in December 2023. - Whole system Day of Care Audit will be taking place on March 25th to try to support sites to decompress prior to Easter break. - Planned care programme numbers have been submitted to Scottish Government. NHS GGC are predicted to overachieve in all areas and have not had to sacrifice the planned care programme to accommodate the winter pressures which is positive. - Priorities going forward will include reducing delayed discharges and making sure longest waiting times are lowered. <p>The Committee discussed the recent ward closures, particularly at the Royal Infirmary. Mr Edwards assured that these closures have</p>		

			ACTION BY
	reduced and have returned to normal levels due to the reduction in covid.		
	The Committee praised the service for the reduction of outpatient wait times and the balancing of winter pressures and continued elective activity and were content to note the update		
	<u>NOTED</u>		
20.	Report on Visit to Neurorehabilitation Unit		
	<p>The Committee considered the Report on the Visit to the Neurorehabilitation Unit presented by Dr Paul Ryan, Vice Chair.</p> <p>This service supports adults who have experienced catastrophic neurological injuries or conditions with the main aim of supporting recovery, facilitating independence and safe transition back to the community in the post-acute phase.</p> <p>6 members of the Committee met the staff and commended their enthusiasm and commitment. It was suggested that it may be worth using the endowment fund to help increase storage space at the unit.</p> <p>The Committee were content to note the update.</p> <p><u>NOTED</u></p>		
21.	Patient Experience Report		
	<p>The Committee considered the 'Patient Experience Report' [Paper 24/06] presented by Professor Angela Wallace, Director of Nursing. The following was highlighted:</p> <ul style="list-style-type: none"> - This is a complaints report for the acute service for Q3 - Busy winter time but complaints response targets are still being met. Meeting the national KPI of 80%. - Main themes of complaints were around wait times and staff attitude/behavior. - The number of complaints received is very small in comparison to patients who come into contact with our services, however it is still valuable to investigate these complaints and seek to improve the service further. 		

			ACTION BY
	<ul style="list-style-type: none"> - Focus on the power of apology. We want to assure families that we have learned. <p>The Committee discussed the high number of complaints around unexpected outcomes and queried whether this indicated a communication gap with the patient. Ms Mandy Crawford, Complaints Manager, noted that communication is important but often there is a difference between the expectations of patients and their families. This can be a result of the patient not explaining the extent of their condition or treatment to the family.</p> <p>The Committee were assured by the update.</p> <p><u>ASSURED</u></p>		
22.	Acute Services Integrated Performance Report		
	<p>The Committee considered the 'Acute Services Integrated Performance Report' [Paper 24/07] presented by Mr Colin Neil, Director of Finance. The following was highlighted:</p> <ul style="list-style-type: none"> - Progress has been made across outpatient and in patient / day case wait times, remaining within the planned position agreed with Scottish Government. Numbers of new patients waiting over 78 weeks has been reduced significantly. - Overall compliance with the A&E four hour waits (64.5%) represents a marginal reduction in the previous months' position. Performance is in line with the national trend. - Performance in relation to the Cancer 62 Day Waiting Times remained fairly static when compared to the previous month 64.4% in December 2023 and 64.6% in January 2024. This position continues to be challenged due to the significant increase in USOC referrals in comparison to pre-pandemic referrals (54%). - Staff sickness and absence numbers have increased in January. <p>The Committee asked what the average A&E wait time was. This data is not available but Mr Neil confirmed that it is longer than we would like.</p> <p>Higher rates of referral for suspicion of cancer were highlighted. Ms Susan Groom explained that as GPs are being encouraged to</p>		

			ACTION BY
	<p>detect cancer as early as possible this is having an impact on so referral rates. Figures are not out of line with the rest of Scotland.</p> <p>The Committee were assured by the update.</p> <p><u>ASSURED</u></p>		
23.	Financial Monitoring Report		
	<p>The Committee considered the 'Financial Monitoring Report' presented by Mr Colin Neil, Director of Finance. The following was highlighted:</p> <ul style="list-style-type: none"> - This is the month 10 report. As at the 31st January 2024 Acute Services finance ledger is reporting a deficit of [REDACTED]. - Unachieved savings are [REDACTED] YTD. - Pays are [REDACTED] over budget, with Medical and Nursing pays being the main drivers. - Non Pays are [REDACTED] over budget with Drugs, Surgical Sundries, Equipment and CSSD/Diagnostic supplies and Other Therapeutics being the key pressures. - The total forecast for 2023/24 is [REDACTED], with pay and non pay headings being [REDACTED] and unachieved savings being [REDACTED]. - We are in receipt of the month 11 position which has seen a slight improvement to nursing pays and non-pay figures. <p>The Committee were content to note the update</p> <p><u>NOTED</u></p>		
24.	Update on the Corporate Risk Register and Review of Acute Services Risks		
	<p>The Committee considered the Extract from Corporate Risk Register [Paper 24/09] presented by Ms Katrina Heenan, Chief Risk Officer. Ms Heenan also gave a presentation on the Corporate Risk Register. The following was highlighted:</p> <ul style="list-style-type: none"> - This presentation was put together to give the Committee a stronger understanding of how risks are calculated and registered. 		

			ACTION BY
	<ul style="list-style-type: none"> - The process to identify risks was shown. - There are 6 new Board members starting in June and risk management will be included in the induction processes. <p>The Committee asked who is responsible for identifying risks. Ms Heenan explained that the framework is created by NHS Scotland and a review is carried out by examining objectives. This will be carried out by the service/directorate owner.</p> <p>Ms Heenan gave the following update from the Corporate Risk Register Extract:</p> <ul style="list-style-type: none"> - Risk scores remain static for this reporting period, with no proposed changes to risk scores. - A deep dive of Unscheduled Care Waiting Time Targets Risk has been arranged, however due to resource this date is currently being rescheduled. <p>The Committee were content to approve the update.</p> <p><u>APPROVED</u></p>		
25.	Committee Terms of Reference		
	<p>The Committee considered the Committee Terms of Reference [Paper 24/10] presented by Ms Kim Donald, Corporate Services Manager – Governance.</p> <p>The Committee were content to approve the Terms of Reference.</p> <p><u>APPROVED</u></p>		
26.	Closing Remarks and Key Messages for the Board		
	<p>The Chair thanked Members for attending the Acute Services Committee.</p> <p><u>NOTED</u></p>		
27.	Date and Time of Next Scheduled Meeting		
	<p>The next meeting would be held on Tuesday, 7 May 2024 at 9.30am via Microsoft Teams.</p>		

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NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Acute Services Committee held on Tuesday 7 May 2024 at 9.30am via Microsoft Teams

PRESENT

Mr Ian Ritchie (in the Chair)

Cllr Chris Cunningham	Dr Lesley Rousselet
Ms Jane Grant	Dr Paul Ryan
Mr Graham Haddock OBE	Mr Colin Neil
Dr Becky Metcalfe	Prof Angela Wallace
Ms Colette McDiarmid	

IN ATTENDANCE

Ms Sandra Bustillo	Director of Communications and Public Engagement
Ms Jacqueline Carrigan	Assistant Director of Finance Acute/Access
Dr Scott Davidson	Deputy Medical Director, Acute
Ms Kim Donald	Corporate Services Manager, Governance
Ms Morag Gardener	Deputy Nurse Director - Acute Services
Ms Katrina Heenan	Chief Risk Officer
Ms Louise Russell	Secretariat (Minutes)
Ms Anne MacPherson	Director of Human Resources and Organisational Development
Mr Scott Wilson	Senior Business and Delivery Manager to CEO
Mr William Edwards	Chief Operating Officer
Ms Susan Groom	Director of Regional Services
Ms Mandy Crawford	Corporate Services Manager - Complaints
Dr Lesley Thomson KC	NHSGGC Chair

		ACTION BY
28.	Welcome and Apologies	
	The Chair welcomed those present to the May meeting of the Committee. The Chair welcomed Mr David Gould who was in attendance to observe proceedings. Mr Gould would be appointed as the Chair of the Committee as of July 2024.	
	Apologies were noted on behalf of Ms Susan McFadyen.	

			ACTION BY
29.	Declaration(s) of Interest(s)		
	The Chair invited members to declare any interests in any of the matters being discussed. No interests were declared. <u>NOTED</u>		
30.	Minutes of Previous Meeting		
	The Committee considered the minute of the previous meeting, Tuesday, 19 th March 2024 [Paper No. ASC(M)24/02], and were content to approve the minute as a complete and accurate record. <u>APPROVED</u>		
31.	Matters Arising		
a)	Rolling Action List		
	The Committee considered the Rolling Action List [Paper No. 24/11]. <u>Item 18 – Urgent Items of Business</u> The Committee were content to approve the item recommended for closure. The Committee noted that further work had been agreed in relation to the AMMA Birth report and noted that Clinical and Care Governance Committee would oversee the governance. <u>APPROVED</u>		
32.	Urgent Items of Business		
	There were no urgent items of business. <u>NOTED</u>		
33.	Acute Update		
	The Committee considered the presentation on the Acute / Winter Update provided by Mr William Edwards, Chief Operating Officer – Acute. The following was highlighted: <ul style="list-style-type: none"> - Occupancy rates remained above 95% across all NHSGGC sites. - Additional beds had been closed. 		

			ACTION BY
	<ul style="list-style-type: none"> - As at April 2024, the Unscheduled Care rate was 70.1%. This was slightly above the national average and in line with other larger Boards. - The Planned Care Programme continued to be delivered. <p>In response to a question regarding inclusion of NHS Forth Valley and the Golden Jubilee National Hospital in the Planned Care Programme, Mr Edwards reported that the Delivery Plan had been drafted based on the assumption delivery would occur this financial year and dialogue was ongoing.</p> <p>The Committee noted the work was that ongoing in Acute Services and thanked the team recognising the increasing pressure across the sectors.</p> <p><u>NOTED</u></p>		
34.	RHC Front Door Visit		
	<p>The Committee noted the paper 'RHC Front Door Visit [Paper 24/12] presented by Mr Graham Haddock, OBE.</p> <p>The Committee noted the information in the report and noted the observations. Overall the visit was positive. The Committee noted a minor amendment; Dr Scott Robertson to be amended to Dr Scott Davidson. The Committee agreed it would be helpful to circulate the report to other Non-Executive Board members.</p> <p>The Committee were content to note the update provided.</p> <p><u>NOTED</u></p>		Secretary
35.	Acute Services Integrated Performance Report		
	<p>The Committee noted the paper 'Acute Services Integrated Performance Report' [Paper 24/13] presented by Mr Colin Neil, Director of Finance.</p> <p>Mr Neil provided a summary of performance against the respective Key Performance Indicators (KPI's). He reported that performance in relation to new outpatient, TTG, and endoscopy activity had exceeded the planned position for the period April - March 2024 and imaging activity had exceeded the year end planned position. Mr Neil highlighted that although the number of new outpatients waiting >78 weeks was above the planned position for March 2024,</p>		

		ACTION BY
	<p>there had been a significant reduction in the numbers waiting, reducing from 632 in March 2023 to six in March 2024.</p> <p>As at March 2024, the Cancer 31 Day waiting times position saw an increase on the previous month, increasing from 94.1% in February 2024 to 95.1. Mr Neil highlighted that a significant increase in urgent suspicion of cancer referrals was having an impact. He also summarised:</p> <ul style="list-style-type: none"> - The number of inpatient/day case patients waiting >52 weeks had increased by 3% compared to the previous month and was now marginally above the planned position for March 2024. - There had been a marginal increase in overall compliance with the A&E four hour waits compared to the previous months' position, however performance was in line with the national trend. - Performance in relation to the Cancer 62 Day Waiting Times saw a marginal decrease when compared to the previous month. - Overall sickness absence decreased marginally on the previous months' position, however performance remained above the local 5% target. <p>In response to a question regarding the cancer waiting times, the Committee received assurance that work remained ongoing to reduce waiting times including benchmarking exercises and learning from other Boards. It was agreed that trend analysis would be included in future reports. With regards to the urgent suspicion of cancer referrals, the Committee noted that a GP Referral Template was being submitted to the Referral Management Group and three new pathways had been implemented into gynaecology. The National Cancer meetings continued to take place, where innovative ideas were shared.</p> <p>In response to a question regarding TTGs and day cases, the Committee were advised that there had been a steady increase in theatre sessions throughout the year.</p> <p>The Committee recognised the challenges ahead, however received assurance that there was a regular focus reviewing the list of the longest waiting times.</p> <p>The Committee noted the update provided.</p> <p><u>NOTED</u></p>	<p>William Edwards/ Susan Groom</p>

		ACTION BY
36.	Financial Monitoring Report	
	<p>The Committee noted the paper 'Financial Monitoring Report' [Paper 24/14] presented by Mr Colin Neil, Director of Finance.</p> <p>Mr Neil informed the Committee that as at 31st March 2024, the Board had managed to break even; subject to the year-end audit. The finance ledger reported a deficit of [REDACTED], which was a betterment against the forecast position of [REDACTED]. He further summarised:</p> <ul style="list-style-type: none"> • Unachieved savings were [REDACTED]. • Pays were [REDACTED] over budget with Medical and Nursing pays being the main drivers. • Non Pays were [REDACTED] over budget. • Medical Salaries were [REDACTED] over budget, Nursing pays were [REDACTED] over budget. • Other pays were collectively [REDACTED] under budget. • A detailed piece of work was being carried out on product reviews to try and reduce surgical sundries further. <p>The Committee noted the update provided.</p> <p>NOTED</p>	
37.	Financial Overview of Medical and Nursing Controls	
	<p>The Committee received a presentation on 'Financial Overview of Medical and Nursing Controls' by Ms Jacqueline Carrigan, Assistant Director of Finance Acute/Access and Dr Scott Davidson, Deputy Medical Director.</p> <p>The presentation highlighted that the position across Medical and Nursing Salaries remained challenging due to a range of factors. There had been significant focus on agency spend, which had resulted in a reduction in all areas. The Committee noted the challenges and the actions taken in relation to Senior Medical Pays and Junior Medical Pays, noting the particular challenge in relation to Band 3 Rotas.</p> <p>In response to a question regarding Band 3 Rotas, the Committee were advised that there were rota challenges over a number of different areas. A common theme included natural breaks. The Committee received assurance that non-compliance would be addressed through the correct process. In addition, the Committee</p>	

			ACTION BY
	<p>also noted that Band 8a and above posts continued to be monitored on a monthly basis.</p> <p>The Committee noted the update provided.</p> <p><u>NOTED</u></p>		
38.	Committee Annual Report		
	<p>The Committee noted the paper 'Committee Annual Report' [Paper 24/15] which summarised the work that had been carried out over the past year.</p> <p>The Committee were content to approve the report.</p> <p><u>APPROVED</u></p>		
39.	Update on the Corporate Risk Register and Review of Acute Services Risks		
	<p>The Committee noted the paper 'Update on Corporate Risk Register and Review of Acute Services Risks' presented by Ms Katrina Heenan, Chief Risk Officer. The following was highlighted:</p> <ul style="list-style-type: none"> - The risk scores for the three risks relating to Acute Services, around scheduled waiting time targets, remained static. - No proposed changes were put forward for this period. - The Review Notes column in Appendix B had been updated to reflect the changes made to the risks each month, such as control, score or actions changes. <p>The Committee were content to approve the Corporate Risk Register.</p> <p><u>APPROVED</u></p>		
40.	Annual Cycle of Business		
	<p>The Committee noted the paper 'Annual Cycle of Business [Paper 24/17] presented by Ms Elaine Vanhegan, Corporate Services Manager (Governance).</p> <p>The Annual Cycle of Business continued to be reviewed at agenda setting meetings to ensure a stable process of assurance across the work of the Committee.</p>		

			ACTION BY
	<p>The Committee were content to approve the Annual Cycle of Business.</p> <p><u>APPROVED</u></p>		
41.	Closing Remarks and Key Messages for the Board		
	<p>The Committee noted that Mr Ritchie's tenure as Chair had come to an end and was being succeeded by Mr David Gould. Mr Ritchie thanked the Committee and noted that during his time as Chair he had gained significant assurance of the work carried out by the Board Executive Team.</p> <p>The NHSGGC Chair thanked Mr Ritchie on behalf of the Board and colleagues for his commitment over the last 8 years.</p> <p>Mr Ryan also thanked Mr Ritchie for his work and support as an Organ Donation Champion for NHSGGC.</p> <p><u>NOTED</u></p>		
42.	Date and Time of Next Scheduled Meeting		
	The next meeting would be held on Tuesday, 10 September 2024 at 9.30am via Microsoft Teams.		

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NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Acute Services Committee held on Tuesday 10 September 2024 at 9.30am via Microsoft Teams

PRESENT

Mr David Gould (in the Chair)

Cllr Chris Cunningham	Mr Colin Neil
Ms Jane Grant	Dr Becky Metcalfe
Mr Graham Haddock OBE	Dr Lesley Rousselet

IN ATTENDANCE

Ms Jacqueline Carrigan	Assistant Director of Finance Acute/Access
Dr Scott Davidson	Deputy Medical Director, Acute
Ms Kim Donald	Corporate Services Manager, Governance
Mr William Edwards	Chief Operating Officer
Ms Morag Gardner	Deputy Nurse Director - Acute Services
Ms Susan Groom	Director of Regional Services
Ms Katrina Heenan	Chief Risk Officer
Ms Natalie Kerr	Secretariat (Minutes)
Ms Susan McFadyen	Director of Access
Ms Anne MacPherson	Director of Human Resources and Organisational Development
Ms Louise Russell	Secretariat Manager
Ms Natalie Smith	Depute Director of Human Resources
Dr Lesley Thomson KC	NHSGGC Chair

		ACTION BY
43.	Welcome and Apologies	
	The Chair welcomed those present to the September meeting of the Acute Services Committee.	
	Apologies were noted on behalf of, Angela Wallace, Jennifer Armstrong, Sandra Bustillo, Collette McDiarmid and Elaine Vanhegan.	
	<u>NOTED</u>	
44.	Declaration(s) of Interest(s)	

			ACTION BY
	The Chair invited members to declare any interests in any of the matters being discussed. No interests were declared. <u>NOTED</u>		
45.	Minutes of Previous Meeting		
	The Committee considered the minute of the previous meeting, Tuesday 7 th May 2024, and were content to approve the minute as a complete and accurate record. <u>APPROVED</u>		
46.	Matters Arising		
a)	Rolling Action List		
	The Committee considered the Rolling Action List and were content to approve the items recommended for closure. <u>APPROVED</u>		
47.	Urgent Items of Business		
	There were no urgent items of business. <u>NOTED</u>		
	Committee Vice Chair		
	Mr Graham Haddock was nominated as Vice Chair by the Committee Chair, Mr David Gould, and was approved by the Committee. <u>NOTED</u>		
48.	Acute Update		
	Mr William Edwards, Chief Operating Officer, Acute Services, provided a verbal update for assurance.		

		ACTION BY
	<p>Mr Edwards reported that performance in relation to the 4-hour A&E target had improved, however, there were ongoing challenges with regards to occupancy across the Board. He assured the Committee that work was ongoing to optimise flow throughout the sites; but noted delayed discharges remained challenging.</p> <p>With regards to the HIS Emergency Department Review, Mr Edwards noted that we were working collaboratively with HIS regarding the information requested and further updates will be provided, when available. Mr Edwards outlines that it was still anticipated that the review would issue a draft report for factual accuracy to NHS GG&C in December 2024, with a final version being published in January 2025 when the review is expected to conclude.</p> <p>The committee were content to note the update.</p> <p><u>NOTED</u></p>	
49.	Acute Services Integrated Performance Report	
	<p>The Committee considered the paper 'Performance Report - July 2024 [Paper No. 24/12] presented by Mr Colin Neil for assurance.</p> <p>Mr Neil reported that, overall compliance with the A&E four-hour waits was 69.7% which was an increase on the previous months' position of 68.5%. The Committee noted that performance was marginally below the 2024-25 ADP planned position of 70%.</p> <p>Performance in relation to the Cancer 31 Day waiting times reported a slight decrease on the previous month's position, from 95.8% in June 2024 to 93.8% in July 2024. This was below the national target of 95%.</p> <p>Whilst performance in relation to the Cancer 62 Day waiting times reported an improvement on the previous month's position, increasing from 66.1% in June 2024 to 68.6% in July 2024, performance remained challenged due to the significant increase in Urgent Suspicion of Cancer referrals.</p> <p>Overall sickness absence levels increased on the previous months' position, and performance remained above the local 5% target.</p> <p>In response to a question regarding a timescale for the review of Primary Care referral templates, the Committee noted that work on the necessary changes were made to SCI Gateway on 19th August 2024 for Urology and Breast templates. There would be ongoing</p>	

		ACTION BY
	<p>engagement with GPs to audit the templates, and monitoring will be fed back through the performance report.</p> <p>In response to a question regarding funding for the expansion of Orthopaedic elective activity, the Committee noted that discussions remained ongoing and the complexities surrounding access money in relation to SLAs with other Health Boards.</p> <p>The Committee discussed the importance of staff wellbeing and were assured that there were champions and processes in place to ensure this remained a priority.</p> <p>The Committee noted the update provided.</p> <p><u>NOTED</u></p>	
50.	Financial Monitoring Report	
	<p>The Committee considered the paper [Finance Paper Month 4 - Paper No. 24/13] presented by Mr Colin Neil for awareness.</p> <p>Mr Neil reported that, as at 31st July 2024, Acute Services finance ledger reported a deficit of [REDACTED].</p> <p>The Junior Medical position for Acute reported an overspend of [REDACTED], with a forecast of [REDACTED], which was at the same financial position as the 23/24 outturn. He explained that Band 3 rotas were challenging, and national discussions were underway.</p> <p>The Senior Medical position reported an overspend of [REDACTED], with the Clyde sector and Women and Children being the main drivers of the pressure. The year end forecast was [REDACTED].</p> <p>Overall, Nursing pays reported an overspend of [REDACTED]. The forecast outturn was [REDACTED] based on the month 4 position and there were actions in place to reduce spend.</p> <p>Mr Neil highlighted that there was a national target in place to cease agency spend and the Board were working towards that.</p> <p>Non-pays reported an overspend of [REDACTED], with work underway to understand the drivers.</p> <p>The Committee discussed the scope of the financial challenge, noting the actions already underway to mitigate further overspend. The Committee also considered the importance of collaboration</p>	

		ACTION BY
	with the Area Partnership Forums with regards to staff communication and ongoing engagement.	
	The Committee noted the update provided.	
	<u>NOTED</u>	
51.	Cancer Performance Update and USOC Referral Review	
	<p>The Committee considered the Cancer Performance Update and USOC Referral Review presentation delivered by Ms Susan Groom for assurance.</p> <p>Ms Groom reported the increase in Urgent Suspicion of Cancer (USOC) referrals which continued to impact on capacity, particularly in the diagnostic part of the pathway. Ms Groom explained that there had been a change to national guidance which removed some referral exemptions which had also contributed to the number of referrals received.</p> <p>She noted that the referrals received in July 2024 were 79.4% higher when compared against July 2019, with notable increases in urology and colorectal referrals, and the overall number of patients treated had grown by 6% from 2019 to date. Colorectal cancer had increased by 15% and Urology cancer had increased by 22%. She highlighted that the increase was in line with other Health Boards, that there was an ageing population as well as campaigns to detect cancer early which would be contributing to the increase.</p> <p>Ms Groom noted areas of focus for 31-day performance within Colorectal, Urology and Breast. There were actions being taken forward to improve the 62 Day performance within Breast, Cervical and Ovarian, Colorectal, Endoscopy, Head and Neck, Lung and Melanoma Cancers.</p> <p>Ms Groom reported that pressure from increased USOC referrals continued to be a challenge, particularly in matching diagnostic capacity to demand. She highlighted that the action taken to date had resulted in an upward trend in the 31 day and 62-day performance. She highlighted that the GP referral pathways and templates remain under review, along with benchmarking work and ensuring we continue to learn from best practice nationally.</p>	

		ACTION BY
	<p>The Committee discussed the effects of repeated treatment, e.g. bladder cancer, and were assured that resection rates were considered within the figures.</p> <p>With regards to transnasal endoscopy service expansion, Dr Davidson advised that this had increased to 5 sessions and work was underway with Gastroenterology to identify patients.</p> <p>The Committee noted the update provided.</p> <p><u>NOTED</u></p>	
52.	Acute Nursing and Midwifery Update	
	<p>The Committee considered the circulated presentation Acute Nursing and Midwifery Update presented by Ms Morag Gardener for assurance.</p> <p>Ms Gardner assured the Committee that the nursing workforce was becoming increasingly stable, however, pressure remained within Acute Band 5 establishment which was sitting at 89.0%.</p> <p>Ms Gardner provided an overview of the actions that had been taken to develop the workforce, including recruitment campaigns, training and development, International Nurses recruitment and support and Newly Qualified Practitioners (NQP) Recruitment Campaigns.</p> <p>Ms Gardner reported that 2023/24 had seen a successful NQP recruitment campaign, with a high number of offers of employment issued. She reported that support continued to be provided to internationally educated Nurses, with establishment of International Nurse Recruitment multi-professional oversight group.</p> <p>The Committee noted that the trainee Assistant Practitioner campaign for 2024/25 was underway with Glasgow Clyde College and Glasgow Kelvin College confirming training days.</p> <p>Ms Gardner provided an update on the quality measures, confirming that there was an improvement in quality data. Patient Experience and feedback continued to be closely monitored and remained a central focus for teams at all levels.</p> <p>Ms Gardner provided a brief overview of the HIS Inspection Reports on the work being undertaken at Queen Elizabeth University Hospital, Royal Alexandra Hospital and Glasgow Royal</p>	

			ACTION BY
	<p>Infirmary. Ms Gardner also reported on the progress of the requirements raised for each site, noting that the 5 requirements raised for the QEUH had been completed. The Committee noted that engagement with public partners was arranged through the Public Engagement Team.</p> <p>In response to a question regarding the media reporting of nursing vacancies within NHSGGC, Ms Gardner explained that all vacant posts had been advertised but if a NQN had been offered more than one post they had the option to choose employment with another Health Board.</p> <p>The Committee noted the update provided.</p> <p><u>NOTED</u></p>		
53.	Extract from Corporate Risk Register		
	<p>The Committee considered the paper [ASC Corporate Risk Register - Paper No. 24/14] presented by Ms Katrina Heenan for approval.</p> <p>The risk scores for two risks relating to Acute Services around In Patient/Day Case Treatment Time Guarantee and Outpatients Scheduled Care Waiting Time Targets, had been rescored and reduced from 16 to 15. No changes were proposed for the risk in relation to Unscheduled Care, however significant work was ongoing to review the risk.</p> <p>The Committee were content to approve the Corporate Risk Register.</p> <p><u>APPROVED</u></p>		
54.	Annual Cycle of Business		
	<p>The Committee considered the paper [Annual Cycle of Business - Paper No. 24/15] presented by Ms Kim Donald for approval.</p> <p>Ms Donald highlighted that Patient Experience Reports were previously on the cycle of business, however, following the development of the Assurance Information Framework and the updated Scheme of Delegation this would now be delegated to Clinical and Care Governance Committee.</p>		

			ACTION BY
	<p>The Annual Cycle of Business would continue to be reviewed at agenda setting meetings to ensure a stable process of assurance across the work of the Committee.</p> <p>The Committee were content to approve the Annual Cycle of Business.</p> <p><u>APPROVED</u></p>		
55.	Closing Remarks and Key Messages for the Board		
	<p>The Chair provided an overview of the discussion which took place in today's Acute Services Committee meeting.</p> <p>The Chair thanked the committee for welcoming him as the new chair and for their attendance.</p> <p><u>NOTED</u></p>		
56.	Date and Time of Next Scheduled Meeting		
	The next meeting would be held on Tuesday, 12 November 2024 at 9.30am via Microsoft Teams.		

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NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Acute Services Committee held on Tuesday 12 November 2024 at 9.30 am via Microsoft Teams

PRESENT

Mr David Gould (in the Chair)

Cllr Chris Cunningham	Mr Colin Neil
Ms Jane Grant	Dr Lesley Rousselet
Mr Graham Haddock OBE	Dr Lesley Thomson KC
Dr Becky Metcalfe	Cllr Colette McDiarmid

IN ATTENDANCE

Ms Sandra Bustillo	Director of Communications and Public Engagement
Ms Jacqueline Carrigan	Assistant Director of Finance Acute/Access
Ms Kim Donald	Corporate Services Manager, Governance
Ms Gillian Duncan	Corporate Executive Business Manager (minutes)
Mr William Edwards	Chief Operating Officer, Acute Services
Ms Morag Gardner	Deputy Nurse Director, Acute Services
Ms Susan Groom	Director of Regional Services
Dr Claire Harrow	Deputy Medical Director, Acute
Ms Katrina Heenan	Chief Risk Officer
Ms Claire MacDonald	Business Manager, Acute Division
Ms Anne MacPherson	Director of Human Resources and Organisational Development
Ms Susan McFadyen	Director of Access
Professor Kevin Rooney	Clinical Lead in Organ Donation
Ms Natalie Smith	Depute Director of Human Resources
Professor Angela Wallace	Nurse Director
Mr Scott Wilson	Senior Business and Delivery Manager, Chief Executive's Office

		ACTION BY
57.	Welcome and Apologies	
	The Chair welcomed those present to the November meeting of the Acute Services Committee.	
	There were no apologies noted.	
	NOTED	

		ACTION BY
58.	Declaration(s) of Interest(s)	
	<p>The Chair invited members to declare any interests in any of the matters being discussed.</p> <p>The Chair advised that in relation to Item 10 – Organ Donation Update, he was also Chair of the Organ Donation and Transplantation Committee. No further interests were declared.</p> <p><u>NOTED</u></p>	
59.	Minutes of Previous Meeting	
	<p>The Committee considered the minute of the previous meeting held on Tuesday 10 September 2024, and were content to approve the minute as a complete and accurate record.</p> <p><u>APPROVED</u></p>	
60.	Matters Arising	
	<p>a) <u>Rolling Action List</u></p> <p>The Committee noted that there had been no actions from the previous meeting on 10 September 2024.</p> <p><u>NOTED</u></p>	
61.	Urgent Items of Business	
	<p>There were no urgent items of business.</p> <p><u>NOTED</u></p>	
62.	Acute Update	
	<p>Mr William Edwards, Chief Operating Officer, Acute Services, provided a verbal update for assurance.</p> <p>Mr Edwards reported that Healthcare Improvement Scotland (HIS) had advised that the timescales for the outcome of the ED review had changed and it was now anticipated that the report would be published in March 2025. He said that engagement continued across the sites as part of the programme of work and HIS had noted their appreciation to staff for their proactive contribution.</p>	

		ACTION BY
	<p>The Committee were content to note the update.</p> <p><u>NOTED</u></p>	
63.	Acute Services Integrated Performance Report	
	<p>The Committee considered the Acute Services Integrated Performance Report [Paper No. 24/16] presented by Mr Colin Neil, Director of Finance, for assurance.</p> <p>Mr Neil said that that activity delivered for new outpatients, TTG and imaging had all exceeded the planned position agreed with the Scottish Government for the first six months of the financial year. ED 4 hour waits compliance had marginally increased on the previous month's position at 72.5%, however, this remained an area of ongoing pressure and provisional data for week ending 3 November 2024 was showing a decrease in compliance at 68.8%.</p> <p>New outpatients waiting over 52 weeks and 78 weeks remained above the planned position and the number of inpatients/daycases waiting more than 52 weeks had increased marginally and was above the planned position. The cancer 31 day target had reported a marginal decrease on the previous month's position at 92.9% which was below the national target of 95%. There had been a slight improvement in relation to 62 day cancer target to 63.1% but overall performance remained challenging due to the significant increase in Urgent Suspicion of Cancer (USOC) referrals since the pandemic. Overall sickness absence was at 6.7% which was a marginal improvement on the previous month but this remained above the local 5% target and continued to be an area of focus.</p> <p>In response to a query about USOC, Ms Groom provided further details on the contact with NHS Lanarkshire to understand their delivery models and pathways and said that they had been very helpful in sharing their approach and data. She also confirmed that despite recent media coverage on prostate cancer there was no increase in prostate referrals into secondary care being seen nationally at the moment.</p> <p>There was a query about whether it would be possible for the Committee to receive further data and information on some specific areas of concern, including those patients waiting over 100 weeks and data on the distribution of the number of days that individuals were missing targets by. In terms of the 100 day pathway, Mr Edwards provided assurance that there</p>	

		ACTION BY
	<p>was regular contact with patients on the longest waiting pathway who were continually monitored and their progress tracked.</p> <p>In response to a query about whether there were any particular areas where sickness absence was a concern, Mrs MacPherson said that work was underway with Directors and the Heads of HR in all areas identified as “hotspots” and there was discussion on this at the Acute Senior Management Group. Mrs MacPherson said that this sickness absence had been increased into a risk which would ensure there was a focus across the Board.</p> <p>The Chair thanked Mr Neil for the update and noted that it was important to recognise the positive achievements and not just focus on the areas of challenge.</p> <p>The Committee were content to note the update.</p> <p><u>NOTED</u></p>	
64.	Financial Monitoring Report	
	<p>The Committee considered the Financial Monitoring Report [Paper No. 24/17] presented by Mr Colin Neil, Director of Finance, for awareness.</p> <p>Mr Neil said that at the end of September 2024, the acute services finance ledger was reporting a deficit of [REDACTED]. Of this, unachieved savings accounted for [REDACTED] with pay at [REDACTED] and non-pay at [REDACTED] over budget. Pay spend was predominantly on medical salaries and Mr Neil said that it was important to recognise that nursing pay costs had show a significant level of progress from the previous report. He said that prescribing and surgical sundries were the predominant factors in the non pay overspend. He said that senior medical spend was close to break even and some further work had been identified to achieve that. There was a workstream looking specifically at Junior Doctors. Overall, Mr Neil said that there would need to be further improvement over the second half of the year to ensure breakeven.</p> <p>In response to a query regarding the savings plan and potential impact on service delivery, Mrs MacPherson said that there were reviews underway and there was a robust process and risk assessment element in place for each vacancy. Mrs Grant said that the Scottish Government had asked Boards to review their staffing numbers now compared with 2019. Mr Neil said it was important to ensure that the</p>	

		ACTION BY
	<p>Board would breakeven while ensuring a balance between service delivery and savings.</p> <p>Mr Gould thanked Mr Neil for the overview and noted the significant work that was ongoing.</p> <p>The Committee were content to note the update.</p> <p><u>NOTED</u></p>	
65.	Junior Doctor Workforce/Educational Review	
	<p>The Committee considered the Junior Doctor Workforce/ Educational Review [Paper 24/18] presented by Dr Claire Harrow, Deputy Medical Director, Acute Services, for assurance.</p> <p>Dr Harrow introduced the key themes from the report which provided an update on the quality of the training and education experience of medical staff, working closely with services and NES and ensuring that this adhered to standards set by the GMC and the Deanery. She said that resident doctors and clinical fellows accounted for around 40% of NHSGGC staff therefore training and education was an essential core function. The paper set out the activities over the last year. Dr Harrow said that one site in NHSGGC, QEUH medicine, remained on enhanced monitoring but year on year improvement had been noted by NES. She said that it was positive that four sites had been removed from Deanery recurrent visit processes in the last year as there had been satisfactory progress recorded. There was regular feedback to the Acute Clinical Governance Forum on this work.</p> <p>Dr Harrow also highlighted the ongoing Medical Education workstreams and the work of the DME team who had worked with NES to devise an enhanced leadership programme for selected Chief Residents. She also said that there was an active Medical Wellbeing group who had a range of positive initiatives.</p> <p>In response to a query about ensuring concerns were raised and responded to appropriately, Dr Harrow confirmed that the whistleblowing policy was regularly circulated and promoted. She said that colleagues were also encouraged to use DATIX as a means for raising concerns although she appreciated that this was not anonymous.</p>	

		ACTION BY
	<p>Dr Harrow said that there was continued dialogue around the work towards removing enhanced monitoring as a priority and provided reassurance that senior staff were sighted on this. Mr Edwards said that work was ongoing around the common themes raised around the QEUH and there was also ongoing engagement and communication.</p> <p>Mrs MacPherson also provided assurance that there were regular reports to the Staff Governance Committee. She said there were now 637 peer supporters across the sites who staff could speak to in confidence and there were Junior Doctor representatives on the medical wellbeing group. Dr Harrow said that this was a rolling programme of work as there were always new doctors coming into the organisation. In terms of retention and recruitment, Mrs MacPherson said that NHSGGC had good levels of Junior Doctors and Clinical Fellows as well as an active medical bank.</p> <p>The Committee were content to note the update.</p> <p><u>NOTED</u></p>	
66.	Organ Donation Update	
	<p>The Committee considered Organ Donation Update [Paper No. 24/19] presented by Professor Kevin Rooney, Clinical Lead in Organ Donation, for assurance.</p> <p>Professor Rooney set out the figures for donation in 2023/24 noting that these had returned to pre-pandemic levels. However, he said that NHSGGC, in line with the rest of Scotland, was below average in terms of family support rates and actions continued to be taken to improve this. Professor Rooney said that BAME donation was a key focus as this group were more likely to need transplants but less likely to find suitable donors. He said that this was a challenge for the whole of the UK and set out the work that had been undertaken locally to address this, including faith and community engagement.</p> <p>Professor Rooney said that better communication and raising awareness of organ and tissue donation was key in improving donor numbers and discussed the various initiatives that were underway, including work with the realistic medicine team and discussion at the recent regional collaborative about using the 2026 Commonwealth Games in Glasgow as a platform to create a legacy of increased donors on the register. The Committee Chair agreed that one of the challenges was promoting awareness and it was agreed that Ms Bustillo</p>	

		ACTION BY
	<p>would ask the communications team to link in with Professor Rooney to discuss what further support and advice they could provide.</p> <p>Mr Gould thanked Professor Rooney for the engaging and thought-provoking presentation.</p> <p>The Committee were content to note the update.</p> <p><u>NOTED</u></p>	Ms Bustillo
67.	Extract from Corporate Risk Register	
	<p>The Committee considered the Corporate Risk Register [Paper No. 24/20] presented by Ms Katrina Heenan, Chief Risk Officer, for approval.</p> <p>Ms Heenan said that there were three risks assigned to the Committee and confirmed that 100% of these risks had been reviewed since the previous meeting with no changes to the risk scores proposed. She said that the Unscheduled Care review had now been completed and would be presented to the Corporate Management Team for approval followed by the next meeting of the Committee. Full details of all risks and actions were set out in the appendix.</p> <p>The Committee were content to approve the Corporate Risk Register.</p> <p><u>APPROVED</u></p>	
68.	Closing Remarks and Key Messages for the Board	
	<p>The Chair provided an overview of the discussion which took place in today's Acute Services Committee meeting. The Chair thanked the Committee for their attendance and closed the meeting.</p> <p><u>NOTED</u></p>	
69.	Date and Time of Next Scheduled Meeting	
	The next meeting would be held on Tuesday 14 January 2025 at 9.30 am via Microsoft Teams.	



SCOTTISH HOSPITALS INQUIRY

Bundle of documents for Oral hearings commencing from 13 May 2025 in relation to the
Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow
Bundle 36 – Acute Services Committee Minutes and Relevant Papers